MEDI-CAL
NOVEMBER 2023
LOCAL ASSISTANCE ESTIMATE
for
FISCAL YEARS
2023-24 *and* 2024-25

The Great Seal

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

MEDI-CAL
NOVEMBER 2023
LOCAL ASSISTANCE ESTIMATE
for
FISCAL YEARS
2023-24 and 2024-25

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

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CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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Michelle Baass
Director
Department of Health Care Services

NOVEMBER 2023 MEDI-CAL ESTIMATE

TABLE OF CONTENTS

The November 2023 Medi-Cal Local Assistance Estimate is organized into several sections, listed below.

COUNTY ADMINISTRATION

The County Administration section provides a detailed overview of estimated expenditures for counties to determine Medi-Cal eligibility for both current and budget years.

OTHER ADMINISTRATION

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

ADDITIONAL INFORMATION

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

November 2023 Medi-Cal Estimate
Alphabetic List of Policy Changes

PC Number	PC Name	Estimate Section	Page
16	1% FMAP INCREASE FOR PREVENTIVE SERVICES	Regular PC	42
90	2023 MCO ENROLLMENT TAX MANAGED CARE PLANS	Regular PC	210
89	2023 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	Regular PC	208
66	2023 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	Regular PC	177
103	AB 97 ELIMINATIONS	Regular PC	244
185	ABORTION SUPPLEMENTAL PAYMENT PROGRAM	Regular PC	473
18	ACA DSH REDUCTION	Regular PC	47
15	ACTUARIAL COSTS FOR RATE DEVELOPMENT	Other Admin	66
108	ACUPUNCTURE RATE INCREASE	Regular PC	265
152	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	Regular PC	409
219	ADVISORY COUNCIL ON PHYS. FIT. & MENTAL WELL-BEING	Regular PC	542
82	AIDS HEALTHCARE CENTERS (OTHER M/C)	Base PC	65
220	ASSET LIMIT INCREASE & ELIM. - CNTY BH FUNDING	Regular PC	544
171	ASSISTED LIVING WAIVER EXPANSION	Regular PC	443
204	AUDIT SETTLEMENTS	Regular PC	508
217	BASE RECOVERIES	Base PC	101
36	BCCTP DRUG REBATES	Regular PC	105
159	BEHAVIORAL HEALTH BRIDGE HOUSING	Regular PC	415
49	BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE	Regular PC	133
23	BEHAVIORAL HEALTH TREATMENT	Regular PC	67
4	BREAST AND CERVICAL CANCER TREATMENT	Regular PC	14
54	CALAIM - BH - CONNECT DEMONSTRATION	Regular PC	150
57	CALAIM - BH - CONNECT DEMONSTRATION ADMIN	Other Admin	155
162	CALAIM - BH PAYMENT REFORM	Regular PC	420
51	CALAIM - BH QUALITY IMPROVEMENT PROGRAM	Regular PC	142
212	CALAIM - DENTAL INITIATIVES	Regular PC	529
7	CALAIM - INMATE PRE-RELEASE PROGRAM	Regular PC	21
38	CALAIM - INMATE PRE-RELEASE PROGRAM ADMIN	Other Admin	118
56	CALAIM - JUSTICE INVOLVED MAA	Other Admin	153
32	CALAIM - LTC BENEFIT TRANSITION	Regular PC	93
1	CALAIM - PATH	Other Admin	23
179	CALAIM - PATH FOR CLINICS	Regular PC	461
169	CALAIM - PATH WPC	Regular PC	438
11	CALAIM - POPULATION HEALTH MANAGEMENT	Other Admin	55
60	CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES	Regular PC	168
30	CALAIM MLTSS & D-SNP INTEGRATION ACTIVITIES	Other Admin	101
77	CALHEERS DEVELOPMENT	Other Admin	211
88	CALHHS AGENCY HIPAA FUNDING	Other Admin	235
175	CALHOPE	Regular PC	453
22	CALIFORNIA COMMUNITY TRANSITIONS COSTS	Regular PC	62
46	CALIFORNIA HEALTH INTERVIEW SURVEY	Other Admin	134
86	CALIFORNIA SMOKERS' HELPLINE	Other Admin	231
4	CALWORKS APPLICATIONS	County Admin	15
129	CAPITAL PROJECT DEBT REIMBURSEMENT	Regular PC	338
87	CAPITATED RATE ADJUSTMENT FOR FY 2024-25	Regular PC	204
21	CAPMAN	Other Admin	81
180	CARE ACT	Regular PC	463

November 2023 Medi-Cal Estimate
Alphabetic List of Policy Changes

November 2023 Medi-Cal Estimate
Alphabetic List of Policy Changes

November 2023 Medi-Cal Estimate
Alphabetic List of Policy Changes

PC Number	PC Name	Estimate Section	Page
106	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	Regular PC	258
112	GDSP PRENATAL SCREENING PROGRAM FEE INCREASE	Regular PC	275
133	GEMT SUPPLEMENTAL PAYMENT PROGRAM	Regular PC	353
48	GENDER-AFFIRMING CARE	Other Admin	138
67	GEOGRAPHIC MANAGED CARE	Base PC	41
59	GLOBAL PAYMENT PROGRAM	Regular PC	163
118	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	Regular PC	297
99	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	Regular PC	234
20	HCBA WAIVER ADMINISTRATIVE COST	Other Admin	79
203	HCBS SP - ALW FUNDING SHIFT	Regular PC	506
196	HCBS SP - CALBRIDGE BH NAVIGATOR PROGRAM	Regular PC	495
43	HCBS SP - CONTINGENCY MANAGEMENT	Regular PC	122
37	HCBS SP - CONTINGENCY MANAGEMENT ADMIN	Other Admin	116
199	HCBS SP - ETSB FOR LAGUNA HONDA HOSPITAL RESIDENTS	Regular PC	501
73	HCBS SP - HOUSING AND HOMELESSNESS INCENTIVE PROG	Regular PC	189
193	HCBS SP - NON-IHSS CARE ECONOMY PMTS	Regular PC	487
158	HCBS SP CDDS	Regular PC	412
87	HCBS SP CDDS - OTHER ADMIN	Other Admin	233
69	HCO COST REIMBURSEMENT 2017 CONTRACT	Other Admin	190
71	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	Other Admin	194
70	HCO OPERATIONS 2017 CONTRACT	Other Admin	192
23	HEALTH ENROLLMENT NAVIGATORS	Other Admin	86
6	HEALTH ENROLLMENT NAVIGATORS FOR CLINICS	Regular PC	19
95	HEALTH FOR FOSTER CARE CHILDREN ADMIN COSTS	Other Admin	245
41	HEALTH INFORMATION EXCHANGE INTEROPERABILITY	Other Admin	124
81	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	Other Admin	221
54	HEALTH PLAN OF SAN MATEO DENTAL INTEGRATION EVAL	Other Admin	151
76	HEALTH-RELATED ACTIVITIES - CDSS	Other Admin	209
27	HEARING AID COVERAGE FOR CHILDREN PROGRAM	Regular PC	79
200	HIPP PREMIUM PAYOUTS (MISC. SVCS.)	Base PC	99
166	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER	Regular PC	430
155	HOME & COMMUNITY-BASED SVCS.-CDDS (MISC.)	Base PC	82
107	HOSPICE RATE INCREASES	Regular PC	261
189	HOSPITAL & SNF COVID-19 WORKER RETENTION PAYMENTS	Regular PC	479
123	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	Regular PC	317
15	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	Regular PC	40
17	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	Regular PC	45
209	HOSPITAL QAF - CHILDREN'S HEALTH CARE	Regular PC	521
116	HOSPITAL QAF - FFS PAYMENTS	Regular PC	288
115	HOSPITAL QAF - MANAGED CARE PAYMENTS	Regular PC	285
190	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	Regular PC	481
173	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	Regular PC	449
141	IGT ADMIN. & PROCESSING FEE	Regular PC	377
205	IMD ANCILLARY SERVICES	Regular PC	510
178	INDIAN HEALTH SERVICES	Regular PC	459
211	INDIAN HEALTH SERVICES FUNDING SHIFT	Regular PC	527
184	INFANT DEVELOPMENT PROGRAM	Regular PC	471

November 2023 Medi-Cal Estimate
Alphabetic List of Policy Changes

PC Number	PC Name	Estimate Section	Page
58	INTERIM AND FINAL COST SETTLEMENTS - SMHS	Regular PC	159
14	INTERIM AND FINAL COST SETTLEMENTS-SMHS	Other Admin	63
92	KIT FOR NEW PARENTS	Other Admin	242
170	LA COUNTY JUSTICE-INVOLVED POP. SVCS & SUPPORTS	Regular PC	441
29	LA COUNTY PUBLIC HEALTH NURSING PILOT	Other Admin	99
113	LABORATORY RATE METHODOLOGY CHANGE	Regular PC	279
177	LAWSUITS/CLAIMS	Base PC	91
35	LITIGATION SETTLEMENTS	Regular PC	103
19	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	Regular PC	52
110	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	Regular PC	269
6	LOS ANGELES COUNTY HOSPITAL INTAKES	County Admin	19
105	LTC RATE ADJUSTMENT	Regular PC	252
88	MANAGED CARE DISTRICT HOSPITAL DIRECTED PAYMENTS	Regular PC	206
79	MANAGED CARE DP-NF PASS-THROUGH PAYMENT PROGRAM	Regular PC	198
68	MANAGED CARE HEALTH CARE FINANCING PROGRAM	Regular PC	180
114	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	Regular PC	282
71	MANAGED CARE PUBLIC HOSPITAL EPP	Regular PC	186
91	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	Regular PC	212
125	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	Regular PC	323
78	MATERNAL AND CHILD HEALTH	Other Admin	215
49	MEDCOMPASS SOLUTION	Other Admin	140
62	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	Regular PC	173
84	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	Base PC	70
80	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	Base PC	62
12	MEDI-CAL COUNTY INMATE REIMBURSEMENT	Regular PC	32
34	MEDI-CAL DRUG REBATE FUND	Regular PC	99
44	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	Other Admin	130
62	MEDICAL FI BO & IT CHANGE ORDERS	Other Admin	170
60	MEDICAL FI BO & IT COST REIMBURSEMENT	Other Admin	163
67	MEDICAL FI BO HOURLY REIMBURSEMENT	Other Admin	186
68	MEDICAL FI BO MISCELLANEOUS EXPENSES	Other Admin	188
64	MEDICAL FI BO OTHER ESTIMATED COSTS	Other Admin	177
65	MEDICAL FI BO TELEPHONE SERVICE CENTER	Other Admin	181
66	MEDICAL FI BUSINESS OPERATIONS	Other Admin	183
61	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	Other Admin	168
63	MEDICAL FI IT INFRASTRUCTURE SERVICES	Other Admin	174
89	MEDI-CAL INPATIENT SERVICES FOR INMATES	Other Admin	237
25	MEDICAL INTERPRETER PILOT PROJECT	Regular PC	74
174	MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG	Regular PC	451
95	MEDI-CAL PROVIDER PAYMENT RESERVE FUND	Regular PC	222
97	MEDI-CAL PROVIDER RATE INCREASE	Regular PC	229
226	MEDI-CAL PROVIDER RATE INCREASE 2025	Regular PC	552
19	MEDI-CAL RECOVERY CONTRACTS	Other Admin	76
134	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	Regular PC	357
136	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	Regular PC	363
7	MEDI-CAL RX - ADMINISTRATIVE COSTS	Other Admin	44
3	MEDI-CAL STATE INMATE PROGRAMS	Regular PC	11

November 2023 Medi-Cal Estimate
Alphabetic List of Policy Changes

PC Number	PC Name	Estimate Section	Page
39	MEDICAL SUPPLY REBATES	Regular PC	114
187	MEDI-CAL TCM PROGRAM	Base PC	96
42	MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM	Other Admin	126
154	MEDICARE PAYMENTS - PART D PHASED-DOWN	Base PC	78
153	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	Base PC	75
33	MEDICATION THERAPY MANAGEMENT PROGRAM	Regular PC	96
93	MERIT SYSTEM SERVICES FOR COUNTIES	Other Admin	244
45	MFP/CCT SUPPLEMENTAL FUNDING	Other Admin	132
69	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	Regular PC	183
52	MHP COSTS FOR CONTINUUM OF CARE REFORM	Regular PC	144
50	MHP COSTS FOR FFPSA	Regular PC	136
9	MHSF - PROVIDER ACES TRAININGS	Other Admin	50
186	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	Regular PC	475
26	MITA	Other Admin	92
52	MMA - DSH ANNUAL INDEPENDENT AUDIT	Other Admin	145
21	MULTIPURPOSE SENIOR SERVICES PROGRAM	Regular PC	59
127	NDPH IGT SUPPLEMENTAL PAYMENTS	Regular PC	332
138	NDPH SUPPLEMENTAL PAYMENT	Regular PC	368
31	NEWBORN HEARING SCREENING PROGRAM	Other Admin	103
10	NON-EMERGENCY FUNDING ADJUSTMENT	Regular PC	28
128	NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS	Regular PC	335
9	NON-OTLICP CHIP	Regular PC	25
98	NURSING FACILITY RATE ADJUSTMENTS	Regular PC	231
13	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	Other Admin	59
53	OUT OF STATE YOUTH - SMHS	Regular PC	147
28	OUTREACH & ENROLLMENT ASSIST. FOR DUAL BENES	Other Admin	97
72	PACE (OTHER M/C)	Base PC	52
36	PACES	Other Admin	114
27	PASRR	Other Admin	95
22	PAVE SYSTEM	Other Admin	84
183	PEER SUPPORT SPECIALIST SERVICES	Regular PC	468
75	PERSONAL CARE SERVICES	Other Admin	207
156	PERSONAL CARE SERVICES (MISC. SVCS.)	Base PC	84
38	PHARMACY RETROACTIVE ADJUSTMENTS	Regular PC	111
145	PHARMACY-BASED COVID-19 TESTS	Regular PC	388
5	PHASING IN THE MEDI-CAL ASSET LIMIT REPEAL	Regular PC	17
96	PIA EYEWEAR COURIER SERVICE	Other Admin	247
18	POSTAGE & PRINTING	Other Admin	73
2	POSTPARTUM CARE EXTENSION	Regular PC	9
96	PP-GEMT IGT PROGRAM	Regular PC	225
119	PRIVATE HOSPITAL DSH REPLACEMENT	Regular PC	301
120	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	Regular PC	304
85	PROP 56 - BEHAVIORAL HEALTH INCENTIVE PROGRAM	Regular PC	202
130	PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS	Regular PC	343
93	PROP 56 - DIRECTED PAYMENT RISK MITIGATION	Regular PC	216
231	PROP 56 - FUNDING REDUCTION	Regular PC	554
121	PROP 56 - MEDI-CAL FAMILY PLANNING	Regular PC	309

November 2023 Medi-Cal Estimate
Alphabetic List of Policy Changes

PC Number	PC Name	Estimate Section	Page
117	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	Regular PC	292
194	PROP 56 - PROVIDER ACES TRAININGS	Regular PC	489
137	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	Regular PC	365
142	PROPOSITION 56 FUNDING	Regular PC	379
47	PROTECTION OF PHI DATA	Other Admin	136
39	PUBLIC HEALTH REGISTRIES SUPPORT	Other Admin	120
195	QAF WITHHOLD TRANSFER	Regular PC	491
164	QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES	Regular PC	425
139	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	Regular PC	372
94	RATE INCREASE FOR FQHCS/RHCS/CBRCS	Regular PC	219
111	REDUCTION TO RADIOLOGY RATES	Regular PC	272
8	REFUGEE MEDICAL ASSISTANCE	Regular PC	23
70	REGIONAL MODEL	Base PC	46
97	REPRODUCTIVE HEALTH ACCESS DEMO 1115 WAIVER	Other Admin	249
223	RESPIRATORY SYNCYTIAL VIRUS VACCINES	Regular PC	548
74	RETRO MC RATE ADJUSTMENTS	Regular PC	192
8	SAVE	County Admin	24
2	SAWS	County Admin	10
11	SCHIP FUNDING FOR PRENATAL CARE	Regular PC	30
5	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	Other Admin	39
35	SDMC SYSTEM M&O SUPPORT	Other Admin	112
176	SECTION 19.56 LEGISLATIVE PRIORITIES	Regular PC	456
165	SELF-DETERMINATION PROGRAM - CDDS	Regular PC	428
78	SENIOR CARE ACTION NETWORK (OTHER M/C)	Base PC	59
55	SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS	Regular PC	153
56	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	Regular PC	155
8	SMH MAA	Other Admin	48
47	SMHS FOR ADULTS	Base PC	19
48	SMHS FOR CHILDREN	Base PC	24
50	SSA COSTS FOR HEALTH COVERAGE INFO.	Other Admin	142
40	STATE SUPPLEMENTAL DRUG REBATES	Regular PC	116
132	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	Regular PC	350
151	STATE-ONLY CLAIMING ADJUSTMENTS - RETRO ADJ.	Regular PC	405
32	STATEWIDE VERIFICATION HUB	Other Admin	105
160	TARGETED CASE MGMT. SVCS. - CDDS (MISC. SVCS.)	Base PC	89
40	T-MSIS	Other Admin	122
64	TWO PLAN MODEL	Base PC	29
61	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	Regular PC	171
1	UNDOCUMENTED EXPANSION AGES 26 THROUGH 49	Regular PC	7
202	URBAN INDIAN ORGANIZATIONS FUNDING SHIFT	Regular PC	504
90	VETERANS BENEFITS	Other Admin	239
91	VITAL RECORDS	Other Admin	240
75	WORKFORCE & QUALITY INCENTIVE PROGRAM	Regular PC	194
198	WPCS WORKERS' COMPENSATION	Regular PC	499

NOVEMBER 2023 MEDI-CAL ESTIMATE
GUIDE TO KEY FEATURES OF REGULAR POLICY CHANGES

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

PROP 56 - DEVELOPMENTAL SCREENINGS

Typically, cash basis amount amount, after application of cash lags. (In some rare cases, an unlagged accrual amount is used.)

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

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

Permanent reference number, does not change each November.

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

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

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

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

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

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

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

Interdependent Policy Changes:
Proposition 56 Funds Transfer

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

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

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.

NOTE: FOR THE NOVEMBER 2023 ESTIMATE:

- CURRENT YEAR = FY 2023-24
- BUDGET YEAR = FY 2024-25
- APPROPRIATION = MAY 2023 ESTIMATE + BUDGET ACT CHANGES, FY 2023-24

November 2023 Medi-Cal Estimate

Current Year (FY 2023-24) Projected Expenditures Compared to the Appropriation

(Dollars in Millions)

Medical Care Services	FY 2023-24 Appropriation	Nov 2023 Estimate	Change	
			Amount	Percent
Total Funds	$144,616.9	$150,102.5	$5,485.6	3.8%
Federal Funds	$85,287.4	$90,205.4	$4,918.0	5.8%
General Fund	**$35,686.4**	**$35,625.7**	**($60.7)**	**-0.2%**
Other Non-Federal Funds	$23,643.1	$24,271.4	$628.3	2.7%

County Administration	FY 2023-24 Appropriation	Nov 2023 Estimate	Change	
			Amount	Percent
Total Funds	$6,617.2	$6,813.0	$195.8	3.0%
Federal Funds	$4,758.8	$5,127.4	$368.6	7.7%
General Fund	**$1,683.2**	**$1,547.9**	**($135.3)**	**-8.0%**
Other Non-Federal Funds	$175.2	$137.7	($37.5)	-21.4%

Fiscal Intermediary	FY 2023-24 Appropriation	Nov 2023 Estimate	Change	
			Amount	Percent
Total Funds	$589.9	$576.3	($13.6)	-2.3%
Federal Funds	$432.8	$418.9	($13.9)	-3.2%
General Fund	**$157.1**	**$157.4**	**$0.3**	**0.2%**
Other Non-Federal Funds	$0.0	$0.0	$0.0	n/a

Total Expenditures	FY 2023-24 Appropriation	Nov 2023 Estimate	Change	
			Amount	Percent
Total Funds	$151,824.0	$157,491.9	$5,667.9	3.7%
Federal Funds	$90,479.0	$95,751.7	$5,272.7	5.8%
General Fund	**$37,526.6**	**$37,331.0**	**($195.6)**	**-0.5%**
Other Non-Federal Funds	$23,818.3	$24,409.1	$590.8	2.5%

Note: Totals may not add due to rounding.

November 2023 Medi-Cal Estimate

Budget Year (FY 2024-25) Projected Expenditures Compared to Current Year (FY 2023-24)

(Dollars in Millions)

Medical Care Services	FY 2023-24 Estimate	FY 2024-25 Estimate	Change	
			Amount	Percent
Total Funds	$150,102.5	$149,761.8	($340.7)	-0.2%
Federal Funds	$90,205.4	$92,313.5	$2,108.1	2.3%
General Fund	**$35,625.7**	**$34,348.8**	**($1,276.9)**	**-3.6%**
Other Non-Federal Funds	$24,271.4	$23,099.5	($1,171.9)	-4.8%

County Administration	FY 2023-24 Estimate	FY 2024-25 Estimate	Change	
			Amount	Percent
Total Funds	$6,813.0	$6,329.0	($484.0)	-7.1%
Federal Funds	$5,127.4	$4,859.3	($268.1)	-5.2%
General Fund	**$1,547.9**	**$1,400.4**	**($147.5)**	**-9.5%**
Other Non-Federal Funds	$137.7	$69.3	($68.4)	-49.7%

Fiscal Intermediary	FY 2023-24 Estimate	FY 2024-25 Estimate	Change	
			Amount	Percent
Total Funds	$576.3	$547.40	($28.9)	-5.0%
Federal Funds	$418.9	$383.4	($35.5)	-8.5%
General Fund	**$157.4**	**$164.0**	**$6.6**	**4.2%**
Other Non-Federal Funds	$0.0	$0.0	$0.0	$0.0

Total Expenditures	FY 2023-24 Estimate	FY 2024-25 Estimate	Change	
			Amount	Percent
Total Funds	$157,491.9	$156,638.2	($853.7)	-0.5%
Federal Funds	$95,751.7	$97,556.2	$1,804.4	1.9%
General Fund	**$37,331.0**	**$35,913.2**	**($1,417.8)**	**-3.8%**
Other Non-Federal Funds	$24,409.1	$23,168.8	($1,240.3)	-5.1%

Note: Totals may not add due to rounding.

Medi-Cal Local Assistance Estimate

Management Summary

November 2023

This document is intended to provide a high-level overview of the November 2023 Medi-Cal Local Assistance Estimate (Estimate).

The Department of Health Care Services (DHCS) estimates Medi-Cal spending to be $157.5 billion total funds ($37.3 billion General Fund) in Fiscal Year (FY) 2023-24 and $156.6 billion total funds ($35.9 billion General Fund) in FY 2024-25. This does not include Certified Public Expenditures of local governments or General Fund expenditures in other state departments.

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

- Overview of Major New Items
- Summary of Estimate Totals
- Major Drivers of Changes in General Fund Spending
- Caseload Projections
- Reference Information

Overview of Major Items

This section summarizes major new proposals in the Governor's Budget that affect spending in Medi-Cal.

- ***Full-Scope Adult Expansion.*** The Governor's Budget includes $1.4 billion total funds ($1.2 billion General Fund) in FY 2023-24 and $3.4 billion total funds ($2.9 billion General Fund) in FY 2024-25 to maintain the expansion of full-scope Medi-Cal coverage to all adults regardless of immigration status effective January 1, 2024. Of these amounts, $1.4 billion total funds ($1.2 billion General Fund) in FY 2023-24 and $3.3 billion total funds ($2.9 billion General Fund) in FY 2024-25 are included in the Medi-Cal Estimate. Remaining estimated costs are for In-Home Supportive Services (IHSS) and are budgeted in the California Department of Social Services budget.

- ***Managed Care Organization (MCO) Tax and Provider Rate Increases.*** In December 2023, the federal government approved California's Managed Care Organization Provider Tax (MCO Tax) effective April 1, 2023, through December 31, 2026. Given the projected budget shortfall, the Administration is seeking early action by the Legislature to request the federal government approve an amendment to increase the tax to achieve $20.9 billion in total funding to the state, an increase of $1.5 billion compared to the approved MCO Tax. The Budget proposes $12.9 billion to support the Medi-Cal program and maintain a balanced budget, and $8 billion for targeted rate increases and investments. As proposed, the MCO Tax helps maintain existing services in the Medi-Cal program and minimizes the need for reductions in the program. The Budget proposes $2.8 billion ($1.2 billion Medi-Cal Provider Payment Reserve Fund) in 2024-25 and approximately $6.5 billion ($2.7 billion Medi-Cal Provider Payment Reserve Fund) in 2025-26 for targeted rate increases and investments consistent with the 2023 Budget Act, of which $727 million ($291 million Medi-Cal Provider Payment Reserve Fund) annually is for rate increases effective January 1, 2024.

- ***Asset Limit Elimination.*** The Governor's Budget includes $101.1 million total funds ($50.5 million General Fund) in FY 2023-24 and $195.4 million total funds ($97.7 million General Fund) in FY 2024-25 for the previously implemented increase, and January 1, 2024 elimination, of the Medi-Cal asset limit. The Budget also includes $6.1 million in FY 2024-25 to reimburse county behavioral health departments for estimated increased behavioral health costs related to this policy.

- ***Children and Youth Behavioral Health Initiative (CYBHI) Wellness Coach Benefit.*** The Governor's Budget proposes to establish the wellness coach benefit in Medi-Cal, effective January 1, 2025, in accordance with the build out of the CYBHI plan. Wellness coaches will primarily serve children and youth and operate as part of

a care team, including in school-linked settings; however, wellness coaches could be deployed across the Medi-Cal behavioral health delivery system. Wellness Coaches will offer six core services, including:1) wellness promotion and education; 2) screening; 3) care coordination; 4) individual support; 5) group support; and 6) crisis referral. Implementation is expected to phase-in over several years with estimated costs of $9.5 million total funds ($4.1 million General Fund) starting in FY 2024-25.

- ***Assisted Living Waiver (ALW) Slot Increase.*** The Budget includes an additional $2.1 million total funds (-$0.5 million General Fund) in FY 2023-24 (after accounting for HCBS Spending Plan funds, captured in the HCBS SP – ALW Funding shift policy change (PC), covering a portion of the General Fund cost) and -$14.1 million total funds (-$7 million General Fund) in FY 2024-25 to increase the number of slots for the ALW as the waiver will reach capacity in FY 2024-25. This change would increase enrollment into the ALW, generating additional Waiver costs. However, to the extent that new enrollment is from individuals leaving institutional settings, there would be offsetting savings in future years. Additionally, this proposal would result in new costs of $84,000 total funds ($42,000 General Fund) in FY 2023-24 and $2.1 million totals funds ($1 million General Fund) in FY 2024-25 related to minimum wage impacts for ALW providers.

- ***Home and Community-Based Alternatives (HCBA) Waiver Slot Increase.*** The Budget assumes an increase in slot allocations for the HCBA Waiver. As some members will be transitioning from Skilled Nursing Facilities, a savings of $1.7 million total funds ($866,000 General Fund) in FY 2023-24 and $12.9 million total funds ($6.4 million General Fund) in FY 2024-25 are estimated to be realized. Additionally, there would be an increase in administrative costs of $335,000 total funds ($167,000 General Fund) in FY 2023-24 and $3.3 million total funds ($1.6 million General Fund) in FY 2024-25.

- ***Reproductive Health Access Demonstration 1115 Waiver.*** The Budget includes $200 million total funds ($100 million General Fund) in FY 2024-25 to provide funding for the California's Reproductive Health Access Demonstration (CalRHAD). By FY 2026-27, $85 million of the General Fund cost will be offset by the Designated State Health Programs (DSHP) federal funding stream. CalRHAD is pending CMS approval with program operations to begin no sooner than July 1, 2024. CalRHAD will promote the following objectives:

    - Support access to whole-person sexual and reproductive health services for Medi-Cal enrollees, as well as other individuals who may face barriers to access.

- Support the capacity and sustainability of California's reproductive-health provider safety net.

- Promote system transformation for California's sexual and reproductive health safety net.

- ***Respiratory Syncytial Virus (RSV) Vaccine Impacts.*** The federal Food and Drug Administration (FDA) and the Centers for Disease Control and Prevention (CDC) approved two RSV vaccines and one injectable drug to protect against RSV. The vaccines are targeted to older adult sand pregnant individuals. Healthy children have the option of the injectable drug. The RSV vaccines and injectable drugs were available starting in October 2023, and costs are estimated to be $138.7 million total funds ($61.4 million General Fund) in FY 2023-24 and $215.8 million total fund ($95.5 million General Fund in FY 2024-25.

- ***Updated Timeline for Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment* (*BH-CONNECT) Implementation.*** Based on timelines to submit federal waiver applications, the BH-CONNECT demonstration is now anticipated to begin January 1, 2025. As a result, costs previously estimated for FY 2023-24 have shifted to FY 2024-25. The DHCS budget includes $40.6 million total funds ($762,000 General Fund) in FY 2024-25 for BH-CONNECT.

- ***Caseload Impacts of Redeterminations.*** Following the end of the COVID-19 public health emergency continuous enrollment requirement, the Medi-Cal caseload peaked in June 2023 and began declining in July 2023, consistent with the resumption of eligibility redeterminations. Redeterminations are estimated to reduce Medi-Cal spending by $3.1 billion total funds ($1.2 billion General Fund) in FY 2023-24.

- ***Budget Solutions.*** The Governor's Budget includes some adjustments to reduce General Fund costs in light of the state's overall General Fund condition:

    - ***Withdrawal from Safety Net Reserve.*** The Governor's Budget assumes the withdrawal of $900 million from the Safety Net Reserve in FY 2024-25, to maintain existing program benefits and services for the Medi-Cal and CalWORKs program. Note: The Safety Net Reserve is not budgeted in the Medi-Cal Estimate.

    - ***Proposition 56 Funding Reduction.*** Due to declining Proposition 56 revenues and the overall condition of the state budget, the Governor's Budget reduces funding for Proposition 56 supplemental payments for physician services by $193.4 million ($77.1 million Proposition 56 funding).

- ***Delay Behavioral Health Continuum Infrastructure Program (BHCIP) Payments.*** The Governor's Budget assumes that $140.4 million General Fund associated with Round 6 in the BHCIP program is delayed from 2024-25 to 2025-26.

- ***Delay Behavioral Health Bridge Housing (BHBH) Payments.*** The Governor's Budget delays $265 million from the Mental Health Services Fund (MHSF) in FY 2023-24 to 2024-25 and replaces it with General Fund, addressing a reduction in the amount of MHSF projected to be available. Additionally, the Budget delays the remaining $235 million General Fund appropriation originally intended for 2024-25 to 2025-26.

- ***Reduce Medi-Cal Drug Rebate Fund Reserves.*** Typically, the Department targets a reserve of approximately $220 million in the Medi-Cal Drug Rebate Fund in order to cushion against volatility in drug rebate collections that otherwise would be deposited in the General Fund. The Governor's Budget allows the full amount of projected drug rebate collections to flow to the General Fund, instead of maintaining rebate transfers at 2023 Budget Act levels in 2023-24 and targeting a $220 million reserve in 2024-25. This results in General Fund savings of $135.1 million in 2023-24 and $27.6 million in 2024-25.

- ***Withdraw Buy-Back of Two-Week Checkwrite Hold.*** The 2023 Budget Act deferred until 2024-25 the planned buy-back of an existing two-week hold on fee-for-service Medi-Cal payments each June until the following fiscal year. The Governor's Budge withdraws the proposed buy-back, resulting in an estimated General Fund savings of $532.5 million in 2024-25.

- ***Forego Transfer of Remaining Clinic Workforce Stabilization Retention Payment Funding to Department of Health Care Access and Information (HCAI).*** The Budget Act of 2022 provided $70 million for these payments, with any unspent funds to be transferred to HCAI for workforce purposes. The Governor's Budget foregoes the transfer of an estimated $14.9 million in unspent funds.

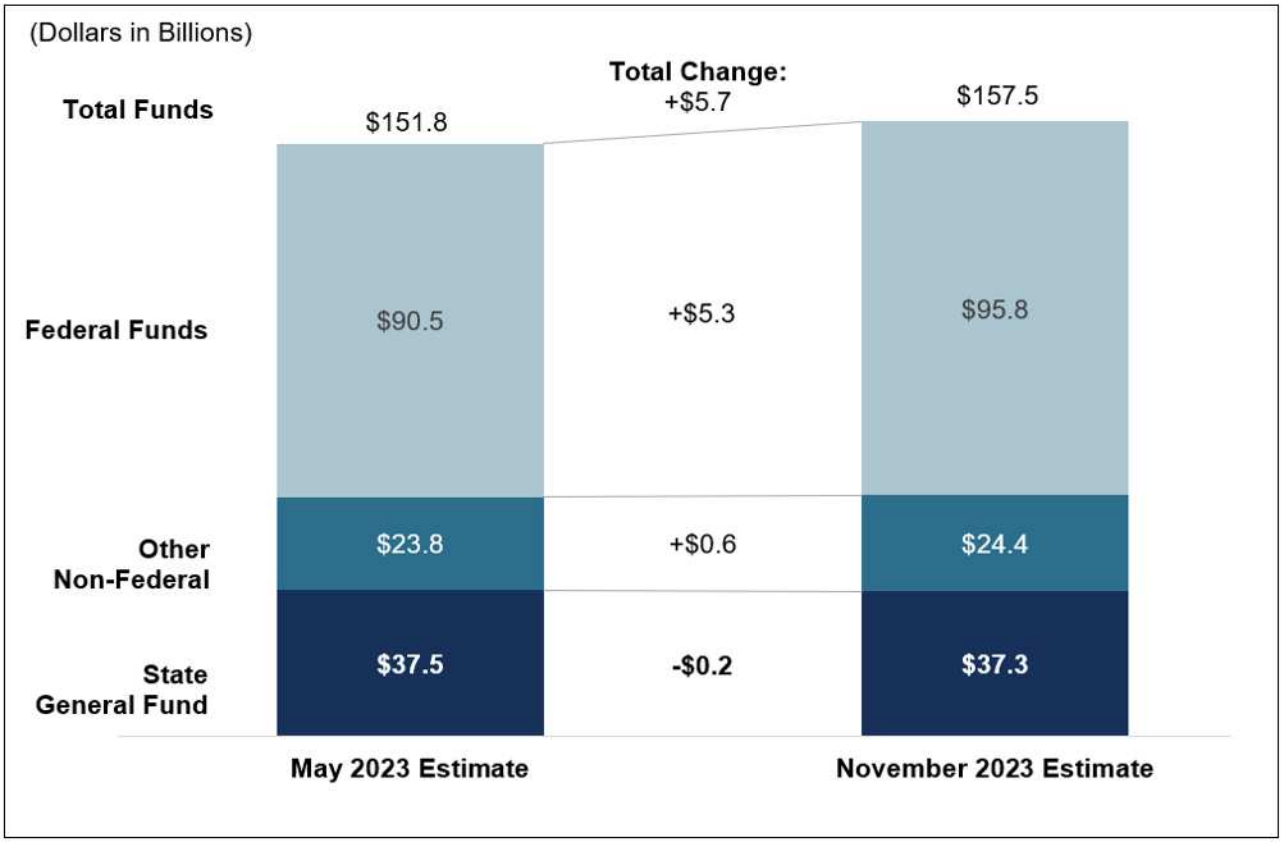
- ***Defer Chaptered Legislation Local Assistance Impact.*** The Governor's Budget defers the consideration of resource requests associated with recently chaptered legislation to the May Revision, including: AB 425 (Chapter 329, Statutes of 2023) related to pharmacogenomic testing; AB 1163 (Chapter 832, Statutes of 2023) related to lesbian, gay, bisexual, and transgender disparities reduction; SB 311 (Chapter 707, Statutes of 2023) related to Medicare Part A buy-in; and SB 496 (Chapter 496, Statutes of 2023) related to biomarker testing.

Summary of Estimate Totals

This section provides a summary of bottom-line total spending amounts in the Estimate. Later sections will describe factors that drive changes in projected General Fund spending.

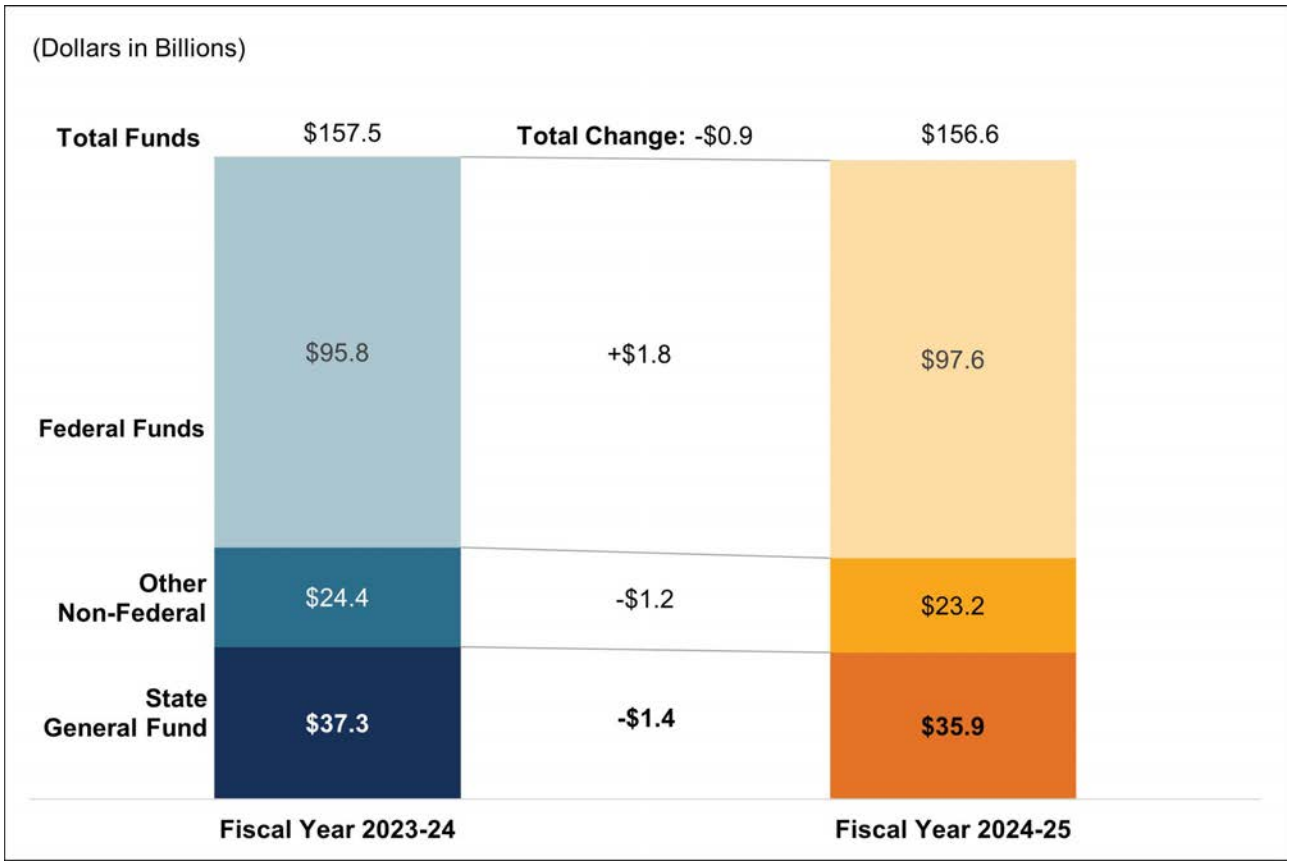
As shown below, the November 2023 Estimate for FY 2023-24 projects a $5.7 billion, or 3.7 percent, increase in total spending and a $0.2 billion, or 0.5 percent, decrease in General Fund spending compared to the May 2023 Estimate.

FY 2023-24 Comparison



As shown below, the Estimate projects that total spending will decrease by $0.9 billion (0.5 percent) and General Fund spending will decrease by $1.4 billion (3.8 percent) between FY 2023-24 and FY 2024-25.

Year over Year Change from FY 2023-24 to FY 2024-25



Major Drivers of Changes in General Fund Spending

The primary non-federal funding source for Medi-Cal is the state General Fund. A number of factors contribute to changes in projected General Fund spending in Medi-Cal in the Estimate. The table below and the narrative that follows describe the most significant factors driving changes in General Fund spending.

Summary of Major Drivers of Changes in General Fund Spending Between May 2023 and November 2023 Estimates

Dollars in Millions

	Current Year FY 2023-24	**Budget Year FY 2024-25**
	Change from May 2023 Estimate	*Change from FY 2023-24*
Changes in MCO tax impacts	-$738.3	-$502.9
Changes in General Fund costs for Proposition 56 payments	-$184.7	$123.1
Changes in General Fund savings from drug rebates	-$135.1	$388.8
Changes in deferrals impacts	-$102.2	$706.5
Shifts in the anticipated timing of payments into FY 2023-24	-$70.8	
Changes in Designated State Health Program funding	-$56.1	$19.2
COVID-19 vaccines	$16.4	$42.2
RSV vaccine	$61.4	$34.1
Changes in spending levels for items planned to be expended over multiple years	$70.4	-$692.9
Increased one-time federal state-only claiming repayment	$481.5	
Reduced projection for members leaving due to redeterminations	$499.0	
Full-year impact from members leaving due to redeterminations		-$2,331.0

	Current Year FY 2023-24	Budget Year FY 2024-25
	Change from May 2023 Estimate	*Change from FY 2023-24*
One-time payments not continuing in FY 2024-25		-$4,019.8
Delay BHBH funding previously planned for FY 2024-25		-$235.0
Delay BHCIP funding		-$140.4
Asset limit elimination		$47.2
Full year of CARE Act funding		$65.3
Reproductive health waiver		$100.0
Growth in base fee-for-service costs *		$121.7
End of HCBS Spending Plan funding for ALW expansion		$141.9
Replace Mental Health Services Fund for BHBH in FY 2023-24 with General Fund in FY 2024-25		$265.0
Growth in Medicare-related costs *		$461.1
End of temporary increase in transfers from Hospital Quality Assurance Fee program		$702.9
Phase-Out of COVID-19 increased FMAP		$750.1
Growth in base managed care costs *		$886.3
Full year of undocumented full-scope expansion ages 26-49		$1,629.4
Subtotals	-$158.5	-$1,437.2
Various other changes	-$37.1	$19.4
Totals	**-$195.6**	**-$1,417.8**

* Before accounting for redetermination impacts beyond July 2023.

Major factors driving changes in projected General Fund spending are described in greater detail below:

- ***Changes in MCO Tax Impacts.*** The 2023 MCO tax is projected to cover $4.4 billion in FY 2023-24 and $4.6 billion in FY 2024-25 of what otherwise would be General

Fund costs to support the Medi-Cal program. This includes the additional MCO tax support for the General Fund of $1 billion in FY 2023-24 and $2.8 billion in FY 2024-25. The Estimate also refines assumptions for impacts from the MCO tax in FY 2023-24 by (1) accounting for the impact of COVID-19 increased federal medical assistance percentage (FMAP) and updating the anticipated timing of revenue collections relative to costs to pay higher capitation to managed care plans.

- ***Changes in General Fund Costs for Proposition 56 Payments.*** The previous Estimate projected that $254 million would be needed from the General Fund to cover Proposition 56 supplemental payment costs (and base rate increases implementing January 1, 2024 that overlap with current Proposition 56 supplemental payments) due to insufficient Proposition 56 revenue. The Estimate now projects that only $69.5 million from the General Fund will be required in FY 2023-24. This reflects reduced General Fund costs of $184.7 million. This change is primarily due to additional net recoupments from managed care plans pursuant to risk corridors in place on supplemental payments.

  In FY 2024-25, the need for General Fund support is projected to grow to $192.6 million, after accounting for the Proposition 56 funding reduction described earlier. This results in a year-over-year increase of $123.1 million General Fund.

- ***Changes in General Fund Savings from Drug Rebates.*** As a budget solution, the Governor's Budget adds $135.1 million of General Fund savings from drug rebates available to be transferred from the Medi-Cal Drug Rebate Fund in FY 2023-24. After depleting all available drug rebate fund reserves in FY 2023-24, the Estimate projects the transfer of $2.5 billion of General Fund savings from rebate collections in FY 2024-25. This results in $388.8 million less General Fund savings from drug rebates in FY 2024-25 compared to FY 2023-24.

- ***Changes in Deferrals Impacts.*** From the prior estimate, CMS deferral impacts reflects a $102.2 million reductions in net General Fund costs due to updated deferral repayment and resolution assumptions in FY 2023-24***.*** Repayments due to CMS in FY 2023-24 were updated based on (1) actual deferrals received through Federal Fiscal Year (FFY) 2023 Quarter 2 and (2) estimating an additional quarter of state-only related pharmacy deferrals. In addition, the estimated resolved deferrals were updated to include additional actual deferral resolutions returned to the General Fund in FY 2023-24. The change from FY 2023-24 to FY 2024-25 is a $706.5 million General Fund increase due to estimating the managed care state only deferrals resolutions occurred in FY 2023-24, leaving a lower amount of deferral resolutions to be included in FY 2024-25.

- ***Shifts in Anticipated Timing of Payments into FY 2023-24.*** Changes in the anticipated timing of certain payments result in reduced General Fund spending of $70.8 million compared to the prior Estimate. Major updates include:

- A $115 million repayment to CMS related to In-Home Supportive Services reconciliations from the former Coordinated Care Initiative program shifted from FY 2022-23 into FY 2023-24.

- A $185.8 million transfer from the previous MCO tax to the General Fund was shifted from FY 2022-23 to FY 2023-24.

- ***Changes in Designated State Health Program (DSHP) Funding.*** Based on CMS guidance, DSHP claiming has switched from a Benefits expenditure item to Other Administration expenditure item in this estimate. In addition, compared to the prior estimate, $56.1 million additional General Fund savings are estimated in FY 2023-24 based on the net impact from (1) the delayed start of CalAIM DSHP claiming from FY 2022-23 to 2023-24, (2) including a quarter of DSHP claims from the new California's Reproductive Health Access Demonstration (CalRHAD) Demonstration, and (3) removing the January 2024 targeted provider rate increases to be budgeted in the Medi-Cal Provider Rate Increase policy change. Savings are estimated to decrease by $19.2 million General Fund from FY 2023-24 to 2024-25 due to estimating one less quarter (four quarters instead of five quarters) of DSHP claiming in 2024-25.

- ***COVID-19 Vaccine impacts.*** When the COVID-19 vaccines became available in 2021, the federal government covered the cost of the COVID-19 vaccine. Medi-Cal was required to reimburse for the COVID-19 vaccine administration costs, and these were paid according to the provisions of the American Rescue Plan Act (ARPA). ARPA provided for 100% federal funding for vaccine administration costs and a rate of $40 per dose for most providers through September 30, 2024. The following changes are expected for COVID-19 vaccine reimbursements:

  - Beginning September 2023, the federal government will no longer purchase COVID-19 vaccines for states and Medi-Cal, in addition to paying for vaccine administration costs, will have to start reimbursing for COVID-19 vaccine ingredient costs and applicable pharmacy dispensing fees. The federal government, however, will provide 100% FMAP for these costs through September 30, 2024.

  - Beginning October 1, 2024,
    - The 100% FMAP funding will end.
    - The vaccine administration rates, for non-FQHC/RHC providers, are assumed to decrease from $40 to the standard rate.

To capture these changes:

- A new policy change, titled “COVID-19 Vaccines”, is included in this estimate to reflect the total estimate for COVID-19 ingredient costs, vaccine administration costs, and dispensing fee costs in 2023-24 and 2024-25. The COVID-19 vaccines costs are estimated to be, $300.4 million total fund ($107.9 million General Fund), in 2023-24 and $358.1 million total funds ($128.7 million General Fund) in 2024-25.

- A separate policy change titled, “COVID-19 Vaccine Funding Adjustments”, is included to show the 100% FMAP funding adjustments through September 30, 2024.

- The net impacts from the two new policy changes are estimated to be $300.4 million total fund ($20.9 million General Fund), in FY 2023-24 and $358.1 million total funds ($63.1 million General Fund) in FY 2024-25. This reflects a $16.4 million General Fund increase in FY 2023-24 compared to the previous Estimate, and a $42.2 million General Fund increase in 2024-25 compared to 2023-24.

- ***Respiratory Syncytial Virus*** (***RSV) Vaccine Impacts.*** As described previously, the Estimate includes impacts of the RSV vaccine through Medi-Cal. Costs are estimated to be $138.7 million total funds ($61.4 million General Fund) in 2023-24 and $215.8 million total fund ($95.5 million General Fund) in 2024-25, consistent with a year-over-year growth in General Fund costs of $34.1 million.

- ***Changes in Spending Levels for Items Planned to Be Expended Over Multiple Years.*** The Estimate includes spending on several major initiatives that are to be completed over multiple years. These items will naturally have changes from year to year in spending amounts as programs ramp up and wind down. General Fund spending in FY 2023-24 is projected to be $70.4 higher than in the previous Estimate. Spending on multiyear items is then projected to be $692.9 million lower in FY 2024-25 compared to FY 2023-24 due to different funding levels for these multiyear items in different years, consistent with revised expectations for when funds will be spent and ongoing implementation of these items. Major items with significant year over year changes in projected spending include:

  - The Estimate projects $300 million in General Fund spending in FY 2023-24 and $239.6 million in General Fund spending in FY 2024-25 on the Behavioral Health Continuum Infrastructure Program (BHCIP), a $60.4 million year over year decrease. At the end of FY 2024-25, $862.5 million of the total funding provided for BHCIP will remain to be spent.

- The Estimate projects $426.5 million General Fund in FY 2023-24 and $207.4 million General Fund in FY 2024-25 for the Providing Access and Transforming Health (PATH) program, a $219 million year over year decrease. Overall planned spending on PATH is unchanged. The nonfederal share costs for PATH are ultimately covered by increased federal funding through the DSHP funding stream, although the timing of the additional funds does not align with the timing of PATH payments.

- The Estimate projects $351.5 million in General Fund spending in FY 2023-24 and $198.5 million in General Fund spending in FY 2024-25 on the CYBHI – School Behavioral Health Partnership and Capacity item, a $153 million year over year decrease. At the end of FY 2024-25, all funding approved for this item is projected to have been spent.

- The Estimate projects $242.5 million in General Fund spending in 2023-24 and $151.6 million in General Fund spending in 2024-25 on the CYBHI – Evidence-Based Practices item, a $91 million year over year decrease. At the end of FY 2024-25, all funding approved for this item is projected to have been spent.

- The Estimate projects $106 million in General Fund spending in FY 2023-24 and $29 million in General Fund spending in FY 2024-25 for the CYBHI – Urgent Needs and Emergent Issues item, a $77 million year over year decline. This is consistent with all funding previously appropriated for this item being spent by the end of FY 2024-25 and new authority of $29 million to be provided in FY 2024-25.

- The Estimate projects $484 million in General Fund spending in FY 2023-24 and $456.6 million in General Fund spending in FY 2024-25 on the Behavioral Health Bridge Housing (BHBH) program, a $27.4 million decline year over year. This includes the shift of $265 million of MHSF support for BHBH to General Fund in FY 2024-25, as well as the delay of $235 million in new General Fund authority that otherwise would have been provided in FY 2024-25 but due to the General Fund condition is being delayed.

- The Estimate projects $247.2 million in General Fund spending in FY 2023-24 and $210 million in General Fund spending in FY 2024-25 for the CYBHI – Behavioral Health Services and Supports Platform, a $37.2 million year over year decrease. At the end of FY 2024-25, a projected $13.6 million will remain unspent of the of the total funds previously appropriated for this item and the $143.9 million proposed to be newly provided in FY 2024-25.

- A $99.2 million payment to Los Angeles County for justice-involved population services and supports occurred early in FY 2023-24 instead of FY 2022-23 as previously planned. The full appropriation will have been entirely spent by the end of FY 2023-24.

- As planned, funding for CalAIM managed care plan incentives is scheduled to decrease from $600 million total funds ($300 million General Fund) in FY 2023-24 to $300 million total funds ($150 million General Fund) in FY 2024-25, resulting in a year over year decrease of $150 million General Fund.

- ***Increased One-Time Federal State-Only Claiming Repayment.*** Early in FY 2023-24, the Department completed the bulk of a $4 billion retroactive repayment to CMS related to the methodology for calculating state-only costs for populations with unsatisfactory immigration status (UIS) in Medi-Cal managed care. This repayment was previously estimated at approximately $3 billion, representing a roughly $1 billion increase. This increase in the repayment relative to prior estimates is due to differences between the estimated rates and final rates approved by CMS as well as differences in the number of members to which the adjustment would apply. The $1 billion increase relative to the previous estimate is offset by $567 million in new retroactive claiming for certain populations that the state is able to claim federal funding for but for which federal funding was not previously claimed. This new claiming was previously anticipated to occur late in 2022-23 but shifted into 2023-24. On net, retroactive repayments to CMS related to state-only claiming are up $481.5 million in 2023-24 compared to the previous Estimate.

  In FY 2024-25, net repayments to CMS are down significantly, to less than $1 million General Fund.

- ***Redeterminations Impacts.*** The Medi-Cal caseload began declining in July 2023, consistent with the resumption of eligibility redeterminations. The May 2023 Estimate projected that the number of members enrolled in Medi-Cal would decline over 12 months to approximately 12.8 million. Based on very early data on redeterminations, the Estimate revises this projection and assumes that fewer members will leave Medi-Cal, with the assumed ongoing caseload settling at approximately 13.8 million members by July 2024. This revised assumption increases General Fund costs in Medi-Cal by $499 million in FY 2023-24 compared to the previous Estimate.

  In FY 2024-25, a full year of impact from the lower caseload will reduce General Fund spending by $2.3 billion compared to FY 2023-24.

- ***One-Time Payments Not Continuing in FY 2024-25.*** There are several significant spending items included in FY 2023-24 that do not continue into FY 2024-25. This results in year over year reduction in General Fund spending of $4 billion. Major items include:

    - $3.6 billion in net repayments to CMS related to state-only claiming.

    - $250 million to initially fund the non-federal share of behavioral-health related services at the start of CalAIM Behavioral Health Payment Reform.

    - A net $84 million for the CCI IHSS reconciliation.

    - $99.2 million to Los Angeles County for justice-involved population services and supports.

    - $49.2 million related to Section 19.56 legislative priorities.

    - $48.1 million in temporary funding to support county eligibility redetermination activities.

    - $15 million in CARE Act start-up funding.

- ***Delay of BHBH and BHCIP Funding.*** As described previously, the Governor's Budget delays $235 million General Fund for BHBH and $140.4 million General Fund for BHCIP from FY 2024-25 to FY 2025-26, resulting in General Fund savings in FY 2024-25.

- ***Asset Limit Elimination.*** As described previously, the Governor's budget includes $101.1 million total funds ($50.5 million General Fund) in 2023-24 and $195.4 million total funds ($97.7 million General Fund) in 2024-25 for the previously implemented increase, and January 1, 2024 elimination, of the Medi-Cal asset limit. This represents an increase in General Fund costs of $47.2 million from 2023-24 to 2024-25 due to the full elimination of the asset limit.

- ***Full Year of CARE Act Funding*.** FY 2023-24 estimates the initial costs for eight counties implementing CARE Act, totaling $39.7 million General Fund. The remaining counties are estimated to implement the CARE Act by December 1, 2024. The cash basis estimate for a full year cost of the initial counties and the costs for additional counties are estimated in FY 2024-25 for a total of $104.9 million General Fund. This results in an increase of $65.3 million General Fund from 2023-24 to 2024-25.

- ***Reproductive Health Waiver.*** As described earlier, the Estimate includes $200 million total funds ($100 million General Fund) for the CalRHAD demonstration. $85 million of this amount will ultimately be covered by Designated State Health Program funding.

- ***Growth in Fee-for-Services (FFS) Base Costs.*** The Estimate projects growth in General Fund costs for base FFS expenditures of $121.7 million from 2023-24 to 2024-25. This increase is mainly attributable to year over year growth in estimated pharmacy spending. Note: This spending will be significantly offset by the impact of eligibility redeterminations, which are budgeted separately.

- ***End of HCBS Spending Plan Funding for ALW Expansion.*** Funding from the Home and Community-Based Services (HCBS) Spending Plan has been used to cover the non-federal share of cost for an expansion in slots in the ALW waiver. This temporary HCBS Spending Plan funding is set to end in FY 2024-25, resulting General Fund costs of $141.9 million.

- ***Replace MHSF in BHBH with General Fund.*** As described earlier, the Governor's Budget replaces MHSF for BHBH in 2023-24 with $265 million from the General Fund in 2024-25.

- ***Growth in Medicare-Related Costs.*** Medicare costs typically grow from year to year based on adjustments applied by the federal government. The Estimate assumes that General Fund costs related to Medicare (including premium payments on behalf of Medi-Cal enrollees and Part D clawback costs) will grow by $461.1 million from 2023-24 to 2024-25, after excluding the impact of COVID-19 increased FMAP. Note: This spending will be significantly offset by the impact of eligibility redeterminations, which are budgeted separately.

- ***End of Temporary Increase in Transfers from Hospital Quality Assurance Fee (HQAF) Program.*** HQAF children's health care coverage payments from the HQAF VI program period in FY 2019-20 and FY 2020-21, totaling $690.9 million General Fund savings, were postponed due to the COVID-19 public health emergency (PHE). These postponed payments are estimated to be paid in FY 2023-24. As a result, there is a temporary increase in children's health care coverage payments in FY 2023-24. As the delayed payments are completed in FY 2023-24, the savings in FY 2024-25 will return to the estimated annual payments. In addition, the savings from Calendar Year (CY) 2024 HQAF VIII payments are estimated to be slightly less than HQAF VIII CY 2023. Taking the FY 2024-25 changes together, a total of $1.3 billion General Fund savings is estimated in FY 2024-25, representing a $702.9 million reduction in General Fund offset when comparing FY 2023-24 to FY 2024-25.

- ***Phase-Out of COVID-19 Increased FMAP.*** Increased FMAP made available during the COVID-19 is gradually phasing out through December 2023. The Estimate includes $860 million in General Fund savings from increased FMAP in FY 2023-24, but only $110 million in FY 2024-25 (largely from funding streams with longer payment lags). This leads to a year over year loss of $750 million in General Fund savings.

- ***Growth in Managed Care Base Costs.*** Managed care costs typically grow from year to year through the rate setting process, and due to changes in enrollment. General Fund spending in managed care base policy changes increase by $886.3 million in 2024-25 compared to 2023-24. This is primarily due to projected typical increases in capitated rates. Note: the managed care base assumes constant enrollment at the July 2023 level and does not account for the impact of eligibility redeterminations. These increased costs are significantly offset by reductions in General Fund spending due to redeterminations, budgeted in the COVID-19 Redeterminations Impact policy change.

- ***Full-Year of Impact for Undocumented Full-Scope Expansion Ages 26-49.*** The previous Estimate included $1.4 billion total funds ($1.2 billion General Fund) to expand full-scope Medi-Cal coverage to unsatisfactory immigration status members aged 26 through 49 in FY 2023-24. The November 2023 Estimate revises this impact to $1.4 billion total funds ($1.2 billion General Fund), a $14.9 million increase in General Fund costs compared to the previous Estimate. The Undocumented Expansion Ages 26 through 49 policy change has been revised to account for new caseload trends due to the most recent redeterminations data. Additionally, the November 2023 Estimate includes $3.3 billion total funds ($2.9 billion General Fund) for FY 2024-25, a $1.7 billion increase year over year in General Fund spending. (Costs for IHSS are accounted for separately in the Department of Social Services Budget.)

Caseload Projections

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

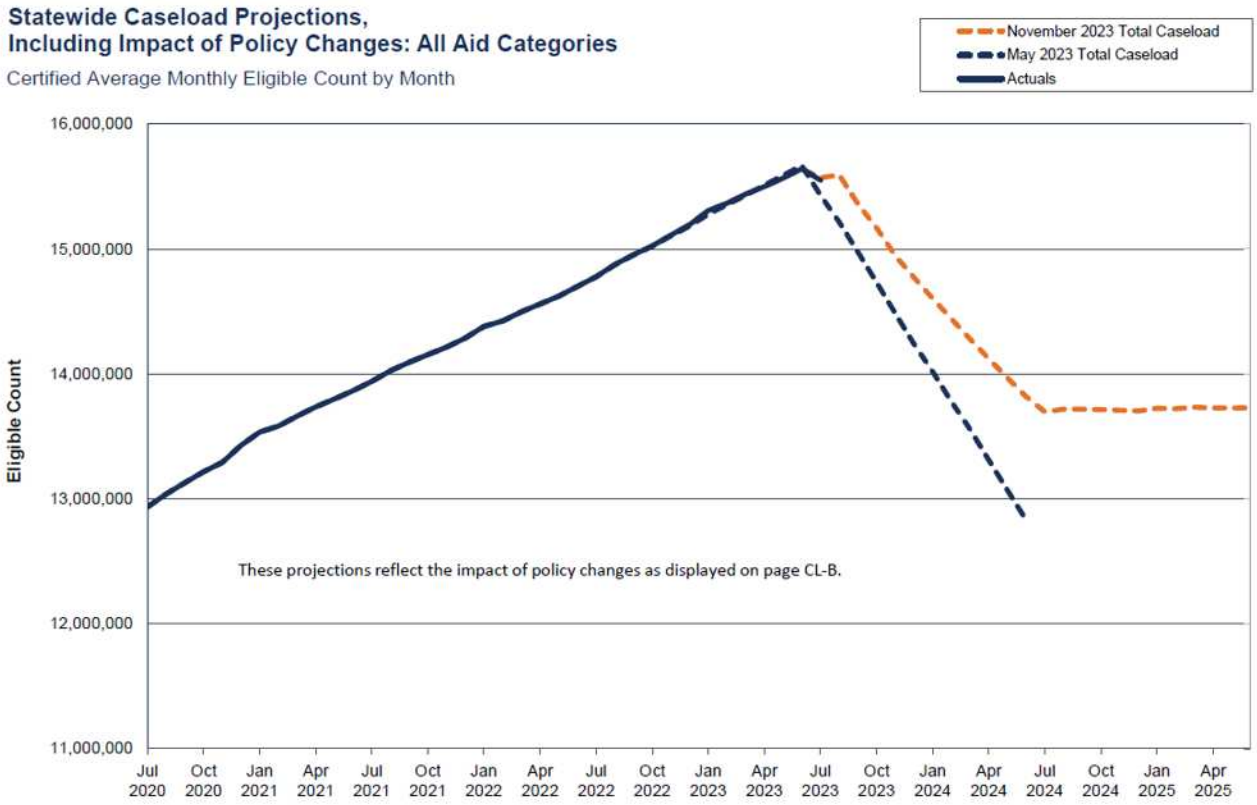
Estimated Average Monthly
Certified Eligible Members
November 2023
Estimate

	Members			Year over Year Change Percent	
	FY 2022-23	FY 2023-24	FY 2024-25	FY 2022-23 to FY 2023-24	FY 2023-24 to FY 2024-25
Seniors	1,203,200	1,218,900	1,209,900	1.30%	-0.74%
Persons with Disabilities	1,087,100	1,062,900	1,044,200	-2.23%	-1.76%
Families and Children	7,835,000	7,492,000	6,950,100	-4.38%	-7.23%
Optional Expansion	5,085,400	4,925,300	4,493,100	-3.15%	-8.78%
Miscellaneous	63,300	64,700	64,100	2.21%	-0.93%
Total	15,274,000	14,763,800	13,761,400	-3.34%	-6.79%

Change from
May 2023 Estimate

	Members		Percent	
	FY 2022-23	FY 2023-24	FY 2022-23	FY 2023-24
Seniors	2,700	1,700	0.22%	0.14%
Persons with Disabilities	1,600	(24,700)	0.15%	-2.27%
Families and Children	(3,300)	216,400	-0.04%	2.97%
Optional Expansion	1,200	390,800	0.02%	8.62%
Miscellaneous	-	(600)	0.00%	-0.92%
Total	**2,200**	**583,600**	**0.01%**	**4.12%**

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



As summarized in the tables and plot above, the Medi-Cal caseload has started to decline due to the resumption of eligibility redeterminations. Based on very initial data, the Estimate projects that the Medi-Cal caseload will fall to an estimated 13.8 million members following the redetermination period. This projection is highly uncertain and will be refined for the May Revision for FY 2024-25 as more data is available.

Reference Information

The table below provides policy change-level detail on certain key program areas, including:

- New Items
- Medi-Cal Provider Payment Increases
- CalAIM
- Home and Community-Based Services Spending Plan
- CYBHI / BCHIP/ Behavioral Health Bridge Housing
- Proposition 56

			November 2023 Estimated Amount (In Thousands)				Change from May 2023 Estimate (In Thousands)		November 2023 Estimate Year-over-Year Change (In Thousands)	
			2023-24 (CY)		2024-25 (BY)		2023-24 (CY)		2023-24 to 2024-25	
PC Type	PC #	Policy Change Title	TF	GF	TF	GF	TF	GF	TF	GF
New Items										
Reg.	222	CYBHI WELLNESS COACH BENEFIT	$0	$0	$9,513	$4,123	$0	$0	$9,513	$4,123
Reg.	223	RESPIRATORY SYNCYTIAL VIRUS VACCINES	$138,738	$61,418	$215,762	$95,516	$138,738	$61,418	$77,024	$34,098
Other Admin.	56	CALAIM - JUSTICE INVOLVED MAA	$0	$0	$12,000	$6,000	$0	$0	$12,000	$6,000
Other Admin.	97	REPRODUCTIVE HEALTH ACCESS DEMO 1115 WAIVER	$0	$0	$200,000	$100,000	$0	$0	$200,000	$100,000
		Totals	**$138,738**	**$61,418**	**$437,275**	**$205,640**	**$138,738**	**$61,418**	**$298,537**	**$144,222**
Medi-Cal Provider Payment Increases										
Reg.	97	MEDI-CAL PROVIDER RATE INCREASE	$303,000	$121,000	$727,000	$291,000	$88,303	$31,402	$424,000	$170,000
Reg.	226	MEDI-CAL PROVIDER RATE INCREASE 2025	$0	$0	$1,921,950	$773,859	$0	$0	$1,921,950	$773,859
Reg.	95	MEDI-CAL PROVIDER PAYMENT RESERVE FUND	$200,000	-$121,000	$30,308	-$1,064,859	-$722,724	-$22,768	-$169,692	-$943,859
		Totals	**$503,000**	**$0**	**$2,679,258**	**$0**	**-$634,421**	**$8,634**	**$2,176,258**	**$0**
CalAIM										
Reg.	60	CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES	$1,829,376	$748,822	$1,590,844	$621,263	$0	$0	-$238,532	-$127,559
Reg.	162	CALAIM - BH PAYMENT REFORM	$250,000	$250,000	$0	$0	$0	$0	-$250,000	-$250,000

PC Type	PC #	Policy Change Title	November 2023 Estimated Amount (In Thousands) 2023-24 (CY) TF	GF	2024-25 (BY) TF	GF	Change from May 2023 Estimate (In Thousands) 2023-24 (CY) TF	GF	November 2023 Estimate Year-over-Year Change (In Thousands) 2023-24 to 2024-25 TF	GF
Other Admin.	1	CALAIM - PATH	$1,045,000	$426,500	$478,800	$207,400	$277,400	$124,200	-$566,200	-$219,100
Reg.	179	CALAIM - PATH FOR CLINICS	$40,000	$40,000	$0	$0	$40,000	$40,000	-$40,000	-$40,000
Reg.	169	CALAIM - PATH WPC	$101,000	$0	$0	$0	$101,000	$0	-$101,000	$0
Reg.	212	CALAIM - DENTAL INITIATIVES	$250,903	$120,225	$250,903	$120,225	$0	$0	$0	$0
Reg.	32	CALAIM - LTC BENEFIT TRANSITION	-$175,788	-$80,826	$4,318	$1,985	-$16,998	-$12,252	$180,106	$82,811
Reg.	N/A	CALAIM - TRANSITIONING POPULATIONS	$0	$0	$0	$0	-$25,981	-$10,394	$0	$0
Reg.	54	CALAIM - BH - CONNECT DEMONSTRATION	$0	$0	$39,043	$655	$0	$0	$39,043	$655
Other Admin.	57	CALAIM - BH - CONNECT DEMONSTRATION ADMIN	$0	$0	$1,554	$107	$0	$0	$1,554	$107
Reg.	51	CALAIM - BH QUALITY IMPROVEMENT PROGRAM	$21,347	$21,347	$0	$0	$0	$0	-$21,347	-$21,347
Other Admin	11	CALAIM - POPULATION HEALTH MANAGEMENT	$49,601	$4,960	$52,668	$5,267	-$3,067	-$307	$3,067	$307
Reg.	7	CALAIM - INMATE PRE-RELEASE PROGRAM	$0	$0	$47,916	$16,291	-$7,145	-$2,429	$47,916	$16,291
Other Admin.	38	CALAIM - INMATE PRE-RELEASE PROGRAM ADMIN	$2,746	$1,373	$2,746	$1,373	$0	$0	$0	$0
Reg.	N/A	CALAIM - ORGAN TRANSPLANT	$0	$0	$0	$0	-$20,703	-$6,603	$0	$0
Other Admin.	30	CALAIM MLTSS & D-SNP INTEGRATION ACTIVITIES	$7,100	$3,550	$0	$0	$7,100	$3,550	-$7,100	-$3,550
Other Admin.	56	CALAIM - JUSTICE INVOLVED MAA	$0	$0	$12,000	$6,000	$0	$0	$12,000	$6,000
Other Admin.	98	DESIGNATED STATE HEALTH PROGRAMS	$0	-$202,008	$0	-$161,606	-$22,710	-$49,036	$0	$40,402
		Totals	**$3,421,285**	**$1,333,943**	**$2,480,792**	**$818,960**	**$328,896**	**$86,730**	**-$940,493**	**-$514,983**
Home and Community-Based Services Spending Plan										
Reg.	73	HCBS SP - HOUSING AND HOMELESSNESS INCENTIVE PROG	$557,414	$0	$0	$0	-$86,586	$0	-$557,414	$0
Reg.	199	HCBS SP - ETSB FOR LAGUNA HONDA HOSPITAL RESIDENTS	$550	$0	$0	$0	$0	$0	-$550	$0
Reg.	158	HCBS SP CDDS	$601,116	$0	$105,028	$0	$81,504	$0	-$496,088	$0
Other Admin	87	HCBS SP CDDS - OTHER ADMIN	$2,457	$0	$0	$0	-$15	$0	-$2,457	$0
Reg.	171	ASSISTED LIVING WAIVER EXPANSION	$281,016	$140,508	$0	$0	$191,243	$95,693	-$281,016	-$140,508
Reg.	203	HCBS SP - ALW FUNDING SHIFT	$0	-$140,508	$0	$0	$0	-$95,693	$0	$140,508
Reg.	43	HCBS SP - CONTINGENCY MANAGEMENT	$21,562	$0	$82,682	$0	-$14,020	$0	$61,120	$0

PC Type	PC #	Policy Change Title	November 2023 Estimated Amount (In Thousands) 2023-24 (CY) TF	GF	2024-25 (BY) TF	GF	Change from May 2023 Estimate (In Thousands) 2023-24 (CY) TF	GF	November 2023 Estimate Year-over-Year Change (In Thousands) 2023-24 to 2024-25 TF	GF
Other Admin.	37	HCBS SP - CONTINGENCY MANAGEMENT ADMIN	$2,768	$0	$6,119	$0	-$2,232	$0	$3,351	$0
Reg.	193	HCBS SP - NON-IHSS CARE ECONOMY PMTS	$3,080	$0	$0	$0	-$9,170	$0	-$3,080	$0
Reg.	196	HCBS SP - CALBRIDGE BH NAVIGATOR PROGRAM	$1,056	$0	$89	$0	-$89	$0	-$967	$0
		Totals	**$1,471,019**	**$0**	**$193,918**	**$0**	**$160,635**	**$0**	**-$1,277,101**	**$0**
Children and Youth Behavioral Health Initiative / Behavioral Health Continuum Infrastructure / BH Bridge Housing										
Reg.	161	CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY	$351,500	$351,500	$198,500	$198,500	-$39,750	-$39,750	-$153,000	-$153,000
Reg.	163	CYBHI - EVIDENCE-BASED BH PRACTICES	$242,450	$242,450	$151,610	$151,610	-$45,050	-$45,050	-$90,840	-$90,840
Other Admin.	3	CYBHI - BH SERVICES AND SUPPORTS PLATFORM	$247,172	$247,172	$209,964	$209,964	-$47,728	-$47,728	-$37,208	-$37,208
Reg.	77	CYBHI - STUDENT BH INCENTIVE PROGRAM	$85,422	$42,711	$85,422	$42,711	$137	$69	$0	$0
Reg.	24	CYBHI - DYADIC SERVICES	$128,012	$52,168	$170,579	$70,717	$309	-$17	$42,567	$18,549
Reg.	181	CYBHI - CALHOPE STUDENT SUPPORT	$32,000	$32,000	$0	$0	$8,000	$8,000	-$32,000	-$32,000
Reg.	167	CYBHI - URGENT NEEDS AND EMERGENT ISSUES	$106,000	$106,000	$29,000	$29,000	$21,500	$21,500	-$77,000	-$77,000
Reg.	222	CYBHI WELLNESS COACH BENEFIT	$0	$0	$9,513	$4,123	$0	$0	$9,513	$4,123
Other Admin.	N/A	CYBHI - FEE SCHEDULE THIRD PARTY ADMINISTRATOR	$10,000	$0	$0	$0	$0	$0	-$10,000	$0
Reg.	49	BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE	$300,030	$300,030	$239,600	$239,600	$37,521	$37,521	-$60,430	-$60,430
Reg.	159	BEHAVIORAL HEALTH BRIDGE HOUSING	$483,968	$483,968	$456,587	$456,587	-$315,000	-$50,000	-$27,381	-$27,381
		Totals	**$1,986,554**	**$1,857,999**	**$1,550,775**	**$1,402,813**	**-$380,061**	**-$115,456**	**-$435,779**	**-$455,186**
Proposition 56										
Reg.	117	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	$1,435,814	$555,310	$1,360,367	$542,349	$66,273	$40,538	-$75,447	-$12,961
Reg.	130	PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS	$712,573	$279,992	$788,662	$315,198	$114,215	$54,793	$76,089	$35,206
Reg.	121	PROP 56 - MEDI-CAL FAMILY PLANNING	$505,912	$101,315	$481,460	$96,562	$25,918	$4,656	-$24,452	-$4,754
Reg.	85	PROP 56 - BEHAVIORAL HEALTH INCENTIVE PROGRAM	$2,156	$171	$0	$0	$2,156	$171	-$2,156	-$171
Reg.	137	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	$62,132	$25,585	$76,365	$30,445	-$37,605	-$13,748	$14,233	$4,860

			November 2023 Estimated Amount (In Thousands)				Change from May 2023 Estimate (In Thousands)		November 2023 Estimate Year-over-Year Change (In Thousands)	
			2023-24 (CY)		2024-25 (BY)		2023-24 (CY)		2023-24 to 2024-25	
PC Type	PC #	Policy Change Title	TF	GF	TF	GF	TF	GF	TF	GF
Reg.	194	PROP 56 - PROVIDER ACES TRAININGS	$1,807	$904	$0	$0	$0	$0	-$1,807	-$904
Reg.	93	PROP 56 - DIRECTED PAYMENT RISK MITIGATION	-$1,373,716	-$126,691	-$400,000	-$120,000	-$1,373,716	-$126,691	$973,716	$6,691
Reg.	174	MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG	$55,581	$0	$65,742	$0	$3,558	$0	$10,161	$0
Reg.	231	PROP 56 - FUNDING REDUCTION	$0	$0	-$193,405	-$77,107	$0	$0	-$193,405	-$77,107
Reg.	142	PROPOSITION 56 FUNDING	$0	-$767,112	$0	-$594,892	$0	-$144,426	$0	$172,220
		Totals	**$1,402,259**	**$69,474**	**$2,179,191**	**$192,555**	**-$1,199,201**	**-$184,706**	**$776,932**	**$123,081**

Medi-Cal Funding Summary
November 2023 Estimate Compared to Appropriation
Fiscal Year 2023 - 2024

TOTAL FUNDS

Benefits:	**Total Appropriation**	**Nov 2023 Estimate**	**Difference Incr./(Decr.)**
4260-101-0001/0890 Medi-Cal General and Federal Funds	$119,967,929,000	$125,109,375,000	$5,141,446,000
4260-101-0080 CLPP Funds	$902,000	$902,000	$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$70,115,000	$70,115,000	$0
4260-101-0233 Prop 99 Physician Srvc. Acct	$19,901,000	$19,901,000	$0
4260-101-0236 Prop 99 Unallocated Account	$28,753,000	$28,753,000	$0
4260-101-3085 Mental Health Services	$337,500,000	$60,500,000	($277,000,000)
4260-101-3168 Emergency Air Transportation Fund	$8,724,000	$2,111,000	($6,613,000)
4260-101-3305 Healthcare Treatment Fund	$876,866,000	$836,586,000	($40,280,000)
4260-101-3375 Medi-Cal Loan Repayment Program	$0	$0	$0
4260-101-3398 California Emergency Relief Fund	$0	$5,984,000	$5,984,000
4260-101-3428 MCO Tax 2023	$7,248,256,000	$7,873,000,000	$624,744,000
4260-101-3431 Medi-Cal Provider Payment Reserve Fund	$1,020,956,000	$321,000,000	($699,956,000)
4260-101-8507 Home & Community Based Services (101)*	$356,223,000	$397,335,000	$41,112,000
4260-611-0001/0890 Home & Community Based Services(611)*	$0	$0	$0
4260-698-0001 Home & Community Based Services (698-0001)*	$0	$0	$0
4260-698-8507 Home & Community Based Services (698-8507)*	$0	$0	$0
4260-102-0001/0890 Capital Debt	$85,066,000	$78,235,000	($6,831,000)
4260-102-3305 Prop 56 Loan Forgiveness Program	$0	$0	$0
4260-103-3305 Prop 56 Value-Based Payment	$0	$0	$0
4260-601-3375 Medi-Cal Loan Repayment Program 601	$52,023,000	$55,581,000	$3,558,000
4260-104-0001 NDPH Hosp Supp	$1,900,000	$1,900,000	$0
4260-601-3096 NDPH Suppl	$1,748,000	$1,862,000	$114,000
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	($1,900,000)	($1,900,000)	$0
4260-105-0001 Private Hosp Supp Fund	$118,400,000	$118,400,000	$0
4260-601-3097 Private Hosp Suppl	$342,117,000	$326,036,000	($16,081,000)
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($118,400,000)	($118,400,000)	$0
4260-106-0890 Money Follows Person Federal Grant	$36,234,000	$36,198,000	($36,000)
4260-112-0001 GF Support for Prop 56 Payments*	$254,180,000	$69,474,000	($184,706,000)
4260-695-3305 Health Care Treatment Fund (Less GF)	($254,180,000)	($69,474,000)	$184,706,000
4260-119-0001 Behavioral Health Payment Reform	$250,000,000	$250,000,000	$0
4260-601-3420 Behavioral Health IGT Fund	$1,232,774,000	$1,221,944,000	($10,830,000)
4260-695-3420 Transfer to Behavioral Health IGT Fund	($250,000,000)	($250,000,000)	$0
4260-162-8506 State Fiscal Recovery Fund of 2021	$0	$0	$0
4260-601-0942142 Local Trauma Centers	$77,403,000	$56,411,000	($20,992,000)
4260-601-0942 Health Homes Program Account	$0	$0	$0
4260-601-0995 Reimbursements	$1,867,704,000	$2,088,571,000	$220,867,000
4260-601-3156 MCO Tax Fund	$0	$175,439,000	$175,439,000
4260-601-3213 LTC QA Fund	$471,515,000	$540,161,000	$68,646,000
4260-601-3293 MCO Tax Fund 2016	$0	$0	$0
4260-601-3323 Medi-Cal Emergency Transport Fund	$57,418,000	$49,288,000	($8,130,000)
4260-601-3331 Medi-Cal Drug Rebates Fund	$2,736,987,000	$2,872,071,000	$135,084,000
4260-601-3334 MCO Tax (HCS Special Fund)	$0	$0	$0
4260-601-7502 Demonstration DSH Fund	$97,837,000	$166,811,000	$68,974,000
4260-601-7503 Health Care Support Fund	$162,210,000	$712,000	($161,498,000)
4260-601-8108 Global Payment Program Fund	$1,111,984,000	$1,314,355,000	$202,371,000
4260-601-8113 DPH GME Special Fund	$261,179,000	$282,492,000	$21,313,000
4260-602-0309 Perinatal Insurance Fund	$16,079,000	$22,981,000	$6,902,000
4260-605-0001 SNF Quality & Accountability	$0	$0	$0
4260-605-3167 SNF Quality & Accountability (Non-GF) Only	$0	$0	$0
4260-605-3167 SNF Quality & Accountability	$1,176,000	$1,176,000	$0
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	$0	$0	$0
4260-606-0834 SB 1100 DSH	$157,415,000	$115,043,000	($42,372,000)
4260-611-3158/0890 Hospital Quality Assurance	$5,911,901,000	$5,971,583,000	$59,682,000
Total Benefits	**$144,616,895,000**	**$150,102,512,000**	**$5,485,617,000**
County Administration:			
4260-101-0001/0890 Medi-Cal General and Federal Funds	$6,418,031,000	$6,444,340,000	$26,309,000
4260-101-3085 Mental Health Services	$27,545,000	$27,307,000	($238,000)
4260-101-8507 Home & Community Base Services	$1,875,000	$32,521,000	$30,646,000
4260-106-0890 Money Follow Person Fed. Grant	$1,843,000	$2,290,000	$447,000
4260-117-0001/0890 HIPPA	$22,079,000	$19,589,000	($2,490,000)
4260-162-8506 State Fiscal Recovery Fund of 2021	$0	$0	$0
4260-601-0942 Health Homes Program Account	$0	$0	$0
4260-601-0995 Reimbursements	$95,171,000	$77,705,000	($17,466,000)
4260-601-3420 Behavioral Health IGT Fund	$50,536,000	$0	($50,536,000)
4260-601-7503 Health Care Support Fund	$0	$209,091,000	$209,091,000
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$0	$0	$0
4260-605-3167 SNF Quality & Accountability Admin.	$0	$0	$0
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	$150,000	$150,000	$0
Total County Administration	**$6,617,230,000**	**$6,812,993,000**	**$195,763,000**
Fiscal Intermediary:			
4260-101-0001/0890 Medi-Cal General and Federal Funds	$585,997,000	$571,998,000	($13,999,000)
4260-117-0001/0890 HIPAA	$3,897,000	$4,336,000	$439,000
4260-601-0995 Reimbursements	$0	$33,000	$33,000
Total Fiscal Intermediary	**$589,894,000**	**$576,367,000**	**($13,527,000)**
Grand Total - Total Funds	**$151,824,019,000**	**$157,491,872,000**	**$5,667,853,000**

Medi-Cal Funding Summary
November 2023 Estimate Compared to Appropriation
Fiscal Year 2023 - 2024

STATE FUNDS

Benefits:	State Funds Appropriation	Nov 2023 Estimate	Difference Incr./(Decr.)
4260-101-0001 Medi-Cal General Fund*[1]	$35,035,432,000	$35,162,386,000	$126,954,000
4260-101-0080 CLPP Funds	$902,000	$902,000	$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$70,115,000	$70,115,000	$0
4260-101-0233 Prop 99 Physician Srvc. Acct	$19,901,000	$19,901,000	$0
4260-101-0236 Prop 99 Unallocated Account	$28,753,000	$28,753,000	$0
4260-101-3085 Mental Health Services	$337,500,000	$60,500,000	($277,000,000)
4260-101-3168 Emergency Air Transportation Fund	$8,724,000	$2,111,000	($6,613,000)
4260-101-3305 Healthcare Treatment Fund	$876,866,000	$836,586,000	($40,280,000)
4260-101-3375 Medi-Cal Loan Repayment Program	$0	$0	$0
4260-101-3398 California Emergency Relief Fund	$0	$5,984,000	$5,984,000
4260-101-3428 MCO Tax 2023	$7,248,256,000	$7,873,000,000	$624,744,000
4260-101-3431 Medi-Cal Provider Payment Reserve Fund	$1,020,956,000	$321,000,000	($699,956,000)
4260-101-8507 Home & Community Based Services (101)	$356,223,000	$397,335,000	$41,112,000
4260-611-0001 Home & Community Based Services(611)*	$0	$0	$0
4260-698-0001 Home & Community Based Services (698-0001)*	$0	$0	$0
4260-698-8507 Home & Community Based Services (698-8507)	$0	$0	$0
4260-102-0001 Capital Debt *	$26,445,000	$23,568,000	($2,877,000)
4260-102-3305 Prop 56 Loan Forgiveness Program	$0	$0	$0
4260-103-3305 Prop 56 Value-Based Payment	$0	$0	$0
4260-601-3375 Medi-Cal Loan Repayment Program	$52,023,000	$55,581,000	$3,558,000
4260-104-0001 NDPH Hosp Supp *	$1,900,000	$1,900,000	$0
4260-601-3096 NDPH Suppl	$1,748,000	$1,862,000	$114,000
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	($1,900,000)	($1,900,000)	$0
4260-105-0001 Private Hosp Supp Fund *	$118,400,000	$118,400,000	$0
4260-601-3097 Private Hosp Suppl	$342,117,000	$326,036,000	($16,081,000)
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($118,400,000)	($118,400,000)	$0
4260-112-0001 GF Support for Prop 56 Payments*	$254,180,000	$69,474,000	($184,706,000)
4260-695-3305 Health Care Treatment Fund (Less GF)	($254,180,000)	($69,474,000)	$184,706,000
4260-119-0001 Behavioral Health Payment Reform	$250,000,000	$250,000,000	$0
4260-601-3420 Behavioral Health IGT Fund	$1,232,774,000	$1,221,944,000	($10,830,000)
4260-695-3420 Transfer to Behavioral Health IGT Fund	($250,000,000)	($250,000,000)	$0
4260-601-0942142 Local Trauma Centers	$77,403,000	$56,411,000	($20,992,000)
4260-601-0942 Health Homes Program Account	$0	$0	$0
4260-601-0995 Reimbursements	$1,867,704,000	$2,088,571,000	$220,867,000
4260-601-3156 MCO Tax Fund	$0	$175,439,000	$175,439,000
4260-601-3213 LTC QA Fund	$471,515,000	$540,161,000	$68,646,000
4260-601-3293 MCO Tax Fund 2016	$0	$0	$0
4260-601-3323 Medi-Cal Emergency Transport Fund	$57,418,000	$49,288,000	($8,130,000)
4260-601-3331 Medi-Cal Drug Rebates Fund	$2,736,987,000	$2,872,071,000	$135,084,000
4260-601-3334 MCO Tax (HCS Special Fund)	$0	$0	$0
4260-601-8108 Global Payment Program Fund	$1,111,984,000	$1,314,355,000	$202,371,000
4260-601-8113 DPH GME Special Fund	$261,179,000	$282,492,000	$21,313,000
4260-602-0309 Perinatal Insurance Fund	$16,079,000	$22,981,000	$6,902,000
4260-605-0001 SNF Quality & Accountability *	$0	$0	$0
4260-605-3167 SNF Quality & Accountability (Non-GF) Only	$0	$0	$0
4260-605-3167 SNF Quality & Accountability	$1,176,000	$1,176,000	$0
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	$0	$0	$0
4260-606-0834 SB 1100 DSH	$157,415,000	$115,043,000	($42,372,000)
4260-611-3158 Hospital Quality Assurance Revenue	$5,911,901,000	$5,971,583,000	$59,682,000
Total Benefits	**$59,329,496,000**	**$59,897,135,000**	**$567,639,000**
Total Benefits General Fund *	**$35,686,357,000**	**$35,625,728,000**	**($60,629,000)**
County Administration:			
4260-101-0001 Medi-Cal General Fund *	$1,678,346,000	$1,543,352,000	($134,994,000)
4260-101-3085 Mental Health Services	$27,545,000	$27,307,000	($238,000)
4260-101-8507 Home & Community Base Services	$1,875,000	$32,521,000	$30,646,000
4260-117-0001 HIPAA *	$4,804,000	$4,521,000	($283,000)
4260-601-0942 Health Homes Program Account	$0	$0	$0
4260-601-0995 Reimbursements	$95,171,000	$77,705,000	($17,466,000)
4260-601-3420 Behavioral Health IGT Fund	$50,536,000	$0	($50,536,000)
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$0	$0	$0
4260-605-3167 SNF Quality & Accountability Admin.	$0	$0	$0
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	$150,000	$150,000	$0
Total County Administration	**$1,858,427,000**	**$1,685,556,000**	**($172,871,000)**
Total County Administration General Fund *	**$1,683,150,000**	**$1,547,873,000**	**($135,277,000)**
Fiscal Intermediary:			
4260-101-0001 Medi-Cal General Fund *	$156,157,000	$156,398,000	$241,000
4260-117-0001 HIPAA *	$919,000	$1,030,000	$111,000
4260-601-0995 Reimbursements	$0	$33,000	$33,000
Total Fiscal Intermediary	**$157,076,000**	**$157,461,000**	**$385,000**
Total Fiscal Intermediary General Fund *	**$157,076,000**	**$157,428,000**	**$352,000**
Grand Total - State Funds	**$61,344,999,000**	**$61,740,152,000**	**$395,153,000**
Grand Total - General Fund*	**$37,526,583,000**	**$37,331,029,000**	**($195,554,000)**

Medi-Cal Funding Summary

November 2023 Estimate Compared to Appropriation

Fiscal Year 2023 - 2024

FEDERAL FUNDS

	Federal Funds Appropriation	Nov 2023 Estimate	Difference Incr./(Decr.)
Benefits:			
4260-101-0890 Federal Funds [1]	$84,932,497,000	$89,946,989,000	$5,014,492,000
4260-102-0890 Capital Debt	$58,621,000	$54,667,000	($3,954,000)
4260-106-0890 Money Follows Person Federal Grant	$36,234,000	$36,198,000	($36,000)
4260-162-8506 State Fiscal Recovery Fund of 2021	$0	$0	$0
4260-601-7502 Demonstration DSH Fund	$97,837,000	$166,811,000	$68,974,000
4260-601-7503 Health Care Support Fund	$162,210,000	$712,000	($161,498,000)
4260-611-0890 Home & Community Based Services 100% FF	$0	$0	$0
4260-611-0890 Hospital Quality Assurance	$0	$0	$0
Total Benefits	**$85,287,399,000**	**$90,205,377,000**	**$4,917,978,000**
County Administration:			
4260-101-0890 Federal Funds	$4,739,685,000	$4,900,988,000	$161,303,000
4260-106-0890 Money Follows Person Fed. Grant	$1,843,000	$2,290,000	$447,000
4260-117-0890 HIPAA	$17,275,000	$15,068,000	($2,207,000)
4260-162-8506 State Fiscal Recovery Fund of 2021	$0	$0	$0
4260-601-7503 Health Care Support Fund	$0	$209,091,000	$209,091,000
Total County Administration	**$4,758,803,000**	**$5,127,437,000**	**$368,634,000**
Fiscal Intermediary:			
4260-101-0890 Federal Funds	$429,840,000	$415,600,000	($14,240,000)
4260-117-0890 HIPAA	$2,978,000	$3,306,000	$328,000
Total Fiscal Intermediary	**$432,818,000**	**$418,906,000**	**($13,912,000)**
Grand Total - Federal Funds	**$90,479,020,000**	**$95,751,720,000**	**$5,272,700,000**

[1] Reflects mid-year adjustments to the Appropriation

Medi-Cal Funding Summary

November 2023 Estimate Comparison of FY 2023-24 to FY 2024-25

TOTAL FUNDS

Benefits:	FY 2023-24 Estimate	FY 2024-25 Estimate	Difference Incr./(Decr.)
4260-101-0001/0890 Medi-Cal General and Federal Funds	$125,109,375,000	$126,120,042,000	$1,010,667,000
4260-101-0080 CLPP Funds	$902,000	$0	($902,000)
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$70,115,000	$72,477,000	$2,362,000
4260-101-0233 Prop 99 Physician Srvc. Acct	$19,901,000	$20,693,000	$792,000
4260-101-0236 Prop 99 Unallocated Account	$28,753,000	$30,999,000	$2,246,000
4260-101-3085 Mental Health Services	$60,500,000	$9,457,000	($51,043,000)
4260-101-3168 Emergency Air Transportation Fund	$2,111,000	$0	($2,111,000)
4260-101-3305 Healthcare Treatment Fund	$836,586,000	$787,446,000	($49,140,000)
4260-101-3375 Medi-Cal Loan Repayment Program	$0	$0	$0
4260-101-3398 California Emergency Relief Fund	$5,984,000	$0	($5,984,000)
4260-101-3428 MCO Tax 2023	$7,873,000,000	$8,597,541,000	$724,541,000
4260-101-3431 Medi-Cal Provider Payment Reserve Fund	$321,000,000	$1,095,167,000	$774,167,000
4260-101-8507 Home & Community Based Services (101)	$397,335,000	$89,000	($397,246,000)
4260-611-0001/0890 Home & Community Based Services(611)	$0	$0	$0
4260-698-0001 Home & Community Based Services (698-0001)	$0	$0	$0
4260-698-8507 Home & Community Based Services (698-8507)	$0	$0	$0
4260-102-0001/0890 Capital Debt	$78,235,000	$72,562,000	($5,673,000)
4260-102-3305 Prop 56 Loan Forgiveness Program	$0	$0	$0
4260-103-3305 Prop 56 Value-Based Payment	$0	$0	$0
4260-601-3375 Medi-Cal Loan Repayment Program 601	$55,581,000	$65,742,000	$10,161,000
4260-104-0001 NDPH Hosp Supp	$1,900,000	$1,900,000	$0
4260-601-3096 NDPH Suppl	$1,862,000	$7,233,000	$5,371,000
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	($1,900,000)	($1,900,000)	$0
4260-105-0001 Private Hosp Supp Fund	$118,400,000	$118,400,000	$0
4260-601-3097 Private Hosp Suppl	$326,036,000	$191,784,000	($134,252,000)
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($118,400,000)	($118,400,000)	$0
4260-106-0890 Money Follows Person Federal Grant	$36,198,000	$36,103,000	($95,000)
4260-112-0001 GF Support for Prop 56 Payments*	$69,474,000	$192,554,000	$123,080,000
4260-695-3305 Health Care Treatment Fund (Less GF)	($69,474,000)	($192,554,000)	($123,080,000)
4260-119-0001 Behavioral Health Payment Reform	$250,000,000	$0	($250,000,000)
4260-601-3420 Behavioral Health IGT Fund	$1,221,944,000	$1,575,580,000	$353,636,000
4260-695-3420 Transfer to Behavioral Health IGT Fund	($250,000,000)	$0	$250,000,000
4260-162-8506 State Fiscal Recovery Fund of 2021	$0	$0	$0
4260-601-0942142 Local Trauma Centers	$56,411,000	$81,670,000	$25,259,000
4260-601-0942 Health Homes Program Account	$0	$0	$0
4260-601-0995 Reimbursements	$2,088,571,000	$2,183,868,000	$95,297,000
4260-601-3156 MCO Tax Fund	$175,439,000	$0	($175,439,000)
4260-601-3213 LTC QA Fund	$540,161,000	$539,546,000	($615,000)
4260-601-3293 MCO Tax Fund 2016	$0	$0	$0
4260-601-3323 Medi-Cal Emergency Transport Fund	$49,288,000	$49,037,000	($251,000)
4260-601-3331 Medi-Cal Drug Rebates Fund	$2,872,071,000	$2,483,312,000	($388,759,000)
4260-601-3334 MCO Tax (HCS Special Fund)	$0	$0	$0
4260-601-7502 Demonstration DSH Fund	$166,811,000	$120,101,000	($46,710,000)
4260-601-7503 Health Care Support Fund	$712,000	$601,000	($111,000)
4260-601-8108 Global Payment Program Fund	$1,314,355,000	$983,596,000	($330,759,000)
4260-601-8113 DPH GME Special Fund	$282,492,000	$281,222,000	($1,270,000)
4260-602-0309 Perinatal Insurance Fund	$22,981,000	$22,851,000	($130,000)
4260-605-0001 SNF Quality & Accountability	$0	$0	$0
4260-605-3167 SNF Quality & Accountability(Non-GF) Only	$0	$0	$0
4260-605-3167 SNF Quality & Accountability	$1,176,000	$0	($1,176,000)
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	$0	$0	$0
4260-606-0834 SB 1100 DSH	$115,043,000	$125,558,000	$10,515,000
4260-611-3158/0890 Hospital Quality Assurance	$5,971,583,000	$4,207,522,000	($1,764,061,000)
Total Benefits	**$150,102,512,000**	**$149,761,799,000**	**($340,713,000)**
County Administration:			
4260-101-0001/0890 Medi-Cal General and Federal Funds	$6,444,340,000	$6,046,182,000	($398,158,000)
4260-101-3085 Mental Health Services	$27,307,000	$22,750,000	($4,557,000)
4260-101-8507 Home & Community Base Services	$32,521,000	$0	($32,521,000)
4260-106-0890 Money Follow Person Fed. Grant	$2,290,000	$2,290,000	$0
4260-117-0001/0890 HIPPA	$19,589,000	$21,257,000	$1,668,000
4260-162-8506 State Fiscal Recovery Fund of 2021	$0	$0	$0
4260-601-0942 Health Homes Program Account	$0	$0	$0
4260-601-0995 Reimbursements	$77,705,000	$45,753,000	($31,952,000)
4260-601-3420 Behavioral Health IGT Fund	$0	$670,000	$670,000
4260-601-7503 Health Care Support Fund	$209,091,000	$189,939,000	($19,152,000)
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$0	$0	$0
4260-605-3167 SNF Quality & Accountability Admin.	$0	$0	$0
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	$150,000	$150,000	$0
Total County Administration	**$6,812,993,000**	**$6,328,991,000**	**($484,002,000)**
Fiscal Intermediary:			
4260-101-0001/0890 Medi-Cal General and Federal Funds	$571,998,000	$542,972,000	($29,026,000)
4260-117-0001/0890 HIPAA	$4,336,000	$4,444,000	$108,000
4260-601-0995 Reimbursements	$33,000	$11,000	($22,000)
Total Fiscal Intermediary	**$576,367,000**	**$547,427,000**	**($28,940,000)**
Grand Total - Total Funds	**$157,491,872,000**	**$156,638,217,000**	**($853,655,000)**

Medi-Cal Funding Summary
November 2023 Estimate Comparison of FY 2023-24 to FY 2024-25

STATE FUNDS

	FY 2023-24 Estimate	FY 2024-25 Estimate	Difference Incr./(Decr.)
Benefits:			
4260-101-0001 Medi-Cal General Fund*	$35,162,386,000	$34,012,575,000	($1,149,811,000)
4260-101-0080 CLPP Funds	$902,000	$0	($902,000)
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$70,115,000	$72,477,000	$2,362,000
4260-101-0233 Prop 99 Physician Srvc. Acct	$19,901,000	$20,693,000	$792,000
4260-101-0236 Prop 99 Unallocated Account	$28,753,000	$30,999,000	$2,246,000
4260-101-3085 Mental Health Services	$60,500,000	$9,457,000	($51,043,000)
4260-101-3168 Emergency Air Transportation Fund	$2,111,000	$0	($2,111,000)
4260-101-3305 Healthcare Treatment Fund	$836,586,000	$787,446,000	($49,140,000)
4260-101-3375 Medi-Cal Loan Repayment Program	$0	$0	$0
4260-101-3398 California Emergency Relief Fund	$5,984,000	$0	($5,984,000)
4260-101-3428 MCO Tax 2023	$7,873,000,000	$8,597,541,000	$724,541,000
4260-101-3431 Medi-Cal Provider Payment Reserve Fund	$321,000,000	$1,095,167,000	$774,167,000
4260-101-8507 Home & Community Based Services (101)	$397,335,000	$89,000	($397,246,000)
4260-611-0001 Home & Community Based Services(611)*	$0	$0	$0
4260-698-0001 Home & Community Based Services (698-0001)*	$0	$0	$0
4260-698-8507 Home & Community Based Services (698-8507)	$0	$0	$0
4260-102-0001 Capital Debt *	$23,568,000	$23,345,000	($223,000)
4260-102-3305 Prop 56 Loan Forgiveness Program	$0	$0	$0
4260-103-3305 Prop 56 Value-Based Payment	$0	$0	$0
4260-601-3375 Medi-Cal Loan Repayment Program	$55,581,000	$65,742,000	$10,161,000
4260-104-0001 NDPH Hosp Supp *	$1,900,000	$1,900,000	$0
4260-601-3096 NDPH Suppl	$1,862,000	$7,233,000	$5,371,000
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	($1,900,000)	($1,900,000)	$0
4260-105-0001 Private Hosp Supp Fund *	$118,400,000	$118,400,000	$0
4260-601-3097 Private Hosp Suppl	$326,036,000	$191,784,000	($134,252,000)
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($118,400,000)	($118,400,000)	$0
4260-112-0001 GF Support for Prop 56 Payments*	$69,474,000	$192,554,000	$123,080,000
4260-695-3305 Health Care Treatment Fund (Less GF)	($69,474,000)	($192,554,000)	($123,080,000)
4260-119-0001 Behavioral Health Payment Reform	$250,000,000	$0	($250,000,000)
4260-601-3420 Behavioral Health IGT Fund	$1,221,944,000	$1,575,580,000	$353,636,000
4260-695-3420 Transfer to Behavioral Health IGT Fund	($250,000,000)	$0	$250,000,000
4260-601-0942142 Local Trauma Centers	$56,411,000	$81,670,000	$25,259,000
4260-601-0942 Health Homes Program Account	$0	$0	$0
4260-601-0995 Reimbursements	$2,088,571,000	$2,183,868,000	$95,297,000
4260-601-3156 MCO Tax Fund	$175,439,000	$0	($175,439,000)
4260-601-3213 LTC QA Fund	$540,161,000	$539,546,000	($615,000)
4260-601-3293 MCO Tax Fund 2016	$0	$0	$0
4260-601-3323 Medi-Cal Emergency Transport Fund	$49,288,000	$49,037,000	($251,000)
4260-601-3331 Medi-Cal Drug Rebates Fund	$2,872,071,000	$2,483,312,000	($388,759,000)
4260-601-3334 MCO Tax (HCS Special Fund)	$0	$0	$0
4260-601-8108 Global Payment Program Fund	$1,314,355,000	$983,596,000	($330,759,000)
4260-601-8113 DPH GME Special Fund	$282,492,000	$281,222,000	($1,270,000)
4260-602-0309 Perinatal Insurance Fund	$22,981,000	$22,851,000	($130,000)
4260-605-0001 SNF Quality & Accountability *	$0	$0	$0
4260-605-3167 SNF Quality & Accountability (Non-GF) Only	$0	$0	$0
4260-605-3167 SNF Quality & Accountability	$1,176,000	$0	($1,176,000)
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	$0	$0	$0
4260-606-0834 SB 1100 DSH	$115,043,000	$125,558,000	$10,515,000
4260-611-3158 Hospital Quality Assurance Revenue	$5,971,583,000	$4,207,522,000	($1,764,061,000)
Total Benefits	**$59,897,135,000**	**$57,448,310,000**	**($2,448,825,000)**
Total Benefits General Fund *	**$35,625,728,000**	**$34,348,774,000**	**($1,276,954,000)**
County Administration:			
4260-101-0001 Medi-Cal General Fund *	$1,543,352,000	$1,395,548,000	($147,804,000)
4260-101-3085 Mental Health Services	$27,307,000	$22,750,000	($4,557,000)
4260-101-8507 Home & Community Base Services	$32,521,000	$0	($32,521,000)
4260-117-0001 HIPAA *	$4,521,000	$4,865,000	$344,000
4260-601-0942 Health Homes Program Account	$0	$0	$0
4260-601-0995 Reimbursements	$77,705,000	$45,753,000	($31,952,000)
4260-601-3420 Behavioral Health IGT Fund	$0	$670,000	$670,000
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$0	$0	$0
4260-605-3167 SNF Quality & Accountability Admin.	$0	$0	$0
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	$150,000	$150,000	$0
Total County Administration	**$1,685,556,000**	**$1,469,736,000**	**($215,820,000)**
Total County Administration General Fund *	**$1,547,873,000**	**$1,400,413,000**	**($147,460,000)**
Fiscal Intermediary:			
4260-101-0001 Medi-Cal General Fund *	$156,398,000	$162,966,000	$6,568,000
4260-117-0001 HIPAA *	$1,030,000	$1,042,000	$12,000
4260-601-0995 Reimbursements	$33,000	$11,000	($22,000)
Total Fiscal Intermediary	**$157,461,000**	**$164,019,000**	**$6,558,000**
Total Fiscal Intermediary General Fund *	**$157,428,000**	**$164,008,000**	**$6,580,000**
Grand Total - State Funds	**$61,740,152,000**	**$59,082,065,000**	**($2,658,087,000)**
Grand Total - General Fund*	**$37,331,029,000**	**$35,913,195,000**	**($1,417,834,000)**

Medi-Cal Funding Summary

November 2023 Estimate Comparison of FY 2023-24 to FY 2024-25

FEDERAL FUNDS

	FY 2023-24 Estimate	FY 2024-25 Estimate	Difference Incr./(Decr.)
Benefits:			
4260-101-0890 Federal Funds	$89,946,989,000	$92,107,467,000	$2,160,478,000
4260-102-0890 Capital Debt	$54,667,000	$49,217,000	($5,450,000)
4260-106-0890 Money Follows Person Federal Grant	$36,198,000	$36,103,000	($95,000)
4260-162-8506 State Fiscal Recovery Fund of 2021	$0	$0	$0
4260-601-7502 Demonstration DSH Fund	$166,811,000	$120,101,000	($46,710,000)
4260-601-7503 Health Care Support Fund	$712,000	$601,000	($111,000)
4260-611-0890 Home & Community Based Services 100% FF	$0	$0	$0
4260-611-0890 Hospital Quality Assurance	$0	$0	$0
Total Benefits	**$90,205,377,000**	**$92,313,489,000**	**$2,108,112,000**
County Administration:			
4260-101-0890 Federal Funds	$4,900,988,000	$4,650,634,000	($250,354,000)
4260-106-0890 Money Follows Person Fed. Grant	$2,290,000	$2,290,000	$0
4260-117-0890 HIPAA	$15,068,000	$16,392,000	$1,324,000
4260-162-8506 State Fiscal Recovery Fund of 2021	$0	$0	$0
4260-601-7503 Health Care Support Fund	$209,091,000	$189,939,000	($19,152,000)
Total County Administration	**$5,127,437,000**	**$4,859,255,000**	**($268,182,000)**
Fiscal Intermediary:			
4260-101-0890 Federal Funds	$415,600,000	$380,006,000	($35,594,000)
4260-117-0890 HIPAA	$3,306,000	$3,402,000	$96,000
Total Fiscal Intermediary	**$418,906,000**	**$383,408,000**	**($35,498,000)**
Grand Total - Federal Funds	**$95,751,720,000**	**$97,556,152,000**	**$1,804,432,000**

Medi-Cal Funding Summary

November 2023 FY 2023-24 and FY 2024-25 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 2024-25

Benefits:	**FY 2023-24 Estimate**	**FY 2024-25 Estimate**
4260-101-0001 Medi-Cal General Funds	$0	$33,136,281,000
4260-101-0890 Medi-Cal Federal Funds	$0	$92,107,467,000
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$0	$72,477,000
4260-101-0233 Prop 99 Physician Srvc. Acct	$0	$20,693,000
4260-101-0236 Prop 99 Unallocated Account	$0	$30,999,000
4260-101-3305 Healthcare Treatment Fund	$0	$787,446,000
4260-101-3428 MCO Tax 2023	$0	$8,597,541,000
4260-101-3431 Medi-Cal Provider Payment Reserve Fund	$0	$1,095,167,000
4260-102-0001 Capital Debt General Funds	$0	$23,345,000
4260-102-0890 Capital Debt Federal Funds	$0	$49,217,000
4260-104-0001 NDPH Hosp Supp	$0	$1,900,000
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	$0	($1,900,000)
4260-105-0001 Private Hosp Supp Fund	$0	$118,400,000
4260-698-3097 Private Hosp Supp (Less Funded by GF)	$0	($118,400,000)
4260-106-0890 Money Follows Person Federal Grant	$0	$36,103,000
4260-112-0001 GF Support for Prop 56 Payments*	$0	$192,554,000
4260-695-3305 Health Care Treatment Fund (Less GF)	$0	($192,554,000)
4260-601-0995 Reimbursements	$0	$2,183,868,000
4260-602-0309 Perinatal Insurance Fund	$0	$22,851,000
Total Benefits	**$0**	**$138,163,455,000**
County and Other Local Assistance Administration:^		
4260-101-0001 Medi-Cal General Funds	$0	$1,442,719,000
4260-101-0890 Medi-Cal Federal Funds	$0	$5,030,640,000
4260-101-3085 Mental Health Services	$0	$22,750,000
4260-106-0890 Money Follow Person Fed. Grant	$0	$2,290,000
4260-117-0001 HIPAA General Funds	$0	$5,907,000
4260-117-0890 HIPAA Federal Funds	$0	$19,794,000
4260-601-0995 Reimbursements	$0	$45,764,000
Total County Administration	**$0**	**$6,569,864,000**
Appropriation Year 2024-25 - Total Funds	**$0**	**$144,733,319,000**

^Starting with the Budget Act for FY 2024-25, the "County Administration" and "Fiscal Intermediary" categories will be combined into a single "County and Other Local Assistance Administration" grouping.

Medi-Cal Funding Summary
November 2023 FY 2023-24 and FY 2024-25 Breakdown by Appropriation Year

TOTAL FUNDS

Appropriation Year 2023-24

	FY 2023-24 Estimate	FY 2024-25 Estimate
Benefits:		
4260-101-0001 Medi-Cal General Funds	$33,451,482,000	$11,144,000
4260-101-0890 Medi-Cal Federal Funds	$89,946,989,000	$0
4260-101-0080 CLPP Funds	$902,000	$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$70,115,000	$0
4260-101-0233 Prop 99 Physician Srvc. Acct	$19,901,000	$0
4260-101-0236 Prop 99 Unallocated Account	$28,753,000	$0
4260-101-3085 Mental Health Services	$60,500,000	$0
4260-101-3168 Emergency Air Transportation Fund	$2,111,000	$0
4260-101-3305 Healthcare Treatment Fund	$836,586,000	$0
4260-101-3428 MCO Tax 2023	$7,873,000,000	$0
4260-101-3431 Medi-Cal Provider Payment Reserve Fund	$321,000,000	$0
4260-102-0001 Capital Debt General Funds	$23,568,000	$0
4260-102-0890 Capital Debt Federal Funds	$54,667,000	$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	$36,198,000	$0
4260-112-0001 GF Support for Prop 56 Payments*	$69,474,000	$0
4260-695-3305 Health Care Treatment Fund (Less GF)	($69,474,000)	$0
4260-119-0001 Behavioral Health Payment Reform	$250,000,000	$0
4260-695-3420 Transfer to Behavioral Health IGT Fund	($250,000,000)	$0
4260-601-0995 Reimbursements	$2,088,571,000	$0
4260-602-0309 Perinatal Insurance Fund	$22,981,000	$0
Total Benefits	**$134,837,324,000**	**$11,144,000**
County Administration:^		
4260-101-0001 Medi-Cal General Funds	$1,268,942,000	$79,678,000
4260-101-0890 Medi-Cal Federal Funds	$4,900,988,000	$0
4260-101-3085 Mental Health Services	$27,307,000	$0
4260-106-0890 Money Follow Person Fed. Grant	$2,290,000	$0
4260-117-0001 HIPAA General Funds	$4,521,000	$0
4260-117-0890 HIPAA Federal Funds	$15,068,000	$0
4260-601-0995 Reimbursements	$77,705,000	$0
Total County Administration	**$6,296,821,000**	**$79,678,000**
Fiscal Intermediary:^		
4260-101-0001 Medi-Cal General Funds	$156,398,000	$0
4260-101-0890 Medi-Cal Federal Funds	$415,600,000	$0
4260-117-0001 HIPAA General Funds	$1,030,000	$0
4260-117-0890 HIPAA Federal Funds	$3,306,000	$0
4260-601-0995 Reimbursements	$33,000	$0
Total Fiscal Intermediary	**$576,367,000**	**$0**
Appropriation Year 2023-24 - Total Funds	**$141,710,512,000**	**$90,822,000**

^Starting with the Budget Act for FY 2024-25, the "County Administration" and "Fiscal Intermediary" categories will be combined into a single "County and Other Local Assistance Administration" grouping. To facilitate comparison, FY 2024-25 will still be separated into the two unique categories when comparing to FY 2023-24 or other prior budget years.

Medi-Cal Funding Summary
November 2023 FY 2023-24 and FY 2024-25 Breakdown by Appropriation Year

TOTAL FUNDS

Appropriation Year 2022-23

Benefits:	**FY 2023-24 Estimate**	**FY 2024-25 Estimate**
4260-101-0001 Medi-Cal General Funds	$1,378,749,000	$688,562,000
4260-101-3085 Mental Health Services	$0	$9,457,000
Total Benefits	**$1,378,749,000**	**$698,019,000**
County Administration:^		
4260-101-0001 Medi-Cal General Funds	$201,950,000	$0
Total County Administration	**$201,950,000**	**$0**
Appropriation Year 2022-23 - Total Funds	**$1,580,699,000**	**$698,019,000**

Appropriation Year 2021-22

Benefits:	**FY 2023-24 Estimate**	**FY 2024-25 Estimate**
4260-101-0001 Medi-Cal General Funds	$330,150,000	$175,619,000
4260-101-3398 California Emergency Relief Fund	$5,984,000	$0
4260-101-8507 Home & Community Based Services (101)	$397,335,000	$89,000
Total Benefits	**$733,469,000**	**$175,708,000**
County Administration:^		
4260-101-0001 Medi-Cal General Funds	$72,460,000	$36,117,000
4260-101-8507 Home & Community Base Services	$32,521,000	$0
Total County Administration	**$104,981,000**	**$36,117,000**
Appropriation Year 2021-22 - Total Funds	**$838,450,000**	**$211,825,000**

Appropriation Year 2019-20

Benefits:	**FY 2023-24 Estimate**	**FY 2024-25 Estimate**
4260-101-0001 Medi-Cal General Funds	$2,005,000	$969,000
Total Benefits	**$2,005,000**	**$969,000**
Appropriation Year 2019-20 - Total Funds	**$2,005,000**	**$969,000**

Non-Budget Act Items

Benefits:		
4260-601-3375 Medi-Cal Loan Repayment Program 601	$55,581,000	$65,742,000
4260-601-3096 NDPH Suppl	$1,862,000	$7,233,000
4260-601-3097 Private Hosp Suppl	$326,036,000	$191,784,000
4260-601-3420 Behavioral Health IGT Fund	$1,221,944,000	$1,575,580,000
4260-601-0942142 Local Trauma Centers	$56,411,000	$81,670,000
4260-601-3156 MCO Tax Fund	$175,439,000	$0
4260-601-3213 LTC QA Fund	$540,161,000	$539,546,000
4260-601-3323 Medi-Cal Emergency Transport Fund	$49,288,000	$49,037,000
4260-601-3331 Medi-Cal Drug Rebates Fund	$2,872,071,000	$2,483,312,000
4260-601-7502 Demonstration DSH Fund	$166,811,000	$120,101,000
4260-601-7503 Health Care Support Fund	$712,000	$601,000
4260-601-8108 Global Payment Program Fund	$1,314,355,000	$983,596,000
4260-601-8113 DPH GME Special Fund	$282,492,000	$281,222,000
4260-605-3167 SNF Quality & Accountability	$1,176,000	$0
4260-606-0834 SB 1100 DSH	$115,043,000	$125,558,000
4260-611-3158 Hospital Quality Assurance Revenue	$5,971,583,000	$4,207,522,000
Total Benefits	**$13,150,965,000**	**$10,712,504,000**
County Administration:^		
4260-601-3420 Behavioral Health IGT Fund	$0	$670,000
4260-601-7503 Health Care Support Fund	$209,091,000	$189,939,000
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	$150,000	$150,000
Total County Administration	**$209,241,000**	**$190,759,000**
Non-Budget Act Items - Total Funds	**$13,360,206,000**	**$10,903,263,000**
Grand Total - Total Funds	**$157,491,872,000**	**$156,638,217,000**

^Starting with the Budget Act for FY 2024-25, the "County Administration" and "Fiscal Intermediary" categories will be combined into a single "County and Other Local Assistance Administration" grouping. To facilitate comparison, FY 2024-25 will still be separated into the two unique categories when comparing to FY 2023-24 or other prior budget years.

TABLE OF CONTENTS

CURRENT YEAR

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

MEDI-CAL PROGRAM ESTIMATE SUMMARY
FISCAL YEAR 2023-24

	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
I. BASE ESTIMATES				
A. C/Y FFS BASE	$30,741,720,750	$15,370,860,370	$15,370,860,370	$0
B. C/Y BASE POLICY CHANGES	$73,912,372,000	$45,245,177,230	$27,699,165,770	$968,028,990
C. BASE ADJUSTMENTS	($250,307,000)	($234,351,550)	($15,955,450)	$0
D. ADJUSTED BASE	**$104,403,785,740**	**$60,381,686,060**	**$43,054,070,690**	**$968,028,990**
II. REGULAR POLICY CHANGES				
A. ELIGIBILITY	$1,833,614,550	($844,477,420)	$2,666,130,980	$11,961,000
B. AFFORDABLE CARE ACT	$7,194,275,000	$7,608,702,200	($164,471,200)	($249,956,000)
C. BENEFITS	$768,958,840	$738,143,840	$30,815,000	$0
D. PHARMACY	($4,428,773,710)	($4,427,620,840)	($2,873,223,870)	$2,872,071,000
E. DRUG MEDI-CAL	$34,834,000	$26,135,850	$623,150	$8,075,000
F. MENTAL HEALTH	$309,040,980	($34,357,940)	$336,350,150	$7,048,770
G. WAIVER--MH/UCD & BTR	$5,026,194,000	$2,712,373,750	$749,509,250	$1,564,311,000
H. MANAGED CARE	$15,823,767,000	$9,702,628,740	($4,062,091,750)	$10,183,230,000
I. PROVIDER RATES	$1,772,163,650	$1,448,563,230	($687,302,020)	$1,010,902,440
J. SUPPLEMENTAL PMNTS.	$16,158,971,370	$10,190,366,690	$473,051,330	$5,495,553,350
K. COVID-19	($2,838,758,890)	($1,067,677,910)	($1,771,080,970)	$0
L. STATE-ONLY CLAIMING	($3,844,000)	($3,577,490,000)	$3,573,646,000	$0
M. OTHER DEPARTMENTS	$719,320,000	$719,320,000	$0	$0
N. OTHER	$3,328,964,120	$6,629,081,880	($5,700,298,760)	$2,400,181,000
O. TOTAL CHANGES	**$45,698,726,920**	**$29,823,692,070**	**($7,428,342,710)**	**$23,303,377,560**
III. TOTAL MEDI-CAL ESTIMATE	**$150,102,512,660**	**$90,205,378,130**	**$35,625,727,980**	**$24,271,406,560**

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2023-24

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	ELIGIBILITY				
1	UNDOCUMENTED EXPANSION AGES 26 THROUGH 49	$1,436,027,000	$208,017,000	$1,228,010,000	$0
2	POSTPARTUM CARE EXTENSION	$255,889,000	$130,049,000	$115,566,000	$10,274,000
3	MEDI-CAL STATE INMATE PROGRAMS	$43,024,000	$43,024,000	$0	$0
4	BREAST AND CERVICAL CANCER TREATMENT	$39,356,000	$24,108,250	$15,247,750	$0
5	PHASING IN THE MEDI-CAL ASSET LIMIT REPEAL	$39,318,560	$19,659,280	$19,659,280	$0
6	HEALTH ENROLLMENT NAVIGATORS FOR CLINICS	$20,000,000	$10,000,000	$10,000,000	$0
8	REFUGEE MEDICAL ASSISTANCE	$0	$0	($136,000)	$136,000
9	NON-OTLICP CHIP	$0	$123,270,450	($123,270,450)	$0
10	NON-EMERGENCY FUNDING ADJUSTMENT	$0	($1,610,512,300)	$1,610,512,300	$0
11	SCHIP FUNDING FOR PRENATAL CARE	$0	$79,960,900	($79,960,900)	$0
12	MEDI-CAL COUNTY INMATE REIMBURSEMENT	$0	$0	($1,551,000)	$1,551,000
13	CS3 PROXY ADJUSTMENT	$0	$127,946,000	($127,946,000)	$0
	ELIGIBILITY SUBTOTAL	**$1,833,614,560**	**($844,477,420)**	**$2,666,130,980**	**$11,961,000**
	AFFORDABLE CARE ACT				
14	COMMUNITY FIRST CHOICE OPTION	$8,010,345,000	$8,010,345,000	$0	$0
15	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	$21,774,000	$21,774,000	$0	$0
16	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	$9,748,000	($9,748,000)	$0
17	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	$0	$33,281,200	($33,281,200)	$0
18	ACA DSH REDUCTION	($837,844,000)	($466,446,000)	($121,442,000)	($249,956,000)
	AFFORDABLE CARE ACT SUBTOTAL	**$7,194,275,000**	**$7,608,702,200**	**($164,471,200)**	**($249,956,000)**
	BENEFITS				
19	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$578,033,000	$578,033,000	$0	$0
20	FAMILY PACT PROGRAM	$225,304,000	$170,595,200	$54,708,800	$0
21	MULTIPURPOSE SENIOR SERVICES PROGRAM	$63,951,000	$32,615,500	$31,335,500	$0
22	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$48,808,000	$37,954,000	$10,854,000	$0
23	BEHAVIORAL HEALTH TREATMENT	$19,667,000	$10,559,050	$9,107,950	$0
24	CYBHI - DYADIC SERVICES	$3,328,310	$1,971,950	$1,356,370	$0
25	MEDICAL INTERPRETER PILOT PROJECT	$2,005,000	$0	$2,005,000	$0
26	CCS DEMONSTRATION PROJECT	$1,730,000	$922,450	$807,550	$0
27	HEARING AID COVERAGE FOR CHILDREN PROGRAM	$1,357,440	$0	$1,357,440	$0
28	CCT FUND TRANSFER TO CDSS	$295,000	$295,000	$0	$0
29	DOULA BENEFIT	$268,090	$159,600	$108,490	$0
30	COMMUNITY HEALTH WORKER	$0	$0	$0	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2023-24

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	BENEFITS				
31	FPACT HPV VACCINE COVERAGE	$0	$0	$0	$0
32	CALAIM - LTC BENEFIT TRANSITION	($175,788,000)	($94,961,900)	($80,826,100)	$0
	BENEFITS SUBTOTAL	**$768,958,840**	**$738,143,840**	**$30,815,000**	**$0**
	PHARMACY				
33	MEDICATION THERAPY MANAGEMENT PROGRAM	$2,340,290	$1,580,510	$759,780	$0
34	MEDI-CAL DRUG REBATE FUND	$0	$0	($2,872,071,000)	$2,872,071,000
35	LITIGATION SETTLEMENTS	($8,000)	$0	($8,000)	$0
36	BCCTP DRUG REBATES	($3,218,000)	($3,218,000)	$0	$0
37	FAMILY PACT DRUG REBATES	($3,391,000)	($3,391,000)	$0	$0
38	PHARMACY RETROACTIVE ADJUSTMENTS	($80,859,000)	($104,096,050)	$23,237,050	$0
39	MEDICAL SUPPLY REBATES	($173,120,000)	($86,560,000)	($86,560,000)	$0
40	STATE SUPPLEMENTAL DRUG REBATES	($198,756,000)	($198,756,000)	$0	$0
41	FEDERAL DRUG REBATES	($4,110,500,000)	($4,110,500,000)	$0	$0
223	RESPIRATORY SYNCYTIAL VIRUS VACCINES	$138,738,000	$77,319,700	$61,418,300	$0
	PHARMACY SUBTOTAL	**($4,428,773,710)**	**($4,427,620,840)**	**($2,873,223,870)**	**$2,872,071,000**
	DRUG MEDI-CAL				
43	HCBS SP - CONTINGENCY MANAGEMENT	$21,562,000	$16,547,000	$0	$5,015,000
44	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	$14,999,000	$10,995,850	$943,150	$3,060,000
46	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	($1,727,000)	($1,407,000)	($320,000)	$0
	DRUG MEDI-CAL SUBTOTAL	**$34,834,000**	**$26,135,850**	**$623,150**	**$8,075,000**
	MENTAL HEALTH				
49	BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE	$300,030,000	$0	$300,030,000	$0
50	MHP COSTS FOR FFPSA	$43,444,980	$25,366,210	$11,230,000	$6,848,770
51	CALAIM - BH QUALITY IMPROVEMENT PROGRAM	$21,347,000	$0	$21,347,000	$0
52	MHP COSTS FOR CONTINUUM OF CARE REFORM	$3,639,000	$951,850	$2,687,150	$0
53	OUT OF STATE YOUTH - SMHS	$2,112,000	$1,056,000	$1,056,000	$0
55	SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS	$0	($158,000)	$158,000	$0
56	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	$0	$0	($200,000)	$200,000
57	CHART REVIEW	($74,000)	($74,000)	$0	$0
58	INTERIM AND FINAL COST SETTLEMENTS - SMHS	($61,458,000)	($61,500,000)	$42,000	$0
	MENTAL HEALTH SUBTOTAL	**$309,040,980**	**($34,357,940)**	**$336,350,150**	**$7,048,770**

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2023-24

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	WAIVER--MH/UCD & BTR				
59	GLOBAL PAYMENT PROGRAM	$3,195,419,000	$1,631,108,000	$0	$1,564,311,000
60	CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES	$1,829,376,000	$1,080,553,750	$748,822,250	$0
61	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	$712,000	$712,000	$0	$0
62	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	$687,000	$0	$687,000	$0
	WAIVER--MH/UCD & BTR SUBTOTAL	**$5,026,194,000**	**$2,712,373,750**	**$749,509,250**	**$1,564,311,000**
	MANAGED CARE				
66	2023 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	$9,649,139,000	$5,903,027,500	$3,746,111,500	$0
68	MANAGED CARE HEALTH CARE FINANCING PROGRAM	$2,163,690,000	$1,435,869,400	$727,820,600	$0
69	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	$2,058,008,000	$1,497,483,350	$560,524,650	$0
71	MANAGED CARE PUBLIC HOSPITAL EPP	$1,853,760,000	$1,376,141,250	$477,618,750	$0
73	HCBS SP - HOUSING AND HOMELESSNESS INCENTIVE PROG	$557,414,000	$307,430,000	$0	$249,984,000
74	RETRO MC RATE ADJUSTMENTS	$629,178,000	$285,253,400	$168,485,600	$175,439,000
75	WORKFORCE & QUALITY INCENTIVE PROGRAM	$280,000,000	$140,394,500	$139,605,500	$0
77	CYBHI - STUDENT BH INCENTIVE PROGRAM	$85,422,000	$42,711,000	$42,711,000	$0
81	CCI-QUALITY WITHHOLD REPAYMENTS	$29,976,000	$14,988,000	$14,988,000	$0
85	PROP 56 - BEHAVIORAL HEALTH INCENTIVE PROGRAM	$2,156,000	$1,985,000	$171,000	$0
89	2023 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	$0	$0	($3,464,400,000)	$3,464,400,000
90	2023 MCO ENROLLMENT TAX MANAGED CARE PLANS	$0	$0	($4,408,600,000)	$4,408,600,000
91	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	$0	$0	($1,884,807,000)	$1,884,807,000
92	COORDINATED CARE INITIATIVE RISK MITIGATION	($111,260,000)	($55,630,000)	($55,630,000)	$0
93	PROP 56 - DIRECTED PAYMENT RISK MITIGATION	($1,373,716,000)	($1,247,024,660)	($126,691,340)	$0
	MANAGED CARE SUBTOTAL	**$15,823,767,000**	**$9,702,628,740**	**($4,062,091,740)**	**$10,183,230,000**
	PROVIDER RATES				
94	RATE INCREASE FOR FQHCS/RHCS/CBRCS	$377,651,650	$240,175,210	$137,476,430	$0
95	MEDI-CAL PROVIDER PAYMENT RESERVE FUND	$200,000,000	$0	($121,000,000)	$321,000,000
96	PP-GEMT IGT PROGRAM	$272,500,070	$180,541,190	($8,494,930)	$100,453,810
97	MEDI-CAL PROVIDER RATE INCREASE	$303,000,000	$182,000,000	$121,000,000	$0
98	NURSING FACILITY RATE ADJUSTMENTS	$180,326,220	$94,851,620	$85,474,600	$0
99	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	$144,543,940	$101,045,640	($5,789,340)	$49,287,630
100	FQHC/RHC/CBRC RECONCILIATION PROCESS	$121,559,560	$77,308,120	$44,251,440	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2023-24

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	PROVIDER RATES				
101	DPH INTERIM & FINAL RECONS	$47,457,000	$47,457,000	$0	$0
102	DPH INTERIM RATE COVID-19 INCREASED FMAP ADJUST	$45,246,000	$45,246,000	$0	$0
103	AB 97 ELIMINATIONS	$40,046,190	$24,297,610	$15,748,580	$0
104	DPH INTERIM RATE GROWTH	$22,693,000	$15,571,300	$7,121,700	$0
105	LTC RATE ADJUSTMENT	$20,075,360	$10,313,420	$9,761,940	$0
106	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	$1,608,640	$975,310	$633,320	$0
107	HOSPICE RATE INCREASES	$651,280	$343,220	$308,060	$0
108	ACUPUNCTURE RATE INCREASE	$34,760	$24,230	$10,520	$0
109	DPH INTERIM RATE	$0	$431,425,800	($431,425,800)	$0
110	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	$0	$0	($540,161,000)	$540,161,000
111	REDUCTION TO RADIOLOGY RATES	($1,160,000)	($677,250)	($482,750)	$0
112	GDSP PRENATAL SCREENING PROGRAM FEE INCREASE	$43,000	$25,900	$17,100	$0
113	LABORATORY RATE METHODOLOGY CHANGE	($4,113,000)	($2,361,100)	($1,751,900)	$0
	PROVIDER RATES SUBTOTAL	**$1,772,163,650**	**$1,448,563,230**	**($687,302,020)**	**$1,010,902,440**
	SUPPLEMENTAL PMNTS.				
114	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	$3,617,930,000	$2,456,690,000	$0	$1,161,240,000
115	HOSPITAL QAF - MANAGED CARE PAYMENTS	$3,594,800,000	$2,496,755,650	$0	$1,098,044,350
116	HOSPITAL QAF - FFS PAYMENTS	$3,268,514,000	$1,510,939,000	$2,172,000	$1,755,403,000
117	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	$1,373,786,840	$842,466,080	$531,320,750	$0
118	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	$827,005,000	$559,131,000	$0	$267,874,000
119	PRIVATE HOSPITAL DSH REPLACEMENT	$711,882,000	$361,722,000	$350,160,000	$0
120	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	$685,566,000	$359,530,000	$118,400,000	$207,636,000
121	PROP 56 - MEDI-CAL FAMILY PLANNING	$487,446,210	$389,829,020	$97,617,200	$0
122	DSH PAYMENT	$451,274,000	$349,120,000	$32,527,000	$69,627,000
123	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$274,979,000	$274,979,000	$0	$0
124	FFP FOR LOCAL TRAUMA CENTERS	$138,083,000	$81,672,000	$0	$56,411,000
125	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	$119,735,000	$69,759,000	$1,053,000	$48,923,000
126	DPH PHYSICIAN & NON-PHYS. COST	$113,695,000	$113,695,000	$0	$0
127	NDPH IGT SUPPLEMENTAL PAYMENTS	$108,900,000	$65,702,000	($2,218,000)	$45,416,000
128	NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS	$105,000,000	$53,550,000	$51,450,000	$0
129	CAPITAL PROJECT DEBT REIMBURSEMENT	$94,594,000	$71,026,000	$23,568,000	$0
130	PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS	$81,874,640	$49,703,530	$32,171,110	$0

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SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2023-24

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	SUPPLEMENTAL PMNTS.				
131	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	$57,687,000	$57,687,000	$0	$0
132	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	$20,715,000	$20,715,000	$0	$0
133	GEMT SUPPLEMENTAL PAYMENT PROGRAM	($15,797,000)	($15,797,000)	$0	$0
134	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	$10,000,000	$5,100,000	$4,900,000	$0
135	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	$9,272,000	$5,585,000	$1,576,000	$2,111,000
136	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	$8,000,000	$4,080,000	$3,920,000	$0
137	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	$5,498,680	$3,234,410	$2,264,270	$0
138	NDPH SUPPLEMENTAL PAYMENT	$4,179,000	$2,317,000	$1,900,000	($38,000)
139	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	$2,352,000	$1,176,000	$0	$1,176,000
140	FREE CLINICS AUGMENTATION	$2,000,000	$0	$2,000,000	$0
141	IGT ADMIN. & PROCESSING FEE	$0	$0	($14,618,000)	$14,618,000
142	PROPOSITION 56 FUNDING	$0	$0	($767,112,000)	$767,112,000
	SUPPLEMENTAL PMNTS. SUBTOTAL	**$16,158,971,370**	**$10,190,366,690**	**$473,051,330**	**$5,495,553,350**
	COVID-19				
143	COVID-19 VACCINES	$235,840,110	$151,089,240	$84,750,880	$0
144	COVID-19 BEHAVIORAL HEALTH	$113,809,000	$105,538,250	$8,270,750	$0
145	PHARMACY-BASED COVID-19 TESTS	$10,363,000	$6,997,800	$3,365,200	$0
146	COVID-19 VACCINE FUNDING ADJUSTMENT	$0	$86,975,000	($86,975,000)	$0
147	CONTINUOUS CHIP COVERAGE DURING THE COVID-19 PHE	$0	($52,670,000)	$52,670,000	$0
148	COVID-19 ELIGIBILITY	$0	($1,715,000)	$1,715,000	$0
149	COVID-19 INCREASED FMAP - DHCS	($50,018,000)	$613,586,000	($663,604,000)	$0
150	COVID-19 REDETERMINATIONS IMPACT	($3,148,753,000)	($1,977,479,200)	($1,171,273,800)	$0
	COVID-19 SUBTOTAL	**($2,838,758,890)**	**($1,067,677,910)**	**($1,771,080,970)**	**$0**
	STATE-ONLY CLAIMING				
151	STATE-ONLY CLAIMING ADJUSTMENTS - RETRO ADJ.	($3,844,000)	($3,577,490,000)	$3,573,646,000	$0
	STATE-ONLY CLAIMING SUBTOTAL	**($3,844,000)**	**($3,577,490,000)**	**$3,573,646,000**	**$0**
	OTHER DEPARTMENTS				
152	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$719,320,000	$719,320,000	$0	$0
	OTHER DEPARTMENTS SUBTOTAL	**$719,320,000**	**$719,320,000**	**$0**	**$0**
	OTHER				
158	HCBS SP CDDS	$601,116,000	$601,116,000	$0	$0
159	BEHAVIORAL HEALTH BRIDGE HOUSING	$483,968,000	$0	$483,968,000	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2023-24

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER				
161	CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY	$351,500,000	$0	$351,500,000	$0
162	CALAIM - BH PAYMENT REFORM	$250,000,000	$0	$250,000,000	$0
163	CYBHI - EVIDENCE-BASED BH PRACTICES	$242,450,000	$0	$242,450,000	$0
164	QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES	$168,021,000	$142,818,000	$25,203,000	$0
165	SELF-DETERMINATION PROGRAM - CDDS	$120,933,000	$120,933,000	$0	$0
166	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER	$126,240,780	$63,120,390	$63,120,390	$0
167	CYBHI - URGENT NEEDS AND EMERGENT ISSUES	$106,000,000	$0	$106,000,000	$0
168	EVIDENCE-BASED DENTAL PRACTICES	$103,921,000	$69,744,950	$34,176,050	$0
169	CALAIM - PATH WPC	$101,000,000	$50,500,000	$0	$50,500,000
170	LA COUNTY JUSTICE-INVOLVED POP. SVCS & SUPPORTS	$99,220,000	$0	$99,220,000	$0
171	ASSISTED LIVING WAIVER EXPANSION	$96,824,920	$48,412,460	$48,412,460	$0
172	EQUITY & PRACTICE TRANSFORMATION PAYMENTS	$92,500,000	$46,250,000	$46,250,000	$0
173	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	$69,501,000	$69,501,000	$0	$0
174	MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG	$55,581,000	$0	$0	$55,581,000
175	CALHOPE	$51,813,000	$0	$1,313,000	$50,500,000
176	SECTION 19.56 LEGISLATIVE PRIORITIES	$49,224,000	$0	$49,224,000	$0
178	INDIAN HEALTH SERVICES	$41,430,540	$27,620,190	$13,810,340	$0
179	CALAIM - PATH FOR CLINICS	$40,000,000	$0	$40,000,000	$0
180	CARE ACT	$39,656,000	$0	$39,656,000	$0
181	CYBHI - CALHOPE STUDENT SUPPORT	$32,000,000	$0	$32,000,000	$0
183	PEER SUPPORT SPECIALIST SERVICES	$24,820,000	$19,379,000	$0	$5,441,000
184	INFANT DEVELOPMENT PROGRAM	$18,120,000	$18,120,000	$0	$0
185	ABORTION SUPPLEMENTAL PAYMENT PROGRAM	$18,564,000	$0	$18,564,000	$0
186	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	$17,550,870	$8,775,440	$8,775,440	$0
188	CLINIC WORKFORCE STABILIZATION RETENTION PAYMENTS	$0	$0	$0	$0
189	HOSPITAL & SNF COVID-19 WORKER RETENTION PAYMENTS	$5,984,000	$0	$0	$5,984,000
190	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	$11,771,000	$6,374,000	$5,397,000	$0
191	CYBHI - FEE SCHEDULE THIRD PARTY ADMINISTRATOR	$10,000,000	$0	$0	$10,000,000
192	FOSTER YOUTH SUBSTANCE USE DISORDER GRANT PROGRAM	$5,000,000	$0	$5,000,000	$0
193	HCBS SP - NON-IHSS CARE ECONOMY PMTS	$3,080,000	$1,586,000	$0	$1,494,000
194	PROP 56 - PROVIDER ACES TRAININGS	$1,807,000	$903,500	$903,500	$0
195	QAF WITHHOLD TRANSFER	$1,178,000	$942,000	$236,000	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2023-24

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER				
196	HCBS SP - CALBRIDGE BH NAVIGATOR PROGRAM	$1,056,000	$0	$0	$1,056,000
197	CLPP FUND	$902,000	$0	$0	$902,000
198	WPCS WORKERS' COMPENSATION	$620,000	$310,000	$310,000	$0
199	HCBS SP - ETSB FOR LAGUNA HONDA HOSPITAL RESIDENTS	$550,000	$0	$0	$550,000
202	URBAN INDIAN ORGANIZATIONS FUNDING SHIFT	$0	$9,121,000	($9,121,000)	$0
203	HCBS SP - ALW FUNDING SHIFT	$0	$1,400,000	($141,908,000)	$140,508,000
204	AUDIT SETTLEMENTS	$0	($150,000)	$150,000	$0
205	IMD ANCILLARY SERVICES	$0	($50,724,000)	$50,724,000	$0
206	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	$0	($118,769,000)	$118,769,000
207	FUNDING ADJUST.—ACA OPT. EXPANSION	$0	$4,654,480,400	($4,654,480,400)	$0
208	FUNDING ADJUST.—OTLICP	$0	$106,386,000	($106,386,000)	$0
209	HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	$0	($1,956,896,000)	$1,956,896,000
210	CMS DEFERRED CLAIMS	$0	$704,530,000	($704,530,000)	$0
211	INDIAN HEALTH SERVICES FUNDING SHIFT	$0	$29,278,000	($29,278,000)	$0
212	CALAIM - DENTAL INITIATIVES	$0	$0	$0	$0
213	DENTAL MANAGED CARE MLR RISK CORRIDOR	($9,800,000)	($6,645,450)	($3,154,550)	$0
214	COUNTY SHARE OF OTLICP-CCS COSTS	($11,993,000)	$0	($11,993,000)	$0
215	CCI IHSS RECONCILIATION	($30,986,000)	($115,000,000)	$84,014,000	$0
216	COUNTY BH RECOUPMENTS	($64,160,000)	$0	($64,160,000)	$0
219	ADVISORY COUNCIL ON PHYS. FIT. & MENTAL WELL-BEING	$2,000,000	$0	$0	$2,000,000
	OTHER SUBTOTAL	**$3,328,964,120**	**$6,629,081,880**	**($5,700,298,760)**	**$2,400,181,000**
	GRAND TOTAL	**$45,698,726,920**	**$29,823,692,070**	**($7,428,342,710)**	**$23,303,377,560**

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

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
FISCAL YEAR 2023-24

SERVICE CATEGORY	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
PROFESSIONAL	$9,115,948,560	$5,190,398,740	$2,759,635,640	$1,165,914,180
PHYSICIANS	$757,638,530	$443,575,530	$237,467,910	$76,595,080
OTHER MEDICAL	$6,168,946,740	$3,535,659,690	$2,389,433,380	$243,853,660
CO. & COMM. OUTPATIENT	$2,189,363,300	$1,211,163,520	$132,734,340	$845,465,430
PHARMACY	$12,510,639,920	$6,251,538,900	$2,896,951,910	$3,362,149,100
HOSPITAL INPATIENT	$12,189,234,140	$7,456,622,710	$1,487,099,570	$3,245,511,860
COUNTY INPATIENT	$4,187,212,190	$2,633,298,080	($29,411,200)	$1,583,325,310
COMMUNITY INPATIENT	$8,002,021,950	$4,823,324,630	$1,516,510,770	$1,662,186,550
LONG TERM CARE	$1,481,157,130	$821,385,400	$608,886,250	$50,885,480
NURSING FACILITIES	$1,143,001,580	$651,872,480	$460,911,410	$30,217,690
ICF-DD	$338,155,550	$169,512,920	$147,974,840	$20,667,790
OTHER SERVICES	$2,197,858,350	$1,414,605,330	$601,159,780	$182,093,240
MEDICAL TRANSPORTATION	$71,759,670	$39,661,740	$24,416,980	$7,680,960
OTHER SERVICES	$1,988,834,050	$1,307,481,920	$509,901,140	$171,451,000
HOME HEALTH	$137,264,620	$67,461,680	$66,841,660	$2,961,280
TOTAL FEE-FOR-SERVICE	**$37,494,838,110**	**$21,134,551,100**	**$8,353,733,150**	**$8,006,553,860**
MANAGED CARE	$79,573,174,540	$45,329,095,400	$19,671,226,710	$14,572,852,430
TWO PLAN MODEL	$48,053,302,600	$27,264,894,010	$11,867,273,300	$8,921,135,290
COUNTY ORGANIZED HEALTH SYSTEMS	$18,010,611,990	$10,283,618,900	$4,362,540,130	$3,364,452,960
GEOGRAPHIC MANAGED CARE	$8,977,716,220	$5,228,521,120	$2,071,858,620	$1,677,336,480
PHP & OTHER MANAG. CARE	$1,720,467,030	$841,300,490	$844,944,380	$34,222,160
REGIONAL MODEL	$2,811,076,700	$1,710,760,880	$524,610,270	$575,705,550
DENTAL	$2,185,448,290	$1,210,662,310	$852,321,730	$122,464,250
MENTAL HEALTH	$3,950,333,350	$2,719,299,870	$182,217,110	$1,048,816,370
AUDITS/ LAWSUITS	$47,197,000	$727,982,500	($680,785,500)	$0
EPSDT SCREENS	$0	$0	$0	$0
MEDICARE PAYMENTS	$7,603,332,950	$1,843,641,690	$5,759,691,260	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$19,939,830	$20,159,770	($219,940)	$0
MISC. SERVICES	$18,941,149,660	$16,866,315,960	$1,620,686,050	$454,147,650
RECOVERIES	($734,464,000)	($424,134,370)	($310,329,630)	$0
DRUG MEDI-CAL	$1,021,562,930	$777,803,900	$177,187,040	$66,571,990
GRAND TOTAL MEDI-CAL	**$150,102,512,660**	**$90,205,378,130**	**$35,625,727,980**	**$24,271,406,560**

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
NOVEMBER 2023 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2023-24

SERVICE CATEGORY	2023-24 APPROPRIATION	NOV. 2023 EST. FOR 2023-24	DOLLAR DIFFERENCE	% CHANGE
PROFESSIONAL	$8,919,167,060	$9,115,948,560	$196,781,510	2.21%
PHYSICIANS	$853,244,160	$757,638,530	($95,605,640)	-11.20%
OTHER MEDICAL	$5,821,683,130	$6,168,946,740	$347,263,610	5.97%
CO. & COMM. OUTPATIENT	$2,244,239,770	$2,189,363,300	($54,876,470)	-2.45%
PHARMACY	$11,788,160,540	$12,510,639,920	$722,479,370	6.13%
HOSPITAL INPATIENT	$11,582,695,700	$12,189,234,140	$606,538,440	5.24%
COUNTY INPATIENT	$3,780,558,390	$4,187,212,190	$406,653,800	10.76%
COMMUNITY INPATIENT	$7,802,137,310	$8,002,021,950	$199,884,640	2.56%
LONG TERM CARE	$506,602,110	$1,481,157,130	$974,555,030	192.37%
NURSING FACILITIES	$130,192,620	$1,143,001,580	$1,012,808,960	777.93%
ICF-DD	$376,409,490	$338,155,550	($38,253,940)	-10.16%
OTHER SERVICES	$2,366,034,980	$2,197,858,350	($168,176,630)	-7.11%
MEDICAL TRANSPORTATION	$109,483,410	$71,759,670	($37,723,740)	-34.46%
OTHER SERVICES	$2,007,209,600	$1,988,834,050	($18,375,550)	-0.92%
HOME HEALTH	$249,341,970	$137,264,620	($112,077,350)	-44.95%
TOTAL FEE-FOR-SERVICE	**$35,162,660,390**	**$37,494,838,110**	**$2,332,177,710**	**6.63%**
MANAGED CARE	$77,012,190,850	$79,573,174,540	$2,560,983,690	3.33%
TWO PLAN MODEL	$45,770,330,850	$48,053,302,600	$2,282,971,750	4.99%
COUNTY ORGANIZED HEALTH SYSTEMS	$18,462,195,900	$18,010,611,990	($451,583,910)	-2.45%
GEOGRAPHIC MANAGED CARE	$8,575,445,660	$8,977,716,220	$402,270,560	4.69%
PHP & OTHER MANAG. CARE	$1,727,560,920	$1,720,467,030	($7,093,890)	-0.41%
REGIONAL MODEL	$2,476,657,510	$2,811,076,700	$334,419,190	13.50%
DENTAL	$2,055,520,250	$2,185,448,290	$129,928,040	6.32%
MENTAL HEALTH	$3,975,662,240	$3,950,333,350	($25,328,890)	-0.64%
AUDITS/ LAWSUITS	$1,350,000	$47,197,000	$45,847,000	3,396.07%
MEDICARE PAYMENTS	$7,533,608,260	$7,603,332,950	$69,724,690	0.93%
STATE HOSP./DEVELOPMENTAL CNTRS.	$29,965,790	$19,939,830	($10,025,960)	-33.46%
MISC. SERVICES	$18,565,700,080	$18,941,149,660	$375,449,580	2.02%
RECOVERIES	($605,697,000)	($734,464,000)	($128,767,000)	21.26%
DRUG MEDI-CAL	$885,935,350	$1,021,562,930	$135,627,580	15.31%
GRAND TOTAL MEDI-CAL	**$144,616,896,210**	**$150,102,512,660**	**$5,485,616,460**	**3.79%**
GENERAL FUNDS	**$35,686,356,760**	**$35,625,727,980**	**($60,628,780)**	**-0.17%**
OTHER STATE FUNDS	**$23,643,139,450**	**$24,271,406,560**	**$628,267,100**	**2.66%**

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2023 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2023-24

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2023-24 APPROPRIATION		NOV. 2023 EST. FOR 2023-24		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		ELIGIBILITY						
7	1	UNDOCUMENTED EXPANSION AGES 26 THROUGH 49	$1,363,653,000	$1,213,077,000	$1,436,027,000	$1,228,010,000	$72,374,000	$14,933,000
3	2	POSTPARTUM CARE EXTENSION	$219,438,000	$105,778,000	$255,889,000	$115,566,000	$36,451,000	$9,788,000
1	3	MEDI-CAL STATE INMATE PROGRAMS	$43,709,000	$0	$43,024,000	$0	($685,000)	$0
4	4	BREAST AND CERVICAL CANCER TREATMENT	$21,829,000	$8,543,400	$39,356,000	$15,247,750	$17,527,000	$6,704,350
2	5	PHASING IN THE MEDI-CAL ASSET LIMIT REPEAL	$104,822,000	$52,411,000	$101,050,000	$50,525,000	($3,772,000)	($1,886,000)
266	6	HEALTH ENROLLMENT NAVIGATORS FOR CLINICS	$10,000,000	$10,000,000	$20,000,000	$10,000,000	$10,000,000	$0
9	8	REFUGEE MEDICAL ASSISTANCE	$0	($300,000)	$0	($136,000)	$0	$164,000
10	9	NON-OTLICP CHIP	$0	($90,724,800)	$0	($123,270,450)	$0	($32,545,650)
11	10	NON-EMERGENCY FUNDING ADJUSTMENT	$0	$2,289,865,050	$0	$1,610,512,300	$0	($679,352,750)
12	11	SCHIP FUNDING FOR PRENATAL CARE	$0	($68,132,950)	$0	($79,960,900)	$0	($11,827,950)
13	12	MEDI-CAL COUNTY INMATE REIMBURSEMENT	$0	($1,617,000)	$0	($1,551,000)	$0	$66,000
15	13	CS3 PROXY ADJUSTMENT	$0	($53,693,400)	$0	($127,946,000)	$0	($74,252,600)
5	--	CALAIM - INMATE PRE-RELEASE PROGRAM	$7,145,000	$2,429,000	$0	$0	($7,145,000)	($2,429,000)
6	--	ACCELERATED ENROLLMENT FOR ADULTS	$3,920,000	$1,960,000	$0	$0	($3,920,000)	($1,960,000)
8	--	MINIMUM WAGE INCREASE - CASELOAD SAVINGS	($64,377,000)	($24,210,900)	$0	$0	$64,377,000	$24,210,900
		ELIGIBILITY SUBTOTAL	**$1,710,139,000**	**$3,445,384,400**	**$1,895,346,000**	**$2,696,996,700**	**$185,207,000**	**($748,387,700)**
		AFFORDABLE CARE ACT						
16	14	COMMUNITY FIRST CHOICE OPTION	$7,697,834,000	$0	$8,010,345,000	$0	$312,511,000	$0
17	15	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	$16,016,000	$0	$21,774,000	$0	$5,758,000	$0
18	16	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	($8,204,000)	$0	($9,748,000)	$0	($1,544,000)

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2023 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2023-24

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2023-24 APPROPRIATION		NOV. 2023 EST. FOR 2023-24		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		AFFORDABLE CARE ACT						
19	17	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	$0	($33,508,800)	$0	($33,281,200)	$0	$227,600
20	18	ACA DSH REDUCTION	($842,079,000)	($122,016,000)	($837,844,000)	($121,442,000)	$4,235,000	$574,000
		AFFORDABLE CARE ACT SUBTOTAL	**$6,871,771,000**	**($163,728,800)**	**$7,194,275,000**	**($164,471,200)**	**$322,504,000**	**($742,400)**
		BENEFITS						
23	19	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$571,902,000	$0	$578,033,000	$0	$6,131,000	$0
24	20	FAMILY PACT PROGRAM	$393,078,000	$94,179,100	$225,304,000	$54,708,800	($167,774,000)	($39,470,300)
27	21	MULTIPURPOSE SENIOR SERVICES PROGRAM	$63,951,000	$31,335,500	$63,951,000	$31,335,500	$0	$0
28	22	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$61,649,000	$18,743,000	$48,808,000	$10,854,000	($12,841,000)	($7,889,000)
22	23	BEHAVIORAL HEALTH TREATMENT	$15,668,000	$7,249,200	$19,667,000	$9,107,950	$3,999,000	$1,858,750
29	24	CYBHI - DYADIC SERVICES	$127,702,850	$52,185,250	$128,012,000	$52,167,950	$309,150	($17,300)
35	25	MEDICAL INTERPRETER PILOT PROJECT	$2,054,000	$2,054,000	$2,005,000	$2,005,000	($49,000)	($49,000)
34	26	CCS DEMONSTRATION PROJECT	$2,430,000	$1,168,050	$1,730,000	$807,550	($700,000)	($360,500)
41	27	HEARING AID COVERAGE FOR CHILDREN PROGRAM	$1,511,730	$1,511,730	$1,515,000	$1,515,000	$3,270	$3,270
42	28	CCT FUND TRANSFER TO CDSS	$135,000	$0	$295,000	$0	$160,000	$0
37	29	DOULA BENEFIT	$557,540	$224,570	$565,000	$228,650	$7,460	$4,080
31	30	COMMUNITY HEALTH WORKER	$91,871,000	$32,393,300	$91,871,000	$32,393,300	$0	$0
33	31	FPACT HPV VACCINE COVERAGE	$8,040,000	$4,580,500	$5,092,000	$2,901,500	($2,948,000)	($1,679,000)
25	32	CALAIM - LTC BENEFIT TRANSITION	($158,790,000)	($68,574,100)	($175,788,000)	($80,826,100)	($16,998,000)	($12,252,000)
26	--	TELEHEALTH	$132,886,000	$66,443,000	$0	$0	($132,886,000)	($66,443,000)
30	--	REMOTE PATIENT MONITORING	$32,037,000	$11,892,500	$0	$0	($32,037,000)	($11,892,500)
32	--	CALAIM - ORGAN TRANSPLANT	$20,703,000	$6,602,500	$0	$0	($20,703,000)	($6,602,500)
38	--	EXPANSION TO SCREENING FOR ADDITIONAL SUBSTANCES	$1,035,000	$385,100	$0	$0	($1,035,000)	($385,100)

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2023 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2023-24

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2023-24 APPROPRIATION		NOV. 2023 EST. FOR 2023-24		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		BENEFITS						
39	--	DIABETES PREVENTION PROGRAM	$1,000,000	$370,100	$0	$0	($1,000,000)	($370,100)
40	--	ROUTINE COSTS FOR CLINICAL TRIALS	$687,000	$277,900	$0	$0	($687,000)	($277,900)
43	--	ANNUAL COGNITIVE ASSESSMENTS	$66,280	$64,540	$0	$0	($66,280)	($64,540)
		BENEFITS SUBTOTAL	**$1,370,174,400**	**$263,085,740**	**$991,060,000**	**$117,199,100**	**($379,114,400)**	**($145,886,640)**
		PHARMACY						
45	33	MEDICATION THERAPY MANAGEMENT PROGRAM	$3,027,390	$1,021,990	$2,448,000	$794,750	($579,390)	($227,240)
46	34	MEDI-CAL DRUG REBATE FUND	$0	($2,736,987,000)	$0	($2,872,071,000)	$0	($135,084,000)
--	35	LITIGATION SETTLEMENTS	$0	$0	($8,000)	($8,000)	($8,000)	($8,000)
48	36	BCCTP DRUG REBATES	($2,655,000)	$0	($3,218,000)	$0	($563,000)	$0
49	37	FAMILY PACT DRUG REBATES	($9,840,000)	$0	($3,391,000)	$0	$6,449,000	$0
50	38	PHARMACY RETROACTIVE ADJUSTMENTS	($69,668,000)	$44,948,050	($80,859,000)	$23,237,050	($11,191,000)	($21,711,000)
52	39	MEDICAL SUPPLY REBATES	($118,668,000)	($59,334,000)	($173,120,000)	($86,560,000)	($54,452,000)	($27,226,000)
51	40	STATE SUPPLEMENTAL DRUG REBATES	($698,092,000)	$0	($198,756,000)	$0	$499,336,000	$0
54	41	FEDERAL DRUG REBATES	($3,203,433,000)	$0	($4,110,500,000)	$0	($907,067,000)	$0
--	223	RESPIRATORY SYNCYTIAL VIRUS VACCINES	$0	$0	$138,738,000	$61,418,300	$138,738,000	$61,418,300
44	--	CONTINUOUS GLUCOSE MONITORING SYSTEMS BENEFIT	($43,078,000)	($16,750,200)	$0	$0	$43,078,000	$16,750,200
		PHARMACY SUBTOTAL	**($4,142,406,610)**	**($2,767,101,160)**	**($4,428,666,000)**	**($2,873,188,900)**	**($286,259,390)**	**($106,087,740)**
		DRUG MEDI-CAL						
56	43	HCBS SP - CONTINGENCY MANAGEMENT	$35,582,000	$0	$21,562,000	$0	($14,020,000)	$0
58	44	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	$1,243,390	$85,740	$14,999,000	$943,150	$13,755,610	$857,410
59	46	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	($954,000)	($254,000)	($1,727,000)	($320,000)	($773,000)	($66,000)
		DRUG MEDI-CAL SUBTOTAL	**$35,871,390**	**($168,260)**	**$34,834,000**	**$623,150**	**($1,037,390)**	**$791,410**

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2023 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2023-24

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2023-24 APPROPRIATION		NOV. 2023 EST. FOR 2023-24		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		MENTAL HEALTH						
60	49	BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE	$262,509,000	$262,509,000	$300,030,000	$300,030,000	$37,521,000	$37,521,000
64	50	MHP COSTS FOR FFPSA	$47,124,000	$12,974,000	$47,538,000	$12,288,000	$414,000	($686,000)
63	51	CALAIM - BH QUALITY IMPROVEMENT PROGRAM	$21,347,000	$21,347,000	$21,347,000	$21,347,000	$0	$0
66	52	MHP COSTS FOR CONTINUUM OF CARE REFORM	$4,310,000	$3,007,800	$3,639,000	$2,687,150	($671,000)	($320,650)
67	53	OUT OF STATE YOUTH - SMHS	$2,112,000	$1,056,000	$2,112,000	$1,056,000	$0	$0
68	55	SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS	$0	$130,000	$0	$158,000	$0	$28,000
69	56	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	$0	($200,000)	$0	($200,000)	$0	$0
70	57	CHART REVIEW	($48,000)	$0	($74,000)	$0	($26,000)	$0
71	58	INTERIM AND FINAL COST SETTLEMENTS - SMHS	($64,790,000)	$45,000	($61,458,000)	$42,000	$3,332,000	($3,000)
243	--	BH - CONNECT DEMONSTRATION	$3,821,000	$0	$0	$0	($3,821,000)	$0
		MENTAL HEALTH SUBTOTAL	**$276,385,000**	**$300,868,800**	**$313,134,000**	**$337,408,150**	**$36,749,000**	**$36,539,350**
		WAIVER--MH/UCD & BTR						
72	59	GLOBAL PAYMENT PROGRAM	$2,787,650,000	$0	$3,195,419,000	$0	$407,769,000	$0
73	60	CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES	$1,829,376,000	$748,822,250	$1,829,376,000	$748,822,250	$0	$0
75	61	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	$604,000	$0	$712,000	$0	$108,000	$0
74	62	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	$1,500,000	$1,500,000	$687,000	$687,000	($813,000)	($813,000)
251	--	CALAIM- DESIGNATED STATE HEALTH PROGRAMS	$22,710,000	($152,972,000)	$0	$0	($22,710,000)	$152,972,000
		WAIVER--MH/UCD & BTR SUBTOTAL	**$4,641,840,000**	**$597,350,250**	**$5,026,194,000**	**$749,509,250**	**$384,354,000**	**$152,159,000**

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2023 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2023-24

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2023-24 APPROPRIATION		NOV. 2023 EST. FOR 2023-24		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		MANAGED CARE						
254	66	2023 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	$9,649,139,000	$3,859,655,750	$9,649,139,000	$3,746,111,500	$0	($113,544,250)
81	68	MANAGED CARE HEALTH CARE FINANCING PROGRAM	$1,864,564,000	$611,641,050	$2,163,690,000	$727,820,600	$299,126,000	$116,179,550
80	69	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	$2,058,008,000	$560,524,650	$2,058,008,000	$560,524,650	$0	$0
82	71	MANAGED CARE PUBLIC HOSPITAL EPP	$1,853,760,000	$421,308,950	$1,853,760,000	$477,618,750	$0	$56,309,800
86	73	HCBS SP - HOUSING AND HOMELESSNESS INCENTIVE PROG	$644,000,000	$0	$557,414,000	$0	($86,586,000)	$0
87	74	RETRO MC RATE ADJUSTMENTS	$748,390,000	$354,317,850	$629,178,000	$168,485,600	($119,212,000)	($185,832,250)
91	75	WORKFORCE & QUALITY INCENTIVE PROGRAM	$280,000,000	$140,000,000	$280,000,000	$139,605,500	$0	($394,500)
89	77	CYBHI - STUDENT BH INCENTIVE PROGRAM	$85,285,000	$42,642,500	$85,422,000	$42,711,000	$137,000	$68,500
96	81	CCI-QUALITY WITHHOLD REPAYMENTS	$16,091,000	$8,045,500	$29,976,000	$14,988,000	$13,885,000	$6,942,500
--	85	PROP 56 - BEHAVIORAL HEALTH INCENTIVE PROGRAM	$0	$0	$2,156,000	$171,000	$2,156,000	$171,000
252	89	2023 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	$0	($3,859,656,000)	$0	($3,464,400,000)	$0	$395,256,000
253	90	2023 MCO ENROLLMENT TAX MANAGED CARE PLANS	$0	($3,388,600,000)	$0	($4,408,600,000)	$0	($1,020,000,000)
102	91	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	$0	($1,712,925,000)	$0	($1,884,807,000)	$0	($171,882,000)
105	92	COORDINATED CARE INITIATIVE RISK MITIGATION	($111,260,000)	($55,630,000)	($111,260,000)	($55,630,000)	$0	$0
--	93	PROP 56 - DIRECTED PAYMENT RISK MITIGATION	$0	$0	($1,373,716,000)	($126,691,340)	($1,373,716,000)	($126,691,340)
83	--	2020 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	($204,000,000)	($72,012,750)	$0	$0	$204,000,000	$72,012,750
88	--	CALAIM - TRANSITIONING POPULATIONS	$25,981,000	$10,393,750	$0	$0	($25,981,000)	($10,393,750)
101	--	CAPITATED RATE ADJUSTMENT FOR FY 2023-24	$3,637,851,000	$1,371,147,700	$0	$0	($3,637,851,000)	($1,371,147,700)
		MANAGED CARE SUBTOTAL	**$20,547,809,000**	**($1,709,146,050)**	**$15,823,767,000**	**($4,062,091,740)**	**($4,724,042,000)**	**($2,352,945,700)**

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2023 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2023-24

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2023-24 APPROPRIATION		NOV. 2023 EST. FOR 2023-24		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		PROVIDER RATES						
107	94	RATE INCREASE FOR FQHCS/RHCS/CBRCS	$325,234,640	$120,053,630	$379,358,760	$138,097,870	$54,124,120	$18,044,240
265	95	MEDI-CAL PROVIDER PAYMENT RESERVE FUND	$922,724,000	($98,232,000)	$200,000,000	($121,000,000)	($722,724,000)	($22,768,000)
109	96	PP-GEMT IGT PROGRAM	$275,003,080	($8,795,800)	$275,197,000	($8,579,000)	$193,920	$216,800
262	97	MEDI-CAL PROVIDER RATE INCREASE	$214,697,000	$89,598,350	$303,000,000	$121,000,000	$88,303,000	$31,401,650
106	98	NURSING FACILITY RATE ADJUSTMENTS	$690,522,000	$327,307,800	$695,703,000	$329,763,100	$5,181,000	$2,455,300
108	99	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	$169,672,000	($6,014,000)	$149,554,000	($5,990,000)	($20,118,000)	$24,000
110	100	FQHC/RHC/CBRC RECONCILIATION PROCESS	$133,637,000	$49,329,350	$152,809,000	$55,627,200	$19,172,000	$6,297,850
126	101	DPH INTERIM & FINAL RECONS	$186,048,000	$0	$47,457,000	$0	($138,591,000)	$0
112	102	DPH INTERIM RATE COVID-19 INCREASED FMAP ADJUST	$29,334,000	$0	$45,246,000	$0	$15,912,000	$0
115	103	AB 97 ELIMINATIONS	$42,970,000	$16,884,900	$44,476,000	$17,490,650	$1,506,000	$605,750
111	104	DPH INTERIM RATE GROWTH	$63,924,940	$20,239,100	$22,693,000	$7,121,700	($41,231,940)	($13,117,400)
113	105	LTC RATE ADJUSTMENT	$122,772,170	$59,911,590	$162,422,000	$78,980,100	$39,649,830	$19,068,510
118	106	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	$6,432,000	$2,523,650	$4,461,000	$1,756,300	($1,971,000)	($767,350)
119	107	HOSPICE RATE INCREASES	$12,639,190	$6,016,410	$1,126,000	$532,600	($11,513,190)	($5,483,810)
116	108	ACUPUNCTURE RATE INCREASE	$26,749,000	$8,100,900	$26,735,000	$8,094,300	($14,000)	($6,600)
122	109	DPH INTERIM RATE	$0	($430,947,200)	$0	($431,425,800)	$0	($478,600)
123	110	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	$0	($471,515,000)	$0	($540,161,000)	$0	($68,646,000)
125	111	REDUCTION TO RADIOLOGY RATES	($11,209,160)	($4,849,910)	($1,160,000)	($482,750)	$10,049,160	$4,367,160
120	112	GDSP PRENATAL SCREENING PROGRAM FEE INCREASE	($5,050,000)	($1,981,550)	$43,000	$17,100	$5,093,000	$1,998,650
117	113	LABORATORY RATE METHODOLOGY CHANGE	($11,191,000)	($4,749,200)	($4,113,000)	($1,751,900)	$7,078,000	$2,997,300
121	--	DURABLE MEDICAL EQUIPMENT RATE ADJUSTMENT	$751,640	$308,170	$0	$0	($751,640)	($308,170)

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2023 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2023-24

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2023-24 APPROPRIATION		NOV. 2023 EST. FOR 2023-24		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		PROVIDER RATES						
124	--	10% PROVIDER PAYMENT REDUCTION	($280,524,000)	($74,231,350)	$0	$0	$280,524,000	$74,231,350
264	--	FREESTANDING PEDIATRIC SUBACUTE RATES	$1,672,000	$836,000	$0	$0	($1,672,000)	($836,000)
		PROVIDER RATES SUBTOTAL	**$2,916,808,510**	**($400,206,150)**	**$2,505,007,760**	**($350,909,530)**	**($411,800,750)**	**$49,296,620**
		SUPPLEMENTAL PMNTS.						
127	114	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	$3,617,930,000	$0	$3,617,930,000	$0	$0	$0
154	115	HOSPITAL QAF - MANAGED CARE PAYMENTS	$3,594,800,000	$0	$3,594,800,000	$0	$0	$0
128	116	HOSPITAL QAF - FFS PAYMENTS	$3,277,268,000	$0	$3,268,514,000	$2,172,000	($8,754,000)	$2,172,000
129	117	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	$1,369,541,000	$514,772,000	$1,435,814,000	$555,310,150	$66,273,000	$40,538,150
130	118	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	$577,200,000	$0	$827,005,000	$0	$249,805,000	$0
131	119	PRIVATE HOSPITAL DSH REPLACEMENT	$709,646,000	$349,455,000	$711,882,000	$350,160,000	$2,236,000	$705,000
134	120	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	$718,481,000	$118,400,000	$685,566,000	$118,400,000	($32,915,000)	$0
133	121	PROP 56 - MEDI-CAL FAMILY PLANNING	$479,994,000	$96,658,800	$505,912,000	$101,315,200	$25,918,000	$4,656,400
132	122	DSH PAYMENT	$459,165,000	$25,625,000	$451,274,000	$32,527,000	($7,891,000)	$6,902,000
135	123	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$246,136,000	$0	$274,979,000	$0	$28,843,000	$0
137	124	FFP FOR LOCAL TRAUMA CENTERS	$191,538,000	$0	$138,083,000	$0	($53,455,000)	$0
139	125	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	$116,395,000	$172,000	$119,735,000	$1,053,000	$3,340,000	$881,000
138	126	DPH PHYSICIAN & NON-PHYS. COST	$131,129,000	$0	$113,695,000	$0	($17,434,000)	$0
144	127	NDPH IGT SUPPLEMENTAL PAYMENTS	$114,937,000	($2,317,000)	$108,900,000	($2,218,000)	($6,037,000)	$99,000
136	128	NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS	$105,000,000	$51,450,000	$105,000,000	$51,450,000	$0	$0
140	129	CAPITAL PROJECT DEBT REIMBURSEMENT	$102,576,000	$26,444,500	$94,594,000	$23,568,000	($7,982,000)	($2,876,500)

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2023 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2023-24

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2023-24 APPROPRIATION		NOV. 2023 EST. FOR 2023-24		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		SUPPLEMENTAL PMNTS.						
142	130	PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS	$598,358,000	$225,198,950	$712,573,000	$279,992,250	$114,215,000	$54,793,300
141	131	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	$60,061,000	$0	$57,687,000	$0	($2,374,000)	$0
147	132	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	$20,229,000	$0	$20,715,000	$0	$486,000	$0
143	133	GEMT SUPPLEMENTAL PAYMENT PROGRAM	$3,108,000	$0	($15,797,000)	$0	($18,905,000)	$0
148	134	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	$10,000,000	$4,900,000	$10,000,000	$4,900,000	$0	$0
150	135	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	$18,507,000	($286,000)	$9,272,000	$1,576,000	($9,235,000)	$1,862,000
149	136	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	$8,000,000	$3,920,000	$8,000,000	$3,920,000	$0	$0
151	137	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	$99,737,000	$39,333,000	$62,132,000	$25,585,000	($37,605,000)	($13,748,000)
152	138	NDPH SUPPLEMENTAL PAYMENT	$4,192,000	$1,900,000	$4,179,000	$1,900,000	($13,000)	$0
145	139	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	$2,352,000	$0	$2,352,000	$0	$0	$0
153	140	FREE CLINICS AUGMENTATION	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$0	$0
156	141	IGT ADMIN. & PROCESSING FEE	$0	($12,229,000)	$0	($14,618,000)	$0	($2,389,000)
155	142	PROPOSITION 56 FUNDING	$0	($622,686,000)	$0	($767,112,000)	$0	($144,426,000)
		SUPPLEMENTAL PMNTS. SUBTOTAL	**$16,638,280,000**	**$822,711,250**	**$16,926,796,000**	**$771,880,600**	**$288,516,000**	**($50,830,650)**
		COVID-19						
--	143	COVID-19 VACCINES	$0	$0	$300,395,000	$107,949,150	$300,395,000	$107,949,150
159	144	COVID-19 BEHAVIORAL HEALTH	$71,583,000	$5,393,350	$113,809,000	$8,270,750	$42,226,000	$2,877,400
161	145	PHARMACY-BASED COVID-19 TESTS	$115,434,230	$38,968,550	$10,363,000	$3,365,200	($105,071,230)	($35,603,350)
--	146	COVID-19 VACCINE FUNDING ADJUSTMENT	$0	$0	$0	($86,975,000)	$0	($86,975,000)
165	147	CONTINUOUS CHIP COVERAGE DURING THE COVID-19 PHE	$0	$61,985,000	$0	$52,670,000	$0	($9,315,000)

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2023 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2023-24

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2023-24 APPROPRIATION		NOV. 2023 EST. FOR 2023-24		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		COVID-19						
163	148	COVID-19 ELIGIBILITY	$69,221,000	$34,610,000	$0	$1,715,000	($69,221,000)	($32,895,000)
167	149	COVID-19 INCREASED FMAP - DHCS	($114,909,000)	($708,324,000)	($50,018,000)	($663,604,000)	$64,891,000	$44,720,000
157	150	COVID-19 REDETERMINATIONS IMPACT	$12,782,802,000	$3,961,285,400	($3,148,753,000)	($1,171,273,800)	($15,931,555,000)	($5,132,559,200)
164	--	COVID-19 VACCINE ADMINISTRATION	$0	$0	$0	$0	$0	$0
166	--	COVID-19 LTC REIMBURSEMENT RATES	$27,891,000	$11,147,900	$0	$0	($27,891,000)	($11,147,900)
168	--	COVID-19 CASELOAD IMPACT BASE ADJUSTMENT	($17,267,600,000)	($5,382,173,100)	$0	$0	$17,267,600,000	$5,382,173,100
		COVID-19 SUBTOTAL	**($4,315,577,770)**	**($1,977,106,900)**	**($2,774,204,000)**	**($1,747,882,700)**	**$1,541,373,770**	**$229,224,200**
		STATE-ONLY CLAIMING						
260	151	STATE-ONLY CLAIMING ADJUSTMENTS - RETRO ADJ.	($1,068,000)	$3,092,112,000	($3,844,000)	$3,573,646,000	($2,776,000)	$481,534,000
261	--	STATE-ONLY CLAIMING ADJUSTMENTS - PROSP. ADJ.	$131,805,000	$1,224,713,000	$0	$0	($131,805,000)	($1,224,713,000)
		STATE-ONLY CLAIMING SUBTOTAL	**$130,737,000**	**$4,316,825,000**	**($3,844,000)**	**$3,573,646,000**	**($134,581,000)**	**($743,179,000)**
		OTHER DEPARTMENTS						
171	152	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$618,220,000	$0	$719,320,000	$0	$101,100,000	$0
		OTHER DEPARTMENTS SUBTOTAL	**$618,220,000**	**$0**	**$719,320,000**	**$0**	**$101,100,000**	**$0**
		OTHER						
186	158	HCBS SP CDDS	$519,612,000	$0	$601,116,000	$0	$81,504,000	$0
181	159	BEHAVIORAL HEALTH BRIDGE HOUSING	$798,968,000	$533,968,000	$483,968,000	$483,968,000	($315,000,000)	($50,000,000)
182	161	CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY	$391,250,000	$391,250,000	$351,500,000	$351,500,000	($39,750,000)	($39,750,000)
228	162	CALAIM - BH PAYMENT REFORM	$250,000,000	$250,000,000	$250,000,000	$250,000,000	$0	$0
183	163	CYBHI - EVIDENCE-BASED BH PRACTICES	$287,500,000	$287,500,000	$242,450,000	$242,450,000	($45,050,000)	($45,050,000)

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2023 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2023-24

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2023-24 APPROPRIATION		NOV. 2023 EST. FOR 2023-24		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER						
194	164	QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES	$168,773,000	$25,316,000	$168,021,000	$25,203,000	($752,000)	($113,000)
201	165	SELF-DETERMINATION PROGRAM - CDDS	$147,596,000	$0	$120,933,000	$0	($26,663,000)	$0
188	166	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER	$323,885,000	$161,942,500	$393,887,000	$196,943,500	$70,002,000	$35,001,000
189	167	CYBHI - URGENT NEEDS AND EMERGENT ISSUES	$84,500,000	$84,500,000	$106,000,000	$106,000,000	$21,500,000	$21,500,000
202	168	EVIDENCE-BASED DENTAL PRACTICES	$36,428,000	$11,324,950	$103,921,000	$34,176,050	$67,493,000	$22,851,100
--	169	CALAIM - PATH WPC	$0	$0	$101,000,000	$0	$101,000,000	$0
--	170	LA COUNTY JUSTICE-INVOLVED POP. SVCS & SUPPORTS	$0	$0	$99,220,000	$99,220,000	$99,220,000	$99,220,000
207	171	ASSISTED LIVING WAIVER EXPANSION	$32,526,000	($28,981,000)	$171,099,000	$85,549,500	$138,573,000	$114,530,500
187	172	EQUITY & PRACTICE TRANSFORMATION PAYMENTS	$92,500,000	$46,250,000	$92,500,000	$46,250,000	$0	$0
198	173	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	$59,114,000	$0	$69,501,000	$0	$10,387,000	$0
200	174	MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG	$52,023,000	$0	$55,581,000	$0	$3,558,000	$0
192	175	CALHOPE	$62,500,000	$0	$51,813,000	$1,313,000	($10,687,000)	$1,313,000
--	176	SECTION 19.56 LEGISLATIVE PRIORITIES	$0	$0	$49,224,000	$49,224,000	$49,224,000	$49,224,000
196	178	INDIAN HEALTH SERVICES	$41,731,000	$13,910,500	$41,731,000	$13,910,500	$0	$0
267	179	CALAIM - PATH FOR CLINICS	$40,000,000	$40,000,000	$40,000,000	$40,000,000	$0	$0
193	180	CARE ACT	$52,334,000	$52,334,000	$39,656,000	$39,656,000	($12,678,000)	($12,678,000)
208	181	CYBHI - CALHOPE STUDENT SUPPORT	$24,000,000	$24,000,000	$32,000,000	$32,000,000	$8,000,000	$8,000,000
212	183	PEER SUPPORT SPECIALIST SERVICES	$25,545,000	$0	$24,820,000	$0	($725,000)	$0
205	184	INFANT DEVELOPMENT PROGRAM	$22,875,000	$0	$18,120,000	$0	($4,755,000)	$0
219	185	ABORTION SUPPLEMENTAL PAYMENT PROGRAM	$25,107,000	$25,107,000	$18,564,000	$18,564,000	($6,543,000)	($6,543,000)
209	186	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	$83,370,100	$40,603,170	$94,716,000	$47,358,000	$11,345,900	$6,754,830

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2023 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2023-24

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2023-24 APPROPRIATION		NOV. 2023 EST. FOR 2023-24		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER						
--	188	CLINIC WORKFORCE STABILIZATION RETENTION PAYMENTS	$0	$0	$0	$0	$0	$0
--	189	HOSPITAL & SNF COVID-19 WORKER RETENTION PAYMENTS	$0	$0	$5,984,000	$0	$5,984,000	$0
213	190	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	$10,143,000	$4,641,000	$11,771,000	$5,397,000	$1,628,000	$756,000
269	191	CYBHI - FEE SCHEDULE THIRD PARTY ADMINISTRATOR	$10,000,000	$0	$10,000,000	$0	$0	$0
223	192	FOSTER YOUTH SUBSTANCE USE DISORDER GRANT PROGRAM	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$0	$0
217	193	HCBS SP - NON-IHSS CARE ECONOMY PMTS	$12,250,000	$0	$3,080,000	$0	($9,170,000)	$0
220	194	PROP 56 - PROVIDER ACES TRAININGS	$1,807,000	$903,500	$1,807,000	$903,500	$0	$0
222	195	QAF WITHHOLD TRANSFER	$1,479,000	$458,500	$1,178,000	$236,000	($301,000)	($222,500)
203	196	HCBS SP - CALBRIDGE BH NAVIGATOR PROGRAM	$1,145,000	$0	$1,056,000	$0	($89,000)	$0
224	197	CLPP FUND	$902,000	$0	$902,000	$0	$0	$0
225	198	WPCS WORKERS' COMPENSATION	$620,000	$310,000	$620,000	$310,000	$0	$0
227	199	HCBS SP - ETSB FOR LAGUNA HONDA HOSPITAL RESIDENTS	$550,000	$0	$550,000	$0	$0	$0
229	202	URBAN INDIAN ORGANIZATIONS FUNDING SHIFT	$0	($8,050,000)	$0	($9,121,000)	$0	($1,071,000)
--	203	HCBS SP - ALW FUNDING SHIFT	$0	$0	$0	($141,908,000)	$0	($141,908,000)
--	204	AUDIT SETTLEMENTS	$0	$0	$0	$150,000	$0	$150,000
231	205	IMD ANCILLARY SERVICES	$0	$53,948,000	$0	$50,724,000	$0	($3,224,000)
232	206	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	($118,769,000)	$0	($118,769,000)	$0	$0
233	207	FUNDING ADJUST.—ACA OPT. EXPANSION	$0	($4,524,034,000)	$0	($4,654,480,400)	$0	($130,446,400)
234	208	FUNDING ADJUST.—OTLICP	$0	($109,528,650)	$0	($106,386,000)	$0	$3,142,650
235	209	HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	($1,958,596,000)	$0	($1,956,896,000)	$0	$1,700,000
237	210	CMS DEFERRED CLAIMS	$0	($606,287,000)	$0	($704,530,000)	$0	($98,243,000)

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2023 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2023-24

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2023-24 APPROPRIATION		NOV. 2023 EST. FOR 2023-24		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER						
236	211	INDIAN HEALTH SERVICES FUNDING SHIFT	$0	($15,115,500)	$0	($29,278,000)	$0	($14,162,500)
221	212	CALAIM - DENTAL INITIATIVES	$250,903,000	$120,224,950	$250,903,000	$120,224,950	$0	$0
--	213	DENTAL MANAGED CARE MLR RISK CORRIDOR	$0	$0	($9,800,000)	($3,154,550)	($9,800,000)	($3,154,550)
239	214	COUNTY SHARE OF OTLICP-CCS COSTS	($20,874,000)	($20,874,000)	($11,993,000)	($11,993,000)	$8,881,000	$8,881,000
184	215	CCI IHSS RECONCILIATION	($30,986,000)	($30,986,000)	($30,986,000)	$84,014,000	$0	$115,000,000
249	216	COUNTY BH RECOUPMENTS	($63,468,000)	($63,468,000)	($64,160,000)	($64,160,000)	($692,000)	($692,000)
--	219	ADVISORY COUNCIL ON PHYS. FIT. & MENTAL WELL-BEING	$0	$0	$2,000,000	$0	$2,000,000	$0
258	--	REPAYMENT OF FEDERAL FUNDS FOR NON-COMPLIANT PASRR	$0	$5,000,000	$0	$0	$0	($5,000,000)
268	--	RECONCILIATION - BENEFITS	($10,000,000)	($10,000,000)	$0	$0	$10,000,000	$10,000,000
		OTHER SUBTOTAL	**$3,791,608,100**	**($5,316,197,080)**	**$3,999,253,000**	**($5,370,430,950)**	**$207,644,900**	**($54,233,870)**
		GRAND TOTAL	**$51,091,659,010**	**($2,587,428,970)**	**$48,222,272,760**	**($6,321,712,070)**	**($2,869,386,250)**	**($3,734,283,100)**

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

FISCAL YEAR 2023-24 COST PER ELIGIBLE BASED ON NOVEMBER 2023 ESTIMATE

SERVICE CATEGORY	PA-OAS	NEWLY	PA-ATD	PA-AFDC	LT-OAS	H-PE
PHYSICIANS	$1,077,430	$133,188,760	$53,144,630	$42,286,960	$567,670	$60,716,640
OTHER MEDICAL	$114,521,210	$1,882,528,950	$475,222,460	$466,165,430	$3,522,050	$36,160,700
CO. & COMM. OUTPATIENT	$1,032,280	$119,636,910	$74,029,640	$47,090,090	$236,060	$53,755,530
PHARMACY	$70,233,750	$6,524,050,070	$2,117,835,080	$461,665,280	$8,279,180	$25,243,080
COUNTY INPATIENT	$2,547,880	$492,696,590	$41,290,970	$35,854,310	$1,127,190	$90,886,970
COMMUNITY INPATIENT	$21,327,020	$998,062,140	$363,014,560	$303,725,070	$4,235,600	$362,619,600
NURSING FACILITIES	$40,802,840	$113,497,330	$276,193,410	$7,889,580	$224,515,730	$3,564,490
ICF-DD	$2,684,630	$9,806,250	$122,850,560	$2,186,490	$53,614,090	$0
MEDICAL TRANSPORTATION	$315,910	$31,167,920	$8,451,640	$4,880,480	$341,610	$9,578,190
OTHER SERVICES	$120,925,250	$65,927,660	$749,560,150	$100,715,390	$24,375,720	$3,371,570
HOME HEALTH	$2,583,610	$1,613,110	$68,067,570	$6,118,710	$1,470	$204,230
FFS SUBTOTAL	**$378,051,800**	**$10,372,175,700**	**$4,349,660,670**	**$1,478,577,800**	**$320,816,360**	**$646,101,010**
DENTAL	$50,823,580	$421,450,090	$116,402,400	$224,232,980	$9,383,460	$1,599,930
MENTAL HEALTH	$13,042,200	$430,469,320	$1,421,245,740	$991,400,510	$925,780	$11,207,220
TWO PLAN MODEL	$2,156,700,240	$16,719,691,810	$5,617,500,370	$2,090,406,270	$2,182,449,530	$0
COUNTY ORGANIZED HEALTH SYSTEMS	$842,548,980	$6,396,312,110	$2,160,617,260	$537,774,460	$69,675,990	$0
GEOGRAPHIC MANAGED CARE	$326,915,380	$3,151,710,160	$1,109,632,060	$341,591,410	$403,647,350	$0
PHP & OTHER MANAG. CARE	$414,844,180	$27,133,590	$239,820,810	$4,046,470	$15,850,480	$0
MEDICARE PAYMENTS	$2,000,498,370	$320,607,980	$1,780,356,240	$0	$156,043,490	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	($880)	$0	($1,510)	($1,990)	($80)	$0
MISC. SERVICES	$54,489,490	$720	$359,644,170	$6,818,910	$0	$0
DRUG MEDI-CAL	$27,237,890	$389,987,070	$58,042,710	$75,665,520	$2,370,890	$20,000
REGIONAL MODEL	$64,524,330	$889,853,980	$369,762,060	$102,327,180	$184,234,730	$0
NON-FFS SUBTOTAL	**$5,951,623,760**	**$28,747,216,820**	**$13,233,022,310**	**$4,374,261,740**	**$3,024,581,610**	**$12,827,140**
TOTAL DOLLARS (1)	**$6,329,675,560**	**$39,119,392,520**	**$17,582,682,990**	**$5,852,839,540**	**$3,345,397,970**	**$658,928,160**
ELIGIBLES * **	**422,000**	**4,925,300**	**864,700**	**1,158,300**	**34,000**	**36,700**
ANNUAL $/ELIGIBLE	**$14,999**	**$7,943**	**$20,334**	**$5,053**	**$98,394**	**$17,954**
AVG. MO. $/ELIGIBLE	**$1,250**	**$662**	**$1,694**	**$421**	**$8,200**	**$1,496**

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

FISCAL YEAR 2023-24 COST PER ELIGIBLE BASED ON NOVEMBER 2023 ESTIMATE

SERVICE CATEGORY	LT-ATD	POV 250	MN-OAS	MN-ATD	MN-AFDC	MI-C
PHYSICIANS	$452,320	$15,106,640	$9,875,770	$6,377,820	$100,247,510	$27,590,280
OTHER MEDICAL	$1,913,990	$199,702,540	$293,895,540	$95,086,220	$1,493,976,010	$113,275,620
CO. & COMM. OUTPATIENT	$175,330	$24,542,940	$9,967,320	$7,851,720	$136,573,770	$16,449,180
PHARMACY	$3,980,090	$248,207,590	$442,133,820	$194,113,110	$2,125,408,730	$62,943,880
COUNTY INPATIENT	$318,020	$6,049,810	$27,963,230	$10,546,270	$130,719,020	$12,183,770
COMMUNITY INPATIENT	$3,751,570	$78,281,970	$77,871,440	$27,262,180	$678,795,570	$67,042,740
NURSING FACILITIES	$67,342,270	$2,877,370	$220,936,570	$35,353,630	$23,223,670	$8,574,250
ICF-DD	$116,793,810	$152,470	$2,455,660	$8,131,250	$1,513,880	$4,692,910
MEDICAL TRANSPORTATION	$249,510	$658,630	$2,856,680	$1,749,030	$9,161,310	$4,792,550
OTHER SERVICES	$6,258,440	$29,861,030	$215,859,850	$171,794,700	$100,593,960	$46,839,850
HOME HEALTH	$6,690	$7,132,480	$1,208,600	$20,390,420	$10,067,250	$10,464,280
FFS SUBTOTAL	**$201,242,040**	**$612,573,470**	**$1,305,024,490**	**$578,656,350**	**$4,810,280,670**	**$374,849,300**
DENTAL	$2,712,100	$170,743,310	$72,208,740	$24,673,220	$585,927,770	$24,227,430
MENTAL HEALTH	$2,183,890	$103,762,070	$17,824,730	$135,359,380	$750,946,980	$109,267,730
TWO PLAN MODEL	$377,736,040	$868,193,100	$3,759,073,060	$1,254,930,120	$6,076,092,970	$52,415,220
COUNTY ORGANIZED HEALTH SYSTEMS	$15,881,130	$380,639,830	$1,666,048,010	$630,703,350	$2,523,087,480	$40,560,660
GEOGRAPHIC MANAGED CARE	$63,162,370	$169,496,330	$510,520,680	$267,841,910	$1,312,321,360	$7,888,060
PHP & OTHER MANAG. CARE	$1,223,680	($778,340)	$708,072,500	$58,579,120	$341,490	($4,810)
MEDICARE PAYMENTS	$0	$0	$2,406,763,110	$795,249,000	$143,814,740	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	($20)	$0	($1,600)	($360)	($6,200)	($260)
MISC. SERVICES	$0	$0	$98,850,770	$88,909,790	$21,278,900	$891,620
DRUG MEDI-CAL	$545,660	$62,872,910	$47,946,170	$14,201,640	$235,282,890	$10,208,480
REGIONAL MODEL	$16,090,000	$44,091,020	$157,727,340	$112,934,920	$382,569,220	$2,184,850
NON-FFS SUBTOTAL	**$479,534,860**	**$1,799,020,240**	**$9,445,033,530**	**$3,383,382,090**	**$12,031,657,630**	**$247,638,980**
TOTAL DOLLARS (1)	**$680,776,900**	**$2,411,593,710**	**$10,750,058,020**	**$3,962,038,440**	**$16,841,938,290**	**$622,488,290**
ELIGIBLES * **	**7,300**	**883,900**	**770,500**	**196,000**	**3,797,700**	**148,200**
ANNUAL $/ELIGIBLE	**$93,257**	**$2,728**	**$13,952**	**$20,214**	**$4,435**	**$4,200**
AVG. MO. $/ELIGIBLE	**$7,771**	**$227**	**$1,163**	**$1,685**	**$370**	**$350**

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

FISCAL YEAR 2023-24 COST PER ELIGIBLE BASED ON NOVEMBER 2023 ESTIMATE

SERVICE CATEGORY	MI-A	REFUGEE	OBRA	POV 185	POV 133	POV 100
PHYSICIANS	$370,300	$255,850	$1,130	$77,332,300	$16,294,300	$6,799,910
OTHER MEDICAL	$393,910	$4,173,470	$1,040	$293,211,300	$271,101,360	$131,602,900
CO. & COMM. OUTPATIENT	$70,910	$225,860	$130	$28,176,540	$16,898,620	$12,238,710
PHARMACY	$1,521,610	$5,018,870	$650	$60,330,640	$98,550,290	$109,941,250
COUNTY INPATIENT	$5,341,960	$32,970	$0	$97,645,640	$4,918,350	$2,321,000
COMMUNITY INPATIENT	$1,646,710	$510,200	$1,710	$598,179,760	$91,193,380	$30,246,600
NURSING FACILITIES	$10,242,650	$0	$96,050	$1,108,310	$6,612,450	$1,277,970
ICF-DD	$1,159,480	$0	$480	$150	$244,020	$27,240
MEDICAL TRANSPORTATION	$55,910	$29,150	$160	$2,626,400	$707,830	$368,710
OTHER SERVICES	$443,350	$87,220	$120	$7,603,720	$35,032,680	$14,287,390
HOME HEALTH	$0	$0	$0	$2,352,700	$4,080,370	$2,363,800
FFS SUBTOTAL	**$21,246,780**	**$10,333,590**	**$101,470**	**$1,168,567,460**	**$545,633,650**	**$311,475,480**
DENTAL	$145,450	$1,185,350	$0	$16,909,780	$219,264,110	$90,686,970
MENTAL HEALTH	$0	$204,420	$2,044,170	$2,237,650	$32,962,440	$50,103,800
TWO PLAN MODEL	$863,420	$5,927,740	$0	$476,964,180	$810,222,840	$412,931,210
COUNTY ORGANIZED HEALTH SYSTEMS	$366,680	$1,616,490	$0	$212,873,350	$297,058,050	$159,018,460
GEOGRAPHIC MANAGED CARE	$75,010	$3,347,050	$0	$95,179,460	$150,746,110	$65,796,780
PHP & OTHER MANAG. CARE	($34,810)	$0	$0	($483,320)	($589,750)	($589,750)
MEDICARE PAYMENTS	$0	$0	$0	$0	$0	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	($10)	$0	$0	($590)	$0	($690)
MISC. SERVICES	$280	$0	$0	$31,380	$4,597,590	$2,372,110
DRUG MEDI-CAL	$195,360	$485,680	$0	$22,120,920	$50,551,280	$26,109,490
REGIONAL MODEL	$90,550	$219,640	$0	$27,432,650	$41,309,610	$19,981,200
NON-FFS SUBTOTAL	**$1,701,930**	**$12,986,360**	**$2,044,170**	**$853,265,460**	**$1,606,122,270**	**$826,409,580**
TOTAL DOLLARS (1)	**$22,948,710**	**$23,319,960**	**$2,145,640**	**$2,021,832,920**	**$2,151,755,920**	**$1,137,885,060**
ELIGIBLES * **	**3,000**	**6,000**	**0**	**364,800**	**768,000**	**371,100**
ANNUAL $/ELIGIBLE	**$7,650**	**$3,887**		**$5,542**	**$2,802**	**$3,066**
AVG. MO. $/ELIGIBLE	**$637**	**$324**		**$462**	**$233**	**$256**

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Refer to page following for listing of excluded policy changes.

FISCAL YEAR 2023-24 COST PER ELIGIBLE BASED ON NOVEMBER 2023 ESTIMATE

SERVICE CATEGORY	TOTAL
PHYSICIANS	**$551,686,220**
OTHER MEDICAL	**$5,876,454,700**
CO. & COMM. OUTPATIENT	**$548,951,530**
PHARMACY	**$12,559,456,980**
COUNTY INPATIENT	**$962,443,940**
COMMUNITY INPATIENT	**$3,707,767,830**
NURSING FACILITIES	**$1,044,108,590**
ICF-DD	**$326,313,370**
MEDICAL TRANSPORTATION	**$77,991,610**
OTHER SERVICES	**$1,693,538,040**
HOME HEALTH	**$136,655,290**
FFS SUBTOTAL	**$27,485,368,100**
DENTAL	**$2,032,576,650**
MENTAL HEALTH	**$4,075,188,050**
TWO PLAN MODEL	**$42,862,098,140**
COUNTY ORGANIZED HEALTH SYSTEMS	**$15,934,782,290**
GEOGRAPHIC MANAGED CARE	**$7,979,871,480**
PHP & OTHER MANAG. CARE	**$1,467,431,540**
MEDICARE PAYMENTS	**$7,603,332,950**
STATE HOSP./DEVELOPMENTAL CNTRS.	**($14,170)**
MISC. SERVICES	**$637,885,740**
DRUG MEDI-CAL	**$1,023,844,550**
REGIONAL MODEL	**$2,415,333,300**
NON-FFS SUBTOTAL	**$86,032,330,500**
TOTAL DOLLARS (1)	**$113,517,698,600**
ELIGIBLES * **	**14,757,500**
ANNUAL $/ELIGIBLE	**$7,692**
AVG. MO. $/ELIGIBLE	**$641**

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

FISCAL YEAR 2023-24 COST PER ELIGIBLE BASED ON NOVEMBER 2023 ESTIMATE

EXCLUDED POLICY CHANGES: 116

	QAF WITHHOLD TRANSFER ADJUSTMENT
	QAF WITHHOLD ADJUSTMENT
2	POSTPARTUM CARE EXTENSION
4	BREAST AND CERVICAL CANCER TREATMENT
6	HEALTH ENROLLMENT NAVIGATORS FOR CLINICS
13	CS3 PROXY ADJUSTMENT
14	COMMUNITY FIRST CHOICE OPTION
16	1% FMAP INCREASE FOR PREVENTIVE SERVICES
17	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.
18	ACA DSH REDUCTION
20	FAMILY PACT PROGRAM
22	CALIFORNIA COMMUNITY TRANSITIONS COSTS
25	MEDICAL INTERPRETER PILOT PROJECT
31	FPACT HPV VACCINE COVERAGE
35	LITIGATION SETTLEMENTS
37	FAMILY PACT DRUG REBATES
38	PHARMACY RETROACTIVE ADJUSTMENTS
46	DRUG MEDI-CAL PROGRAM COST SETTLEMENT
49	BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE
51	CALAIM - BH QUALITY IMPROVEMENT PROGRAM
55	SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS
56	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT
57	CHART REVIEW
58	INTERIM AND FINAL COST SETTLEMENTS - SMHS
59	GLOBAL PAYMENT PROGRAM
60	CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES
61	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG
76	DENTAL MANAGED CARE (Other M/C)
77	CYBHI - STUDENT BH INCENTIVE PROGRAM
80	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL
83	COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM
84	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL
85	PROP 56 - BEHAVIORAL HEALTH INCENTIVE PROGRAM
91	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND

FISCAL YEAR 2023-24 COST PER ELIGIBLE BASED ON NOVEMBER 2023 ESTIMATE

EXCLUDED POLICY CHANGES: 116

93	PROP 56 - DIRECTED PAYMENT RISK MITIGATION
95	MEDI-CAL PROVIDER PAYMENT RESERVE FUND
99	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF
110	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES
114	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS
115	HOSPITAL QAF - MANAGED CARE PAYMENTS
116	HOSPITAL QAF - FFS PAYMENTS
118	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS
119	PRIVATE HOSPITAL DSH REPLACEMENT
120	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
121	PROP 56 - MEDI-CAL FAMILY PLANNING
122	DSH PAYMENT
123	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS
124	FFP FOR LOCAL TRAUMA CENTERS
125	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS
126	DPH PHYSICIAN & NON-PHYS. COST
127	NDPH IGT SUPPLEMENTAL PAYMENTS
129	CAPITAL PROJECT DEBT REIMBURSEMENT
130	PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS
131	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS
132	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS
133	GEMT SUPPLEMENTAL PAYMENT PROGRAM
134	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH
135	EMERGENCY MEDICAL AIR TRANSPORTATION ACT
136	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH
137	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS
138	NDPH SUPPLEMENTAL PAYMENT
139	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS
140	FREE CLINICS AUGMENTATION
141	IGT ADMIN. & PROCESSING FEE
142	PROPOSITION 56 FUNDING
148	COVID-19 ELIGIBILITY
151	STATE-ONLY CLAIMING ADJUSTMENTS - RETRO ADJ.
152	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS

FISCAL YEAR 2023-24 COST PER ELIGIBLE BASED ON NOVEMBER 2023 ESTIMATE

EXCLUDED POLICY CHANGES: 116

155	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)
156	PERSONAL CARE SERVICES (Misc. Svcs.)
159	BEHAVIORAL HEALTH BRIDGE HOUSING
160	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)
161	CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY
163	CYBHI - EVIDENCE-BASED BH PRACTICES
165	SELF-DETERMINATION PROGRAM - CDDS
166	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER
167	CYBHI - URGENT NEEDS AND EMERGENT ISSUES
168	EVIDENCE-BASED DENTAL PRACTICES
169	CALAIM - PATH WPC
170	LA COUNTY JUSTICE-INVOLVED POP. SVCS & SUPPORTS
171	ASSISTED LIVING WAIVER EXPANSION
172	EQUITY & PRACTICE TRANSFORMATION PAYMENTS
173	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS
174	MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG
175	CALHOPE
176	SECTION 19.56 LEGISLATIVE PRIORITIES
177	LAWSUITS/CLAIMS
179	CALAIM - PATH FOR CLINICS
181	CYBHI - CALHOPE STUDENT SUPPORT
182	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC
185	ABORTION SUPPLEMENTAL PAYMENT PROGRAM
186	MINIMUM WAGE INCREASE FOR HCBS WAIVERS
187	MEDI-CAL TCM PROGRAM
188	CLINIC WORKFORCE STABILIZATION RETENTION PAYMENTS
189	HOSPITAL & SNF COVID-19 WORKER RETENTION PAYMENTS
190	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS
191	CYBHI - FEE SCHEDULE THIRD PARTY ADMINISTRATOR
192	FOSTER YOUTH SUBSTANCE USE DISORDER GRANT PROGRAM
193	HCBS SP - NON-IHSS CARE ECONOMY PMTS
194	PROP 56 - PROVIDER ACES TRAININGS
195	QAF WITHHOLD TRANSFER
196	HCBS SP - CALBRIDGE BH NAVIGATOR PROGRAM

FISCAL YEAR 2023-24 COST PER ELIGIBLE BASED ON NOVEMBER 2023 ESTIMATE

EXCLUDED POLICY CHANGES: 116

197	CLPP FUND
199	HCBS SP - ETSB FOR LAGUNA HONDA HOSPITAL RESIDENTS
202	URBAN INDIAN ORGANIZATIONS FUNDING SHIFT
204	AUDIT SETTLEMENTS
206	CIGARETTE AND TOBACCO SURTAX FUNDS
209	HOSPITAL QAF - CHILDREN'S HEALTH CARE
210	CMS DEFERRED CLAIMS
212	CALAIM - DENTAL INITIATIVES
213	DENTAL MANAGED CARE MLR RISK CORRIDOR
214	COUNTY SHARE OF OTLICP-CCS COSTS
215	CCI IHSS RECONCILIATION
216	COUNTY BH RECOUPMENTS
217	BASE RECOVERIES
219	ADVISORY COUNCIL ON PHYS. FIT. & MENTAL WELL-BEING
220	ASSET LIMIT INCREASE & ELIM. - CNTY BH FUNDING
225	ENHANCED CARE MANAGEMENT RISK CORRIDOR

TABLE OF CONTENTS

BUDGET YEAR

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

MEDI-CAL PROGRAM ESTIMATE SUMMARY
FISCAL YEAR 2024-25

	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
I. BASE ESTIMATES				
A. B/Y FFS BASE	$31,456,902,070	$15,728,451,040	$15,728,451,040	$0
B. B/Y BASE POLICY CHANGES	$76,182,680,010	$46,179,915,180	$28,468,643,830	$1,534,121,000
C. BASE ADJUSTMENTS	($251,974,000)	($235,108,450)	($16,865,550)	$0
D. ADJUSTED BASE	**$107,387,608,080**	**$61,673,257,760**	**$44,180,229,320**	**$1,534,121,000**
II. REGULAR POLICY CHANGES				
A. ELIGIBILITY	$3,787,031,140	($580,239,230)	$4,354,954,370	$12,316,000
B. AFFORDABLE CARE ACT	$7,503,561,000	$8,082,915,600	($173,704,600)	($405,650,000)
C. BENEFITS	$1,293,375,060	$1,157,335,050	$136,040,010	$0
D. PHARMACY	($4,200,980,720)	($4,250,191,790)	($2,434,100,930)	$2,483,312,000
E. DRUG MEDI-CAL	$101,566,000	$76,806,250	$985,750	$23,774,000
F. MENTAL HEALTH	$264,989,000	($13,380,950)	$254,900,950	$23,469,000
G. WAIVER--MH/UCD & BTR	$4,324,575,000	$2,332,574,300	$602,754,700	$1,389,246,000
H. MANAGED CARE	$18,220,487,000	$11,438,982,850	($3,850,370,850)	$10,631,875,000
I. PROVIDER RATES	$4,129,537,680	$3,002,606,690	($653,419,290)	$1,780,350,270
J. SUPPLEMENTAL PMNTS.	$13,335,852,490	$8,622,264,650	$548,006,440	$4,165,581,400
K. COVID-19	($9,329,371,460)	($5,872,683,720)	($3,456,687,750)	$0
L. STATE-ONLY CLAIMING	$0	($944,000)	$944,000	$0
M. OTHER DEPARTMENTS	$751,126,000	$751,126,000	$0	$0
N. OTHER	$2,192,442,980	$5,893,059,390	($5,161,758,410)	$1,461,142,000
O. TOTAL CHANGES	**$42,374,191,160**	**$30,640,231,090**	**($9,831,455,600)**	**$21,565,415,670**
III. TOTAL MEDI-CAL ESTIMATE	**$149,761,799,240**	**$92,313,488,850**	**$34,348,773,720**	**$23,099,536,670**

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2024-25

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	ELIGIBILITY				
1	UNDOCUMENTED EXPANSION AGES 26 THROUGH 49	$3,315,909,000	$458,514,000	$2,857,395,000	$0
2	POSTPARTUM CARE EXTENSION	$264,796,000	$134,566,000	$119,648,000	$10,582,000
3	MEDI-CAL STATE INMATE PROGRAMS	$43,024,000	$43,024,000	$0	$0
4	BREAST AND CERVICAL CANCER TREATMENT	$39,356,000	$24,103,250	$15,252,750	$0
5	PHASING IN THE MEDI-CAL ASSET LIMIT REPEAL	$76,030,140	$38,015,070	$38,015,070	$0
7	CALAIM - INMATE PRE-RELEASE PROGRAM	$47,916,000	$31,625,000	$16,291,000	$0
8	REFUGEE MEDICAL ASSISTANCE	$0	$0	($120,000)	$120,000
9	NON-OTLICP CHIP	$0	$122,167,200	($122,167,200)	$0
10	NON-EMERGENCY FUNDING ADJUSTMENT	$0	($1,610,512,300)	$1,610,512,300	$0
11	SCHIP FUNDING FOR PRENATAL CARE	$0	$78,895,050	($78,895,050)	$0
12	MEDI-CAL COUNTY INMATE REIMBURSEMENT	$0	$0	($1,614,000)	$1,614,000
13	CS3 PROXY ADJUSTMENT	$0	$99,363,500	($99,363,500)	$0
	ELIGIBILITY SUBTOTAL	**$3,787,031,140**	**($580,239,230)**	**$4,354,954,370**	**$12,316,000**
	AFFORDABLE CARE ACT				
14	COMMUNITY FIRST CHOICE OPTION	$8,687,097,000	$8,687,097,000	$0	$0
15	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	$16,016,000	$16,016,000	$0	$0
16	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	$5,807,000	($5,807,000)	$0
17	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	$0	$32,817,600	($32,817,600)	$0
18	ACA DSH REDUCTION	($1,199,552,000)	($658,822,000)	($135,080,000)	($405,650,000)
	AFFORDABLE CARE ACT SUBTOTAL	**$7,503,561,000**	**$8,082,915,600**	**($173,704,600)**	**($405,650,000)**
	BENEFITS				
19	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$845,986,000	$845,986,000	$0	$0
20	FAMILY PACT PROGRAM	$290,328,000	$219,829,300	$70,498,700	$0
21	MULTIPURPOSE SENIOR SERVICES PROGRAM	$63,951,000	$31,975,500	$31,975,500	$0
22	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$62,090,000	$44,404,000	$17,686,000	$0
23	BEHAVIORAL HEALTH TREATMENT	$12,078,000	$6,350,100	$5,727,900	$0
24	CYBHI - DYADIC SERVICES	$409,390	$239,670	$169,720	$0
25	MEDICAL INTERPRETER PILOT PROJECT	$969,000	$0	$969,000	$0
27	HEARING AID COVERAGE FOR CHILDREN PROGRAM	$2,607,000	$0	$2,607,000	$0
28	CCT FUND TRANSFER TO CDSS	$391,000	$391,000	$0	$0
29	DOULA BENEFIT	$734,670	$437,230	$297,440	$0
30	COMMUNITY HEALTH WORKER	$0	$0	$0	$0
32	CALAIM - LTC BENEFIT TRANSITION	$4,318,000	$2,332,700	$1,985,300	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2024-25

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	BENEFITS				
222	CYBHI WELLNESS COACH BENEFIT	$9,513,000	$5,389,550	$4,123,450	$0
	BENEFITS SUBTOTAL	**$1,293,375,060**	**$1,157,335,050**	**$136,040,010**	**$0**
	PHARMACY				
33	MEDICATION THERAPY MANAGEMENT PROGRAM	$3,753,280	$2,534,560	$1,218,720	$0
34	MEDI-CAL DRUG REBATE FUND	$0	$0	($2,483,312,000)	$2,483,312,000
36	BCCTP DRUG REBATES	($3,334,000)	($3,334,000)	$0	$0
37	FAMILY PACT DRUG REBATES	($5,437,000)	($5,437,000)	$0	$0
38	PHARMACY RETROACTIVE ADJUSTMENTS	$0	($17,396,000)	$17,396,000	$0
39	MEDICAL SUPPLY REBATES	($129,840,000)	($64,920,000)	($64,920,000)	$0
40	STATE SUPPLEMENTAL DRUG REBATES	($201,968,000)	($201,968,000)	$0	$0
41	FEDERAL DRUG REBATES	($4,079,917,000)	($4,079,917,000)	$0	$0
223	RESPIRATORY SYNCYTIAL VIRUS VACCINES	$215,762,000	$120,245,650	$95,516,350	$0
	PHARMACY SUBTOTAL	**($4,200,980,720)**	**($4,250,191,790)**	**($2,434,100,930)**	**$2,483,312,000**
	DRUG MEDI-CAL				
43	HCBS SP - CONTINGENCY MANAGEMENT	$82,682,000	$63,172,000	$0	$19,510,000
44	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	$20,478,000	$14,925,250	$1,288,750	$4,264,000
46	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	($1,594,000)	($1,291,000)	($303,000)	$0
	DRUG MEDI-CAL SUBTOTAL	**$101,566,000**	**$76,806,250**	**$985,750**	**$23,774,000**
	MENTAL HEALTH				
49	BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE	$239,600,000	$0	$239,600,000	$0
50	MHP COSTS FOR FFPSA	$43,195,000	$21,777,000	$10,721,000	$10,697,000
52	MHP COSTS FOR CONTINUUM OF CARE REFORM	$3,919,000	$1,076,550	$2,842,450	$0
53	OUT OF STATE YOUTH - SMHS	$2,163,000	$1,081,500	$1,081,500	$0
54	CALAIM - BH - CONNECT DEMONSTRATION	$39,043,000	$25,816,000	$655,000	$12,572,000
55	SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS	$0	($159,000)	$159,000	$0
56	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	$0	$0	($200,000)	$200,000
57	CHART REVIEW	($10,000)	($10,000)	$0	$0
58	INTERIM AND FINAL COST SETTLEMENTS - SMHS	($62,921,000)	($62,963,000)	$42,000	$0
	MENTAL HEALTH SUBTOTAL	**$264,989,000**	**($13,380,950)**	**$254,900,950**	**$23,469,000**
	WAIVER--MH/UCD & BTR				
59	GLOBAL PAYMENT PROGRAM	$2,778,489,000	$1,389,243,000	$0	$1,389,246,000

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2024-25

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	WAIVER--MH/UCD & BTR				
60	CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES	$1,590,844,000	$969,581,000	$621,263,000	$0
61	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	$601,000	$601,000	$0	$0
225	ENHANCED CARE MANAGEMENT RISK CORRIDOR	($45,359,000)	($26,850,700)	($18,508,300)	$0
	WAIVER--MH/UCD & BTR SUBTOTAL	**$4,324,575,000**	**$2,332,574,300**	**$602,754,700**	**$1,389,246,000**
	MANAGED CARE				
66	2023 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	$9,914,615,000	$5,946,847,950	$3,967,767,050	$0
68	MANAGED CARE HEALTH CARE FINANCING PROGRAM	$2,163,690,000	$1,399,324,400	$764,365,600	$0
69	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	$2,121,737,000	$1,512,126,100	$609,610,900	$0
71	MANAGED CARE PUBLIC HOSPITAL EPP	$1,913,968,000	$1,403,126,650	$510,841,350	$0
74	RETRO MC RATE ADJUSTMENTS	$287,132,000	$130,424,250	$156,707,750	$0
75	WORKFORCE & QUALITY INCENTIVE PROGRAM	$296,845,000	$148,840,900	$148,004,100	$0
77	CYBHI - STUDENT BH INCENTIVE PROGRAM	$85,422,000	$42,711,000	$42,711,000	$0
79	MANAGED CARE DP-NF PASS-THROUGH PAYMENT PROGRAM	$62,638,000	$33,493,000	$29,145,000	$0
81	CCI-QUALITY WITHHOLD REPAYMENTS	$16,676,000	$8,338,000	$8,338,000	$0
87	CAPITATED RATE ADJUSTMENT FOR FY 2024-25	$1,657,764,000	$1,022,965,600	$634,798,400	$0
88	MANAGED CARE DISTRICT HOSPITAL DIRECTED PAYMENTS	$100,000,000	$70,785,000	$0	$29,215,000
89	2023 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	$0	$0	($3,960,627,000)	$3,960,627,000
90	2023 MCO ENROLLMENT TAX MANAGED CARE PLANS	$0	$0	($4,636,914,000)	$4,636,914,000
91	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	$0	$0	($2,005,119,000)	$2,005,119,000
93	PROP 56 - DIRECTED PAYMENT RISK MITIGATION	($400,000,000)	($280,000,000)	($120,000,000)	$0
	MANAGED CARE SUBTOTAL	**$18,220,487,000**	**$11,438,982,850**	**($3,850,370,850)**	**$10,631,875,000**
	PROVIDER RATES				
94	RATE INCREASE FOR FQHCS/RHCS/CBRCS	$442,656,790	$281,516,250	$161,140,540	$0
95	MEDI-CAL PROVIDER PAYMENT RESERVE FUND	$30,308,000	$0	($1,064,859,000)	$1,095,167,000
96	PP-GEMT IGT PROGRAM	$248,646,000	$160,178,000	($8,132,000)	$96,600,000
97	MEDI-CAL PROVIDER RATE INCREASE	$727,000,000	$436,000,000	$291,000,000	$0
98	NURSING FACILITY RATE ADJUSTMENTS	$192,391,650	$101,198,090	$91,193,560	$0
99	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	$136,221,680	$93,203,210	($6,018,810)	$49,037,280
100	FQHC/RHC/CBRC RECONCILIATION PROCESS	$159,541,000	$101,463,500	$58,077,500	$0
101	DPH INTERIM & FINAL RECONS	$159,712,000	$159,712,000	$0	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2024-25

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	PROVIDER RATES				
103	AB 97 ELIMINATIONS	$24,489,260	$14,987,190	$9,502,070	$0
104	DPH INTERIM RATE GROWTH	$79,885,000	$54,952,900	$24,932,100	$0
105	LTC RATE ADJUSTMENT	$18,856,920	$9,687,450	$9,169,470	$0
106	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	$1,533,880	$930,020	$603,860	$0
107	HOSPICE RATE INCREASES	$1,252,900	$660,190	$592,710	$0
108	ACUPUNCTURE RATE INCREASE	$32,980	$23,000	$9,980	$0
109	DPH INTERIM RATE	$0	$448,531,800	($448,531,800)	$0
110	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	$0	$0	($539,546,000)	$539,546,000
111	REDUCTION TO RADIOLOGY RATES	($5,606,370)	($3,309,970)	($2,296,400)	$0
112	GDSP PRENATAL SCREENING PROGRAM FEE INCREASE	$4,182,000	$2,541,850	$1,640,150	$0
113	LABORATORY RATE METHODOLOGY CHANGE	($13,516,000)	($7,759,800)	($5,756,200)	$0
226	MEDI-CAL PROVIDER RATE INCREASE 2025	$1,921,950,000	$1,148,091,000	$773,859,000	$0
	PROVIDER RATES SUBTOTAL	**$4,129,537,680**	**$3,002,606,690**	**($653,419,290)**	**$1,780,350,280**
	SUPPLEMENTAL PMNTS.				
114	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	$4,550,530,000	$3,098,418,100	$0	$1,452,111,900
115	HOSPITAL QAF - MANAGED CARE PAYMENTS	$1,297,400,000	$876,467,500	$0	$420,932,500
116	HOSPITAL QAF - FFS PAYMENTS	$2,565,503,000	$1,485,025,000	$0	$1,080,478,000
117	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	$1,298,334,260	$780,716,470	$517,617,790	$0
118	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	$617,054,000	$348,719,000	$0	$268,335,000
119	PRIVATE HOSPITAL DSH REPLACEMENT	$712,818,000	$356,409,000	$356,409,000	$0
120	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	$459,199,000	$267,415,000	$118,400,000	$73,384,000
121	PROP 56 - MEDI-CAL FAMILY PLANNING	$463,068,230	$370,195,380	$92,872,850	$0
122	DSH PAYMENT	$461,140,000	$347,960,000	$24,974,000	$88,206,000
123	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$249,637,000	$249,637,000	$0	$0
124	FFP FOR LOCAL TRAUMA CENTERS	$182,729,000	$101,059,000	$0	$81,670,000
125	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	$119,017,000	$68,788,000	$229,000	$50,000,000
126	DPH PHYSICIAN & NON-PHYS. COST	$92,801,000	$92,801,000	$0	$0
127	NDPH IGT SUPPLEMENTAL PAYMENTS	$78,610,000	$43,705,000	($2,447,000)	$37,352,000
128	NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS	$105,000,000	$52,500,000	$52,500,000	$0
129	CAPITAL PROJECT DEBT REIMBURSEMENT	$84,513,000	$61,168,500	$23,344,500	$0
130	PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS	$85,096,630	$51,086,770	$34,009,860	$0
131	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	$53,799,000	$53,799,000	$0	$0

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SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2024-25

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	SUPPLEMENTAL PMNTS.				
132	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	$21,618,000	$21,618,000	$0	$0
133	GEMT SUPPLEMENTAL PAYMENT PROGRAM	($8,733,000)	($8,733,000)	$0	$0
134	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	$10,000,000	$5,000,000	$5,000,000	$0
136	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	$8,000,000	$4,000,000	$4,000,000	$0
137	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	$5,223,370	$3,140,930	$2,082,440	$0
138	NDPH SUPPLEMENTAL PAYMENT	$14,900,000	$7,667,000	$1,900,000	$5,333,000
140	FREE CLINICS AUGMENTATION	$2,000,000	$0	$2,000,000	$0
141	IGT ADMIN. & PROCESSING FEE	$0	$0	($12,887,000)	$12,887,000
142	PROPOSITION 56 FUNDING	$0	$0	($594,892,000)	$594,892,000
231	PROP 56 - FUNDING REDUCTION	($193,405,000)	($116,298,000)	($77,107,000)	$0
	SUPPLEMENTAL PMNTS. SUBTOTAL	**$13,335,852,490**	**$8,622,264,650**	**$548,006,440**	**$4,165,581,400**
	COVID-19				
143	COVID-19 VACCINES	$293,566,540	$188,071,440	$105,495,100	$0
144	COVID-19 BEHAVIORAL HEALTH	$814,000	$755,600	$58,400	$0
145	PHARMACY-BASED COVID-19 TESTS	$14,665,000	$9,902,850	$4,762,150	$0
146	COVID-19 VACCINE FUNDING ADJUSTMENT	$0	$65,541,000	($65,541,000)	$0
149	COVID-19 INCREASED FMAP - DHCS	$0	($820,000)	$820,000	$0
150	COVID-19 REDETERMINATIONS IMPACT	($9,638,417,000)	($6,136,134,600)	($3,502,282,400)	$0
	COVID-19 SUBTOTAL	**($9,329,371,460)**	**($5,872,683,710)**	**($3,456,687,750)**	**$0**
	STATE-ONLY CLAIMING				
151	STATE-ONLY CLAIMING ADJUSTMENTS - RETRO ADJ.	$0	($944,000)	$944,000	$0
	STATE-ONLY CLAIMING SUBTOTAL	**$0**	**($944,000)**	**$944,000**	**$0**
	OTHER DEPARTMENTS				
152	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$751,126,000	$751,126,000	$0	$0
	OTHER DEPARTMENTS SUBTOTAL	**$751,126,000**	**$751,126,000**	**$0**	**$0**
	OTHER				
158	HCBS SP CDDS	$105,028,000	$105,028,000	$0	$0
159	BEHAVIORAL HEALTH BRIDGE HOUSING	$456,587,000	$0	$456,587,000	$0
161	CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY	$198,500,000	$0	$198,500,000	$0
163	CYBHI - EVIDENCE-BASED BH PRACTICES	$151,610,000	$0	$151,610,000	$0
164	QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES	$299,723,000	$254,765,000	$44,958,000	$0
165	SELF-DETERMINATION PROGRAM - CDDS	$186,473,000	$186,473,000	$0	$0

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SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2024-25

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER				
166	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER	$113,687,500	$56,843,750	$56,843,750	$0
167	CYBHI - URGENT NEEDS AND EMERGENT ISSUES	$29,000,000	$0	$29,000,000	$0
168	EVIDENCE-BASED DENTAL PRACTICES	$102,642,000	$68,867,450	$33,774,550	$0
171	ASSISTED LIVING WAIVER EXPANSION	$92,547,000	$46,273,500	$46,273,500	$0
172	EQUITY & PRACTICE TRANSFORMATION PAYMENTS	$135,000,000	$67,500,000	$67,500,000	$0
173	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	$69,462,000	$69,462,000	$0	$0
174	MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG	$65,742,000	$0	$0	$65,742,000
175	CALHOPE	$25,880,000	$0	$16,423,000	$9,457,000
178	INDIAN HEALTH SERVICES	$20,691,000	$13,794,000	$6,897,000	$0
180	CARE ACT	$104,928,000	$0	$104,928,000	$0
183	PEER SUPPORT SPECIALIST SERVICES	$27,255,000	$20,570,000	$0	$6,685,000
184	INFANT DEVELOPMENT PROGRAM	$14,530,000	$14,530,000	$0	$0
185	ABORTION SUPPLEMENTAL PAYMENT PROGRAM	$11,144,000	$0	$11,144,000	$0
186	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	$44,041,480	$22,020,740	$22,020,740	$0
190	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	$10,724,000	$5,798,000	$4,926,000	$0
195	QAF WITHHOLD TRANSFER	$384,000	$192,000	$192,000	$0
196	HCBS SP - CALBRIDGE BH NAVIGATOR PROGRAM	$89,000	$0	$0	$89,000
198	WPCS WORKERS' COMPENSATION	$620,000	$310,000	$310,000	$0
205	IMD ANCILLARY SERVICES	$0	($68,936,000)	$68,936,000	$0
206	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	$0	($124,169,000)	$124,169,000
207	FUNDING ADJUST.—ACA OPT. EXPANSION	$0	$4,888,713,200	($4,888,713,200)	$0
208	FUNDING ADJUST.—OTLICP	$0	$108,033,750	($108,033,750)	$0
209	HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	$0	($1,254,000,000)	$1,254,000,000
210	CMS DEFERRED CLAIMS	$0	$2,000,000	($2,000,000)	$0
211	INDIAN HEALTH SERVICES FUNDING SHIFT	$0	$30,821,000	($30,821,000)	$0
212	CALAIM - DENTAL INITIATIVES	$0	$0	$0	$0
214	COUNTY SHARE OF OTLICP-CCS COSTS	($16,769,000)	$0	($16,769,000)	$0
216	COUNTY BH RECOUPMENTS	($64,160,000)	$0	($64,160,000)	$0
219	ADVISORY COUNCIL ON PHYS. FIT. & MENTAL WELL-BEING	$1,000,000	$0	$0	$1,000,000
220	ASSET LIMIT INCREASE & ELIM. - CNTY BH FUNDING	$6,084,000	$0	$6,084,000	$0
	OTHER SUBTOTAL	**$2,192,442,980**	**$5,893,059,390**	**($5,161,758,410)**	**$1,461,142,000**
	GRAND TOTAL	**$42,374,191,160**	**$30,640,231,090**	**($9,831,455,600)**	**$21,565,415,680**

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

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

SERVICE CATEGORY	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
PROFESSIONAL	$8,815,528,480	$5,057,171,990	$2,924,094,780	$834,261,720
PHYSICIANS	$740,154,760	$409,117,440	$256,824,760	$74,212,570
OTHER MEDICAL	$6,169,243,460	$3,491,375,480	$2,519,660,850	$158,207,130
CO. & COMM. OUTPATIENT	$1,906,130,260	$1,156,679,070	$147,609,170	$601,842,020
PHARMACY	$12,623,926,580	$6,213,659,060	$3,590,822,000	$2,819,445,520
HOSPITAL INPATIENT	$10,746,383,720	$6,756,226,490	$1,662,289,870	$2,327,867,360
COUNTY INPATIENT	$3,750,833,910	$2,380,651,620	($8,697,330)	$1,378,879,620
COMMUNITY INPATIENT	$6,995,549,820	$4,375,574,870	$1,670,987,200	$948,987,750
LONG TERM CARE	$849,148,980	$456,316,550	$345,821,670	$47,010,760
NURSING FACILITIES	$795,600,340	$448,245,870	$320,785,740	$26,568,740
ICF-DD	$53,548,640	$8,070,680	$25,035,940	$20,442,020
OTHER SERVICES	$2,414,354,250	$1,638,039,740	$757,729,840	$18,584,670
MEDICAL TRANSPORTATION	$42,995,330	$22,936,800	$23,322,390	($3,263,850)
OTHER SERVICES	$2,238,533,660	$1,552,181,580	$666,386,920	$19,965,150
HOME HEALTH	$132,825,250	$62,921,360	$68,020,530	$1,883,360
TOTAL FEE-FOR-SERVICE	**$35,449,342,010**	**$20,121,413,840**	**$9,280,758,150**	**$6,047,170,030**
MANAGED CARE	$80,899,178,110	$48,675,533,140	$18,092,572,590	$14,131,072,380
TWO PLAN MODEL	$47,807,344,200	$28,690,816,190	$10,443,241,100	$8,673,286,900
COUNTY ORGANIZED HEALTH SYSTEMS	$18,049,710,230	$10,941,986,250	$3,877,699,410	$3,230,024,560
GEOGRAPHIC MANAGED CARE	$8,936,526,530	$5,477,211,230	$1,833,529,100	$1,625,786,200
PHP & OTHER MANAG. CARE	$1,878,040,280	$939,553,630	$908,641,060	$29,845,590
REGIONAL MODEL	$4,227,556,870	$2,625,965,830	$1,029,461,910	$572,129,120
DENTAL	$2,054,240,960	$1,142,557,600	$826,889,070	$84,794,290
MENTAL HEALTH	$4,189,040,420	$2,515,939,600	$108,427,110	$1,564,673,710
AUDITS/ LAWSUITS	$1,350,000	$2,675,000	($1,325,000)	$0
EPSDT SCREENS	$0	$0	$0	$0
MEDICARE PAYMENTS	$7,868,948,000	$1,631,718,840	$6,237,229,160	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$20,177,280	$20,177,160	$110	$0
MISC. SERVICES	$18,974,702,090	$17,823,937,350	($8,920,430)	$1,159,685,160
RECOVERIES	($717,129,000)	($414,125,980)	($303,003,020)	$0
DRUG MEDI-CAL	$1,021,949,380	$793,662,290	$116,145,980	$112,141,110
GRAND TOTAL MEDI-CAL	**$149,761,799,240**	**$92,313,488,850**	**$34,348,773,720**	**$23,099,536,670**

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2023-24 AND 2024-25

SERVICE CATEGORY	NOV. 2023 EST. FOR 2023-24	NOV. 2023 EST. FOR 2024-25	DOLLAR DIFFERENCE	% CHANGE
PROFESSIONAL	$9,115,948,560	$8,815,528,480	($300,420,080)	-3.30%
PHYSICIANS	$757,638,530	$740,154,760	($17,483,760)	-2.31%
OTHER MEDICAL	$6,168,946,740	$6,169,243,460	$296,720	0.00%
CO. & COMM. OUTPATIENT	$2,189,363,300	$1,906,130,260	($283,233,040)	-12.94%
PHARMACY	$12,510,639,920	$12,623,926,580	$113,286,660	0.91%
HOSPITAL INPATIENT	$12,189,234,140	$10,746,383,720	($1,442,850,420)	-11.84%
COUNTY INPATIENT	$4,187,212,190	$3,750,833,910	($436,378,290)	-10.42%
COMMUNITY INPATIENT	$8,002,021,950	$6,995,549,820	($1,006,472,130)	-12.58%
LONG TERM CARE	$1,481,157,130	$849,148,980	($632,008,150)	-42.67%
NURSING FACILITIES	$1,143,001,580	$795,600,340	($347,401,240)	-30.39%
ICF-DD	$338,155,550	$53,548,640	($284,606,910)	-84.16%
OTHER SERVICES	$2,197,858,350	$2,414,354,250	$216,495,900	9.85%
MEDICAL TRANSPORTATION	$71,759,670	$42,995,330	($28,764,340)	-40.08%
OTHER SERVICES	$1,988,834,050	$2,238,533,660	$249,699,610	12.56%
HOME HEALTH	$137,264,620	$132,825,250	($4,439,370)	-3.23%
TOTAL FEE-FOR-SERVICE	**$37,494,838,110**	**$35,449,342,010**	**($2,045,496,090)**	**-5.46%**
MANAGED CARE	$79,573,174,540	$80,899,178,110	$1,326,003,560	1.67%
TWO PLAN MODEL	$48,053,302,600	$47,807,344,200	($245,958,400)	-0.51%
COUNTY ORGANIZED HEALTH SYSTEMS	$18,010,611,990	$18,049,710,230	$39,098,240	0.22%
GEOGRAPHIC MANAGED CARE	$8,977,716,220	$8,936,526,530	($41,189,690)	-0.46%
PHP & OTHER MANAG. CARE	$1,720,467,030	$1,878,040,280	$157,573,250	9.16%
REGIONAL MODEL	$2,811,076,700	$4,227,556,870	$1,416,480,170	50.39%
DENTAL	$2,185,448,290	$2,054,240,960	($131,207,330)	-6.00%
MENTAL HEALTH	$3,950,333,350	$4,189,040,420	$238,707,070	6.04%
AUDITS/ LAWSUITS	$47,197,000	$1,350,000	($45,847,000)	-97.14%
MEDICARE PAYMENTS	$7,603,332,950	$7,868,948,000	$265,615,050	3.49%
STATE HOSP./DEVELOPMENTAL CNTRS.	$19,939,830	$20,177,280	$237,450	1.19%
MISC. SERVICES	$18,941,149,660	$18,974,702,090	$33,552,420	0.18%
RECOVERIES	($734,464,000)	($717,129,000)	$17,335,000	-2.36%
DRUG MEDI-CAL	$1,021,562,930	$1,021,949,380	$386,450	0.04%
GRAND TOTAL MEDI-CAL	**$150,102,512,660**	**$149,761,799,240**	**($340,713,430)**	**-0.23%**
GENERAL FUNDS	**$35,625,727,980**	**$34,348,773,720**	**($1,276,954,260)**	**-3.58%**
OTHER STATE FUNDS	**$24,271,406,560**	**$23,099,536,670**	**($1,171,869,880)**	**-4.83%**

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2023-24 AND 2024-25

NO.	POLICY CHANGE TITLE	NOV. 2023 EST. FOR 2023-24		NOV. 2023 EST. FOR 2024-25		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	ELIGIBILITY						
1	UNDOCUMENTED EXPANSION AGES 26 THROUGH 49	$1,436,027,000	$1,228,010,000	$3,315,909,000	$2,857,395,000	$1,879,882,000	$1,629,385,000
2	POSTPARTUM CARE EXTENSION	$255,889,000	$115,566,000	$264,796,000	$119,648,000	$8,907,000	$4,082,000
3	MEDI-CAL STATE INMATE PROGRAMS	$43,024,000	$0	$43,024,000	$0	$0	$0
4	BREAST AND CERVICAL CANCER TREATMENT	$39,356,000	$15,247,750	$39,356,000	$15,252,750	$0	$5,000
5	PHASING IN THE MEDI-CAL ASSET LIMIT REPEAL	$101,050,000	$50,525,000	$195,400,000	$97,700,000	$94,350,000	$47,175,000
6	HEALTH ENROLLMENT NAVIGATORS FOR CLINICS	$20,000,000	$10,000,000	$0	$0	($20,000,000)	($10,000,000)
7	CALAIM - INMATE PRE-RELEASE PROGRAM	$0	$0	$47,916,000	$16,291,000	$47,916,000	$16,291,000
8	REFUGEE MEDICAL ASSISTANCE	$0	($136,000)	$0	($120,000)	$0	$16,000
9	NON-OTLICP CHIP	$0	($123,270,450)	$0	($122,167,200)	$0	$1,103,250
10	NON-EMERGENCY FUNDING ADJUSTMENT	$0	$1,610,512,300	$0	$1,610,512,300	$0	$0
11	SCHIP FUNDING FOR PRENATAL CARE	$0	($79,960,900)	$0	($78,895,050)	$0	$1,065,850
12	MEDI-CAL COUNTY INMATE REIMBURSEMENT	$0	($1,551,000)	$0	($1,614,000)	$0	($63,000)
13	CS3 PROXY ADJUSTMENT	$0	($127,946,000)	$0	($99,363,500)	$0	$28,582,500
	ELIGIBILITY SUBTOTAL	**$1,895,346,000**	**$2,696,996,700**	**$3,906,401,000**	**$4,414,639,300**	**$2,011,055,000**	**$1,717,642,600**
	AFFORDABLE CARE ACT						
14	COMMUNITY FIRST CHOICE OPTION	$8,010,345,000	$0	$8,687,097,000	$0	$676,752,000	$0
15	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	$21,774,000	$0	$16,016,000	$0	($5,758,000)	$0
16	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	($9,748,000)	$0	($5,807,000)	$0	$3,941,000
17	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	$0	($33,281,200)	$0	($32,817,600)	$0	$463,600
18	ACA DSH REDUCTION	($837,844,000)	($121,442,000)	($1,199,552,000)	($135,080,000)	($361,708,000)	($13,638,000)
	AFFORDABLE CARE ACT SUBTOTAL	**$7,194,275,000**	**($164,471,200)**	**$7,503,561,000**	**($173,704,600)**	**$309,286,000**	**($9,233,400)**

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 2023-24 AND 2024-25

NO.	POLICY CHANGE TITLE	NOV. 2023 EST. FOR 2023-24		NOV. 2023 EST. FOR 2024-25		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	BENEFITS						
19	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$578,033,000	$0	$845,986,000	$0	$267,953,000	$0
20	FAMILY PACT PROGRAM	$225,304,000	$54,708,800	$290,328,000	$70,498,700	$65,024,000	$15,789,900
21	MULTIPURPOSE SENIOR SERVICES PROGRAM	$63,951,000	$31,335,500	$63,951,000	$31,975,500	$0	$640,000
22	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$48,808,000	$10,854,000	$62,090,000	$17,686,000	$13,282,000	$6,832,000
23	BEHAVIORAL HEALTH TREATMENT	$19,667,000	$9,107,950	$12,078,000	$5,727,900	($7,589,000)	($3,380,050)
24	CYBHI - DYADIC SERVICES	$128,012,000	$52,167,950	$170,579,000	$70,717,050	$42,567,000	$18,549,100
25	MEDICAL INTERPRETER PILOT PROJECT	$2,005,000	$2,005,000	$969,000	$969,000	($1,036,000)	($1,036,000)
26	CCS DEMONSTRATION PROJECT	$1,730,000	$807,550	$0	$0	($1,730,000)	($807,550)
27	HEARING AID COVERAGE FOR CHILDREN PROGRAM	$1,515,000	$1,515,000	$2,607,000	$2,607,000	$1,092,000	$1,092,000
28	CCT FUND TRANSFER TO CDSS	$295,000	$0	$391,000	$0	$96,000	$0
29	DOULA BENEFIT	$565,000	$228,650	$1,132,000	$458,300	$567,000	$229,650
30	COMMUNITY HEALTH WORKER	$91,871,000	$32,393,300	$91,871,000	$32,393,300	$0	$0
31	FPACT HPV VACCINE COVERAGE	$5,092,000	$2,901,500	$0	$0	($5,092,000)	($2,901,500)
32	CALAIM - LTC BENEFIT TRANSITION	($175,788,000)	($80,826,100)	$4,318,000	$1,985,300	$180,106,000	$82,811,400
222	CYBHI WELLNESS COACH BENEFIT	$0	$0	$9,513,000	$4,123,450	$9,513,000	$4,123,450
	BENEFITS SUBTOTAL	**$991,060,000**	**$117,199,100**	**$1,555,813,000**	**$239,141,500**	**$564,753,000**	**$121,942,400**
	PHARMACY						
33	MEDICATION THERAPY MANAGEMENT PROGRAM	$2,448,000	$794,750	$3,861,000	$1,253,700	$1,413,000	$458,950
34	MEDI-CAL DRUG REBATE FUND	$0	($2,872,071,000)	$0	($2,483,312,000)	$0	$388,759,000
35	LITIGATION SETTLEMENTS	($8,000)	($8,000)	$0	$0	$8,000	$8,000
36	BCCTP DRUG REBATES	($3,218,000)	$0	($3,334,000)	$0	($116,000)	$0
37	FAMILY PACT DRUG REBATES	($3,391,000)	$0	($5,437,000)	$0	($2,046,000)	$0
38	PHARMACY RETROACTIVE ADJUSTMENTS	($80,859,000)	$23,237,050	$0	$17,396,000	$80,859,000	($5,841,050)
39	MEDICAL SUPPLY REBATES	($173,120,000)	($86,560,000)	($129,840,000)	($64,920,000)	$43,280,000	$21,640,000

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2023-24 AND 2024-25

NO.	POLICY CHANGE TITLE	NOV. 2023 EST. FOR 2023-24		NOV. 2023 EST. FOR 2024-25		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	PHARMACY						
40	STATE SUPPLEMENTAL DRUG REBATES	($198,756,000)	$0	($201,968,000)	$0	($3,212,000)	$0
41	FEDERAL DRUG REBATES	($4,110,500,000)	$0	($4,079,917,000)	$0	$30,583,000	$0
223	RESPIRATORY SYNCYTIAL VIRUS VACCINES	$138,738,000	$61,418,300	$215,762,000	$95,516,350	$77,024,000	$34,098,050
	PHARMACY SUBTOTAL	**($4,428,666,000)**	**($2,873,188,900)**	**($4,200,873,000)**	**($2,434,065,950)**	**$227,793,000**	**$439,122,950**
	DRUG MEDI-CAL						
43	HCBS SP - CONTINGENCY MANAGEMENT	$21,562,000	$0	$82,682,000	$0	$61,120,000	$0
44	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	$14,999,000	$943,150	$20,478,000	$1,288,750	$5,479,000	$345,600
46	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	($1,727,000)	($320,000)	($1,594,000)	($303,000)	$133,000	$17,000
	DRUG MEDI-CAL SUBTOTAL	**$34,834,000**	**$623,150**	**$101,566,000**	**$985,750**	**$66,732,000**	**$362,600**
	MENTAL HEALTH						
49	BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE	$300,030,000	$300,030,000	$239,600,000	$239,600,000	($60,430,000)	($60,430,000)
50	MHP COSTS FOR FFPSA	$47,538,000	$12,288,000	$43,195,000	$10,721,000	($4,343,000)	($1,567,000)
51	CALAIM - BH QUALITY IMPROVEMENT PROGRAM	$21,347,000	$21,347,000	$0	$0	($21,347,000)	($21,347,000)
52	MHP COSTS FOR CONTINUUM OF CARE REFORM	$3,639,000	$2,687,150	$3,919,000	$2,842,450	$280,000	$155,300
53	OUT OF STATE YOUTH - SMHS	$2,112,000	$1,056,000	$2,163,000	$1,081,500	$51,000	$25,500
54	CALAIM - BH - CONNECT DEMONSTRATION	$0	$0	$39,043,000	$655,000	$39,043,000	$655,000
55	SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS	$0	$158,000	$0	$159,000	$0	$1,000
56	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	$0	($200,000)	$0	($200,000)	$0	$0
57	CHART REVIEW	($74,000)	$0	($10,000)	$0	$64,000	$0
58	INTERIM AND FINAL COST SETTLEMENTS - SMHS	($61,458,000)	$42,000	($62,921,000)	$42,000	($1,463,000)	$0
	MENTAL HEALTH SUBTOTAL	**$313,134,000**	**$337,408,150**	**$264,989,000**	**$254,900,950**	**($48,145,000)**	**($82,507,200)**

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2023-24 AND 2024-25

NO.	POLICY CHANGE TITLE	NOV. 2023 EST. FOR 2023-24		NOV. 2023 EST. FOR 2024-25		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	WAIVER--MH/UCD & BTR						
59	GLOBAL PAYMENT PROGRAM	$3,195,419,000	$0	$2,778,489,000	$0	($416,930,000)	$0
60	CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES	$1,829,376,000	$748,822,250	$1,590,844,000	$621,263,000	($238,532,000)	($127,559,250)
61	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	$712,000	$0	$601,000	$0	($111,000)	$0
62	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	$687,000	$687,000	$0	$0	($687,000)	($687,000)
225	ENHANCED CARE MANAGEMENT RISK CORRIDOR	$0	$0	($45,359,000)	($18,508,300)	($45,359,000)	($18,508,300)
	WAIVER--MH/UCD & BTR SUBTOTAL	**$5,026,194,000**	**$749,509,250**	**$4,324,575,000**	**$602,754,700**	**($701,619,000)**	**($146,754,550)**
	MANAGED CARE						
66	2023 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	$9,649,139,000	$3,746,111,500	$9,914,615,000	$3,967,767,050	$265,476,000	$221,655,550
68	MANAGED CARE HEALTH CARE FINANCING PROGRAM	$2,163,690,000	$727,820,600	$2,163,690,000	$764,365,600	$0	$36,545,000
69	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	$2,058,008,000	$560,524,650	$2,121,737,000	$609,610,900	$63,729,000	$49,086,250
71	MANAGED CARE PUBLIC HOSPITAL EPP	$1,853,760,000	$477,618,750	$1,913,968,000	$510,841,350	$60,208,000	$33,222,600
73	HCBS SP - HOUSING AND HOMELESSNESS INCENTIVE PROG	$557,414,000	$0	$0	$0	($557,414,000)	$0
74	RETRO MC RATE ADJUSTMENTS	$629,178,000	$168,485,600	$287,132,000	$156,707,750	($342,046,000)	($11,777,850)
75	WORKFORCE & QUALITY INCENTIVE PROGRAM	$280,000,000	$139,605,500	$296,845,000	$148,004,100	$16,845,000	$8,398,600
77	CYBHI - STUDENT BH INCENTIVE PROGRAM	$85,422,000	$42,711,000	$85,422,000	$42,711,000	$0	$0
79	MANAGED CARE DP-NF PASS-THROUGH PAYMENT PROGRAM	$0	$0	$62,638,000	$29,145,000	$62,638,000	$29,145,000
81	CCI-QUALITY WITHHOLD REPAYMENTS	$29,976,000	$14,988,000	$16,676,000	$8,338,000	($13,300,000)	($6,650,000)
85	PROP 56 - BEHAVIORAL HEALTH INCENTIVE PROGRAM	$2,156,000	$171,000	$0	$0	($2,156,000)	($171,000)
87	CAPITATED RATE ADJUSTMENT FOR FY 2024-25	$0	$0	$1,657,764,000	$634,798,400	$1,657,764,000	$634,798,400
88	MANAGED CARE DISTRICT HOSPITAL DIRECTED PAYMENTS	$0	$0	$100,000,000	$0	$100,000,000	$0

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2023-24 AND 2024-25

NO.	POLICY CHANGE TITLE	NOV. 2023 EST. FOR 2023-24		NOV. 2023 EST. FOR 2024-25		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	MANAGED CARE						
89	2023 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	$0	($3,464,400,000)	$0	($3,960,627,000)	$0	($496,227,000)
90	2023 MCO ENROLLMENT TAX MANAGED CARE PLANS	$0	($4,408,600,000)	$0	($4,636,914,000)	$0	($228,314,000)
91	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	$0	($1,884,807,000)	$0	($2,005,119,000)	$0	($120,312,000)
92	COORDINATED CARE INITIATIVE RISK MITIGATION	($111,260,000)	($55,630,000)	$0	$0	$111,260,000	$55,630,000
93	PROP 56 - DIRECTED PAYMENT RISK MITIGATION	($1,373,716,000)	($126,691,340)	($400,000,000)	($120,000,000)	$973,716,000	$6,691,340
	MANAGED CARE SUBTOTAL	**$15,823,767,000**	**($4,062,091,740)**	**$18,220,487,000**	**($3,850,370,850)**	**$2,396,720,000**	**$211,720,900**
	PROVIDER RATES						
94	RATE INCREASE FOR FQHCS/RHCS/CBRCS	$379,358,760	$138,097,870	$444,389,910	$161,771,450	$65,031,150	$23,673,570
95	MEDI-CAL PROVIDER PAYMENT RESERVE FUND	$200,000,000	($121,000,000)	$30,308,000	($1,064,859,000)	($169,692,000)	($943,859,000)
96	PP-GEMT IGT PROGRAM	$275,197,000	($8,579,000)	$248,646,000	($8,132,000)	($26,551,000)	$447,000
97	MEDI-CAL PROVIDER RATE INCREASE	$303,000,000	$121,000,000	$727,000,000	$291,000,000	$424,000,000	$170,000,000
98	NURSING FACILITY RATE ADJUSTMENTS	$695,703,000	$329,763,100	$520,822,000	$246,869,400	($174,881,000)	($82,893,700)
99	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	$149,554,000	($5,990,000)	$137,946,000	($6,095,000)	($11,608,000)	($105,000)
100	FQHC/RHC/CBRC RECONCILIATION PROCESS	$152,809,000	$55,627,200	$159,541,000	$58,077,500	$6,732,000	$2,450,300
101	DPH INTERIM & FINAL RECONS	$47,457,000	$0	$159,712,000	$0	$112,255,000	$0
102	DPH INTERIM RATE COVID-19 INCREASED FMAP ADJUST	$45,246,000	$0	$0	$0	($45,246,000)	$0
103	AB 97 ELIMINATIONS	$44,476,000	$17,490,650	$28,423,000	$11,028,400	($16,053,000)	($6,462,250)
104	DPH INTERIM RATE GROWTH	$22,693,000	$7,121,700	$79,885,000	$24,932,100	$57,192,000	$17,810,400
105	LTC RATE ADJUSTMENT	$162,422,000	$78,980,100	$88,655,000	$43,109,850	($73,767,000)	($35,870,250)
106	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	$4,461,000	$1,756,300	$5,253,000	$2,068,000	$792,000	$311,700
107	HOSPICE RATE INCREASES	$1,126,000	$532,600	$1,877,000	$887,950	$751,000	$355,350

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2023-24 AND 2024-25

NO.	POLICY CHANGE TITLE	NOV. 2023 EST. FOR 2023-24		NOV. 2023 EST. FOR 2024-25		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	PROVIDER RATES						
108	ACUPUNCTURE RATE INCREASE	$26,735,000	$8,094,300	$27,487,000	$8,320,300	$752,000	$226,000
109	DPH INTERIM RATE	$0	($431,425,800)	$0	($448,531,800)	$0	($17,106,000)
110	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	$0	($540,161,000)	$0	($539,546,000)	$0	$615,000
111	REDUCTION TO RADIOLOGY RATES	($1,160,000)	($482,750)	($5,663,000)	($2,319,600)	($4,503,000)	($1,836,850)
112	GDSP PRENATAL SCREENING PROGRAM FEE INCREASE	$43,000	$17,100	$4,182,000	$1,640,150	$4,139,000	$1,623,050
113	LABORATORY RATE METHODOLOGY CHANGE	($4,113,000)	($1,751,900)	($13,516,000)	($5,756,200)	($9,403,000)	($4,004,300)
226	MEDI-CAL PROVIDER RATE INCREASE 2025	$0	$0	$1,921,950,000	$773,859,000	$1,921,950,000	$773,859,000
	PROVIDER RATES SUBTOTAL	**$2,505,007,760**	**($350,909,530)**	**$4,566,897,910**	**($451,675,500)**	**$2,061,890,150**	**($100,765,980)**
	SUPPLEMENTAL PMNTS.						
114	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	$3,617,930,000	$0	$4,550,530,000	$0	$932,600,000	$0
115	HOSPITAL QAF - MANAGED CARE PAYMENTS	$3,594,800,000	$0	$1,297,400,000	$0	($2,297,400,000)	$0
116	HOSPITAL QAF - FFS PAYMENTS	$3,268,514,000	$2,172,000	$2,565,503,000	$0	($703,011,000)	($2,172,000)
117	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	$1,435,814,000	$555,310,150	$1,360,367,000	$542,348,900	($75,447,000)	($12,961,250)
118	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	$827,005,000	$0	$617,054,000	$0	($209,951,000)	$0
119	PRIVATE HOSPITAL DSH REPLACEMENT	$711,882,000	$350,160,000	$712,818,000	$356,409,000	$936,000	$6,249,000
120	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	$685,566,000	$118,400,000	$459,199,000	$118,400,000	($226,367,000)	$0
121	PROP 56 - MEDI-CAL FAMILY PLANNING	$505,912,000	$101,315,200	$481,460,000	$96,561,500	($24,452,000)	($4,753,700)
122	DSH PAYMENT	$451,274,000	$32,527,000	$461,140,000	$24,974,000	$9,866,000	($7,553,000)
123	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$274,979,000	$0	$249,637,000	$0	($25,342,000)	$0
124	FFP FOR LOCAL TRAUMA CENTERS	$138,083,000	$0	$182,729,000	$0	$44,646,000	$0
125	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	$119,735,000	$1,053,000	$119,017,000	$229,000	($718,000)	($824,000)

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2023-24 AND 2024-25

NO.	POLICY CHANGE TITLE	NOV. 2023 EST. FOR 2023-24		NOV. 2023 EST. FOR 2024-25		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	SUPPLEMENTAL PMNTS.						
126	DPH PHYSICIAN & NON-PHYS. COST	$113,695,000	$0	$92,801,000	$0	($20,894,000)	$0
127	NDPH IGT SUPPLEMENTAL PAYMENTS	$108,900,000	($2,218,000)	$78,610,000	($2,447,000)	($30,290,000)	($229,000)
128	NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS	$105,000,000	$51,450,000	$105,000,000	$52,500,000	$0	$1,050,000
129	CAPITAL PROJECT DEBT REIMBURSEMENT	$94,594,000	$23,568,000	$84,513,000	$23,344,500	($10,081,000)	($223,500)
130	PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS	$712,573,000	$279,992,250	$788,662,000	$315,198,000	$76,089,000	$35,205,750
131	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	$57,687,000	$0	$53,799,000	$0	($3,888,000)	$0
132	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	$20,715,000	$0	$21,618,000	$0	$903,000	$0
133	GEMT SUPPLEMENTAL PAYMENT PROGRAM	($15,797,000)	$0	($8,733,000)	$0	$7,064,000	$0
134	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	$10,000,000	$4,900,000	$10,000,000	$5,000,000	$0	$100,000
135	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	$9,272,000	$1,576,000	$0	$0	($9,272,000)	($1,576,000)
136	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	$8,000,000	$3,920,000	$8,000,000	$4,000,000	$0	$80,000
137	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	$62,132,000	$25,585,000	$76,365,000	$30,445,000	$14,233,000	$4,860,000
138	NDPH SUPPLEMENTAL PAYMENT	$4,179,000	$1,900,000	$14,900,000	$1,900,000	$10,721,000	$0
139	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	$2,352,000	$0	$0	$0	($2,352,000)	$0
140	FREE CLINICS AUGMENTATION	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$0	$0
141	IGT ADMIN. & PROCESSING FEE	$0	($14,618,000)	$0	($12,887,000)	$0	$1,731,000
142	PROPOSITION 56 FUNDING	$0	($767,112,000)	$0	($594,892,000)	$0	$172,220,000
231	PROP 56 - FUNDING REDUCTION	$0	$0	($193,405,000)	($77,107,000)	($193,405,000)	($77,107,000)
	SUPPLEMENTAL PMNTS. SUBTOTAL	**$16,926,796,000**	**$771,880,600**	**$14,190,984,000**	**$885,976,900**	**($2,735,812,000)**	**$114,096,300**
	COVID-19						
143	COVID-19 VACCINES	$300,395,000	$107,949,150	$358,139,000	$128,699,650	$57,744,000	$20,750,500
144	COVID-19 BEHAVIORAL HEALTH	$113,809,000	$8,270,750	$814,000	$58,400	($112,995,000)	($8,212,350)

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2023-24 AND 2024-25

NO.	POLICY CHANGE TITLE	NOV. 2023 EST. FOR 2023-24		NOV. 2023 EST. FOR 2024-25		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	COVID-19						
145	PHARMACY-BASED COVID-19 TESTS	$10,363,000	$3,365,200	$14,665,000	$4,762,150	$4,302,000	$1,396,950
146	COVID-19 VACCINE FUNDING ADJUSTMENT	$0	($86,975,000)	$0	($65,541,000)	$0	$21,434,000
147	CONTINUOUS CHIP COVERAGE DURING THE COVID-19 PHE	$0	$52,670,000	$0	$0	$0	($52,670,000)
148	COVID-19 ELIGIBILITY	$0	$1,715,000	$0	$0	$0	($1,715,000)
149	COVID-19 INCREASED FMAP - DHCS	($50,018,000)	($663,604,000)	$0	$820,000	$50,018,000	$664,424,000
150	COVID-19 REDETERMINATIONS IMPACT	($3,148,753,000)	($1,171,273,800)	($9,638,417,000)	($3,502,282,400)	($6,489,664,000)	($2,331,008,600)
	COVID-19 SUBTOTAL	**($2,774,204,000)**	**($1,747,882,700)**	**($9,264,799,000)**	**($3,433,483,200)**	**($6,490,595,000)**	**($1,685,600,500)**
	STATE-ONLY CLAIMING						
151	STATE-ONLY CLAIMING ADJUSTMENTS - RETRO ADJ.	($3,844,000)	$3,573,646,000	$0	$944,000	$3,844,000	($3,572,702,000)
	STATE-ONLY CLAIMING SUBTOTAL	**($3,844,000)**	**$3,573,646,000**	**$0**	**$944,000**	**$3,844,000**	**($3,572,702,000)**
	OTHER DEPARTMENTS						
152	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$719,320,000	$0	$751,126,000	$0	$31,806,000	$0
	OTHER DEPARTMENTS SUBTOTAL	**$719,320,000**	**$0**	**$751,126,000**	**$0**	**$31,806,000**	**$0**
	OTHER						
158	HCBS SP CDDS	$601,116,000	$0	$105,028,000	$0	($496,088,000)	$0
159	BEHAVIORAL HEALTH BRIDGE HOUSING	$483,968,000	$483,968,000	$456,587,000	$456,587,000	($27,381,000)	($27,381,000)
161	CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY	$351,500,000	$351,500,000	$198,500,000	$198,500,000	($153,000,000)	($153,000,000)
162	CALAIM - BH PAYMENT REFORM	$250,000,000	$250,000,000	$0	$0	($250,000,000)	($250,000,000)
163	CYBHI - EVIDENCE-BASED BH PRACTICES	$242,450,000	$242,450,000	$151,610,000	$151,610,000	($90,840,000)	($90,840,000)
164	QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES	$168,021,000	$25,203,000	$299,723,000	$44,958,000	$131,702,000	$19,755,000
165	SELF-DETERMINATION PROGRAM - CDDS	$120,933,000	$0	$186,473,000	$0	$65,540,000	$0
166	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER	$393,887,000	$196,943,500	$363,800,000	$181,900,000	($30,087,000)	($15,043,500)

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2023-24 AND 2024-25

NO.	POLICY CHANGE TITLE	NOV. 2023 EST. FOR 2023-24		NOV. 2023 EST. FOR 2024-25		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER						
167	CYBHI - URGENT NEEDS AND EMERGENT ISSUES	$106,000,000	$106,000,000	$29,000,000	$29,000,000	($77,000,000)	($77,000,000)
168	EVIDENCE-BASED DENTAL PRACTICES	$103,921,000	$34,176,050	$102,642,000	$33,774,550	($1,279,000)	($401,500)
169	CALAIM - PATH WPC	$101,000,000	$0	$0	$0	($101,000,000)	$0
170	LA COUNTY JUSTICE-INVOLVED POP. SVCS & SUPPORTS	$99,220,000	$99,220,000	$0	$0	($99,220,000)	($99,220,000)
171	ASSISTED LIVING WAIVER EXPANSION	$171,099,000	$85,549,500	$146,900,000	$73,450,000	($24,199,000)	($12,099,500)
172	EQUITY & PRACTICE TRANSFORMATION PAYMENTS	$92,500,000	$46,250,000	$135,000,000	$67,500,000	$42,500,000	$21,250,000
173	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	$69,501,000	$0	$69,462,000	$0	($39,000)	$0
174	MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG	$55,581,000	$0	$65,742,000	$0	$10,161,000	$0
175	CALHOPE	$51,813,000	$1,313,000	$25,880,000	$16,423,000	($25,933,000)	$15,110,000
176	SECTION 19.56 LEGISLATIVE PRIORITIES	$49,224,000	$49,224,000	$0	$0	($49,224,000)	($49,224,000)
178	INDIAN HEALTH SERVICES	$41,731,000	$13,910,500	$20,691,000	$6,897,000	($21,040,000)	($7,013,500)
179	CALAIM - PATH FOR CLINICS	$40,000,000	$40,000,000	$0	$0	($40,000,000)	($40,000,000)
180	CARE ACT	$39,656,000	$39,656,000	$104,928,000	$104,928,000	$65,272,000	$65,272,000
181	CYBHI - CALHOPE STUDENT SUPPORT	$32,000,000	$32,000,000	$0	$0	($32,000,000)	($32,000,000)
183	PEER SUPPORT SPECIALIST SERVICES	$24,820,000	$0	$27,255,000	$0	$2,435,000	$0
184	INFANT DEVELOPMENT PROGRAM	$18,120,000	$0	$14,530,000	$0	($3,590,000)	$0
185	ABORTION SUPPLEMENTAL PAYMENT PROGRAM	$18,564,000	$18,564,000	$11,144,000	$11,144,000	($7,420,000)	($7,420,000)
186	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	$94,716,000	$47,358,000	$77,456,000	$38,728,000	($17,260,000)	($8,630,000)
188	CLINIC WORKFORCE STABILIZATION RETENTION PAYMENTS	$0	$0	$0	$0	$0	$0
189	HOSPITAL & SNF COVID-19 WORKER RETENTION PAYMENTS	$5,984,000	$0	$0	$0	($5,984,000)	$0
190	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	$11,771,000	$5,397,000	$10,724,000	$4,926,000	($1,047,000)	($471,000)

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2023-24 AND 2024-25

NO.	POLICY CHANGE TITLE	NOV. 2023 EST. FOR 2023-24		NOV. 2023 EST. FOR 2024-25		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER						
191	CYBHI - FEE SCHEDULE THIRD PARTY ADMINISTRATOR	$10,000,000	$0	$0	$0	($10,000,000)	$0
192	FOSTER YOUTH SUBSTANCE USE DISORDER GRANT PROGRAM	$5,000,000	$5,000,000	$0	$0	($5,000,000)	($5,000,000)
193	HCBS SP - NON-IHSS CARE ECONOMY PMTS	$3,080,000	$0	$0	$0	($3,080,000)	$0
194	PROP 56 - PROVIDER ACES TRAININGS	$1,807,000	$903,500	$0	$0	($1,807,000)	($903,500)
195	QAF WITHHOLD TRANSFER	$1,178,000	$236,000	$384,000	$192,000	($794,000)	($44,000)
196	HCBS SP - CALBRIDGE BH NAVIGATOR PROGRAM	$1,056,000	$0	$89,000	$0	($967,000)	$0
197	CLPP FUND	$902,000	$0	$0	$0	($902,000)	$0
198	WPCS WORKERS' COMPENSATION	$620,000	$310,000	$620,000	$310,000	$0	$0
199	HCBS SP - ETSB FOR LAGUNA HONDA HOSPITAL RESIDENTS	$550,000	$0	$0	$0	($550,000)	$0
202	URBAN INDIAN ORGANIZATIONS FUNDING SHIFT	$0	($9,121,000)	$0	$0	$0	$9,121,000
203	HCBS SP - ALW FUNDING SHIFT	$0	($141,908,000)	$0	$0	$0	$141,908,000
204	AUDIT SETTLEMENTS	$0	$150,000	$0	$0	$0	($150,000)
205	IMD ANCILLARY SERVICES	$0	$50,724,000	$0	$68,936,000	$0	$18,212,000
206	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	($118,769,000)	$0	($124,169,000)	$0	($5,400,000)
207	FUNDING ADJUST.—ACA OPT. EXPANSION	$0	($4,654,480,400)	$0	($4,888,713,200)	$0	($234,232,800)
208	FUNDING ADJUST.—OTLICP	$0	($106,386,000)	$0	($108,033,750)	$0	($1,647,750)
209	HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	($1,956,896,000)	$0	($1,254,000,000)	$0	$702,896,000
210	CMS DEFERRED CLAIMS	$0	($704,530,000)	$0	($2,000,000)	$0	$702,530,000
211	INDIAN HEALTH SERVICES FUNDING SHIFT	$0	($29,278,000)	$0	($30,821,000)	$0	($1,543,000)
212	CALAIM - DENTAL INITIATIVES	$250,903,000	$120,224,950	$250,903,000	$120,224,950	$0	$0
213	DENTAL MANAGED CARE MLR RISK CORRIDOR	($9,800,000)	($3,154,550)	$0	$0	$9,800,000	$3,154,550
214	COUNTY SHARE OF OTLICP-CCS COSTS	($11,993,000)	($11,993,000)	($16,769,000)	($16,769,000)	($4,776,000)	($4,776,000)
215	CCI IHSS RECONCILIATION	($30,986,000)	$84,014,000	$0	$0	$30,986,000	($84,014,000)
216	COUNTY BH RECOUPMENTS	($64,160,000)	($64,160,000)	($64,160,000)	($64,160,000)	$0	$0

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2023-24 AND 2024-25

NO.	POLICY CHANGE TITLE	NOV. 2023 EST. FOR 2023-24		NOV. 2023 EST. FOR 2024-25		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER						
219	ADVISORY COUNCIL ON PHYS. FIT. & MENTAL WELL-BEING	$2,000,000	$0	$1,000,000	$0	($1,000,000)	$0
220	ASSET LIMIT INCREASE & ELIM. - CNTY BH FUNDING	$0	$0	$6,084,000	$6,084,000	$6,084,000	$6,084,000
	OTHER SUBTOTAL	**$3,999,253,000**	**($5,370,430,950)**	**$2,781,226,000**	**($4,872,593,450)**	**($1,218,027,000)**	**$497,837,500**
	GRAND TOTAL	**$48,222,272,760**	**($6,321,712,070)**	**$44,701,953,910**	**($8,816,550,450)**	**($3,520,318,850)**	**($2,494,838,380)**

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

FISCAL YEAR 2024-25 COST PER ELIGIBLE BASED ON NOVEMBER 2023 ESTIMATE

SERVICE CATEGORY	PA-OAS	NEWLY	PA-ATD	PA-AFDC	LT-OAS	H-PE
PHYSICIANS	$1,093,910	$128,130,770	$47,959,700	$39,485,580	$531,190	$60,494,090
OTHER MEDICAL	$116,309,660	$1,884,404,880	$464,794,830	$452,277,780	$3,295,980	$36,439,990
CO. & COMM. OUTPATIENT	$1,128,230	$117,073,390	$68,010,530	$46,997,740	$205,710	$53,448,340
PHARMACY	$73,827,640	$6,653,345,870	$1,969,832,970	$425,561,000	$7,616,940	$25,154,640
COUNTY INPATIENT	$3,294,210	$491,642,800	$46,291,470	$40,090,550	$1,345,600	$90,247,140
COMMUNITY INPATIENT	$24,270,240	$987,740,240	$378,384,420	$312,288,950	$4,783,430	$366,162,910
NURSING FACILITIES	$29,809,640	$76,618,420	$178,172,230	$7,211,580	$138,664,480	$3,530,440
ICF-DD	$588,480	$1,633,850	$12,352,930	$2,126,660	$5,528,920	$10
MEDICAL TRANSPORTATION	$215,720	$21,066,060	$4,359,420	$2,672,300	$195,740	$9,075,770
OTHER SERVICES	$113,393,440	$61,802,210	$875,005,520	$120,958,700	$22,572,380	$3,375,330
HOME HEALTH	$2,634,340	$1,566,330	$65,208,220	$5,638,270	$1,430	$209,740
FFS SUBTOTAL	**$366,565,510**	**$10,425,024,820**	**$4,110,372,240**	**$1,455,309,110**	**$184,741,800**	**$648,138,400**
DENTAL	$50,849,220	$388,007,080	$104,760,430	$201,806,360	$8,444,970	$1,600,730
MENTAL HEALTH	$14,079,070	$438,203,570	$1,509,638,300	$1,012,849,410	$896,090	$11,944,400
TWO PLAN MODEL	$2,246,027,020	$16,954,233,730	$5,484,597,430	$2,006,288,180	$2,073,104,390	$0
COUNTY ORGANIZED HEALTH SYSTEMS	$876,821,700	$6,557,150,270	$2,130,392,940	$520,736,850	$66,501,450	$0
GEOGRAPHIC MANAGED CARE	$341,027,230	$3,205,979,010	$1,084,974,510	$328,061,280	$382,016,510	$0
PHP & OTHER MANAG. CARE	$485,062,000	$26,106,310	$253,726,300	$2,745,280	$16,898,980	$0
MEDICARE PAYMENTS	$2,163,953,260	$322,169,010	$1,791,883,320	$0	$157,058,700	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$0	$0	$40	$50	$0	$0
MISC. SERVICES	$9,615,490	$130	$62,967,620	$4,678,790	$0	$0
DRUG MEDI-CAL	$31,196,780	$335,062,210	$63,816,540	$83,217,890	$2,556,910	$20,810
REGIONAL MODEL	$103,136,660	$1,432,354,360	$576,500,570	$157,696,630	$289,905,260	$0
NON-FFS SUBTOTAL	**$6,321,768,420**	**$29,659,265,680**	**$13,063,257,990**	**$4,318,080,720**	**$2,997,383,270**	**$13,565,940**
TOTAL DOLLARS (1)	**$6,688,333,940**	**$40,084,290,500**	**$17,173,630,230**	**$5,773,389,830**	**$3,182,125,080**	**$661,704,340**
ELIGIBLES * **	**422,000**	**4,493,100**	**864,700**	**1,065,600**	**34,000**	**36,600**
ANNUAL $/ELIGIBLE	**$15,849**	**$8,921**	**$19,861**	**$5,418**	**$93,592**	**$18,079**
AVG. MO. $/ELIGIBLE	**$1,321**	**$743**	**$1,655**	**$451**	**$7,799**	**$1,507**

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

FISCAL YEAR 2024-25 COST PER ELIGIBLE BASED ON NOVEMBER 2023 ESTIMATE

SERVICE CATEGORY	LT-ATD	POV 250	MN-OAS	MN-ATD	MN-AFDC	MI-C
PHYSICIANS	$404,210	$13,977,100	$9,529,630	$6,398,350	$101,792,220	$27,477,960
OTHER MEDICAL	$1,792,000	$195,323,750	$287,295,490	$96,950,930	$1,564,780,820	$114,337,000
CO. & COMM. OUTPATIENT	$170,560	$23,693,300	$11,044,320	$8,176,850	$142,218,250	$17,183,950
PHARMACY	$3,680,120	$235,351,190	$411,859,780	$200,750,380	$2,256,658,040	$65,722,400
COUNTY INPATIENT	$239,920	$6,001,840	$31,639,530	$11,889,480	$154,783,020	$13,809,910
COMMUNITY INPATIENT	$3,851,530	$75,757,910	$81,148,290	$31,725,630	$754,420,230	$73,100,640
NURSING FACILITIES	$43,945,550	$3,541,500	$157,332,210	$25,013,840	$15,361,820	$8,273,810
ICF-DD	$11,745,620	$1,557,200	$250,120	$1,655,280	$152,420	$4,721,640
MEDICAL TRANSPORTATION	$137,180	$352,600	$1,786,500	$1,070,940	$5,643,320	$2,791,980
OTHER SERVICES	$5,881,720	$38,514,790	$218,509,750	$207,467,490	$128,558,770	$56,881,680
HOME HEALTH	$5,960	$6,748,060	$1,137,130	$20,514,830	$9,581,390	$10,520,810
FFS SUBTOTAL	**$71,854,380**	**$600,819,230**	**$1,211,532,750**	**$611,614,010**	**$5,133,950,290**	**$394,821,770**
DENTAL	$2,440,850	$153,666,440	$65,305,190	$24,777,950	$577,400,400	$24,239,650
MENTAL HEALTH	$2,113,840	$104,318,830	$18,088,560	$153,365,480	$832,299,630	$121,168,130
TWO PLAN MODEL	$358,890,290	$860,003,180	$3,786,175,030	$1,301,099,120	$6,269,131,800	$54,286,970
COUNTY ORGANIZED HEALTH SYSTEMS	$15,155,230	$379,532,800	$1,689,209,630	$657,948,250	$2,624,649,630	$41,527,050
GEOGRAPHIC MANAGED CARE	$59,792,440	$167,570,480	$515,121,170	$277,954,690	$1,354,613,680	$8,032,670
PHP & OTHER MANAG. CARE	$1,305,220	($2,129,360)	$753,827,960	$69,187,430	$76,190	$0
MEDICARE PAYMENTS	$0	$0	$2,427,417,060	$861,746,390	$144,720,250	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$0	$0	$0	$10	$150	$10
MISC. SERVICES	$0	$2,074,000	$17,443,700	$15,569,950	$14,600,510	$611,780
DRUG MEDI-CAL	$588,470	$58,335,620	$51,885,660	$16,565,730	$258,793,650	$11,877,880
REGIONAL MODEL	$25,309,990	$67,774,520	$248,027,520	$180,572,890	$605,740,450	$3,460,190
NON-FFS SUBTOTAL	**$465,596,340**	**$1,791,146,520**	**$9,572,501,480**	**$3,558,787,910**	**$12,682,026,340**	**$265,204,340**
TOTAL DOLLARS (1)	**$537,450,720**	**$2,391,965,750**	**$10,784,034,230**	**$4,170,401,920**	**$17,815,976,630**	**$660,026,110**
ELIGIBLES * **	**7,300**	**904,500**	**761,500**	**177,300**	**3,472,800**	**148,100**
ANNUAL $/ELIGIBLE	**$73,623**	**$2,645**	**$14,162**	**$23,522**	**$5,130**	**$4,457**
AVG. MO. $/ELIGIBLE	**$6,135**	**$220**	**$1,180**	**$1,960**	**$428**	**$371**

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

FISCAL YEAR 2024-25 COST PER ELIGIBLE BASED ON NOVEMBER 2023 ESTIMATE

SERVICE CATEGORY	MI-A	REFUGEE	OBRA	POV 185	POV 133	POV 100
PHYSICIANS	$371,640	$254,290	$1,290	$73,834,790	$15,226,390	$6,459,760
OTHER MEDICAL	$403,490	$4,177,570	$1,830	$284,931,270	$264,097,070	$129,793,500
CO. & COMM. OUTPATIENT	$72,550	$227,050	$140	$29,475,100	$16,525,640	$11,598,000
PHARMACY	$1,658,270	$5,079,260	$680	$57,288,400	$91,519,160	$105,970,980
COUNTY INPATIENT	$5,884,780	$35,960	$0	$109,537,550	$5,622,070	$2,300,770
COMMUNITY INPATIENT	$1,796,530	$497,560	$1,870	$632,073,400	$93,152,690	$30,531,980
NURSING FACILITIES	$7,423,000	$0	$81,870	$1,066,230	$5,988,330	$1,241,900
ICF-DD	$224,300	$0	$530	$160	$237,060	$28,830
MEDICAL TRANSPORTATION	$34,670	$21,760	$180	$1,441,280	$371,480	$207,640
OTHER SERVICES	$449,480	$88,780	$130	$7,182,390	$43,824,210	$19,678,440
HOME HEALTH	$0	$0	$0	$2,312,420	$3,900,950	$2,261,480
FFS SUBTOTAL	**$18,318,710**	**$10,382,240**	**$88,520**	**$1,199,142,990**	**$540,465,040**	**$310,073,290**
DENTAL	$145,520	$1,184,960	$0	$15,439,710	$197,334,440	$81,616,930
MENTAL HEALTH	$0	$230,590	$2,305,910	$2,260,680	$34,188,190	$51,966,980
TWO PLAN MODEL	$889,060	$5,876,590	$0	$462,085,490	$779,030,710	$396,357,570
COUNTY ORGANIZED HEALTH SYSTEMS	$534,670	$1,600,860	$0	$208,107,800	$287,735,390	$154,023,640
GEOGRAPHIC MANAGED CARE	$77,440	$3,291,420	$0	$92,348,680	$144,822,360	$63,211,220
PHP & OTHER MANAG. CARE	$0	$0	$0	($1,376,700)	($1,625,910)	($1,625,910)
MEDICARE PAYMENTS	$0	$0	$0	$0	$0	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$0	$0	$0	$10	$0	$20
MISC. SERVICES	$70	$0	$0	$7,790	$3,154,630	$1,627,620
DRUG MEDI-CAL	$223,740	$535,600	$0	$24,335,090	$55,611,710	$28,722,280
REGIONAL MODEL	$146,350	$349,750	$0	$42,424,580	$63,675,790	$30,914,950
NON-FFS SUBTOTAL	**$2,016,860**	**$13,069,770**	**$2,305,910**	**$845,633,130**	**$1,563,927,310**	**$806,815,310**
TOTAL DOLLARS (1)	**$20,335,560**	**$23,452,010**	**$2,394,430**	**$2,044,776,120**	**$2,104,392,350**	**$1,116,888,600**
ELIGIBLES * **	**3,000**	**6,000**	**0**	**348,500**	**691,700**	**318,900**
ANNUAL $/ELIGIBLE	**$6,779**	**$3,909**		**$5,867**	**$3,042**	**$3,502**
AVG. MO. $/ELIGIBLE	**$565**	**$326**		**$489**	**$254**	**$292**

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

FISCAL YEAR 2024-25 COST PER ELIGIBLE BASED ON NOVEMBER 2023 ESTIMATE

SERVICE CATEGORY	TOTAL
PHYSICIANS	**$533,422,870**
OTHER MEDICAL	**$5,901,407,830**
CO. & COMM. OUTPATIENT	**$547,249,670**
PHARMACY	**$12,590,877,720**
COUNTY INPATIENT	**$1,014,656,610**
COMMUNITY INPATIENT	**$3,851,688,460**
NURSING FACILITIES	**$703,276,860**
ICF-DD	**$42,803,980**
MEDICAL TRANSPORTATION	**$51,444,560**
OTHER SERVICES	**$1,924,145,200**
HOME HEALTH	**$132,241,370**
FFS SUBTOTAL	**$27,293,215,110**
DENTAL	**$1,899,020,820**
MENTAL HEALTH	**$4,309,917,670**
TWO PLAN MODEL	**$43,038,076,570**
COUNTY ORGANIZED HEALTH SYSTEMS	**$16,211,628,170**
GEOGRAPHIC MANAGED CARE	**$8,028,894,800**
PHP & OTHER MANAG. CARE	**$1,602,177,810**
MEDICARE PAYMENTS	**$7,868,948,000**
STATE HOSP./DEVELOPMENTAL CNTRS.	**$270**
MISC. SERVICES	**$132,352,080**
DRUG MEDI-CAL	**$1,023,346,570**
REGIONAL MODEL	**$3,827,990,470**
NON-FFS SUBTOTAL	**$87,942,353,230**
TOTAL DOLLARS (1)	**$115,235,568,340**
ELIGIBLES * **	**13,755,600**
ANNUAL $/ELIGIBLE	**$8,377**
AVG. MO. $/ELIGIBLE	**$698**

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

FISCAL YEAR 2024-25 COST PER ELIGIBLE BASED ON NOVEMBER 2023 ESTIMATE

EXCLUDED POLICY CHANGES: 116

	QAF WITHHOLD TRANSFER ADJUSTMENT
	QAF WITHHOLD ADJUSTMENT
2	POSTPARTUM CARE EXTENSION
4	BREAST AND CERVICAL CANCER TREATMENT
6	HEALTH ENROLLMENT NAVIGATORS FOR CLINICS
13	CS3 PROXY ADJUSTMENT
14	COMMUNITY FIRST CHOICE OPTION
16	1% FMAP INCREASE FOR PREVENTIVE SERVICES
17	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.
18	ACA DSH REDUCTION
20	FAMILY PACT PROGRAM
22	CALIFORNIA COMMUNITY TRANSITIONS COSTS
25	MEDICAL INTERPRETER PILOT PROJECT
31	FPACT HPV VACCINE COVERAGE
35	LITIGATION SETTLEMENTS
37	FAMILY PACT DRUG REBATES
38	PHARMACY RETROACTIVE ADJUSTMENTS
46	DRUG MEDI-CAL PROGRAM COST SETTLEMENT
49	BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE
51	CALAIM - BH QUALITY IMPROVEMENT PROGRAM
55	SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS
56	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT
57	CHART REVIEW
58	INTERIM AND FINAL COST SETTLEMENTS - SMHS
59	GLOBAL PAYMENT PROGRAM
60	CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES
61	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG
76	DENTAL MANAGED CARE (Other M/C)
77	CYBHI - STUDENT BH INCENTIVE PROGRAM
80	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL
83	COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM
84	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL
85	PROP 56 - BEHAVIORAL HEALTH INCENTIVE PROGRAM
91	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND

FISCAL YEAR 2024-25 COST PER ELIGIBLE BASED ON NOVEMBER 2023 ESTIMATE

EXCLUDED POLICY CHANGES: 116

93	PROP 56 - DIRECTED PAYMENT RISK MITIGATION
95	MEDI-CAL PROVIDER PAYMENT RESERVE FUND
99	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF
110	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES
114	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS
115	HOSPITAL QAF - MANAGED CARE PAYMENTS
116	HOSPITAL QAF - FFS PAYMENTS
118	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS
119	PRIVATE HOSPITAL DSH REPLACEMENT
120	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
121	PROP 56 - MEDI-CAL FAMILY PLANNING
122	DSH PAYMENT
123	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS
124	FFP FOR LOCAL TRAUMA CENTERS
125	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS
126	DPH PHYSICIAN & NON-PHYS. COST
127	NDPH IGT SUPPLEMENTAL PAYMENTS
129	CAPITAL PROJECT DEBT REIMBURSEMENT
130	PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS
131	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS
132	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS
133	GEMT SUPPLEMENTAL PAYMENT PROGRAM
134	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH
135	EMERGENCY MEDICAL AIR TRANSPORTATION ACT
136	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH
137	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS
138	NDPH SUPPLEMENTAL PAYMENT
139	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS
140	FREE CLINICS AUGMENTATION
141	IGT ADMIN. & PROCESSING FEE
142	PROPOSITION 56 FUNDING
148	COVID-19 ELIGIBILITY
151	STATE-ONLY CLAIMING ADJUSTMENTS - RETRO ADJ.
152	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS

FISCAL YEAR 2024-25 COST PER ELIGIBLE BASED ON NOVEMBER 2023 ESTIMATE

EXCLUDED POLICY CHANGES: 116

155	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)
156	PERSONAL CARE SERVICES (Misc. Svcs.)
159	BEHAVIORAL HEALTH BRIDGE HOUSING
160	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)
161	CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY
163	CYBHI - EVIDENCE-BASED BH PRACTICES
165	SELF-DETERMINATION PROGRAM - CDDS
166	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER
167	CYBHI - URGENT NEEDS AND EMERGENT ISSUES
168	EVIDENCE-BASED DENTAL PRACTICES
169	CALAIM - PATH WPC
170	LA COUNTY JUSTICE-INVOLVED POP. SVCS & SUPPORTS
171	ASSISTED LIVING WAIVER EXPANSION
172	EQUITY & PRACTICE TRANSFORMATION PAYMENTS
173	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS
174	MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG
175	CALHOPE
176	SECTION 19.56 LEGISLATIVE PRIORITIES
177	LAWSUITS/CLAIMS
179	CALAIM - PATH FOR CLINICS
181	CYBHI - CALHOPE STUDENT SUPPORT
182	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC
185	ABORTION SUPPLEMENTAL PAYMENT PROGRAM
186	MINIMUM WAGE INCREASE FOR HCBS WAIVERS
187	MEDI-CAL TCM PROGRAM
188	CLINIC WORKFORCE STABILIZATION RETENTION PAYMENTS
189	HOSPITAL & SNF COVID-19 WORKER RETENTION PAYMENTS
190	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS
191	CYBHI - FEE SCHEDULE THIRD PARTY ADMINISTRATOR
192	FOSTER YOUTH SUBSTANCE USE DISORDER GRANT PROGRAM
193	HCBS SP - NON-IHSS CARE ECONOMY PMTS
194	PROP 56 - PROVIDER ACES TRAININGS
195	QAF WITHHOLD TRANSFER
196	HCBS SP - CALBRIDGE BH NAVIGATOR PROGRAM

FISCAL YEAR 2024-25 COST PER ELIGIBLE BASED ON NOVEMBER 2023 ESTIMATE

EXCLUDED POLICY CHANGES: 116

197	CLPP FUND
199	HCBS SP - ETSB FOR LAGUNA HONDA HOSPITAL RESIDENTS
202	URBAN INDIAN ORGANIZATIONS FUNDING SHIFT
204	AUDIT SETTLEMENTS
206	CIGARETTE AND TOBACCO SURTAX FUNDS
209	HOSPITAL QAF - CHILDREN'S HEALTH CARE
210	CMS DEFERRED CLAIMS
212	CALAIM - DENTAL INITIATIVES
213	DENTAL MANAGED CARE MLR RISK CORRIDOR
214	COUNTY SHARE OF OTLICP-CCS COSTS
215	CCI IHSS RECONCILIATION
216	COUNTY BH RECOUPMENTS
217	BASE RECOVERIES
219	ADVISORY COUNCIL ON PHYS. FIT. & MENTAL WELL-BEING
220	ASSET LIMIT INCREASE & ELIM. - CNTY BH FUNDING
225	ENHANCED CARE MANAGEMENT RISK CORRIDOR

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
November 2023 Estimate
Fiscal Years 2022-2023, 2023-2024, & 2024-2025

(With Estimated Impact of Eligibility Policy Changes)*

	2022-2023	2023-2024	2024-2025	22-23 To 23-24 % Change	23-24 To 24-25 % Change
Public Assistance	**2,481,400**	**2,445,000**	**2,352,300**	**-1.47%**	**-3.79%**
Seniors	419,100	422,000	422,000	0.69%	0.00%
Persons with Disabilities	871,300	864,700	864,700	-0.76%	0.00%
Families [1]	1,191,000	1,158,300	1,065,600	-2.75%	-8.00%
Long Term	**41,600**	**41,300**	**41,300**	**-0.72%**	**0.00%**
Seniors	33,900	34,000	34,000	0.29%	0.00%
Persons with Disabilities	7,700	7,300	7,300	-5.19%	0.00%
Medically Needy	**4,967,000**	**4,751,500**	**4,398,900**	**-4.34%**	**-7.42%**
Seniors	750,200	762,900	753,900	1.69%	-1.18%
Persons with Disabilities	208,100	190,900	172,200	-8.27%	-9.80%
Families [1]	4,008,700	3,797,700	3,472,800	-5.26%	-8.56%
Medically Indigent	**150,400**	**151,200**	**151,100**	**0.53%**	**-0.07%**
Children	147,300	148,200	148,100	0.61%	-0.07%
Adults	3,100	3,000	3,000	-3.23%	0.00%
Other	**7,633,600**	**7,374,800**	**6,817,800**	**-3.39%**	**-7.55%**
Refugees	5,300	6,000	6,000	13.21%	0.00%
OBRA [2]	0	0	0	n/a	n/a
185% Poverty [3]	374,100	364,800	348,500	-2.49%	-4.47%
133% Poverty	834,800	768,000	691,700	-8.00%	-9.93%
100% Poverty	422,100	371,100	318,900	-12.08%	-14.07%
Opt. Targeted Low Income Children	857,000	883,900	904,500	3.14%	2.33%
ACA Optional Expansion	5,085,400	4,925,300	4,493,100	-3.15%	-8.78%
Hospital PE	35,900	36,700	36,600	2.23%	-0.27%
Medi-Cal Access Program	5,500	6,300	5,800	14.55%	-7.94%
QMB	13,500	12,700	12,700	-5.93%	0.00%
GRAND TOTAL [4]	**15,274,000**	**14,763,800**	**13,761,400**	**-3.34%**	**-6.79%**
Seniors	**1,203,200**	**1,218,900**	**1,209,900**	1.30%	-0.74%
Persons with Disabilities	**1,087,100**	**1,062,900**	**1,044,200**	-2.23%	-1.76%
Families and Children [5]	**7,835,000**	**7,492,000**	**6,950,100**	-4.38%	-7.23%
ACA Optional Expansion	**5,085,400**	**4,925,300**	**4,493,100**	-3.15%	-8.78%

Note: Graphs of eligibles represent base projections only and do not reflect estimated impact of policy changes.

***** See CL Page B reflecting impact of Policy Changes.**

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

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

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

	2022-2023	2023-2024	2024-2025
Presumptive Eligibility	24,900	25,300	25,300

[4] The following Medi-Cal special program eligibles (average monthly during FY 2022-23 shown in parenthesis are not included above: BCCTP (3,342), Tuberculosis (36), Dialysis (83), TPN (2), TCVAP (795) Family PACT eligibles are also not included above.

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

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

Policy Change	Budget Aid Category	Caseload Change Average Monthly Eligibles *not* in the Base Estimate 2022-23	2023-24	2024-25
PC 3 Medi-Cal State Inmates	LT Seniors	0	1	1
	MN Seniors	20	29	29
	MN Persons with Disabilities	4	6	6
	MI Children	1	2	2
	185% Poverty	1	2	2
	ACA Optional Expansion	156	174	174
	Total	**183**	**213**	**213**
PC 80 Medi-Cal Access Program Mothers 213-322%	MCAP Mothers	3,343	3,926	3,420
	Total	**3,343**	**3,926**	**3,420**
PC 84 Medi-Cal Access Program Infants 266-322%	MCAP Infants	2,146	2,333	2,344
	Total	**2,146**	**2,333**	**2,344**
PC 157 COVID-19 Redetermination Impact	PA Seniors		0	0
	PA Persons with Disabilities		0	0
	PA Families		(80,532)	(173,099)
	LT Seniors		0	0
	LT Persons with Disabilities		0	0
	MN Seniors		(39,639)	(86,657)
	MN Persons with Disabilities		(16,533)	(37,062)
	MN Families		(276,266)	(601,182)
	185% Poverty		(10,952)	(27,285)
	133% Poverty		(57,384)	(133,625)
	100% Poverty		(44,024)	(96,245)
	OTLICP		20,474	41,129
	ACA Optional Expansion		(347,756)	(779,970)
	Total		**(852,613)**	**(1,893,995)**
PC 5 - Phasing in the Medi-Cal Asset Limit Repeal	MN Seniors	0	1,644	8,452
	MN Persons with Disabilities	0	454	2,333
		0	**2,098**	**10,785**

	Budget Aid Category	2022-23	2023-24	2024-25
Total by Aid Category	PA Seniors	0	0	0
	PA Persons with Disabilities	0	0	0
	PA Families	0	(80,532)	(173,099)
	LT Seniors	0	1	1
	LT Persons with Disabilities	0	0	0
	MN Seniors	20	(37,967)	(78,176)
	MN Persons with Disabilities	4	(16,074)	(34,724)
	MN Families	0	(276,266)	(601,182)
	MI Children	1	2	2
	MI Adults	0	0	0
	Undocumented Persons	0	0	0
	185% Poverty	1	(10,950)	(27,283)
	133% Poverty	0	(57,384)	(133,625)
	100% Poverty	0	(44,024)	(96,245)
	OTLICP	0	20,474	41,129
	ACA Optional Expansion	156	(347,582)	(779,796)
	MCAP Infants	2,146	2,333	2,344
	MCAP Mothers	3,343	3,926	3,420
	Total	**5,672**	**(844,043)**	**(1,877,233)**

Comparison of Average Monthly Certified Eligibles
November 2023 Estimate
Fiscal Year 2023-24

(With Estimated Impact of Eligibility Policy Changes)

	Appropriaton 2023-2024	Nov 2023 2023-2024	Appropriation to Nov % Change
Public Assistance	**2,439,600**	**2,445,000**	**0.22%**
Seniors	419,100	422,000	0.69%
Persons with Disabilities	871,800	864,700	-0.81%
Families	1,148,700	1,158,300	0.84%
Long Term	**46,500**	**41,300**	**-11.18%**
Seniors	37,800	34,000	-10.05%
Persons with Disabilities	8,700	7,300	-16.09%
Medically Needy	**4,552,000**	**4,751,500**	**4.38%**
Seniors	760,300	762,900	0.34%
Persons with Disabilities	207,100	190,900	-7.82%
Families	3,584,600	3,797,700	5.94%
Medically Indigent	**153,200**	**151,200**	**-1.31%**
Children	150,200	148,200	-1.33%
Adults	3,000	3,000	0.00%
Other	**6,989,600**	**7,374,800**	**5.51%**
Refugees	7,200	6,000	-16.67%
OBRA	0	0	n/a
185% Poverty	338,800	364,800	7.67%
133% Poverty	774,500	768,000	-0.84%
100% Poverty	399,600	371,100	-7.13%
Opt. Targeted Low Income Children	879,200	883,900	0.53%
ACA Optional Expansion	4,534,500	4,925,300	8.62%
Hospital PE	36,800	36,700	-0.27%
Medi-Cal Access Program	5,200	6,300	21.15%
QMB	13,800	12,700	-7.97%
GRAND TOTAL	**14,180,900**	**14,763,800**	**4.11%**
Seniors	1,217,200	1,218,900	0.14%
Persons with Disabilities	1,087,600	1,062,900	-2.27%
Families and Children	7,275,600	7,492,000	2.97%
ACA Optional Expansion	4,534,500	4,925,300	8.62%

Estimated Average Monthly Certified Eligibles
November 2023 Estimate
Fiscal Years 2022-2023, 2023-2024, & 2024-2025

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

	2022-2023	2023-2024	2024-2025	22-23 To 23-24 % Change	23-24 To 24-25 % Change
Public Assistance	**2,258,128**	**2,326,721**	**2,245,279**	**3.04%**	**-3.50%**
Seniors	357,545	406,743	409,149	13.76%	0.59%
Persons with Disabilities	797,022	837,644	837,898	5.10%	0.03%
Families	1,103,561	1,082,334	998,233	-1.92%	-7.77%
Long Term	**28,435**	**34,734**	**34,732**	**22.15%**	**-0.01%**
Seniors	23,715	29,521	29,519	24.48%	-0.01%
Persons with Disabilities	4,720	5,213	5,213	10.43%	0.00%
Medically Needy	**4,242,986**	**4,368,707**	**4,250,518**	**2.96%**	**-2.71%**
Seniors	625,945	704,699	688,733	12.58%	-2.27%
Persons with Disabilities	171,070	182,126	165,436	6.46%	-9.16%
Families	3,445,970	3,481,882	3,396,348	1.04%	-2.46%
Medically Indigent	**57,334**	**59,616**	**60,098**	**3.98%**	**0.81%**
Children	57,153	59,254	59,740	3.68%	0.82%
Adults	181	362	358	99.57%	-1.02%
Other	**6,923,878**	**6,882,383**	**6,498,392**	**-0.60%**	**-5.58%**
Refugees	3,653	4,283	4,276	17.26%	-0.18%
OBRA	0	0	0	n/a	n/a
185% Poverty	269,622	284,027	273,153	5.34%	-3.83%
133% Poverty	809,490	750,970	681,854	-7.23%	-9.20%
100% Poverty	414,858	366,939	316,450	-11.55%	-13.76%
Opt. Targeted Low Income Children	831,039	859,448	878,179	3.42%	2.18%
ACA Optional Expansion	4,591,602	4,610,659	4,338,922	0.42%	-5.89%
Medi-Cal Access Program	3,614	6,057	5,558	67.61%	-8.24%
GRAND TOTAL [1]	**13,510,761**	**13,672,160**	**13,089,019**	**1.19%**	**-4.27%**
Percent of Statewide	**88.46%**	**92.61%**	**95.11%**		
Seniors	1,007,206	1,140,963	1,127,401	13.28%	-1.19%
Persons with Disabilities	972,812	1,024,982	1,008,546	5.36%	-1.60%
Families and Children	6,931,693	6,884,853	6,603,958	-0.68%	-4.08%
ACA Optional Expansion	4,591,602	4,610,659	4,338,922	0.42%	-5.89%

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

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

Estimated Average Monthly Certified Eligibles
November 2023 Estimate
Fiscal Years 2022-2023, 2023-2024, & 2024-2025

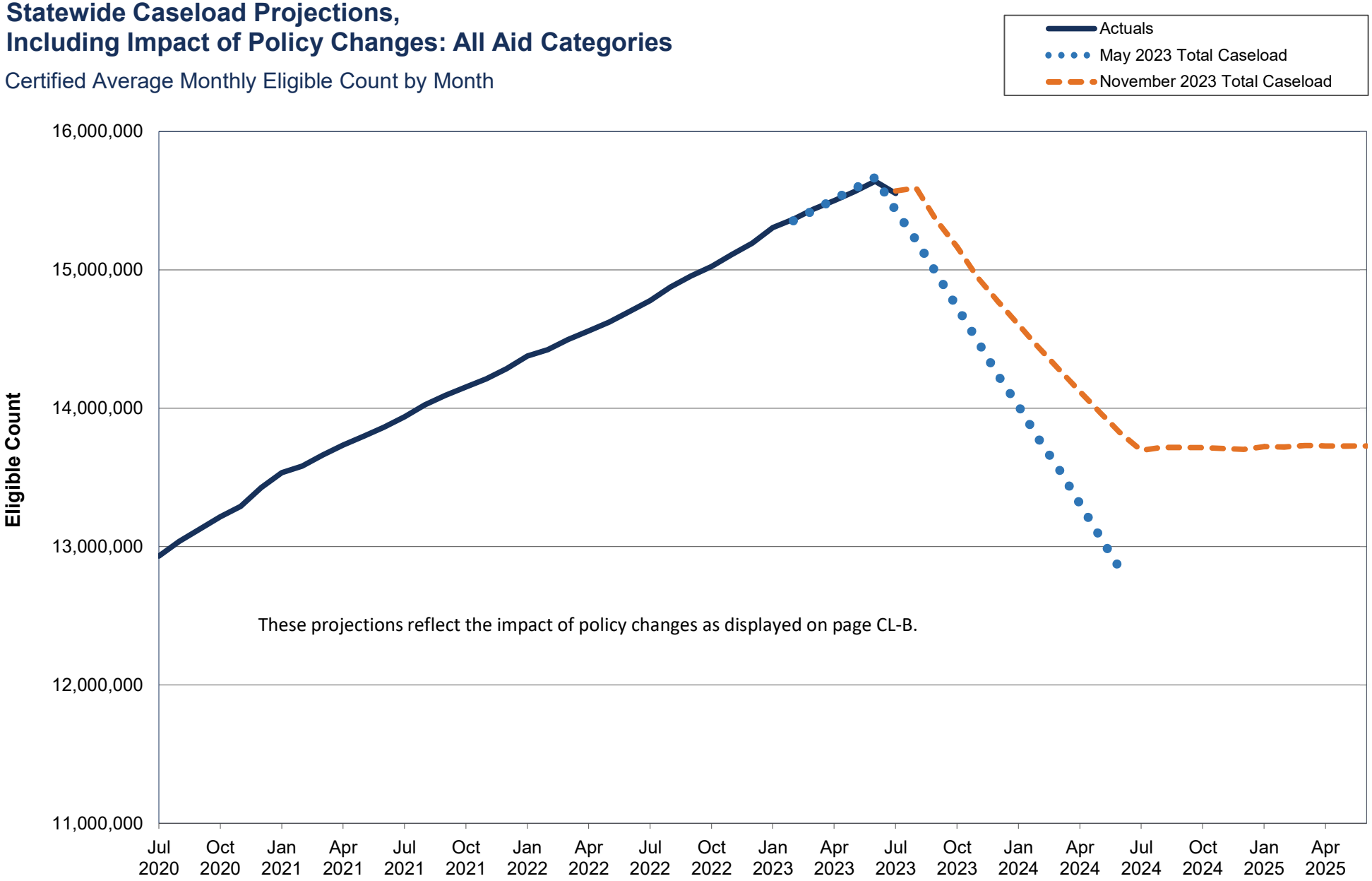
Fee-For-Service
(With Estimated Impact of Eligibility Policy Changes)*

	2022-2023	2023-2024	2024-2025	22-23 To 23-24 % Change	23-24 To 24-25 % Change
Public Assistance	**223,272**	**118,279**	**107,021**	**-47.02%**	**-9.52%**
Seniors	61,555	15,257	12,851	-75.21%	-15.77%
Persons with Disabilities	74,279	27,056	26,802	-63.57%	-0.94%
Families	87,439	75,966	67,367	-13.12%	-11.32%
Long Term	**13,165**	**6,566**	**6,568**	**-50.12%**	**0.03%**
Seniors	10,185	4,479	4,481	-56.03%	0.05%
Persons with Disabilities	2,980	2,087	2,087	-29.95%	-0.01%
Medically Needy	**724,014**	**382,793**	**148,382**	**-47.13%**	**-61.24%**
Seniors	124,255	58,201	65,167	-53.16%	11.97%
Persons with Disabilities	37,030	8,774	6,764	-76.31%	-22.91%
Families	562,730	315,818	76,452	-43.88%	-75.79%
Medically Indigent	**93,066**	**91,584**	**91,002**	**-1.59%**	**-0.64%**
Children	90,148	88,946	88,360	-1.33%	-0.66%
Adults	2,919	2,638	2,642	-9.61%	0.14%
Other	**709,722**	**492,417**	**319,408**	**-30.62%**	**-35.13%**
Refugees	1,647	1,717	1,724	4.22%	0.44%
OBRA	0	(0)	(0)	n/a	9.09%
185% Poverty	104,478	80,773	75,347	-22.69%	-6.72%
133% Poverty	25,310	17,030	9,846	-32.71%	-42.19%
100% Poverty	7,242	4,161	2,450	-42.54%	-41.14%
Opt. Targeted Low Income Children	25,961	24,452	26,321	-5.81%	7.64%
ACA Optional Expansion	493,798	314,641	154,178	-36.28%	-51.00%
Hospital PE	35,900	36,700	36,600	2.23%	-0.27%
Medi-Cal Access Program	1,886	243	242	-87.12%	-0.41%
QMB	13,500	12,700	12,700	-5.93%	0.00%
GRAND TOTAL	**1,763,239**	**1,091,640**	**672,381**	**-38.09%**	**-38.41%**
Percent of Statewide	**11.54%**	**7.39%**	**4.89%**		
Seniors	195,994	77,937	82,499	-60.24%	5.85%
Persons with Disabilities	114,288	37,918	35,654	-66.82%	-5.97%
Families and Children	903,307	607,147	346,142	-32.79%	-42.99%
ACA Optional Expansion	493,798	314,641	154,178	-36.28%	-51.00%

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

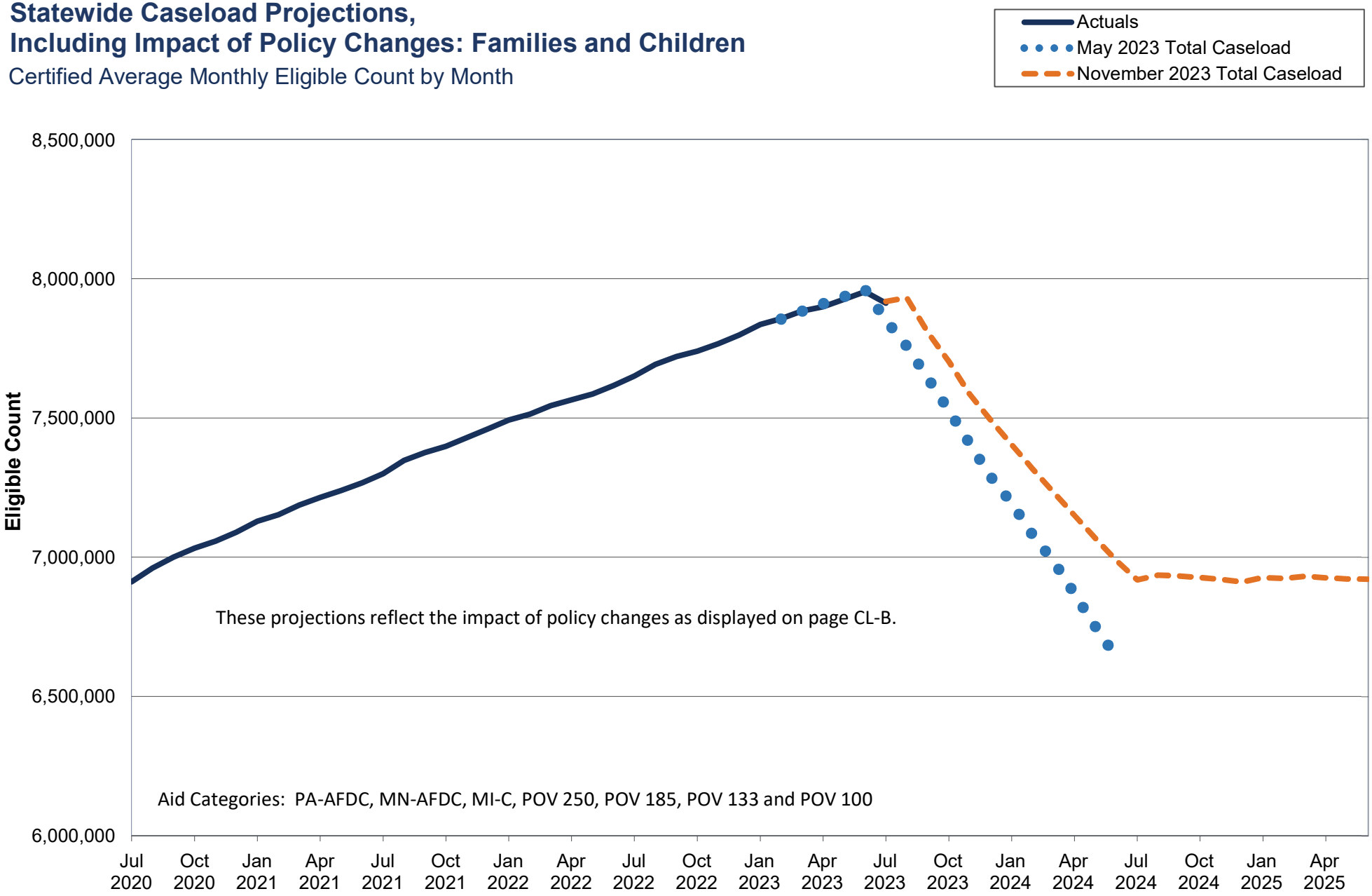
Statewide Caseload Projections, Including Impact of Policy Changes: All Aid Categories

Certified Average Monthly Eligible Count by Month



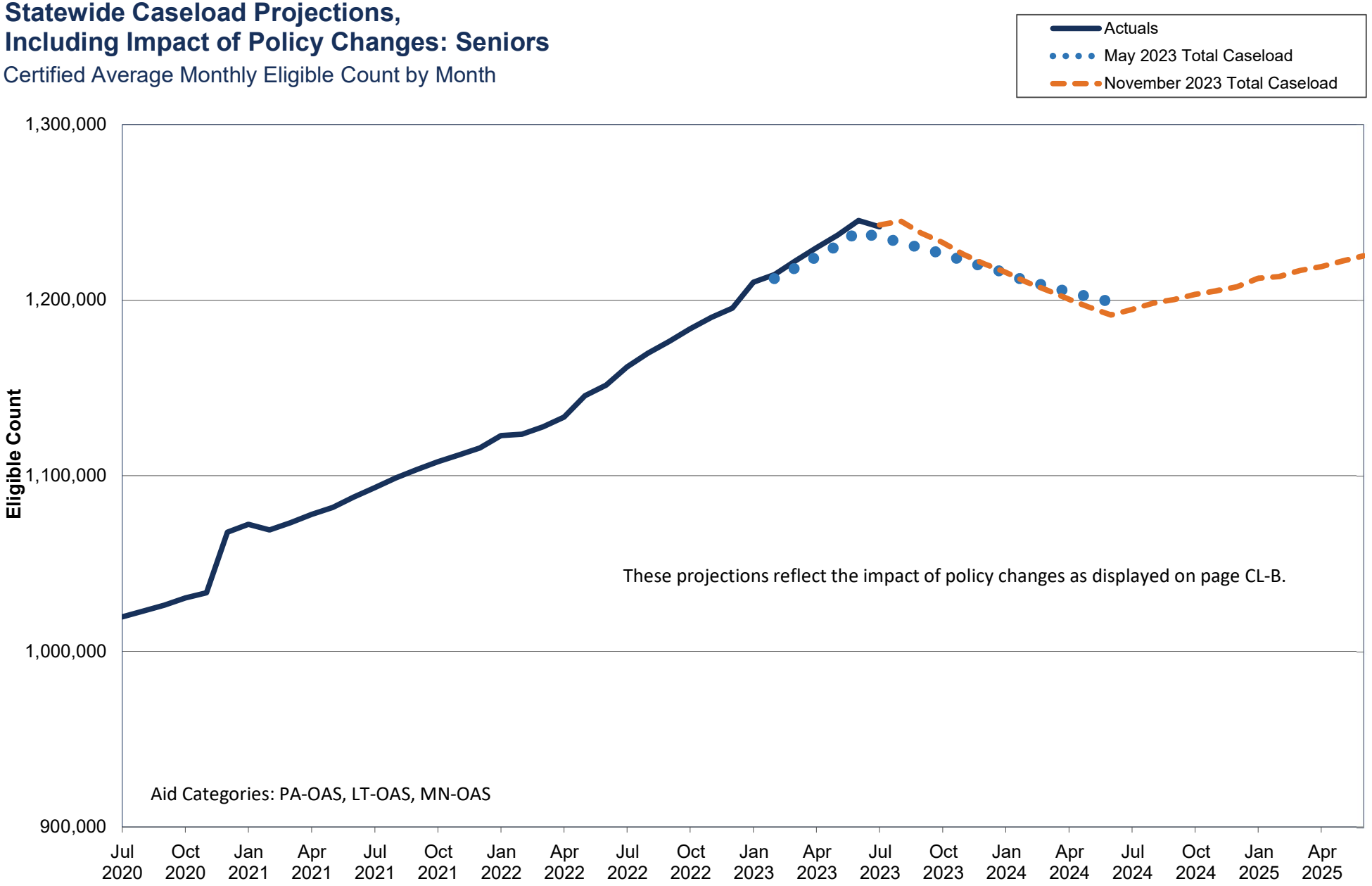
Statewide Caseload Projections, Including Impact of Policy Changes: Families and Children

Certified Average Monthly Eligible Count by Month



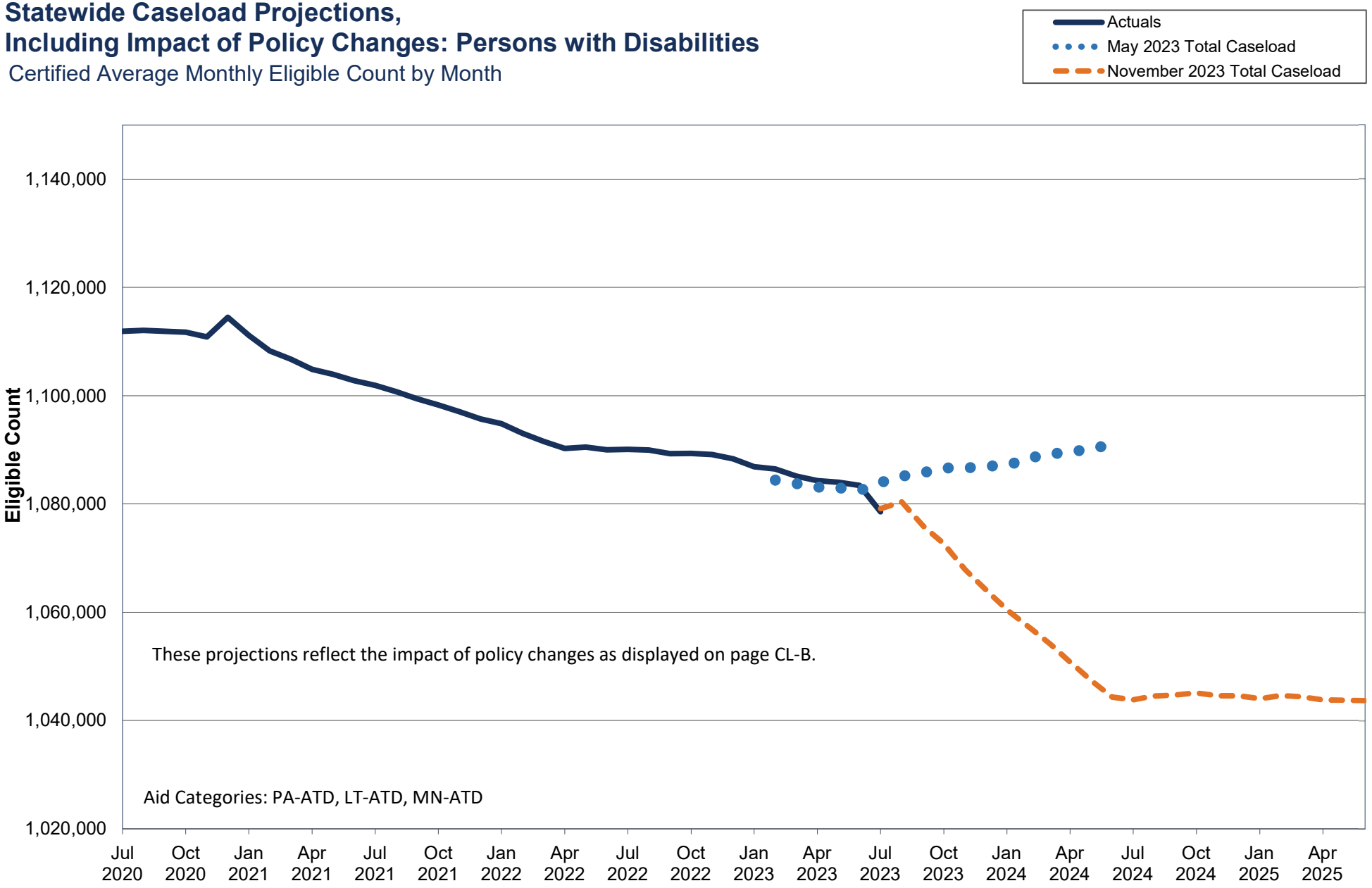
Statewide Caseload Projections, Including Impact of Policy Changes: Seniors

Certified Average Monthly Eligible Count by Month



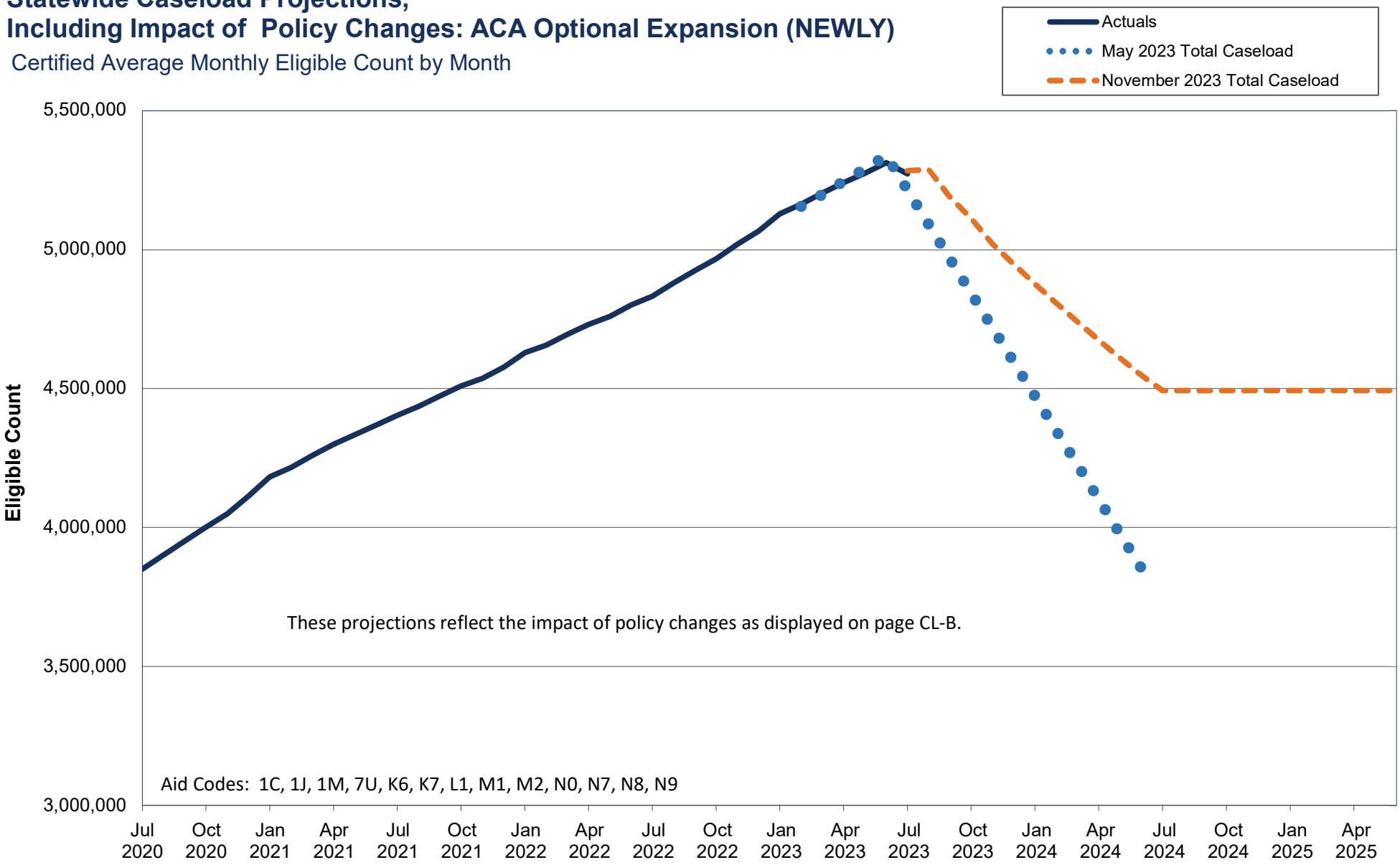
Statewide Caseload Projections, Including Impact of Policy Changes: Persons with Disabilities

Certified Average Monthly Eligible Count by Month



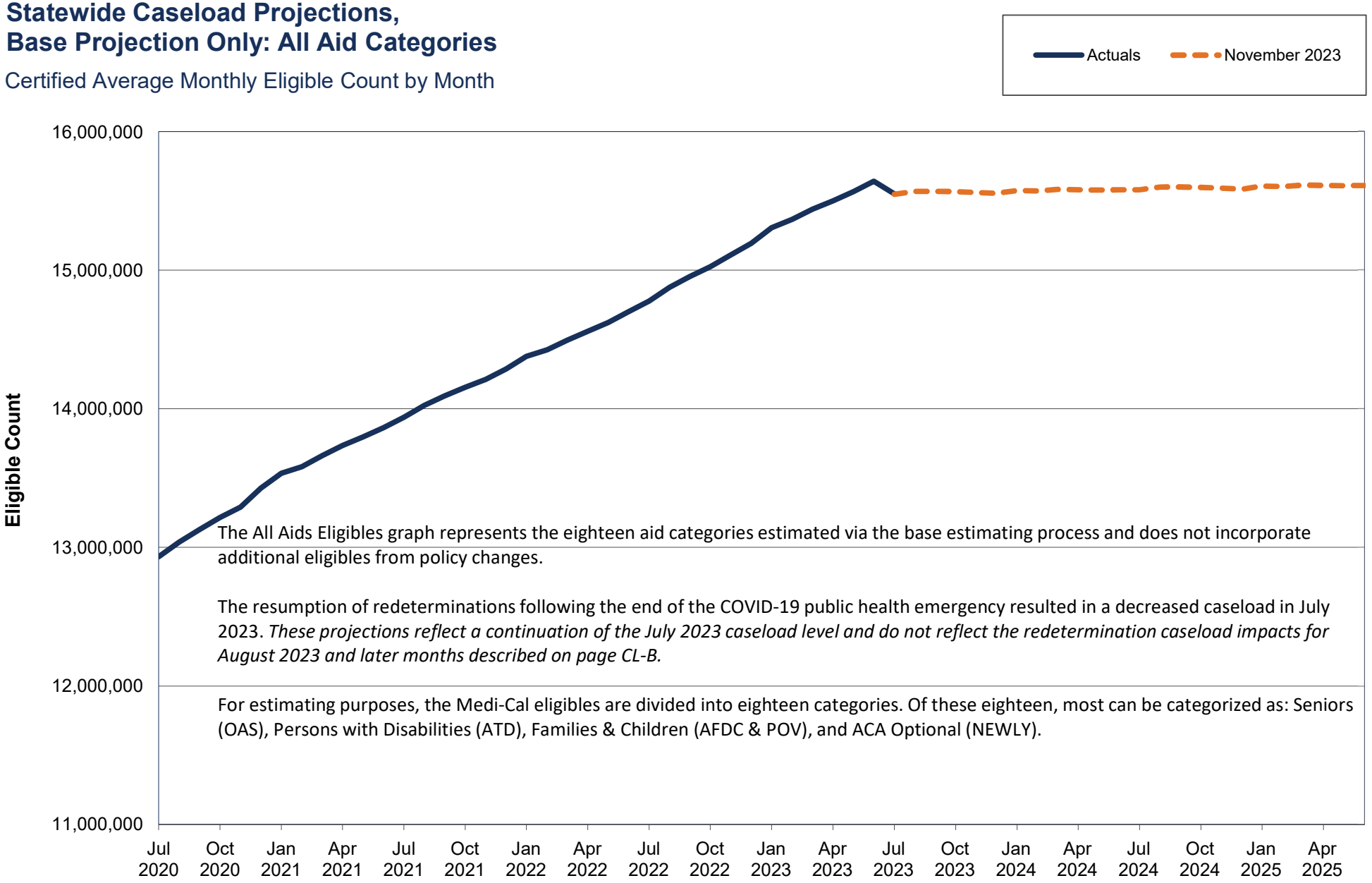
Statewide Caseload Projections, Including Impact of Policy Changes: ACA Optional Expansion (NEWLY)

Certified Average Monthly Eligible Count by Month



Statewide Caseload Projections, Base Projection Only: All Aid Categories

Certified Average Monthly Eligible Count by Month



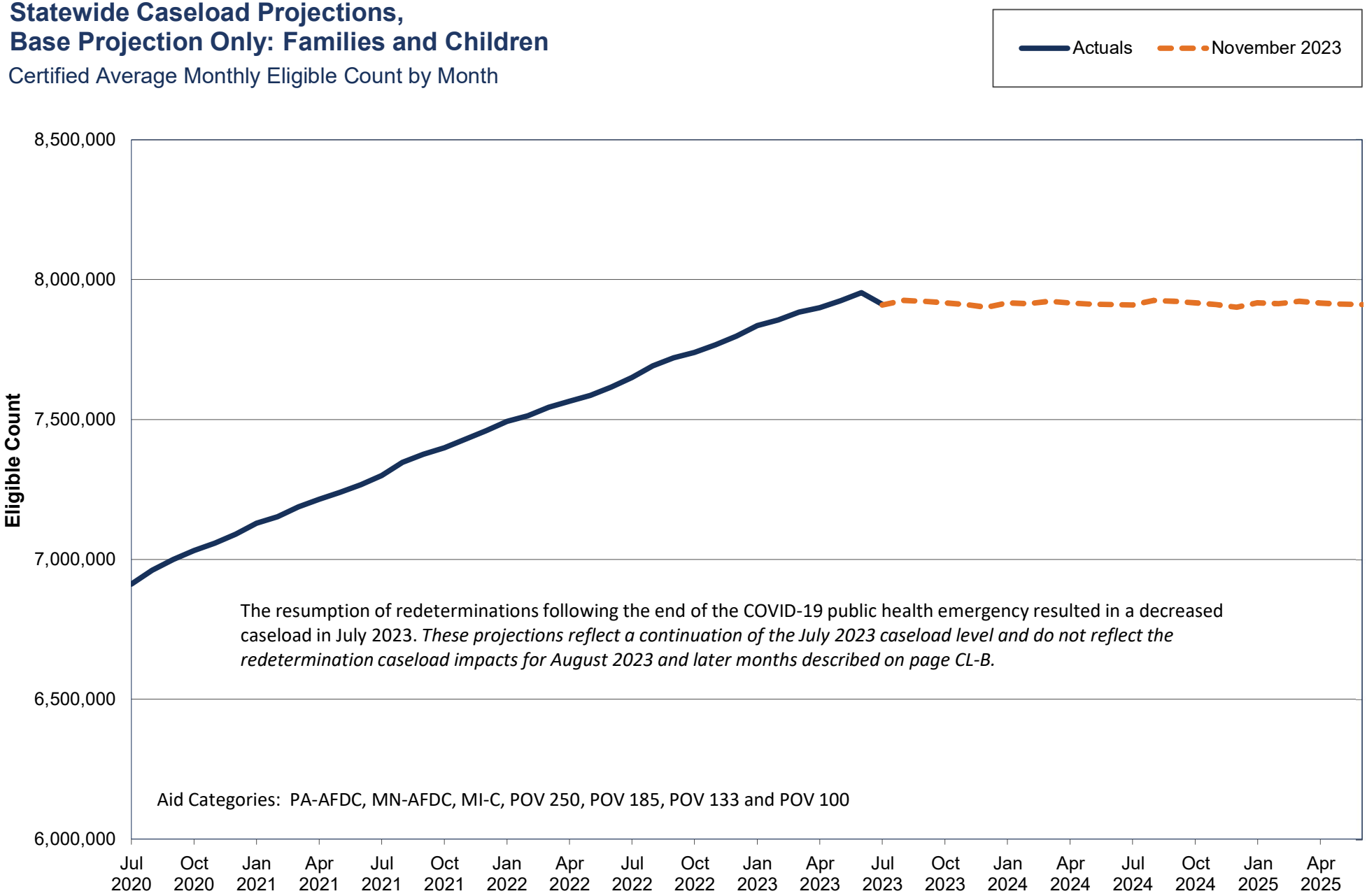
The All Aids Eligibles graph represents the eighteen aid categories estimated via the base estimating process and does not incorporate additional eligibles from policy changes.

The resumption of redeterminations following the end of the COVID-19 public health emergency resulted in a decreased caseload in July 2023. *These projections reflect a continuation of the July 2023 caseload level and do not reflect the redetermination caseload impacts for August 2023 and later months described on page CL-B.*

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

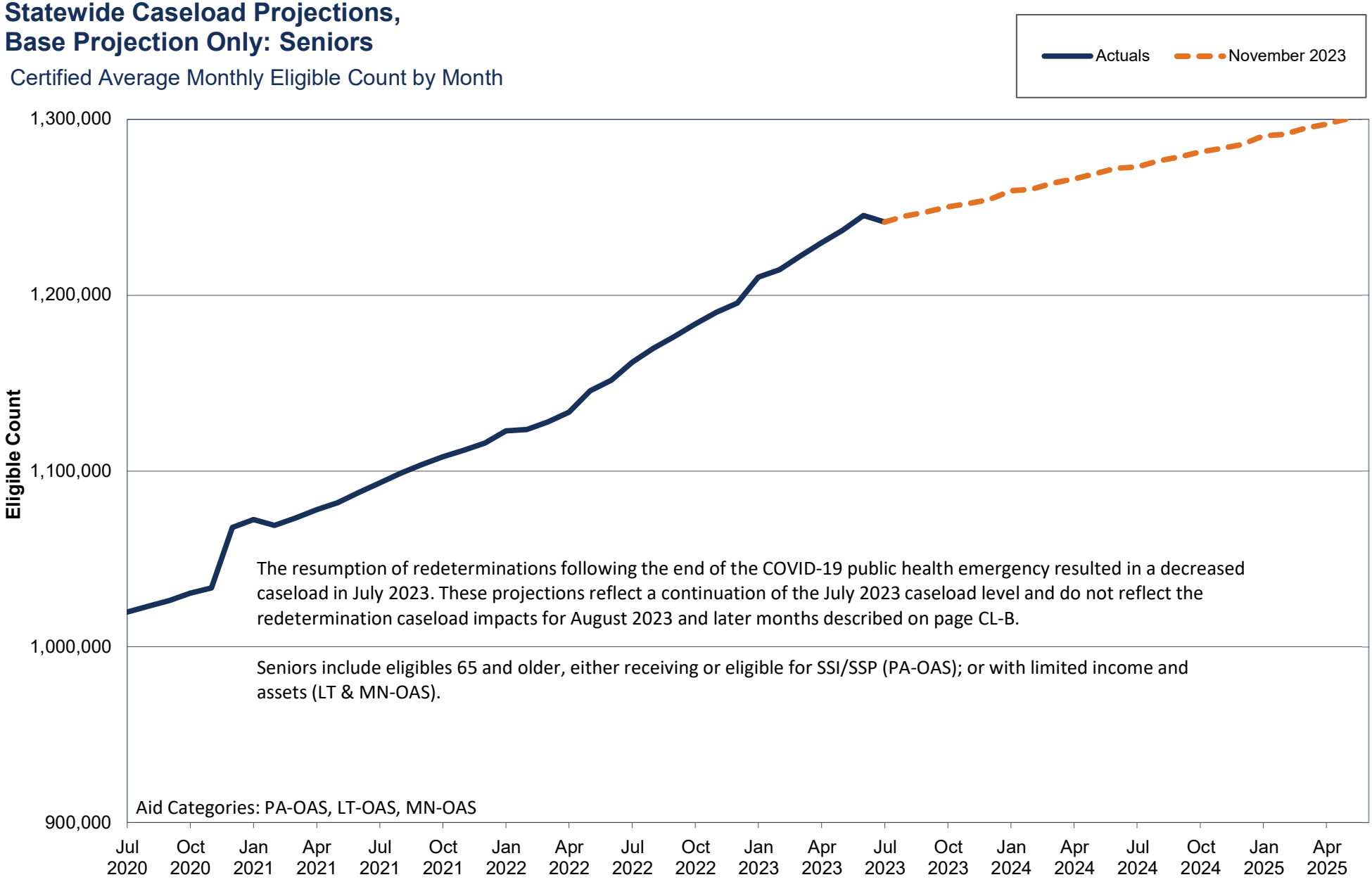
Statewide Caseload Projections, Base Projection Only: Families and Children

Certified Average Monthly Eligible Count by Month



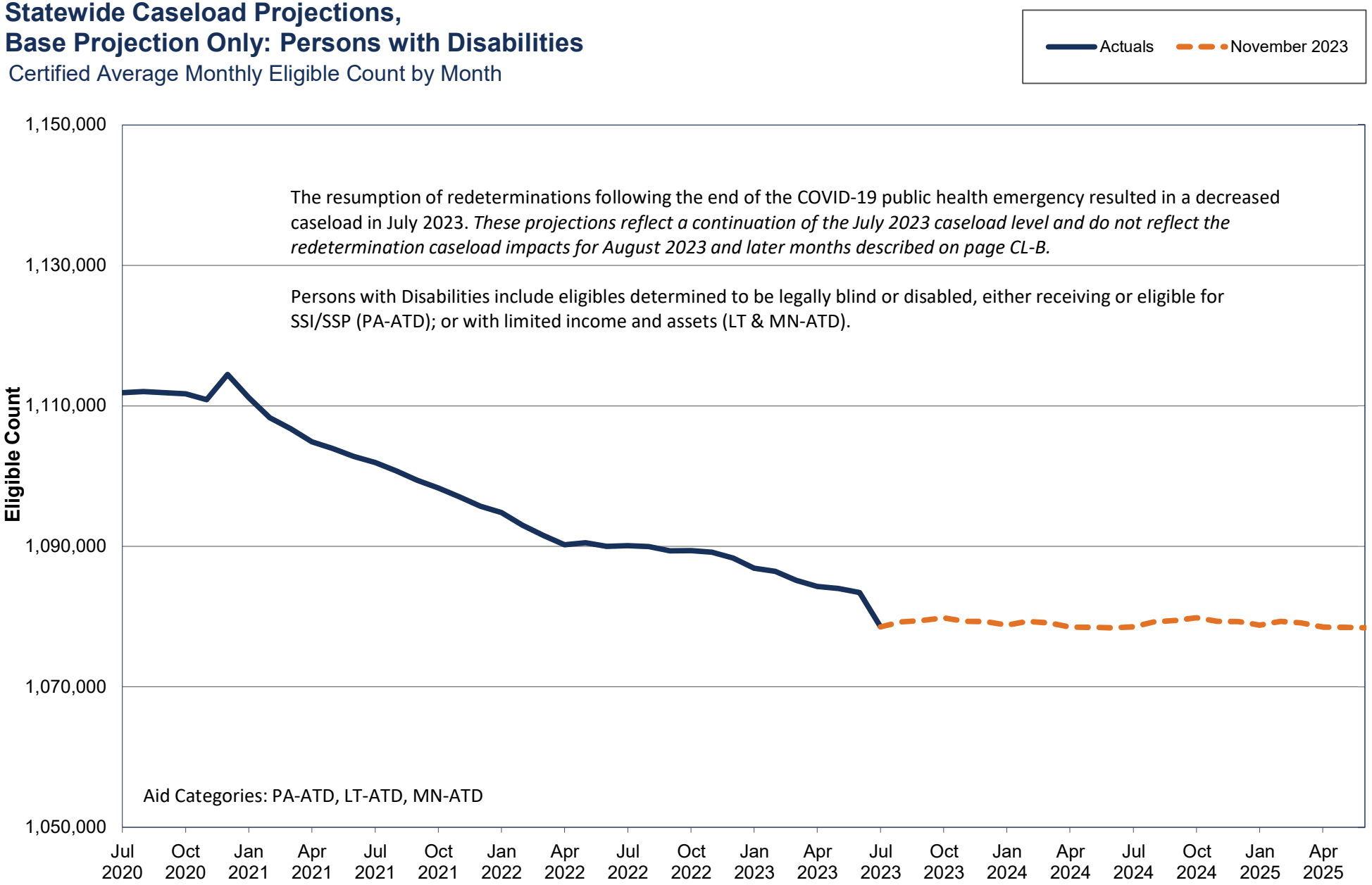
Statewide Caseload Projections, Base Projection Only: Seniors

Certified Average Monthly Eligible Count by Month



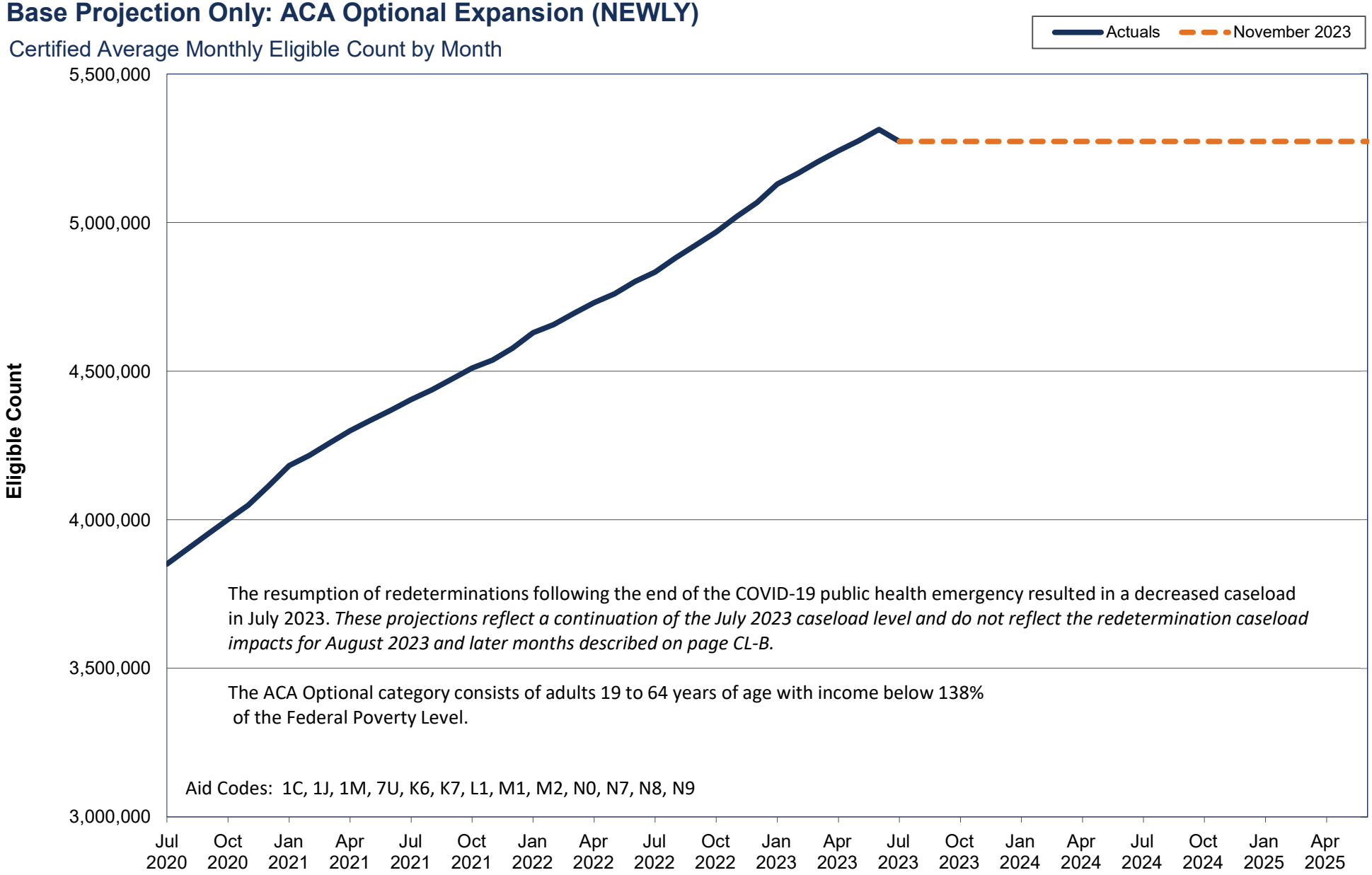
Statewide Caseload Projections, Base Projection Only: Persons with Disabilities

Certified Average Monthly Eligible Count by Month



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

Certified Average Monthly Eligible Count by Month



MEDI-CAL AID CATEGORY DEFINITIONS

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

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.

Medi-Cal Fee-For-Service Base Estimate

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

The Base Expenditure estimate consists of two main groups, (1) fee-for-service and (2) non-fee-for-service. The fee-for-service Base (FFS Base) Estimate is summarized in this section. The data used for these projections consist of the most recent 36 months of claims paid through the Medi-Cal claims processing systems at the California Medicaid Management Information Systems (CA-MMIS) Fiscal Intermediary and beginning in January 2022, the Medi-Cal Rx Fiscal Intermediary for pharmacy claims.

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

FFS Base Estimate Service Categories

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

November 2023 FFS Base Estimate

Fiscal Year		November Estimate Total Expenditure	
PY	FY 2022-23	$30,228,528,900	
CY	FY 2023-24	$30,741,720,700	1.70%
BY	FY 2024-25	$31,456,902,100	2.33%

Fiscal Year	FFS Base Expenditure		
	May-23	Nov-23	% Change
FY 2022-23	$30,331,277,800	$30,228,528,900	-0.34%
FY 2023-24	$31,491,088,900	$30,741,720,700	-2.38%

Overall, the November 2023 FFS Base is estimated at $30.7 billion for FY 2023-24 and $31.5 billion for FY 2024-25. The increase in the budget year is mainly from Pharmacy service category, driven specifically by increases in the average dollar per unit. However, these increases in the base are expected to be offset by reductions in utilization due to eligibility redeterminations. These redetermination impacts are budgeted in a separate policy change.

Items Impacting FFS Base Estimate

Overall Changes: Compared to the M23 estimate, the N23 estimate includes (1) some of the impact of the certain populations and the long-term care benefit transitioning from FFS to managed care under CalAIM in January 2023 and (2) increased pharmacy expenditures due to ongoing rate growth. These specific impacts will be described in each of the service categories.

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

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2023 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
2021-22 *	1	2,439,590	3.01	$257.66	$776.04	$5,679,680,300
2021-22 *	2	2,230,560	2.72	$264.50	$720.31	$4,820,081,100
2021-22 *	3	3,676,520	3.73	$143.45	$534.56	$5,895,929,100
2021-22 *	4	3,984,770	4.13	$132.56	$547.40	$6,543,738,400
2021-22 *	TOTAL	3,082,860	3.53	$175.47	$620.08	$22,939,428,900
2022-23 *	1	4,412,550	4.49	$140.79	$632.51	$8,372,915,600
2022-23 *	2	4,275,030	4.03	$141.48	$570.00	$7,310,281,300
2022-23 *	3	4,359,490	3.83	$162.15	$621.39	$8,126,881,800
2022-23 *	4	3,944,170	3.18	$170.72	$542.44	$6,418,450,100
2022-23 *	TOTAL	4,247,810	3.90	$152.01	$593.02	$30,228,528,900
2023-24 **	1	4,478,470	3.66	$180.17	$659.76	$8,864,124,400
2023-24 **	2	4,204,590	3.29	$179.24	$590.15	$7,443,976,900
2023-24 **	3	4,312,070	3.46	$176.63	$611.86	$7,915,138,400
2023-24 **	4	4,041,740	3.08	$174.64	$537.60	$6,518,481,000
2023-24 **	TOTAL	4,259,220	3.38	$177.83	$601.47	$30,741,720,700
2024-25 **	1	4,511,170	3.70	$181.08	$670.01	$9,067,602,800
2024-25 **	2	4,306,180	3.42	$180.50	$617.04	$7,971,206,800
2024-25 **	3	4,210,470	3.37	$182.51	$614.29	$7,759,391,100
2024-25 **	4	4,041,740	3.08	$178.14	$549.16	$6,658,701,400
2024-25 **	TOTAL	4,267,390	3.40	$180.65	$614.29	$31,456,902,100

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

Physicians Fee-for-Service Base Estimate

Analyst: Violet Chan

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

FISCAL YEAR		USERS		UTILIZATION (Claims per User)		RATE (Cost per Claim)		TOTAL EXPENDITURE	
PY	2022-23	245,290	-	2.39	-	$89.72	-	$632,105,800	-
CY	2023-24	201,830	-17.7%	2.47	3.3%	$96.83	7.9%	$578,776,500	-8.4%
BY	2024-25	201,710	-0.1%	2.45	-0.8%	$96.57	-0.3%	$572,432,100	-1.1%

Users: Users are estimated to decrease by 17.7% for the CY, in part due to the CalAIM implementation in January 2023, which transitioned members from Fee-for-Service to Managed Care, resulting in fewer actual users. Users are estimated to remain relatively unchanged in the BY, before accounting for redetermination impacts.

Utilization: Utilization is estimated to increase by 3.3% in the CY and remain relatively unchanged in the BY.

Rate: The average rate is estimated to increase by 7.9% in the CY, partly due to lower cost users were transitioned from FFS to Managed Care. The rate is estimated to remain relatively unchanged in the BY.

Total Expenditure: The CY is estimated to decrease by 8.4%, mainly due to a decrease in users but also offset by the increased utilization and rate. The BY is estimated to decrease by 1.1%.

Reason for Change from Prior Estimate

FISCAL YEAR	TOTAL EXPENDITURE		
	M23	N23	% Change
FY 2022-23	$642,712,000	$632,105,800	-1.7%
FY 2023-24	$640,897,600	$578,776,500	-9.7%

Compared to the May 2023 Estimate, the November 2023 Estimate for FY 2022-23 decreased by 1.7% due to a decrease in users. The FY 2023-24 estimated decrease of 9.7% is due to a decrease in users and rate.

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2023 BASE ESTIMATES)

PHYSICIANS

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2021-22 *	1	340,860	2.54	$81.09	$205.78	$210,433,600
2021-22 *	2	284,930	2.41	$81.65	$197.16	$168,531,100
2021-22 *	3	295,890	2.21	$81.46	$179.77	$159,580,700
2021-22 *	4	264,650	2.30	$83.40	$192.23	$152,617,600
2021-22 *	TOTAL	296,580	2.37	$81.81	$194.20	$691,162,900
2022-23 *	1	288,900	2.45	$88.79	$217.59	$188,583,500
2022-23 *	2	250,730	2.38	$88.66	$210.63	$158,432,400
2022-23 *	3	249,160	2.39	$87.93	$210.31	$157,203,600
2022-23 *	4	192,380	2.33	$94.98	$221.59	$127,886,300
2022-23 *	TOTAL	245,290	2.39	$89.72	$214.75	$632,105,800
2023-24 **	1	220,330	2.58	$97.61	$251.61	$166,312,700
2023-24 **	2	199,710	2.44	$95.87	$233.68	$140,003,000
2023-24 **	3	207,520	2.44	$96.60	$236.12	$146,996,300
2023-24 **	4	179,760	2.39	$97.15	$232.65	$125,464,600
2023-24 **	TOTAL	201,830	2.47	$96.83	$238.97	$578,776,500
2024-25 **	1	221,210	2.51	$96.96	$243.10	$161,328,600
2024-25 **	2	198,750	2.45	$95.62	$234.72	$139,946,900
2024-25 **	3	207,300	2.43	$96.56	$234.48	$145,824,900
2024-25 **	4	179,590	2.39	$97.14	$232.63	$125,331,600
2024-25 **	TOTAL	201,710	2.45	$96.57	$236.49	$572,432,100

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

Other Medical Fee-for-Service Base Estimate

Analyst: Violet Chan

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

FISCAL YEAR		USERS		UTILIZATION (Claims per User)		RATE (Cost per Claim)		TOTAL EXPENDITURE	
PY	2022-23	1,384,080	-	1.55	-	$195.89	-	$5,033,595,000	-
CY	2023-24	1,380,050	-0.3%	1.53	-1.3%	$202.77	3.5%	$5,125,992,100	1.8%
BY	2024-25	1,380,170	0.0%	1.53	0.0%	$202.75	0.0%	$5,125,066,700	0.0%

Users: Users are estimated to decrease slightly by 0.3% in the CY, potentially due to CalAIM implementation in January 2023 which transitioned members from Fee-for-Service to Managed Care. Users are estimated to remain unchanged in the BY.

Utilization: Utilization is estimated to decrease by 1.3% in the CY and remain unchanged in the BY.

Rate: The average rate is estimated to increase by 3.5% in the CY mainly due to the FQHC/RHC rate adjustment. BY is estimated to remain unchanged. Future FQHC rate increases are estimated in the FQHC/RHC/CBRC Reconciliation Process policy change.

Total Expenditure: The CY is estimated to increase by 1.8%, primarily due to increased rates. The BY is estimated to remain unchanged.

Reason for Change from Prior Estimate

FISCAL YEAR	TOTAL EXPENDITURE		
	M23	N23	% Change
2022-23	$4,967,680,400	$5,033,595,000	1.3%
2023-24	$4,968,788,200	$5,125,992,100	3.2%

Compared to the May 2023 Estimate, the November 2023 Estimate increased by 1.3% and 3.2% for FY 2022-23 and FY 2023-24, respectively. This is due to increased rates at the FQHC facilities.

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2023 BASE ESTIMATES)

OTHER MEDICAL

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2021-22 *	1	1,410,910	1.66	$180.78	$299.36	$1,267,100,000
2021-22 *	2	1,286,700	1.56	$186.65	$290.52	$1,121,443,300
2021-22 *	3	1,210,230	1.54	$181.91	$279.30	$1,014,035,200
2021-22 *	4	1,276,990	1.54	$183.49	$282.68	$1,082,935,600
2021-22 *	TOTAL	1,296,210	1.57	$183.13	$288.37	$4,485,514,200
2022-23 *	1	1,517,330	1.63	$188.52	$306.75	$1,396,305,500
2022-23 *	2	1,373,450	1.53	$195.36	$297.95	$1,227,667,100
2022-23 *	3	1,366,690	1.54	$202.49	$311.78	$1,278,315,800
2022-23 *	4	1,278,850	1.48	$198.75	$294.88	$1,131,306,600
2022-23 *	TOTAL	1,384,080	1.55	$195.89	$303.07	$5,033,595,000
2023-24 **	1	1,530,860	1.59	$203.56	$323.20	$1,484,333,700
2023-24 **	2	1,385,370	1.51	$202.14	$305.51	$1,269,718,700
2023-24 **	3	1,322,550	1.51	$202.54	$306.42	$1,215,773,200
2023-24 **	4	1,281,410	1.48	$202.68	$300.75	$1,156,166,500
2023-24 **	TOTAL	1,380,050	1.53	$202.77	$309.53	$5,125,992,100
2024-25 **	1	1,534,880	1.59	$203.47	$322.60	$1,485,447,000
2024-25 **	2	1,382,860	1.52	$202.28	$307.38	$1,275,184,800
2024-25 **	3	1,321,870	1.51	$202.42	$304.77	$1,208,597,200
2024-25 **	4	1,281,060	1.48	$202.68	$300.75	$1,155,837,600
2024-25 **	TOTAL	1,380,170	1.53	$202.75	$309.45	$5,125,066,700

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

County & Community Outpatient Fee-for-Service Base Estimate

Analyst: Michael Redman

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

FISCAL YEAR		USERS		UTILIZATION (Claims per User)		RATE (Cost per Claim)		TOTAL EXPENDITURE	
PY	2022-23	153,430		1.55		$203.96		$581,237,900	
CY	2023-24	128,920	-16.0%	1.54	-0.6%	$227.41	11.5%	$541,481,700	-6.8%
BY	2024-25	129,800	0.7%	1.54	0.2%	$227.91	0.2%	$545,593,500	0.8%

Users: Users are estimated to decrease by 16% in the CY, partly due to CalAIM transitions from FFS to Managed Care in January 2023. Users are estimated to remain relatively unchanged in the BY.

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

Rate: The average rate is estimated to increase by 11.5% in the CY partly due to lower cost users were transitioned to Managed Care. The average rate is estimated to remain relatively unchanged in the BY.

Total Expenditure: Expenditure is estimated to decrease by 6.8% in the CY due to decrease users and to remain relatively unchanged in the BY.

Reason for Change from Prior Estimate

FISCAL YEAR	TOTAL EXPENDITURE		
	M23	N23	% Change
FY 2022-23	$587,771,600	$581,237,900	-1.1%
FY 2023-24	$590,294,400	$541,481,700	-8.3%

Compared to the May 2023 Estimate, the November 2023 Estimate for total expenditure decreased by 1.1% in FY 2022-23 and decreased by 8.3% in FY 2023-24 expectedly due to new trend level established after the CalAIM transition from FFS to Managed Care.

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2023 BASE ESTIMATES)

CO. & COMM. OUTPATIENT

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2021-22 *	1	219,290	1.61	$178.41	$287.43	$189,092,300
2021-22 *	2	190,640	1.55	$165.82	$256.48	$146,686,000
2021-22 *	3	174,260	1.49	$186.21	$277.07	$144,848,800
2021-22 *	4	159,560	1.55	$170.64	$263.74	$126,243,100
2021-22 *	TOTAL	185,940	1.55	$175.29	$271.99	$606,870,200
2022-23 *	1	181,350	1.58	$200.17	$317.26	$172,602,400
2022-23 *	2	162,590	1.55	$185.92	$288.25	$140,602,600
2022-23 *	3	155,550	1.54	$207.84	$319.30	$148,999,900
2022-23 *	4	114,240	1.50	$231.42	$347.33	$119,033,000
2022-23 *	TOTAL	153,430	1.55	$203.96	$315.69	$581,237,900
2023-24 **	1	148,360	1.58	$227.61	$360.36	$160,395,800
2023-24 **	2	131,720	1.53	$223.70	$343.17	$135,604,000
2023-24 **	3	124,640	1.52	$232.90	$353.28	$132,093,200
2023-24 **	4	110,950	1.51	$225.41	$340.67	$113,388,700
2023-24 **	TOTAL	128,920	1.54	$227.41	$350.02	$541,481,700
2024-25 **	1	150,880	1.57	$230.73	$361.92	$163,816,200
2024-25 **	2	131,600	1.54	$222.77	$344.08	$135,845,500
2024-25 **	3	125,160	1.51	$232.61	$352.04	$132,187,100
2024-25 **	4	111,540	1.51	$224.87	$339.93	$113,744,800
2024-25 **	TOTAL	129,800	1.54	$227.91	$350.29	$545,593,500

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

Pharmacy Fee-for-Service Base Estimate

Analyst: My-Ai Bui

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

FISCAL YEAR		USERS		UTILIZATION (Claims per User)		RATE (Cost per Claim)		TOTAL EXPENDITURE	
PY	2022-23	3,297,020	-	3.64	-	$106.69	-	$15,374,705,100	-
CY	2023-24	3,325,200	0.85%	3.11	-14.56%	$137.36	28.75%	$17,032,107,400	10.78%
BY	2024-25	3,332,040	0.21%	3.13	0.64%	$141.14	2.75%	$17,667,392,700	3.73%

Users: Users are estimated to remain relatively unchanged in both CY and BY. Broader changes in caseload related to redeterminations are captured in the COVID-19 Caseload Redetermination policy change.

Utilization: Utilization is estimated to decrease by 14.56% in the CY. This is due to a large volume of prescriptions were filled/adjusted and later reversed in the same month (with no dollar impact) that were included in the previous estimate but are removed in this estimate.

Rate: The rate is projected to increase by 28.75%. This is partly due to the removal of prescriptions were filled and later reversed in the same month, as described above. This reduces number of prescriptions while also increasing the average cost per claim with no dollar impact. Normal rate growth is also contributing to overall rate increase.

Total Expenditure: Total expenditures are estimated to increase by 10.78% in the CY due user and rate increase. Of these two factors, the growth in users due to caseload growth is the main driver. The 3.61% increase in the BY is due to normal projected increases in utilization and rates in some aid categories.

Reason for Change from Prior Estimate:

FISCAL YEAR	TOTAL EXPENDITURE		
	M23	N23	% Change
2022-23	$15,122,868,100	$15,374,705,100	1.7%
2023-24	$16,253,103,200	$17,032,107,400	4.8%

Compared to the May 2023 Estimate, the November 2023 Estimate of total expenditures for both fiscal years increased is mainly due to normal growth rate for some aid categories.

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2023 BASE ESTIMATES)

PHARMACY

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2021-22 *	1	743,040	2.50	$208.92	$522.34	$1,164,361,200
2021-22 *	2	693,680	2.34	$213.08	$497.60	$1,035,529,800
2021-22 *	3	2,663,400	3.57	$86.59	$309.16	$2,470,228,600
2021-22 *	4	3,029,460	3.91	$86.96	$340.01	$3,090,113,000
2021-22 *	TOTAL	1,782,400	3.48	$104.17	$362.82	$7,760,232,500
2022-23 *	1	3,384,710	4.28	$93.03	$398.33	$4,044,725,800
2022-23 *	2	3,332,320	3.78	$92.62	$350.27	$3,501,619,300
2022-23 *	3	3,437,680	3.54	$119.65	$423.51	$4,367,635,200
2022-23 *	4	3,033,370	2.89	$131.46	$380.30	$3,460,724,800
2022-23 *	TOTAL	3,297,020	3.64	$106.69	$388.60	$15,374,705,100
2023-24 **	1	3,513,360	3.35	$138.59	$464.21	$4,892,803,500
2023-24 **	2	3,254,590	3.03	$136.40	$413.84	$4,040,650,200
2023-24 **	3	3,421,680	3.21	$138.22	$443.38	$4,551,345,100
2023-24 **	4	3,111,160	2.80	$135.71	$380.06	$3,547,308,600
2023-24 **	TOTAL	3,325,200	3.11	$137.36	$426.84	$17,032,107,400
2024-25 **	1	3,540,740	3.40	$140.87	$479.46	$5,092,961,500
2024-25 **	2	3,363,770	3.19	$140.84	$449.19	$4,532,944,700
2024-25 **	3	3,312,500	3.09	$142.81	$440.72	$4,379,651,800
2024-25 **	4	3,111,160	2.80	$139.93	$392.33	$3,661,834,700
2024-25 **	TOTAL	3,332,040	3.13	$141.14	$441.86	$17,667,392,700

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

County Inpatient Fee-for-Service Base Estimate

Analyst: Atsuko Nonoyama

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

FISCAL YEAR		USERS		UTILIZATION (Days per User)		RATE (Cost per Day)		TOTAL EXPENDITURE	
PY	2022-23	3,670	--	5.18	--	$3,756.85	--	$857,129,200	--
CY	2023-24	3,460	-5.7%	5.50	6.2%	$3,790.47	0.9%	$865,618,100	1.0%
BY	2024-25	3,480	0.6%	5.44	-1.1%	$3,796.38	0.2%	$862,171,700	-0.4%

Users: Users are estimated to decrease by 5.7% from PY to CY. This is because CalAIM shifting of Medicare members to Managed Care plans observed in later actuals in PY sets a lower level for CY. A 0.6% increase is projected between CY and BY, effectively unchanged.

Utilization: Utilization, or the number of days stayed per user, is expected to increase by 6.2% from PY to CY. This is because in PY dually eligible Medi-Cal and Medicare members, who have lower than average Medi-Cal costs because Medicare generally covers most inpatient costs, shifted to Managed Care plans. This high level is projected for CY. A 1.1% decrease is projected between CY and BY due to a high July actual in CY.

Rate: Rate, or the average cost per day, is estimated to increase by 0.9% from PY to CY due to regular annual rate increase. BY is effectively unchanged from CY.

Total Expenditures: Total expenditures are estimated to increase by 1.0% from PY to CY as the decrease in users was more than offset by increased utilization and rate. Total expenditures are estimated effectively unchanged between BY and CY.

Reason for Change from Prior Estimate

FISCAL YEAR	TOTAL EXPENDITURE		
	M23	N23	% Change
2022-23	$878,458,500	$857,129,200	-2.4%
2023-24	$922,867,400	$865,618,100	-6.2%

Compared to the May 2023 estimate, the November 2023 estimate is projected to decrease by 2.4% in FY 2022-23. This is due to lower users caused by CalAIM transitioning to Managed Care. For FY 2023-24, a decrease by 6.2%, is because the lower users observed in PY, not completely offset by higher utilization and rate, are assumed for entire CY.

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2023 BASE ESTIMATES)

COUNTY INPATIENT

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2021-22 *	1	4,800	5.12	$3,796.74	$19,434.64	$279,800,600
2021-22 *	2	4,030	5.31	$3,832.80	$20,333.33	$245,667,400
2021-22 *	3	3,520	4.67	$3,648.08	$17,026.66	$179,784,500
2021-22 *	4	3,980	5.33	$3,680.60	$19,600.19	$234,163,400
2021-22 *	TOTAL	4,080	5.12	$3,747.26	$19,177.62	$939,415,800
2022-23 *	1	4,020	5.07	$3,662.40	$18,550.56	$223,534,300
2022-23 *	2	3,920	5.20	$3,783.16	$19,672.47	$231,328,600
2022-23 *	3	3,550	5.19	$3,731.28	$19,371.16	$206,186,600
2022-23 *	4	3,200	5.29	$3,866.69	$20,446.27	$196,079,700
2022-23 *	TOTAL	3,670	5.18	$3,756.85	$19,461.19	$857,129,200
2023-24 **	1	3,670	5.68	$3,752.92	$21,324.67	$234,541,500
2023-24 **	2	3,520	5.39	$3,833.59	$20,644.08	$217,961,500
2023-24 **	3	3,520	5.30	$3,766.76	$19,969.85	$211,092,800
2023-24 **	4	3,140	5.62	$3,813.59	$21,426.51	$202,022,300
2023-24 **	TOTAL	3,460	5.50	$3,790.47	$20,830.23	$865,618,100
2024-25 **	1	3,730	5.49	$3,776.24	$20,740.07	$231,777,100
2024-25 **	2	3,520	5.39	$3,831.85	$20,660.57	$218,283,500
2024-25 **	3	3,520	5.28	$3,765.95	$19,867.66	$210,093,600
2024-25 **	4	3,140	5.62	$3,813.62	$21,427.00	$202,017,500
2024-25 **	TOTAL	3,480	5.44	$3,796.38	$20,654.10	$862,171,700

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

Community Inpatient Fee-for-Service Base Estimate

Analyst: Atsuko Nonoyama

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

FISCAL YEAR		USERS		UTILIZATION (Days per User)		RATE (Cost per Day)		TOTAL EXPENDITURE	
PY	2022-23	20,800	--	5.40	--	$2,611.19	--	$3,520,749,100	--
CY	2023-24	17,320	-16.7%	6.38	18.1%	$2,696.18	3.3%	$3,573,154,900	1.5%
BY	2024-25	17,460	0.8%	6.35	-0.5%	$2,749.93	2.0%	$3,661,088,100	2.5%

Users: Users are estimated to decrease by 16.7% from PY to CY. This is because CalAIM shifting of Medicare members to Managed Care plans observed in later actuals in PY sets a lower level for CY. A 0.8% increase is projected between CY and BY, effectively unchanged.

Utilization: Utilization, or the number of days stayed per user, is expected to increase by 18.1% from PY to CY. This is because in PY dually eligible Medi-Cal and Medicare members, who have lower than average Medi-Cal costs because Medicare generally covers most inpatient services, shifted to Managed Care plans. A 0.5% decrease is projected between CY and BY.

Rate: Rate, or the average cost per day, is estimated to increase by 3.3% from PY to CY, and by 2.0% from CY to BY. This is due to normal rate growth.

Total Expenditures: Total expenditures are estimated to increase by 1.5% from PY to CY as the decrease in users was more than offset by increased utilization and rate. Total expenditures are estimated to increase by 2.5% from CY to BY, due to assumed long-term growth.

Reason for Change from Prior Estimate

FISCAL YEAR	TOTAL EXPENDITURE		
	M23	N23	% Change
2022-23	$3,521,988,900	$3,520,749,100	0.0%
2023-24	$3,537,081,900	$3,573,154,900	1.0%

Compared to the May 2023 estimate, the November 2023 estimate shows no change for FY 2022-23. For 2022-23, the estimate increases by 1.0%, because a large decrease in users in PY is offset by increased utilization and rate and is projected for CY.

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2023 BASE ESTIMATES)

COMMUNITY INPATIENT

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2021-22 *	1	27,880	5.38	$2,696.30	$14,498.41	$1,212,530,800
2021-22 *	2	24,540	5.29	$2,634.52	$13,936.51	$1,026,075,600
2021-22 *	3	22,040	5.43	$2,590.42	$14,066.69	$930,047,600
2021-22 *	4	21,670	5.03	$2,540.76	$12,789.75	$831,589,800
2021-22 *	TOTAL	24,030	5.29	$2,622.24	$13,870.76	$4,000,243,700
2022-23 *	1	25,960	5.13	$2,552.82	$13,089.32	$1,019,566,700
2022-23 *	2	21,560	5.18	$2,623.27	$13,577.60	$878,226,500
2022-23 *	3	21,060	5.46	$2,644.33	$14,428.78	$911,538,400
2022-23 *	4	14,640	6.14	$2,640.31	$16,201.72	$711,417,500
2022-23 *	TOTAL	20,800	5.40	$2,611.19	$14,102.18	$3,520,749,100
2023-24 **	1	19,350	6.46	$2,696.99	$17,427.66	$1,011,784,700
2023-24 **	2	17,880	6.30	$2,678.50	$16,871.15	$904,801,700
2023-24 **	3	17,410	6.42	$2,705.13	$17,376.14	$907,413,900
2023-24 **	4	14,650	6.30	$2,705.81	$17,045.95	$749,154,700
2023-24 **	TOTAL	17,320	6.38	$2,696.18	$17,190.42	$3,573,154,900
2024-25 **	1	19,910	6.35	$2,724.19	$17,296.84	$1,033,188,300
2024-25 **	2	17,880	6.33	$2,739.04	$17,340.17	$929,986,400
2024-25 **	3	17,410	6.43	$2,770.73	$17,809.82	$930,067,500
2024-25 **	4	14,650	6.30	$2,773.33	$17,471.32	$767,845,900
2024-25 **	TOTAL	17,460	6.35	$2,749.93	$17,472.38	$3,661,088,100

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

Nursing Facility Fee-for-Service Base Estimate

Analyst: My-Ai Bui

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

FISCAL YEAR		USERS		UTILIZATION (Claims per User)		RATE (Cost per Claim)		TOTAL EXPENDITURE	
PY	2022-23	19,140	-	32.71	-	$305.67	-	$2,296,057,400	-
CY	2023-24	8,440	-55.9%	32.02	-2.1%	$323.25	5.8%	$1,047,872,000	-54.4%
BY	2024-25	8,450	0.1%	31.83	-0.6%	$323.74	0.2%	$1,044,455,800	-0.3%

Users: Users are estimated to decrease by 55.9% in the CY mainly due to the CalAIM implementation in January 2023 which transitioned members from FFS to Managed Care.

Utilization: Utilization is estimated to decrease by 2.1% in CY and slightly decrease by 0.5% in BY, which reflects a normal fluctuation.

Rate: The rate is estimated to increase by 5.8% in the CY due to CalAIM transition in January 2023 and remain relatively unchanged in BY.

Total Expenditure: The CY is estimated to decrease by 54.4% is mainly decrease users. The BY is estimated to remain relatively unchanged.

Reason for Change from Prior Estimate

FISCAL YEAR	TOTAL EXPENDITURE		
	M23	N23	% Change
2022-23	$2,686,818,000	$2,296,057,400	-14.5%
2023-24	$2,618,136,100	$1,047,872,000	-60.0%

Compared to the May 2023 Estimate, the November 2023 Estimate total expenditures for both fiscal years decrease by 14.5% and 60.0% is mainly due to the CalAIM implementation in January 2023, which transitioned members from FFS to Managed Care.

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2023 BASE ESTIMATES)

NURSING FACILITIES

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2021-22 *	1	24,750	37.96	$299.70	$11,375.49	$844,709,400
2021-22 *	2	23,980	30.94	$292.55	$9,052.14	$651,256,500
2021-22 *	3	22,800	28.29	$295.41	$8,356.33	$571,572,900
2021-22 *	4	22,630	30.83	$286.68	$8,837.74	$599,941,200
2021-22 *	TOTAL	23,540	32.12	$294.03	$9,442.88	$2,667,480,000
2022-23 *	1	23,870	35.17	$310.97	$10,936.04	$782,976,500
2022-23 *	2	23,330	33.29	$303.04	$10,087.62	$706,052,600
2022-23 *	3	20,260	30.56	$297.90	$9,104.66	$553,481,300
2022-23 *	4	9,090	29.55	$314.56	$9,295.95	$253,546,900
2022-23 *	TOTAL	19,140	32.71	$305.67	$9,997.90	$2,296,057,400
2023-24 **	1	9,790	34.45	$324.41	$11,176.58	$328,358,700
2023-24 **	2	8,900	31.18	$320.15	$9,981.41	$266,433,700
2023-24 **	3	8,320	30.78	$328.19	$10,103.26	$252,253,300
2023-24 **	4	6,740	31.10	$319.46	$9,935.47	$200,826,400
2023-24 **	TOTAL	8,440	32.02	$323.25	$10,349.07	$1,047,872,000
2024-25 **	1	9,430	34.29	$329.39	$11,293.60	$319,573,900
2024-25 **	2	8,890	31.25	$320.33	$10,009.84	$266,918,100
2024-25 **	3	8,520	30.38	$325.92	$9,900.94	$253,093,600
2024-25 **	4	6,950	31.00	$317.03	$9,828.68	$204,870,200
2024-25 **	TOTAL	8,450	31.83	$323.74	$10,303.49	$1,044,455,800

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

ICF/DD Fee-for-Service Base Estimate

Analyst: My-Ai Bui

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

FISCAL YEAR		USERS		UTILIZATION (Claims per User)		RATE (Cost per Claim)		TOTAL EXPENDITURE	
PY	2022-23	4,060	-	31.45	-	$349.07	-	$534,312,200	-
CY	2023-24	3,980	-2.0%	31.34	-0.3%	$354.13	1.4%	$529,472,400	-0.9%
BY	2024-25	4,000	0.5%	31.43	0.3%	$353.73	-0.1%	$534,237,100	0.9%

Users: Users are estimated to decrease by 2.0% in CY and remain relatively unchanged in the BY.

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

Rate: The rate is estimated to increase 1.4% in the CY, reflecting rate increase implemented in January 2023. Rates are estimated to remain relatively unchanged in the BY for base projections.

Total Expenditure: Total expenditure is estimated to decrease by 0.9% for the CY due to decrease in users offset by rate increase. BY total expenditure is estimated to increase by 0.9% is due to slightly increase in user and utilization.

Reason for Change from Prior Estimate:

FISCAL YEAR	TOTAL EXPENDITURE		
	M23	N23	% Change
2022-23	$500,661,900	$534,312,200	6.7%
2023-24	$498,366,400	$529,472,400	6.2%

Compared to the May 2023 Estimate, actual total expenditures for FY 2022-23 increase by 6.7%, due to rate increase and one-time retroactive payment for rate increase that were implemented in January and March 2023, respectively. Total expenditures for FY 2023-24 increase 6.2% reflecting rate increase implemented in January 2023.

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2023 BASE ESTIMATES)

ICF-DD

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2021-22 *	1	4,360	38.39	$263.83	$10,127.40	$132,425,900
2021-22 *	2	4,260	31.24	$288.25	$9,004.21	$115,190,900
2021-22 *	3	4,220	28.80	$398.65	$11,481.78	$145,439,700
2021-22 *	4	3,980	29.73	$327.97	$9,749.19	$116,356,600
2021-22 *	TOTAL	4,210	32.12	$314.23	$10,093.18	$509,413,100
2022-23 *	1	4,190	36.22	$326.79	$11,835.98	$148,944,000
2022-23 *	2	4,100	31.07	$329.69	$10,243.48	$125,851,400
2022-23 *	3	4,050	31.18	$391.68	$12,211.30	$148,355,100
2022-23 *	4	3,880	26.99	$353.57	$9,544.24	$111,161,700
2022-23 *	TOTAL	4,060	31.45	$349.07	$10,979.17	$534,312,200
2023-24 **	1	4,040	35.78	$353.50	$12,647.35	$153,359,000
2023-24 **	2	4,010	31.27	$354.07	$11,071.28	$133,092,700
2023-24 **	3	4,020	31.10	$354.91	$11,037.55	$132,966,300
2023-24 **	4	3,840	26.98	$354.14	$9,553.97	$110,054,400
2023-24 **	TOTAL	3,980	31.34	$354.13	$11,096.98	$529,472,400
2024-25 **	1	4,070	36.10	$353.55	$12,764.50	$155,774,100
2024-25 **	2	4,040	31.33	$352.72	$11,050.04	$133,811,200
2024-25 **	3	4,040	31.09	$354.63	$11,024.05	$133,775,200
2024-25 **	4	3,870	26.97	$354.14	$9,552.25	$110,876,500
2024-25 **	TOTAL	4,000	31.43	$353.73	$11,117.09	$534,237,100

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

Medical Transportation Fee-for-Service Base Estimate

Analyst: Ernesto Singson

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

FISCAL YEAR		USERS		UTILIZATION (Claims per User)		RATE (Cost per Claim)		TOTAL EXPENDITURE	
PY	2022-23	16,890	-	2.43	-	$156.89	-	$77,113,200	-
CY	2023-24	11,740	-30.5%	1.70	-30.1%	$275.23	75.4%	$65,799,500	-14.7%
BY	2024-25	11,860	1.0%	1.72	1.2%	$259.51	-5.7%	$63,365,600	-3.7%

Users: Users are estimated to decrease by 30.5% in the CY, due CalAIM implementation in January 2023 transition members from FFS to Managed Care. Users are relatively unchanged in the BY.

Utilization: Utilization is estimated to decrease by 30.1% in the CY due to decrease users relate to CalAIM implementation in January 2023. Utilization is relatively unchanged in the BY.

Rate: The rate is estimated to increase by 75.4% in the CY, due to lower cost users were transition from FFS to Managed Care. The rate is estimated to decreased by 5.7% in the BY.

Total Expenditure: Total expenditure is estimated to decrease by 14.7% in the CY mainly due to decrease users and utilization. BY total expenditure is estimated to decrease by 3.7% due to slightly lower rate.

Reason for Change from Prior Estimate

FISCAL YEAR	TOTAL EXPENDITURE		
	M23	N23	% CHANGE
2022-23	$80,839,500	$77,113,200	-4.6%
2023-24	$78,884,800	$65,799,500	-16.6%

Compared to the May 2023 Estimate, the November 2023 Estimate total expenditure decreased by 4.6% in FY 2022-23 and by 16.6% in FY 2023-24, due to decrease users relate to CalAIM implementation in January 2023, which transition members from FFS to Managed Care.

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2023 BASE ESTIMATES)

MEDICAL TRANSPORTATION

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2021-22 *	1	22,880	2.98	$139.23	$415.09	$28,494,400
2021-22 *	2	20,720	2.65	$139.25	$368.99	$22,934,000
2021-22 *	3	17,920	2.84	$132.80	$376.86	$20,263,900
2021-22 *	4	17,410	2.90	$131.33	$380.20	$19,862,000
2021-22 *	TOTAL	19,730	2.84	$136.00	$386.61	$91,554,400
2022-23 *	1	21,000	2.73	$143.66	$392.55	$24,729,200
2022-23 *	2	19,190	2.64	$137.26	$362.71	$20,877,400
2022-23 *	3	16,660	2.26	$164.10	$370.48	$18,511,700
2022-23 *	4	10,710	1.70	$238.54	$404.50	$12,994,900
2022-23 *	TOTAL	16,890	2.43	$156.89	$380.52	$77,113,200
2023-24 **	1	13,670	1.73	$308.51	$533.99	$21,906,000
2023-24 **	2	13,050	1.68	$263.29	$442.85	$17,343,300
2023-24 **	3	10,820	1.67	$263.03	$439.12	$14,250,000
2023-24 **	4	9,430	1.70	$256.17	$434.61	$12,300,200
2023-24 **	TOTAL	11,740	1.70	$275.23	$466.86	$65,799,500
2024-25 **	1	13,930	1.77	$259.04	$459.54	$19,198,300
2024-25 **	2	13,060	1.70	$262.31	$446.00	$17,477,900
2024-25 **	3	10,920	1.67	$261.71	$436.80	$14,306,200
2024-25 **	4	9,540	1.70	$253.94	$432.60	$12,383,300
2024-25 **	TOTAL	11,860	1.72	$259.51	$445.16	$63,365,600

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

Other Services Fee-for-Service Base Estimate

Analyst: My-Ai Bui

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

FISCAL YEAR		USERS		UTILIZATION (Claims per User)		RATE (Cost per Claim)		TOTAL EXPENDITURE	
PY	2022-23	222,320	-	2.95	-	$147.44	-	$1,162,157,600	-
CY	2023-24	233,360	4.97%	3.06	3.73%	$144.80	-1.78%	$1,241,810,400	6.85%
BY	2024-25	233,940	0.25%	3.09	0.98%	$142.82	-1.37%	$1,240,101,000	-0.14%

Users: Users are estimated to increase in the CY by 4.97%, likely due to increased users in the Multi-purpose Senior Care Services Program waiver services, the expansion of LEA, and the Assisted Living Waiver (ALW) Program. The BY remains relatively unchanged.

Utilization: Utilization is estimated to increase by 3.73% which is likely due to an increase in LEA services. The BY is essentially unchanged from the CY.

Rate: The rate is estimated to decrease by -1.78% in the CY and 1.37% in the BY.

Total Expenditure: Total expenditures are estimated to increase in the CY by 6.85%, primarily due to an increase in users and utilization. The BY total expenditures are down only slightly from the CY.

Reason for Change from Prior Estimate:

FISCAL YEAR	TOTAL EXPENDITURE		
	M23	N23	% Change
2022-23	$1,137,678,800	$1,162,157,600	2.2%
2023-24	$1,124,949,300	$1,241,810,400	10.4%

Compared to the May 2023 Estimate, the November Estimate expenditure increase by 2.2% for FY 2022-23 due to higher users. The FY 2023-24 expenditure estimate increase by 10.4% due to higher users and utilization.

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2023 BASE ESTIMATES)

OTHER SERVICES

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2021-22 *	1	197,040	2.87	$170.75	$490.70	$290,058,800
2021-22 *	2	172,960	2.15	$215.24	$462.85	$240,162,000
2021-22 *	3	165,460	2.74	$161.83	$443.65	$220,225,800
2021-22 *	4	230,560	3.36	$107.38	$361.26	$249,880,700
2021-22 *	TOTAL	191,510	2.83	$153.84	$435.29	$1,000,327,300
2022-23 *	1	216,830	2.98	$164.31	$490.03	$318,760,300
2022-23 *	2	206,810	2.79	$159.80	$446.36	$276,932,700
2022-23 *	3	224,150	3.00	$149.07	$446.51	$300,260,400
2022-23 *	4	241,480	3.03	$121.26	$367.46	$266,204,200
2022-23 *	TOTAL	222,320	2.95	$147.44	$435.62	$1,162,157,600
2023-24 **	1	237,420	3.09	$167.50	$518.06	$368,997,900
2023-24 **	2	218,980	2.83	$151.78	$429.19	$281,948,800
2023-24 **	3	230,500	3.14	$146.13	$458.84	$317,282,800
2023-24 **	4	246,540	3.17	$116.71	$369.90	$273,580,900
2023-24 **	TOTAL	233,360	3.06	$144.80	$443.45	$1,241,810,400
2024-25 **	1	239,070	3.18	$158.74	$504.99	$362,184,800
2024-25 **	2	218,870	2.88	$150.36	$432.56	$284,023,000
2024-25 **	3	230,890	3.13	$146.86	$459.31	$318,147,700
2024-25 **	4	246,940	3.17	$117.52	$372.21	$275,745,500
2024-25 **	TOTAL	233,940	3.09	$142.82	$441.74	$1,240,101,000

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

Home Health Fee-for-Service Base Estimate

Analyst: Ernesto Singson

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

FISCAL YEAR		USERS		UTILIZATION (Claims per User)		RATE (Cost per Claim)		TOTAL EXPENDITURE	
PY	2022-23	2,190	-	6.02	-	$1,007.42	-	$159,366,400	-
CY	2023-24	1,900	-13.2%	5.65	-6.1%	$1,083.53	7.6%	$139,635,800	-12.4%
BY	2024-25	1,910	0.5%	5.69	0.7%	$1,080.42	-0.3%	$140,997,800	1.0%

Users: Users are estimated to decrease by 13.2% in the CY because of Assisted Living Waiver (ALW) Program was billed under Other Services. Users are relatively unchanged in the BY.

Utilization: Utilization is estimated to decrease by 6.1% due to ALW claims were billed under Other Services. Utilization is relatively unchanged in the BY.

Rate: The rate is estimated to increase by 7.6% in the CY absent of ALW claims. Expenditure is estimated to remain relatively unchanged in the BY.

Total Expenditure: Total expenditure is estimated to decrease by 12.4% due to decrease users and utilization. Total expenditure is estimated to remain relatively unchanged in the BY.

Reason for Change from Prior Estimate

FISCAL YEAR	TOTAL EXPENDITURE		
	M23	N23	% CHANGE
2022-23	$203,800,100	$159,366,400	-21.8%
2023-24	$257,719,900	$139,635,800	-45.8%

Compared to the May 2023 Estimate, the November 2023 Estimate for total expenditure decreased by 21.8% in FY 2022-23 and 45.8% in the BY, due to ALW are now estimated under Other Services.

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2023 BASE ESTIMATES)

HOME HEALTH

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2021-22 *	1	2,690	7.25	$1,036.32	$7,512.79	$60,673,300
2021-22 *	2	2,450	6.36	$998.11	$6,346.81	$46,604,600
2021-22 *	3	2,220	5.97	$1,001.59	$5,980.43	$39,901,400
2021-22 *	4	2,650	5.21	$967.93	$5,043.51	$40,035,400
2021-22 *	TOTAL	2,500	6.21	$1,004.16	$6,234.46	$187,214,700
2022-23 *	1	2,690	6.58	$983.76	$6,469.25	$52,187,500
2022-23 *	2	2,280	6.24	$999.36	$6,234.94	$42,690,700
2022-23 *	3	2,070	5.73	$1,021.78	$5,856.74	$36,393,800
2022-23 *	4	1,720	5.19	$1,048.03	$5,443.60	$28,094,400
2022-23 *	TOTAL	2,190	6.02	$1,007.42	$6,062.09	$159,366,400
2023-24 **	1	2,040	6.17	$1,095.45	$6,755.82	$41,331,000
2023-24 **	2	1,970	5.75	$1,073.36	$6,169.69	$36,419,400
2023-24 **	3	1,880	5.45	$1,096.04	$5,971.64	$33,671,500
2023-24 **	4	1,720	5.15	$1,065.07	$5,483.33	$28,213,800
2023-24 **	TOTAL	1,900	5.65	$1,083.53	$6,123.10	$139,635,800
2024-25 **	1	2,080	6.25	$1,084.91	$6,783.20	$42,352,900
2024-25 **	2	1,970	5.82	$1,070.63	$6,231.58	$36,784,800
2024-25 **	3	1,880	5.43	$1,098.97	$5,967.17	$33,646,300
2024-25 **	4	1,720	5.15	$1,065.07	$5,483.33	$28,213,800
2024-25 **	TOTAL	1,910	5.69	$1,080.42	$6,148.86	$140,997,800

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2023 BASE ESTIMATES)

PA-OAS

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2021-22 *	1	58,250	3.72	$206.55	$768.07	$134,210,800
2021-22 *	2	54,680	3.33	$201.23	$670.34	$109,965,400
2021-22 *	3	108,220	2.90	$119.13	$345.39	$112,133,700
2021-22 *	4	125,320	3.02	$105.79	$319.20	$120,008,800
2021-22 *	TOTAL	86,620	3.15	$145.58	$458.26	$476,318,600
2022-23 *	1	141,500	3.32	$114.39	$379.44	$161,072,400
2022-23 *	2	133,120	3.03	$120.95	$366.69	$146,440,600
2022-23 *	3	144,900	2.90	$118.62	$343.69	$149,396,900
2022-23 *	4	120,490	2.24	$112.90	$252.78	$91,373,900
2022-23 *	TOTAL	135,000	2.89	$116.97	$338.44	$548,283,700
2023-24 **	1	142,440	2.53	$110.15	$278.71	$119,100,100
2023-24 **	2	129,540	2.21	$111.78	$247.27	$96,094,900
2023-24 **	3	138,640	2.37	$100.39	$238.34	$99,128,700
2023-24 **	4	122,370	2.18	$108.36	$236.13	$86,681,400
2023-24 **	TOTAL	133,250	2.33	$107.56	$250.79	$401,005,200
2024-25 **	1	143,240	2.54	$108.97	$276.76	$118,929,600
2024-25 **	2	134,600	2.30	$106.53	$244.52	$98,732,400
2024-25 **	3	133,580	2.30	$103.54	$237.75	$95,279,600
2024-25 **	4	122,370	2.17	$107.72	$234.21	$85,977,500
2024-25 **	TOTAL	133,450	2.33	$106.76	$249.11	$398,919,100

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2023 BASE ESTIMATES)

NEWLY

YEAR	QUARTER	AVERAGE MONTHLY USERS	AVERAGE MONTHLY UNIT PER USER	AVERAGE MONTHLY COST PER UNIT	AVERAGE MONTHLY COST PER USER	TOTAL COST
2021-22 *	1	724,140	2.49	$293.52	$730.11	$1,586,097,200
2021-22 *	2	681,980	2.26	$296.63	$670.69	$1,372,203,100
2021-22 *	3	1,268,110	3.88	$131.54	$510.72	$1,942,958,800
2021-22 *	4	1,345,130	4.33	$128.89	$558.51	$2,253,795,100
2021-22 *	TOTAL	1,004,840	3.51	$169.20	$593.38	$7,155,054,100
2022-23 *	1	1,510,360	4.80	$132.63	$637.10	$2,886,751,600
2022-23 *	2	1,446,970	4.18	$137.34	$574.13	$2,492,257,800
2022-23 *	3	1,491,080	4.05	$161.97	$655.38	$2,931,659,100
2022-23 *	4	1,363,720	3.32	$176.17	$585.24	$2,394,293,500
2022-23 *	TOTAL	1,453,030	4.11	$149.50	$613.94	$10,704,962,000
2023-24 **	1	1,555,160	3.93	$182.47	$716.51	$3,342,850,700
2023-24 **	2	1,436,670	3.54	$184.97	$654.18	$2,819,505,900
2023-24 **	3	1,501,640	3.68	$182.46	$671.05	$3,023,031,300
2023-24 **	4	1,400,660	3.14	$185.52	$583.25	$2,450,812,700
2023-24 **	TOTAL	1,473,530	3.58	$183.70	$658.07	$11,636,200,600
2024-25 **	1	1,561,630	3.97	$188.93	$750.03	$3,513,788,800
2024-25 **	2	1,471,620	3.70	$192.16	$710.75	$3,137,857,500
2024-25 **	3	1,466,690	3.54	$192.86	$683.26	$3,006,397,000
2024-25 **	4	1,400,660	3.14	$194.06	$610.13	$2,563,740,100
2024-25 **	TOTAL	1,475,150	3.60	$191.78	$690.43	$12,221,783,500

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2023 BASE ESTIMATES)

PA-ATD

YEAR	QUARTER	AVERAGE MONTHLY USERS	AVERAGE MONTHLY UNIT PER USER	AVERAGE MONTHLY COST PER UNIT	AVERAGE MONTHLY COST PER USER	TOTAL COST
2021-22 *	1	251,630	4.54	$296.01	$1,343.57	$1,014,230,900
2021-22 *	2	233,890	3.98	$303.65	$1,208.15	$847,706,300
2021-22 *	3	378,780	5.83	$161.78	$943.97	$1,072,673,900
2021-22 *	4	407,200	6.42	$151.59	$973.80	$1,189,588,500
2021-22 *	TOTAL	317,870	5.43	$199.28	$1,081.20	$4,124,199,600
2022-23 *	1	428,380	7.29	$162.60	$1,185.10	$1,523,013,400
2022-23 *	2	410,700	6.13	$169.32	$1,038.71	$1,279,797,900
2022-23 *	3	423,560	6.00	$187.49	$1,124.82	$1,429,277,600
2022-23 *	4	385,720	4.83	$198.67	$960.07	$1,110,940,300
2022-23 *	TOTAL	412,090	6.10	$177.27	$1,080.48	$5,343,029,200
2023-24 **	1	416,910	5.80	$208.47	$1,208.81	$1,511,902,900
2023-24 **	2	397,430	4.88	$209.22	$1,021.08	$1,217,421,500
2023-24 **	3	413,290	5.43	$202.92	$1,102.82	$1,367,365,500
2023-24 **	4	391,640	4.67	$200.24	$935.89	$1,099,606,100
2023-24 **	TOTAL	404,820	5.21	$205.37	$1,069.67	$5,196,296,000
2024-25 **	1	418,940	5.86	$206.42	$1,209.72	$1,520,389,900
2024-25 **	2	404,220	5.14	$206.82	$1,063.51	$1,289,664,800
2024-25 **	3	406,510	5.20	$205.51	$1,067.78	$1,302,184,300
2024-25 **	4	391,640	4.67	$200.68	$937.68	$1,101,713,700
2024-25 **	TOTAL	405,330	5.23	$205.05	$1,071.97	$5,213,952,700

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2023 BASE ESTIMATES)

PA-AFDC

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2021-22 *	1	155,520	2.21	$217.89	$481.19	$224,510,100
2021-22 *	2	142,920	2.05	$233.72	$477.98	$204,937,600
2021-22 *	3	226,100	2.97	$118.87	$352.84	$239,337,800
2021-22 *	4	264,810	3.38	$103.62	$350.13	$278,158,200
2021-22 *	TOTAL	197,340	2.79	$143.37	$399.88	$946,943,700
2022-23 *	1	299,660	3.64	$113.99	$415.44	$373,473,100
2022-23 *	2	307,450	3.46	$113.51	$392.87	$362,362,200
2022-23 *	3	309,370	3.20	$140.54	$449.62	$417,292,100
2022-23 *	4	284,240	2.74	$140.20	$383.98	$327,430,000
2022-23 *	TOTAL	300,180	3.27	$125.76	$411.02	$1,480,557,500
2023-24 **	1	325,610	3.00	$155.89	$468.40	$457,552,600
2023-24 **	2	316,280	2.74	$156.42	$429.33	$407,369,300
2023-24 **	3	317,330	2.85	$153.98	$439.60	$418,491,200
2023-24 **	4	299,560	2.68	$146.48	$392.05	$352,328,000
2023-24 **	TOTAL	314,700	2.82	$153.41	$433.16	$1,635,741,100
2024-25 **	1	330,890	3.04	$150.63	$457.76	$454,408,100
2024-25 **	2	322,400	2.84	$154.12	$437.04	$422,701,500
2024-25 **	3	311,210	2.78	$157.41	$437.24	$408,226,400
2024-25 **	4	299,560	2.68	$147.30	$394.28	$354,331,000
2024-25 **	TOTAL	316,010	2.84	$152.41	$432.38	$1,639,667,000

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2023 BASE ESTIMATES)

LT-OAS

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2021-22 *	1	14,930	34.03	$272.49	$9,271.91	$415,224,000
2021-22 *	2	14,330	27.33	$265.62	$7,259.70	$312,123,500
2021-22 *	3	15,690	21.76	$264.53	$5,756.45	$270,932,900
2021-22 *	4	15,990	23.00	$256.22	$5,891.94	$282,607,000
2021-22 *	TOTAL	15,230	26.40	$265.41	$7,006.74	$1,280,887,300
2022-23 *	1	16,600	25.50	$276.06	$7,040.80	$350,695,400
2022-23 *	2	16,110	23.81	$273.46	$6,511.81	$314,748,500
2022-23 *	3	15,040	19.12	$268.34	$5,130.25	$231,533,300
2022-23 *	4	9,620	12.66	$251.07	$3,177.92	$91,718,000
2022-23 *	TOTAL	14,340	21.20	$270.91	$5,743.69	$988,695,200
2023-24 **	1	10,550	14.38	$249.73	$3,590.99	$113,603,400
2023-24 **	2	10,430	12.48	$252.52	$3,151.31	$98,618,700
2023-24 **	3	10,100	11.43	$246.35	$2,816.00	$85,334,200
2023-24 **	4	9,460	9.21	$241.32	$2,221.99	$63,037,200
2023-24 **	TOTAL	10,130	11.95	$248.16	$2,965.33	$360,593,500
2024-25 **	1	10,510	13.01	$254.18	$3,306.59	$104,273,900
2024-25 **	2	10,530	12.18	$249.50	$3,038.31	$96,004,000
2024-25 **	3	10,000	11.28	$248.61	$2,805.49	$84,164,800
2024-25 **	4	9,460	9.25	$242.07	$2,239.20	$63,525,200
2024-25 **	TOTAL	10,130	11.49	$249.26	$2,863.87	$347,967,800

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2023 BASE ESTIMATES)

H-PE

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2021-22 *	1	47,950	4.07	$335.42	$1,365.72	$196,442,800
2021-22 *	2	40,160	4.01	$349.78	$1,401.85	$168,909,000
2021-22 *	3	36,770	3.93	$365.70	$1,437.96	$158,604,600
2021-22 *	4	38,950	4.01	$293.88	$1,177.95	$137,651,000
2021-22 *	TOTAL	40,960	4.01	$335.73	$1,346.15	$661,607,500
2022-23 *	1	46,480	4.32	$300.21	$1,295.82	$180,703,800
2022-23 *	2	41,060	4.14	$304.26	$1,259.52	$155,163,000
2022-23 *	3	39,970	4.21	$311.63	$1,313.14	$157,470,500
2022-23 *	4	36,710	3.80	$311.04	$1,181.38	$130,111,500
2022-23 *	TOTAL	41,060	4.13	$306.29	$1,265.38	$623,448,800
2023-24 **	1	45,080	4.21	$328.33	$1,381.91	$186,908,200
2023-24 **	2	40,430	4.04	$326.56	$1,320.05	$160,124,900
2023-24 **	3	39,700	4.21	$322.38	$1,357.73	$161,714,500
2023-24 **	4	37,440	3.82	$320.92	$1,227.33	$137,860,100
2023-24 **	TOTAL	40,670	4.08	$324.79	$1,325.05	$646,607,700
2024-25 **	1	45,410	4.16	$325.81	$1,356.66	$184,829,600
2024-25 **	2	41,260	4.04	$322.44	$1,304.03	$161,429,500
2024-25 **	3	38,870	4.24	$330.32	$1,399.24	$163,174,200
2024-25 **	4	37,440	3.82	$322.90	$1,234.86	$138,705,100
2024-25 **	TOTAL	40,750	4.07	$325.45	$1,325.51	$648,138,400

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2023 BASE ESTIMATES)

LT-ATD

YEAR	QUARTER	AVERAGE MONTHLY USERS	AVERAGE MONTHLY UNIT PER USER	AVERAGE MONTHLY COST PER UNIT	AVERAGE MONTHLY COST PER USER	TOTAL COST
2021-22 *	1	4,590	34.24	$271.69	$9,301.51	$128,137,600
2021-22 *	2	4,380	27.85	$275.40	$7,670.49	$100,782,600
2021-22 *	3	4,790	22.58	$320.69	$7,241.93	$104,037,600
2021-22 *	4	4,720	23.07	$277.44	$6,399.27	$90,664,800
2021-22 *	TOTAL	4,620	26.85	$284.54	$7,639.86	$423,622,500
2022-23 *	1	4,830	27.75	$294.04	$8,160.02	$118,263,100
2022-23 *	2	4,700	23.91	$293.77	$7,024.62	$98,955,900
2022-23 *	3	4,570	22.02	$319.45	$7,034.24	$96,404,200
2022-23 *	4	3,740	17.38	$308.18	$5,357.71	$60,118,900
2022-23 *	TOTAL	4,460	23.10	$302.40	$6,985.05	$373,742,100
2023-24 **	1	3,930	22.62	$308.48	$6,977.09	$82,335,700
2023-24 **	2	3,860	19.23	$312.60	$6,010.63	$69,657,800
2023-24 **	3	3,870	19.67	$306.33	$6,024.14	$69,852,500
2023-24 **	4	3,670	16.75	$305.38	$5,115.38	$56,334,500
2023-24 **	TOTAL	3,830	19.61	$308.32	$6,047.64	$278,180,400
2024-25 **	1	3,930	22.53	$310.25	$6,990.78	$82,418,000
2024-25 **	2	3,870	19.42	$308.65	$5,995.10	$69,615,600
2024-25 **	3	3,860	19.43	$308.63	$5,995.87	$69,386,900
2024-25 **	4	3,670	16.75	$305.48	$5,116.44	$56,346,100
2024-25 **	TOTAL	3,830	19.58	$308.47	$6,040.14	$277,766,700

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2023 BASE ESTIMATES)

POV 250

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2021-22 *	1	124,530	2.05	$200.33	$410.82	$153,475,100
2021-22 *	2	102,030	1.85	$226.11	$417.79	$127,878,700
2021-22 *	3	161,350	2.36	$126.15	$297.64	$144,072,000
2021-22 *	4	172,330	2.84	$106.11	$301.37	$155,806,900
2021-22 *	TOTAL	140,060	2.35	$147.44	$345.83	$581,232,800
2022-23 *	1	182,740	2.85	$122.21	$348.27	$190,932,300
2022-23 *	2	179,520	2.87	$108.13	$309.92	$166,913,900
2022-23 *	3	174,070	2.60	$133.03	$345.98	$180,667,800
2022-23 *	4	156,860	2.35	$136.20	$320.07	$150,621,300
2022-23 *	TOTAL	173,300	2.68	$123.72	$331.38	$689,135,300
2023-24 **	1	177,570	2.51	$160.16	$401.33	$213,785,700
2023-24 **	2	170,140	2.36	$143.20	$337.74	$172,392,200
2023-24 **	3	165,830	2.43	$139.92	$339.95	$169,122,500
2023-24 **	4	159,050	2.44	$132.30	$322.62	$153,940,000
2023-24 **	TOTAL	168,150	2.43	$144.42	$351.50	$709,240,400
2024-25 **	1	180,260	2.57	$157.54	$404.24	$218,610,300
2024-25 **	2	173,930	2.45	$142.07	$347.48	$181,311,000
2024-25 **	3	162,040	2.40	$141.27	$339.20	$164,896,700
2024-25 **	4	159,050	2.46	$132.19	$325.69	$155,406,900
2024-25 **	TOTAL	168,820	2.47	$143.85	$355.51	$720,225,000

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2023 BASE ESTIMATES)

MN-OAS

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2021-22 *	1	102,890	3.86	$219.06	$846.06	$261,153,600
2021-22 *	2	101,060	3.42	$217.88	$744.90	$225,835,100
2021-22 *	3	168,200	4.27	$129.37	$552.80	$278,942,200
2021-22 *	4	190,910	4.56	$125.91	$574.28	$328,900,600
2021-22 *	TOTAL	140,760	4.14	$156.47	$648.15	$1,094,831,400
2022-23 *	1	222,800	4.99	$132.21	$659.94	$441,097,900
2022-23 *	2	216,900	4.44	$137.10	$609.09	$396,325,200
2022-23 *	3	230,910	4.19	$144.98	$608.08	$421,232,200
2022-23 *	4	202,940	3.37	$155.33	$523.54	$318,739,300
2022-23 *	TOTAL	218,390	4.27	$141.03	$601.92	$1,577,394,600
2023-24 **	1	233,260	3.99	$156.55	$625.18	$437,495,600
2023-24 **	2	216,430	3.49	$157.27	$549.06	$356,497,800
2023-24 **	3	223,500	3.74	$151.92	$568.13	$380,936,400
2023-24 **	4	212,010	3.29	$156.67	$516.16	$328,293,900
2023-24 **	TOTAL	221,300	3.64	$155.54	$566.06	$1,503,223,700
2024-25 **	1	232,860	4.10	$157.96	$647.15	$452,077,600
2024-25 **	2	220,960	3.63	$156.79	$569.19	$377,303,300
2024-25 **	3	218,970	3.69	$156.31	$577.05	$379,071,100
2024-25 **	4	212,010	3.34	$158.72	$529.77	$336,948,400
2024-25 **	TOTAL	221,200	3.70	$157.43	$582.20	$1,545,400,400

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2023 BASE ESTIMATES)

MN-ATD

YEAR	QUARTER	AVERAGE MONTHLY USERS	AVERAGE MONTHLY UNIT PER USER	AVERAGE MONTHLY COST PER UNIT	AVERAGE MONTHLY COST PER USER	TOTAL COST
2021-22 *	1	46,220	4.57	$217.68	$994.79	$137,934,200
2021-22 *	2	42,440	3.92	$219.80	$861.00	$109,632,100
2021-22 *	3	59,960	4.33	$167.47	$725.26	$130,470,700
2021-22 *	4	65,700	4.78	$148.14	$708.34	$139,604,500
2021-22 *	TOTAL	53,580	4.44	$181.38	$805.08	$517,641,500
2022-23 *	1	70,710	5.15	$160.23	$825.74	$175,158,300
2022-23 *	2	67,170	4.54	$164.53	$746.19	$150,361,500
2022-23 *	3	71,840	4.27	$172.77	$737.48	$158,938,500
2022-23 *	4	61,790	3.61	$184.77	$667.73	$123,768,200
2022-23 *	TOTAL	67,880	4.42	$169.10	$746.75	$608,226,500
2023-24 **	1	67,100	4.19	$204.69	$857.79	$172,682,300
2023-24 **	2	62,670	3.74	$200.46	$750.25	$141,046,100
2023-24 **	3	64,970	3.95	$187.52	$741.43	$144,521,100
2023-24 **	4	62,790	3.56	$188.62	$671.87	$126,553,200
2023-24 **	TOTAL	64,380	3.87	$195.66	$756.94	$584,802,600
2024-25 **	1	67,120	4.32	$203.48	$878.53	$176,895,000
2024-25 **	2	63,610	3.86	$198.44	$765.06	$145,990,800
2024-25 **	3	64,030	3.86	$189.18	$730.51	$140,329,000
2024-25 **	4	62,790	3.56	$189.24	$674.04	$126,963,100
2024-25 **	TOTAL	64,390	3.91	$195.57	$763.85	$590,178,000

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2023 BASE ESTIMATES)

MN-AFDC

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2021-22 *	1	611,480	2.28	$205.28	$468.46	$859,361,500
2021-22 *	2	544,050	2.10	$215.39	$453.18	$739,648,800
2021-22 *	3	887,020	3.03	$117.20	$355.55	$946,138,500
2021-22 *	4	943,990	3.41	$110.04	$375.05	$1,062,117,900
2021-22 *	TOTAL	746,640	2.83	$142.32	$402.61	$3,607,266,800
2022-23 *	1	1,030,810	3.63	$118.14	$428.56	$1,325,301,600
2022-23 *	2	981,790	3.34	$117.81	$393.61	$1,159,317,200
2022-23 *	3	991,350	3.18	$140.05	$445.09	$1,323,714,200
2022-23 *	4	906,890	2.73	$148.24	$404.99	$1,101,841,000
2022-23 *	TOTAL	977,710	3.23	$129.41	$418.51	$4,910,174,000
2023-24 **	1	1,027,540	3.11	$159.25	$495.10	$1,526,215,000
2023-24 **	2	963,110	2.91	$155.05	$451.47	$1,304,434,900
2023-24 **	3	985,780	2.99	$155.21	$464.60	$1,373,965,500
2023-24 **	4	927,900	2.70	$149.93	$404.78	$1,126,777,900
2023-24 **	TOTAL	976,080	2.93	$155.14	$455.17	$5,331,393,400
2024-25 **	1	1,036,990	3.14	$157.02	$493.62	$1,535,644,100
2024-25 **	2	987,670	3.00	$153.74	$461.08	$1,366,182,600
2024-25 **	3	961,220	2.93	$157.21	$459.93	$1,326,288,900
2024-25 **	4	927,900	2.70	$150.47	$406.21	$1,130,768,700
2024-25 **	TOTAL	978,440	2.95	$154.80	$456.41	$5,358,884,300

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2023 BASE ESTIMATES)

MI-C

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2021-22 *	1	53,770	2.87	$203.72	$583.81	$94,167,400
2021-22 *	2	51,090	2.68	$209.86	$562.68	$86,241,400
2021-22 *	3	52,970	2.81	$182.06	$510.70	$81,157,000
2021-22 *	4	54,920	3.20	$153.21	$490.40	$80,804,900
2021-22 *	TOTAL	53,190	2.89	$185.43	$536.42	$342,370,700
2022-23 *	1	61,100	3.32	$166.64	$552.93	$101,350,500
2022-23 *	2	58,490	3.15	$153.93	$484.51	$85,013,700
2022-23 *	3	57,970	3.04	$177.67	$540.33	$93,971,800
2022-23 *	4	53,040	2.66	$180.72	$480.23	$76,409,100
2022-23 *	TOTAL	57,650	3.05	$168.90	$515.69	$356,745,100
2023-24 **	1	58,300	3.01	$198.30	$596.13	$104,269,300
2023-24 **	2	56,200	2.72	$197.17	$536.31	$90,428,600
2023-24 **	3	56,120	2.84	$195.88	$556.92	$93,755,000
2023-24 **	4	52,030	2.68	$186.89	$501.38	$78,266,200
2023-24 **	TOTAL	55,660	2.82	$194.87	$549.01	$366,719,100
2024-25 **	1	58,920	3.02	$196.99	$594.95	$105,165,700
2024-25 **	2	57,500	2.76	$197.47	$544.49	$93,927,600
2024-25 **	3	54,820	2.80	$200.43	$561.36	$92,317,500
2024-25 **	4	52,030	2.67	$188.63	$504.43	$78,742,100
2024-25 **	TOTAL	55,820	2.82	$196.10	$552.61	$370,152,800

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2023 BASE ESTIMATES)

MI-A

YEAR	QUARTER	AVERAGE MONTHLY USERS	AVERAGE MONTHLY UNIT PER USER	AVERAGE MONTHLY COST PER UNIT	AVERAGE MONTHLY COST PER USER	TOTAL COST
2021-22 *	1	490	19.89	$298.27	$5,931.54	$8,671,900
2021-22 *	2	490	16.82	$285.04	$4,794.20	$7,009,100
2021-22 *	3	500	15.34	$308.40	$4,731.75	$7,149,700
2021-22 *	4	490	16.01	$303.33	$4,857.02	$7,091,300
2021-22 *	TOTAL	490	17.00	$298.55	$5,075.82	$29,921,900
2022-23 *	1	540	17.94	$286.01	$5,131.04	$8,296,900
2022-23 *	2	500	16.69	$308.24	$5,145.66	$7,754,500
2022-23 *	3	520	15.61	$284.57	$4,443.09	$6,984,500
2022-23 *	4	470	9.75	$311.92	$3,040.45	$4,311,400
2022-23 *	TOTAL	510	15.13	$295.54	$4,472.90	$27,347,300
2023-24 **	1	550	12.08	$297.26	$3,592.08	$5,902,600
2023-24 **	2	520	9.73	$327.34	$3,185.53	$4,988,400
2023-24 **	3	530	11.11	$322.14	$3,579.36	$5,685,000
2023-24 **	4	480	10.01	$327.31	$3,277.94	$4,762,400
2023-24 **	TOTAL	520	10.77	$317.09	$3,413.97	$21,338,400
2024-25 **	1	550	11.61	$304.43	$3,533.41	$5,827,500
2024-25 **	2	530	9.85	$324.85	$3,198.44	$5,096,200
2024-25 **	3	520	11.00	$330.99	$3,642.43	$5,685,500
2024-25 **	4	480	10.01	$331.16	$3,315.98	$4,817,700
2024-25 **	TOTAL	520	10.64	$321.94	$3,424.81	$21,426,800

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2023 BASE ESTIMATES)

REFUGEE

YEAR	QUARTER	AVERAGE MONTHLY USERS	AVERAGE MONTHLY UNIT PER USER	AVERAGE MONTHLY COST PER UNIT	AVERAGE MONTHLY COST PER USER	TOTAL COST
2021-22 *	1	160	2.44	$149.51	$364.56	$174,600
2021-22 *	2	200	3.05	$153.36	$467.92	$283,600
2021-22 *	3	520	3.73	$97.05	$361.64	$564,500
2021-22 *	4	720	3.69	$89.46	$330.17	$708,500
2021-22 *	TOTAL	400	3.50	$103.33	$361.28	$1,731,300
2022-23 *	1	830	3.83	$105.16	$403.08	$1,005,700
2022-23 *	2	1,370	3.73	$104.97	$391.73	$1,613,100
2022-23 *	3	2,040	3.55	$128.73	$457.21	$2,804,500
2022-23 *	4	1,910	3.03	$138.75	$420.36	$2,409,100
2022-23 *	TOTAL	1,540	3.47	$122.23	$423.88	$7,832,400
2023-24 **	1	2,010	3.58	$158.47	$566.91	$3,423,900
2023-24 **	2	1,880	3.57	$150.88	$539.37	$3,039,200
2023-24 **	3	2,060	3.64	$141.48	$514.48	$3,172,800
2023-24 **	4	1,970	3.25	$145.05	$471.92	$2,785,400
2023-24 **	TOTAL	1,980	3.51	$148.97	$523.14	$12,421,300
2024-25 **	1	1,990	3.60	$157.45	$566.18	$3,376,900
2024-25 **	2	1,930	3.54	$151.00	$535.21	$3,101,700
2024-25 **	3	2,000	3.66	$142.43	$521.22	$3,130,600
2024-25 **	4	1,970	3.25	$145.05	$471.92	$2,785,400
2024-25 **	TOTAL	1,970	3.51	$149.02	$523.68	$12,394,600

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2023 BASE ESTIMATES)

OBRA

YEAR	QUARTER	AVERAGE MONTHLY USERS	AVERAGE MONTHLY UNIT PER USER	AVERAGE MONTHLY COST PER UNIT	AVERAGE MONTHLY COST PER USER	TOTAL COST
2021-22 *	1	30	5.18	$289.43	$1,500.52	$154,600
2021-22 *	2	10	7.24	$272.38	$1,972.41	$57,200
2021-22 *	3	20	16.51	$154.58	$2,552.65	$188,900
2021-22 *	4	10	12.04	$355.21	$4,277.96	$98,400
2021-22 *	TOTAL	20	9.79	$222.49	$2,179.22	$499,000
2022-23 *	1	0	2.33	$295.45	$689.39	$2,100
2022-23 *	2	0	13.33	$333.29	$4,443.91	$13,300
2022-23 *	3	0	9.75	$346.62	$3,379.52	$13,500
2022-23 *	4	0	3.25	$131.20	$426.39	$1,700
2022-23 *	TOTAL	0	7.07	$309.33	$2,187.39	$30,600
2023-24 **	1	0	12.68	$292.93	$3,715.71	$21,400
2023-24 **	2	0	21.97	$305.29	$6,707.02	$47,800
2023-24 **	3	0	28.62	$105.80	$3,028.19	$21,600
2023-24 **	4	0	14.93	$83.37	$1,245.14	$8,900
2023-24 **	TOTAL	0	19.90	$184.51	$3,671.90	$99,600
2024-25 **	1	0	12.28	$255.74	$3,140.26	$22,400
2024-25 **	2	0	19.07	$280.97	$5,356.91	$38,200
2024-25 **	3	0	21.57	$121.53	$2,620.88	$18,700
2024-25 **	4	0	14.93	$83.37	$1,245.14	$8,900
2024-25 **	TOTAL	0	16.96	$182.23	$3,090.80	$88,100

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2023 BASE ESTIMATES)

POV 185

YEAR	QUARTER	AVERAGE MONTHLY USERS	AVERAGE MONTHLY UNIT PER USER	AVERAGE MONTHLY COST PER UNIT	AVERAGE MONTHLY COST PER USER	TOTAL COST
2021-22 *	1	86,980	3.01	$363.99	$1,095.86	$285,945,000
2021-22 *	2	77,190	2.82	$372.60	$1,051.13	$243,423,500
2021-22 *	3	94,640	2.87	$284.82	$818.77	$232,473,000
2021-22 *	4	103,110	3.04	$233.55	$709.41	$219,449,700
2021-22 *	TOTAL	90,480	2.94	$307.16	$903.76	$981,291,300
2022-23 *	1	121,510	3.31	$240.81	$796.49	$290,340,700
2022-23 *	2	119,350	3.23	$232.56	$750.83	$268,825,300
2022-23 *	3	124,690	2.98	$263.23	$784.09	$293,293,300
2022-23 *	4	110,140	2.61	$276.28	$720.09	$237,939,300
2022-23 *	TOTAL	118,920	3.04	$251.41	$764.09	$1,090,398,500
2023-24 **	1	128,790	2.90	$295.87	$858.59	$331,746,800
2023-24 **	2	123,280	2.55	$295.84	$755.87	$279,556,100
2023-24 **	3	126,140	2.56	$299.13	$766.70	$290,142,300
2023-24 **	4	109,490	2.56	$284.99	$729.10	$239,495,400
2023-24 **	TOTAL	121,930	2.65	$294.32	$779.79	$1,140,940,700
2024-25 **	1	129,390	2.87	$297.84	$855.35	$332,009,600
2024-25 **	2	127,520	2.56	$295.85	$755.98	$289,196,100
2024-25 **	3	121,910	2.57	$314.50	$806.88	$295,104,000
2024-25 **	4	109,490	2.56	$291.35	$745.24	$244,798,900
2024-25 **	TOTAL	122,080	2.64	$299.97	$792.61	$1,161,108,500

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2023 BASE ESTIMATES)

POV 133

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2021-22 *	1	93,300	1.93	$208.39	$401.44	$112,364,700
2021-22 *	2	87,450	1.76	$221.71	$389.57	$102,200,200
2021-22 *	3	131,660	2.43	$111.65	$271.04	$107,054,200
2021-22 *	4	164,460	2.89	$84.82	$245.34	$121,047,900
2021-22 *	TOTAL	119,220	2.37	$130.73	$309.43	$442,666,900
2022-23 *	1	180,670	2.85	$97.77	$278.51	$150,956,600
2022-23 *	2	199,630	3.12	$76.52	$239.11	$143,196,000
2022-23 *	3	190,080	2.64	$97.13	$256.17	$146,079,600
2022-23 *	4	167,100	2.33	$107.49	$250.54	$125,593,200
2022-23 *	TOTAL	184,370	2.75	$92.94	$255.75	$565,825,300
2023-24 **	1	193,540	2.43	$114.18	$277.98	$161,395,500
2023-24 **	2	187,950	2.17	$115.09	$250.08	$141,011,900
2023-24 **	3	177,860	2.28	$110.59	$252.63	$134,794,900
2023-24 **	4	170,050	2.27	$108.53	$246.54	$125,773,900
2023-24 **	TOTAL	182,350	2.29	$112.22	$257.28	$562,976,200
2024-25 **	1	196,500	2.46	$111.91	$275.70	$162,525,800
2024-25 **	2	193,910	2.27	$111.01	$251.74	$146,440,000
2024-25 **	3	171,900	2.21	$114.65	$252.96	$130,453,000
2024-25 **	4	170,050	2.27	$108.61	$246.70	$125,856,200
2024-25 **	TOTAL	183,090	2.31	$111.54	$257.28	$565,275,100

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2023 BASE ESTIMATES)

POV 100

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2021-22 *	1	62,750	1.89	$189.46	$358.15	$67,424,300
2021-22 *	2	52,200	1.73	$225.57	$391.05	$61,243,900
2021-22 *	3	81,200	2.31	$119.27	$275.22	$67,039,200
2021-22 *	4	86,000	2.76	$106.07	$293.14	$75,634,500
2021-22 *	TOTAL	70,540	2.25	$142.62	$320.56	$271,342,000
2022-23 *	1	93,010	2.77	$122.38	$338.66	$94,500,400
2022-23 *	2	90,200	2.78	$107.82	$300.16	$81,221,600
2022-23 *	3	87,540	2.55	$128.57	$328.05	$86,148,200
2022-23 *	4	78,780	2.31	$129.76	$299.68	$70,830,400
2022-23 *	TOTAL	87,380	2.61	$121.36	$317.28	$332,700,600
2023-24 **	1	90,110	2.44	$140.81	$343.78	$92,932,800
2023-24 **	2	87,740	2.47	$125.85	$310.53	$81,740,900
2023-24 **	3	84,710	2.66	$139.25	$370.29	$94,103,300
2023-24 **	4	81,170	2.66	$131.70	$349.73	$85,163,900
2023-24 **	TOTAL	85,930	2.55	$134.48	$343.23	$353,941,000
2024-25 **	1	92,050	2.60	$134.14	$349.14	$96,410,100
2024-25 **	2	90,120	2.60	$123.19	$320.35	$86,613,900
2024-25 **	3	82,330	2.72	$138.86	$377.68	$93,282,800
2024-25 **	4	81,170	2.73	$131.42	$358.36	$87,266,600
2024-25 **	TOTAL	86,420	2.66	$131.84	$350.60	$363,573,400

* 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.

Medi-Cal Base Policy Changes

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

The base estimate consists of two types. The first type, the Fee-for-Service Base Estimate, is described and summarized in the previous section (FFS Base).

The second type of base estimate, which had traditionally been called the Non-Fee-for-Service (Non-FFS) Base Estimate, is displayed in this section. Because some of these base estimates include services paid on a fee-for-service basis, that name is technically not correct. As a result, this second type of base estimate will be called Base Policy Changes because as in the past they are entered into the Medi-Cal Estimate and displayed using the policy change format. These Base Policy Changes form the base estimates for the last 13 service categories (Managed Care through Drug Medi-Cal) as displayed in most tables throughout this binder and listed below. The data used for these projections come from a variety of sources, such as other claims processing systems, managed care enrollments, and other payment data. Also, some of the projections in this group come directly from other State departments.

Base Policy Change Service Categories:
Two Plan Model
County Organized Health Systems
Geographic Managed Care
Regional Model
PHP & Other Managed Care (Other M/C)
Dental
Mental Health
Audits/Lawsuits
Medicare Payments
State Hospital/Developmental Centers
Miscellaneous Services (Misc. Svcs.)
Recoveries
Drug Medi-Cal

SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2023-24

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	DRUG MEDI-CAL				
42	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	$908,759,000	$715,222,950	$137,902,050	$55,634,000
45	DRUG MEDI-CAL STATE PLAN SERVICES	$10,251,000	$9,389,800	$861,200	$0
	DRUG MEDI-CAL SUBTOTAL	**$919,010,000**	**$724,612,750**	**$138,763,250**	**$55,634,000**
	MENTAL HEALTH				
47	SMHS FOR ADULTS	$1,944,246,000	$1,486,486,200	$102,181,800	$355,578,000
48	SMHS FOR CHILDREN	$1,669,525,000	$1,086,424,800	$38,990,200	$544,110,000
	MENTAL HEALTH SUBTOTAL	**$3,613,771,000**	**$2,572,911,000**	**$141,172,000**	**$899,688,000**
	MANAGED CARE				
64	TWO PLAN MODEL	$31,539,443,000	$18,836,556,250	$12,702,886,750	$0
65	COUNTY ORGANIZED HEALTH SYSTEMS	$11,692,626,000	$7,181,683,700	$4,510,942,300	$0
67	GEOGRAPHIC MANAGED CARE	$5,880,945,000	$3,685,318,800	$2,195,626,200	$0
70	REGIONAL MODEL	$1,943,226,000	$1,255,758,800	$687,467,200	$0
72	PACE (Other M/C)	$1,439,529,000	$720,232,200	$719,296,800	$0
76	DENTAL MANAGED CARE (Other M/C)	$173,593,000	$105,699,750	$67,893,250	$0
78	SENIOR CARE ACTION NETWORK (Other M/C)	$77,569,000	$38,533,500	$39,035,500	$0
80	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	$31,080,000	$18,373,000	$0	$12,707,000
82	AIDS HEALTHCARE CENTERS (Other M/C)	$10,474,000	$5,237,000	$5,237,000	$0
83	COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM	$9,617,000	$6,318,050	$3,298,950	$0
84	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	$5,170,000	$3,396,500	$1,773,500	$0
86	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	$387,000	$0	$387,000	$0
	MANAGED CARE SUBTOTAL	**$52,803,659,000**	**$31,857,107,550**	**$20,933,844,450**	**$12,707,000**
	OTHER				
153	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$4,499,413,000	$1,846,851,000	$2,652,562,000	$0
154	MEDICARE PAYMENTS - PART D PHASED-DOWN	$3,234,728,000	$0	$3,234,728,000	$0
155	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	$3,423,496,000	$3,423,496,000	$0	$0
156	PERSONAL CARE SERVICES (Misc. Svcs.)	$3,616,465,000	$3,616,465,000	$0	$0
157	DENTAL SERVICES	$2,078,914,000	$1,194,090,800	$884,823,200	$0
160	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$375,100,000	$375,100,000	$0	$0
177	LAWSUITS/CLAIMS	$47,205,000	$23,602,500	$23,602,500	$0
182	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$19,954,000	$19,954,000	$0	$0
187	MEDI-CAL TCM PROGRAM	$15,121,000	$15,121,000	$0	$0
200	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$369,000	$184,500	$184,500	$0

SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2023-24

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER				
217	BASE RECOVERIES	($734,833,000)	($424,318,870)	($310,514,130)	$0
	OTHER SUBTOTAL	**$16,575,932,000**	**$10,090,545,930**	**$6,485,386,070**	**$0**
	GRAND TOTAL	**$73,912,372,000**	**$45,245,177,230**	**$27,699,165,770**	**$968,029,000**

SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2024-25

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	DRUG MEDI-CAL				
42	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	$935,952,000	$711,671,000	$139,309,000	$84,972,000
45	DRUG MEDI-CAL STATE PLAN SERVICES	$10,251,000	$9,389,800	$861,200	$0
	DRUG MEDI-CAL SUBTOTAL	**$946,203,000**	**$721,060,800**	**$140,170,200**	**$84,972,000**
	MENTAL HEALTH				
47	SMHS FOR ADULTS	$2,171,065,000	$1,478,620,200	$102,496,800	$589,948,000
48	SMHS FOR CHILDREN	$1,960,124,000	$1,073,778,800	$39,413,200	$846,932,000
	MENTAL HEALTH SUBTOTAL	**$4,131,189,000**	**$2,552,399,000**	**$141,910,000**	**$1,436,880,000**
	MANAGED CARE				
64	TWO PLAN MODEL	$31,756,215,000	$18,955,952,400	$12,800,262,600	$0
65	COUNTY ORGANIZED HEALTH SYSTEMS	$11,706,227,000	$7,189,351,800	$4,516,875,200	$0
67	GEOGRAPHIC MANAGED CARE	$5,917,714,000	$3,706,542,150	$2,211,171,850	$0
70	REGIONAL MODEL	$1,963,772,000	$1,271,467,350	$692,304,650	$0
72	PACE (Other M/C)	$1,692,111,000	$846,605,300	$845,505,700	$0
76	DENTAL MANAGED CARE (Other M/C)	$185,791,000	$113,569,300	$72,221,700	$0
78	SENIOR CARE ACTION NETWORK (Other M/C)	$82,869,000	$41,163,000	$41,706,000	$0
80	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	$29,536,000	$17,267,000	$0	$12,269,000
82	AIDS HEALTHCARE CENTERS (Other M/C)	$11,055,000	$5,527,500	$5,527,500	$0
83	COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM	$9,617,000	$6,251,050	$3,365,950	$0
84	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	$5,418,000	$3,521,700	$1,896,300	$0
	MANAGED CARE SUBTOTAL	**$53,360,325,000**	**$32,157,218,550**	**$21,190,837,450**	**$12,269,000**
	OTHER				
153	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$4,748,528,000	$1,944,915,000	$2,803,613,000	$0
154	MEDICARE PAYMENTS - PART D PHASED-DOWN	$3,609,618,000	$0	$3,609,618,000	$0
155	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	$3,716,028,000	$3,716,028,000	$0	$0
156	PERSONAL CARE SERVICES (Misc. Svcs.)	$3,893,201,000	$3,893,201,000	$0	$0
157	DENTAL SERVICES	$2,078,914,000	$1,194,090,800	$884,823,200	$0
160	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$371,123,000	$371,123,000	$0	$0
177	LAWSUITS/CLAIMS	$1,350,000	$675,000	$675,000	$0
182	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$20,177,000	$20,177,000	$0	$0
187	MEDI-CAL TCM PROGRAM	$23,153,000	$23,153,000	$0	$0
200	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$387,000	$193,500	$193,500	$0

SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2024-25

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER				
217	BASE RECOVERIES	($717,516,000)	($414,319,480)	($303,196,520)	$0
	OTHER SUBTOTAL	**$17,744,963,000**	**$10,749,236,820**	**$6,995,726,180**	**$0**
	GRAND TOTAL	**$76,182,680,000**	**$46,179,915,170**	**$28,468,643,830**	**$1,534,121,000**

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
NOVEMBER 2023 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2023-24

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2023-24 APPROPRIATION		NOV. 2023 EST. FOR 2023-24		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		DRUG MEDI-CAL						
55	42	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	$803,313,000	$106,560,750	$908,759,000	$137,902,050	$105,446,000	$31,341,300
57	45	DRUG MEDI-CAL STATE PLAN SERVICES	$7,553,000	$575,700	$10,251,000	$861,200	$2,698,000	$285,500
		DRUG MEDI-CAL SUBTOTAL	**$810,866,000**	**$107,136,450**	**$919,010,000**	**$138,763,250**	**$108,144,000**	**$31,626,800**
		MENTAL HEALTH						
61	47	SMHS FOR ADULTS	$1,997,567,000	$99,800,900	$1,944,246,000	$102,181,800	($53,321,000)	$2,380,900
62	48	SMHS FOR CHILDREN	$1,682,451,000	$40,818,800	$1,669,525,000	$38,990,200	($12,926,000)	($1,828,600)
		MENTAL HEALTH SUBTOTAL	**$3,680,018,000**	**$140,619,700**	**$3,613,771,000**	**$141,172,000**	**($66,247,000)**	**$552,300**
		MANAGED CARE						
76	64	TWO PLAN MODEL	$24,851,640,000	$10,168,302,500	$31,539,443,000	$12,702,886,750	$6,687,803,000	$2,534,584,250
77	65	COUNTY ORGANIZED HEALTH SYSTEMS	$10,831,489,000	$3,665,579,100	$11,692,626,000	$4,510,942,300	$861,137,000	$845,363,200
78	67	GEOGRAPHIC MANAGED CARE	$4,765,952,000	$1,549,967,500	$5,880,945,000	$2,195,626,200	$1,114,993,000	$645,658,700
84	70	REGIONAL MODEL	$1,459,098,000	$441,340,200	$1,943,226,000	$687,467,200	$484,128,000	$246,127,000
85	72	PACE (Other M/C)	$1,481,941,000	$740,970,500	$1,439,529,000	$719,296,800	($42,412,000)	($21,673,700)
90	76	DENTAL MANAGED CARE (Other M/C)	$164,519,000	$55,427,750	$173,593,000	$67,893,250	$9,074,000	$12,465,500
94	78	SENIOR CARE ACTION NETWORK (Other M/C)	$76,592,000	$38,296,000	$77,569,000	$39,035,500	$977,000	$739,500
95	80	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	$31,312,000	$0	$31,080,000	$0	($232,000)	$0
97	82	AIDS HEALTHCARE CENTERS (Other M/C)	$8,608,000	$4,304,000	$10,474,000	$5,237,000	$1,866,000	$933,000
98	83	COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM	$8,432,000	$2,892,200	$9,617,000	$3,298,950	$1,185,000	$406,750
99	84	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	$4,639,000	$1,591,650	$5,170,000	$1,773,500	$531,000	$181,850
100	86	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	$1,706,000	$1,706,000	$387,000	$387,000	($1,319,000)	($1,319,000)
		MANAGED CARE SUBTOTAL	**$43,685,928,000**	**$16,670,377,400**	**$52,803,659,000**	**$20,933,844,450**	**$9,117,731,000**	**$4,263,467,050**

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
NOVEMBER 2023 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2023-24

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2023-24 APPROPRIATION		NOV. 2023 EST. FOR 2023-24		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER						
174	153	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$4,468,525,000	$2,619,432,500	$4,499,413,000	$2,652,562,000	$30,888,000	$33,129,500
177	154	MEDICARE PAYMENTS - PART D PHASED-DOWN	$3,247,438,000	$3,247,438,000	$3,234,728,000	$3,234,728,000	($12,710,000)	($12,710,000)
175	155	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	$3,193,155,000	$0	$3,423,496,000	$0	$230,341,000	$0
176	156	PERSONAL CARE SERVICES (Misc. Svcs.)	$3,035,505,000	$0	$3,616,465,000	$0	$580,960,000	$0
178	157	DENTAL SERVICES	$2,052,061,000	$815,341,650	$2,078,914,000	$884,823,200	$26,853,000	$69,481,550
185	160	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$358,602,000	$0	$375,100,000	$0	$16,498,000	$0
190	177	LAWSUITS/CLAIMS	$1,350,000	$675,000	$47,205,000	$23,602,500	$45,855,000	$22,927,500
204	182	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$30,028,000	$0	$19,954,000	$0	($10,074,000)	$0
211	187	MEDI-CAL TCM PROGRAM	$16,963,000	$0	$15,121,000	$0	($1,842,000)	$0
226	200	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$236,000	$118,000	$369,000	$184,500	$133,000	$66,500
240	217	BASE RECOVERIES	($605,933,000)	($255,126,000)	($734,833,000)	($310,514,130)	($128,900,000)	($55,388,130)
		OTHER SUBTOTAL	**$15,797,930,000**	**$6,427,879,150**	**$16,575,932,000**	**$6,485,386,070**	**$778,002,000**	**$57,506,920**
		GRAND TOTAL	**$63,974,742,000**	**$23,346,012,700**	**$73,912,372,000**	**$27,699,165,770**	**$9,937,630,000**	**$4,353,153,070**

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2023-24 AND 2024-25

NO.	POLICY CHANGE TITLE	NOV. 2023 EST. FOR 2023-24		NOV. 2023 EST. FOR 2024-25		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	DRUG MEDI-CAL						
42	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	$908,759,000	$137,902,050	$935,952,000	$139,309,000	$27,193,000	$1,406,950
45	DRUG MEDI-CAL STATE PLAN SERVICES	$10,251,000	$861,200	$10,251,000	$861,200	$0	$0
	DRUG MEDI-CAL SUBTOTAL	**$919,010,000**	**$138,763,250**	**$946,203,000**	**$140,170,200**	**$27,193,000**	**$1,406,950**
	MENTAL HEALTH						
47	SMHS FOR ADULTS	$1,944,246,000	$102,181,800	$2,171,065,000	$102,496,800	$226,819,000	$315,000
48	SMHS FOR CHILDREN	$1,669,525,000	$38,990,200	$1,960,124,000	$39,413,200	$290,599,000	$423,000
	MENTAL HEALTH SUBTOTAL	**$3,613,771,000**	**$141,172,000**	**$4,131,189,000**	**$141,910,000**	**$517,418,000**	**$738,000**
	MANAGED CARE						
64	TWO PLAN MODEL	$31,539,443,000	$12,702,886,750	$31,756,215,000	$12,800,262,600	$216,772,000	$97,375,850
65	COUNTY ORGANIZED HEALTH SYSTEMS	$11,692,626,000	$4,510,942,300	$11,706,227,000	$4,516,875,200	$13,601,000	$5,932,900
67	GEOGRAPHIC MANAGED CARE	$5,880,945,000	$2,195,626,200	$5,917,714,000	$2,211,171,850	$36,769,000	$15,545,650
70	REGIONAL MODEL	$1,943,226,000	$687,467,200	$1,963,772,000	$692,304,650	$20,546,000	$4,837,450
72	PACE (Other M/C)	$1,439,529,000	$719,296,800	$1,692,111,000	$845,505,700	$252,582,000	$126,208,900
76	DENTAL MANAGED CARE (Other M/C)	$173,593,000	$67,893,250	$185,791,000	$72,221,700	$12,198,000	$4,328,450
78	SENIOR CARE ACTION NETWORK (Other M/C)	$77,569,000	$39,035,500	$82,869,000	$41,706,000	$5,300,000	$2,670,500
80	MEDI-CAL ACCESS PROGRAM MOTHERS 213 -322% FPL	$31,080,000	$0	$29,536,000	$0	($1,544,000)	$0
82	AIDS HEALTHCARE CENTERS (Other M/C)	$10,474,000	$5,237,000	$11,055,000	$5,527,500	$581,000	$290,500
83	COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM	$9,617,000	$3,298,950	$9,617,000	$3,365,950	$0	$67,000
84	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	$5,170,000	$1,773,500	$5,418,000	$1,896,300	$248,000	$122,800
86	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	$387,000	$387,000	$0	$0	($387,000)	($387,000)
	MANAGED CARE SUBTOTAL	**$52,803,659,000**	**$20,933,844,450**	**$53,360,325,000**	**$21,190,837,450**	**$556,666,000**	**$256,993,000**

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2023-24 AND 2024-25

NO.	POLICY CHANGE TITLE	NOV. 2023 EST. FOR 2023-24		NOV. 2023 EST. FOR 2024-25		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER						
153	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$4,499,413,000	$2,652,562,000	$4,748,528,000	$2,803,613,000	$249,115,000	$151,051,000
154	MEDICARE PAYMENTS - PART D PHASED-DOWN	$3,234,728,000	$3,234,728,000	$3,609,618,000	$3,609,618,000	$374,890,000	$374,890,000
155	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	$3,423,496,000	$0	$3,716,028,000	$0	$292,532,000	$0
156	PERSONAL CARE SERVICES (Misc. Svcs.)	$3,616,465,000	$0	$3,893,201,000	$0	$276,736,000	$0
157	DENTAL SERVICES	$2,078,914,000	$884,823,200	$2,078,914,000	$884,823,200	$0	$0
160	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$375,100,000	$0	$371,123,000	$0	($3,977,000)	$0
177	LAWSUITS/CLAIMS	$47,205,000	$23,602,500	$1,350,000	$675,000	($45,855,000)	($22,927,500)
182	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$19,954,000	$0	$20,177,000	$0	$223,000	$0
187	MEDI-CAL TCM PROGRAM	$15,121,000	$0	$23,153,000	$0	$8,032,000	$0
200	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$369,000	$184,500	$387,000	$193,500	$18,000	$9,000
217	BASE RECOVERIES	($734,833,000)	($310,514,130)	($717,516,000)	($303,196,520)	$17,317,000	$7,317,610
	OTHER SUBTOTAL	**$16,575,932,000**	**$6,485,386,070**	**$17,744,963,000**	**$6,995,726,180**	**$1,169,031,000**	**$510,340,110**
	GRAND TOTAL	**$73,912,372,000**	**$27,699,165,770**	**$76,182,680,000**	**$28,468,643,830**	**$2,270,308,000**	**$769,478,060**

MEDI-CAL PROGRAM BASE
POLICY CHANGE INDEX

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

BASE POLICY CHANGE NUMBER: 42
IMPLEMENTATION DATE: 4/2017
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2012

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$908,759,000	$935,952,000
- STATE FUNDS	$193,536,050	$224,281,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$908,759,000	$935,952,000
STATE FUNDS	$193,536,050	$224,281,000
FEDERAL FUNDS	$715,222,950	$711,671,000

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
Families First Coronavirus Response Act (FFCRA)
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 beneficiaries modeled after the American Society of Addiction Medicine (ASAM) Criteria.

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:

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER
BASE POLICY CHANGE NUMBER: 42

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

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

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

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

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

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

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

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

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

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

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER
BASE POLICY CHANGE NUMBER: 42

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).

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
This change in FY 2023-24, from the prior estimate, is an increase due to the following:

- Addition of Mariposa County to the DMC-ODS waiver.
- Updated claims data reimbursements were higher compared to the previous projection, and as a result, the overall estimate increased.
- The amount of estimated unpaid claims for FY 2020-21, FY 2021-22, and FY 2022-23 increased based on actual claims data.
- Higher DMC-ODS services rates based on the new rate setting methodologies.
- Addition of the 100% GF for State-only claims adjustments for DMC-ODS, which was previously budgeted in the State-Only Claiming Adjustments – Prosp. Adj. policy change.

The change in the current estimate, from FY 2023-24 to FY 2024-25, is a net increase due to the following:

- FY 2023-24 includes more unpaid claims for prior years than FY 2024-25.
- Higher estimated rates for FY 2024-25 services.
- FY 2024-25 including a full years' cost for inter-governmental transfers (IGT) transfers.

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

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

    - Four counties implemented the waiver in FY 2016-17.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER
BASE POLICY CHANGE NUMBER: 42

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

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

4. A total of 20 counties have not opted-in to implement DMC-ODS waiver services.

Net DMC-ODS Waiver Costs

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

(Dollars in Thousands)

DMC-ODS Waiver Net Cost	FY 2023-24	FY 2024-25
Required Services	$140,004	$139,284
Optional Services	$14,405	$12,886
Existing Services	$780,574	$783,782
Total	$934,983	$935,952

6. The Title XIX and Title XXI COVID-19 increased FMAP is assumed for expenditures through December 31, 2023 for this policy change.

7. 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.

8. Effective July 1, 2023, 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. Previously, these costs were reflected in the State-Only Claiming Adjustments – Prosp. Adj. policy change.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER
BASE POLICY CHANGE NUMBER: 42

9. On a cash basis, the total for waiver services costs are estimated to be $908,759,000 TF and $935,952,000 TF in FY 2023-24 and FY 2024-25 respectively.

(Dollars in Thousands)

FY 2023-24	TF	GF	IGT*	FF	COVID-19 FF	CF
Regular						
Current	$319,278	$87,065	$47,067	$159,249	$4,204	$21,693
ACA Optional	$607,601	$50,638	$6,569	$546,841	$0	$3,553
Perinatal						
Current	$6,115	$0	$1,998	$3,057	$82	$978
ACA Optional	$1,989	$199	$0	$1,790	$0	$0
Total	$934,983	**$137,902**	**$55,634**	**$710,937**	**$4,286**	$26,224

(Dollars in Thousands)

FY 2024-25	TF	GF	IGT*	FF
Regular				
Current	$319,601	$88,263	$71,928	$159,410
ACA Optional	$608,216	$50,846	$9,975	$547,395
Perinatal				
Current	$6,138	$0	$3,069	$3,069
ACA Optional	$1,997	$200	$0	$1,797
Total	**$935,952**	**$139,309**	**$84,972**	**$711,671**

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)
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)

DRUG MEDI-CAL STATE PLAN SERVICES

BASE POLICY CHANGE NUMBER: 45
IMPLEMENTATION DATE: 7/2021
ANALYST: Louis Wollenberger
FISCAL REFERENCE NUMBER: 2320

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$10,251,000	$10,251,000
- STATE FUNDS	$861,200	$861,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$10,251,000	$10,251,000
STATE FUNDS	$861,200	$861,200
FEDERAL FUNDS	$9,389,800	$9,389,800

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

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

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

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

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

- Admission physical examinations,
- Intake,
- Medical necessity establishment,

DRUG MEDI-CAL STATE PLAN SERVICES
BASE POLICY CHANGE NUMBER: 45

- Medication services,
- Treatment and discharge planning,
- Crisis intervention,
- Collateral services, and
- Individual and group counseling.

Intensive Outpatient Treatment (IOT) services are provided to beneficiaries with substance use disorder diagnoses. These outpatient counseling and rehabilitation services are provided at least three hours per day, three days per week. Services include:

- Admission physical examinations,
- Intake,
- Medication services,
- Treatment planning,
- Crisis intervention,
- Collateral services,
- Individual and group counseling, and
- Parenting education.

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

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

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

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.

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.

DRUG MEDI-CAL STATE PLAN SERVICES
BASE POLICY CHANGE NUMBER: 45

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

Reason for Change:
The change in FY 2023-24 from the prior estimate is due to an increase in NTP users, mainly from the ACA category.

Methodology:
1. Expenditures are estimated using 36 months of cash-basis expenditure data (July 2020-June 2023) and trending the Users, Units/User, and Rate.

		FY 2023-24				FY 2024-25			
		Average Monthly				Average Monthly			
Modality	Type	Users	Units/ User	Rate	Total	Users	Units/ User	Rate	Total
NTP	All Others	348	54.6	$17.34	$3,948,900	348	54.6	$17.34	$3,948,900
	ACA Optional	550	51.7	$17.57	$5,991,100	550	51.7	$17.57	$5,991,100
	NTP Total				$9,940,000				$9,940,000
ODF	All Others	203	4.9	$75.82	$910,800	203	4.9	$75.82	$910,800
	ACA Optional	271	6.5	$69.51	$1,482,200	271	6.5	$69.51	$1,482,200
	ODF Total				$2,393,000				$2,393,000
IOT	All Others	22	7.3	$158.34	$299,800	22	7.3	$158.34	$299,800
	ACA Optional	8	5.1	$150.09	$77,400	8	5.1	$150.09	$77,400
	IOT Total				$377,200				$377,200
RTS	All Others	1	9.4	$120.93	$11,700	1	9.4	$120.93	$11,700
	ACA Optional	1	7.3	$108.87	$5,600	1	7.3	$108.87	$5,600
	RTS Total				$17,300				$17,300
Overall Total					**$12,727,500**				**$12,727,500**

2. Rates include Final Rate Year (RY) 2022-23 rate increases. RY 2023-24 rate increases are budgeted in the Drug Medi-Cal Annual Rate Adjustment PC.

DRUG MEDI-CAL STATE PLAN SERVICES
BASE POLICY CHANGE NUMBER: 45

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.

Funding:

Total estimated expenditures for DMC State Plan services are:

FY 2023-24	**TF**	**GF**	**FF**	**CF***
Title XIX 100%	$2,470,000	$0	$2,470,000	$2,470,000
50% Title XIX / 50% GF	$211,000	$105,500	$105,500	$0
ACA 90% FFP/10% GF	$7,557,000	$755,700	$6,801,300	$0
Title XXI 100%	$13,000	$0	$13,000	$7,000
Total	**$10,251,000**	**$861,200**	**$9,389,800**	$2,477,000

FY 2024-25	**TF**	**GF**	**FF**	**CF***
Title XIX 100%	$2,470,000	$0	$2,470,000	$2,470,000
50% Title XIX / 50% GF	$211,000	$105,500	$105,500	$0
ACA 90% FFP/10% GF	$7,557,000	$755,700	$6,801,300	$0
Title XXI 100%	$13,000	$0	$13,000	$7,000
Total	**$10,251,000**	**$861,200**	**$9,389,800**	$2,477,000

* County Funds are not included in Total Fund
Note: Totals may differ due to rounding

SMHS FOR ADULTS

BASE POLICY CHANGE NUMBER: 47
IMPLEMENTATION DATE: 7/2012
ANALYST: Elena Susbilla
FISCAL REFERENCE NUMBER: 1780

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$1,944,246,000	$2,171,065,000
- STATE FUNDS	$457,759,800	$692,444,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,944,246,000	$2,171,065,000
STATE FUNDS	$457,759,800	$692,444,800
FEDERAL FUNDS	$1,486,486,200	$1,478,620,200

Purpose:
This policy change estimates the base cost for specialty mental health services (SMHS) provided to adults (21 years of age and older).

Authority:
Welfare & Institutions Code 14680-14685.1
California Constitution Article XIII Section 36
Medi-Cal Specialty Mental Health Services Consolidation (CA-17) Program 1915(b4) Waiver
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
The Medi-Cal SMHS program is “carved-out” of the broader Medi-Cal program and is administered by the Department under the authority of a 1915(b) waiver approved by the Centers for Medicare and Medicaid Services (CMS). The Department contracts with a Mental Health Plan (MHP) in each county to provide or arrange for the provision of Medi-Cal SMHS. All MHPs are county mental health departments.

SMHS are Medi-Cal entitlement services for adults and children who meet criteria for specialty mental health treatment. MHPs must certify that they incurred a cost before seeking reimbursement through claims to the State. MHPs are responsible for most of the non-federal share of Medi-Cal SMHS. Mental health services for Medi-Cal members who do not meet the criteria for SMHS are provided under the Medi-Cal program through Medi-Cal managed care (MC) plans or the fee-for-service Medi-Cal (FFS/MC) program for members not enrolled in a MC plan.

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

SMHS FOR ADULTS
BASE POLICY CHANGE NUMBER: 47

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

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid. 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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

SMHS FOR ADULTS
BASE POLICY CHANGE NUMBER: 47

Reason for Change:

The change in FY 2023-24, from the prior estimate, is due to updating projections based on additional actual SD/MC and FFS Inpatient paid claims data and lower COVID-19 increased FMAP in FY 2023-24.

The change between FY 2023-24 and FY 2024-25, in the current estimate, is due to:

- Updating projections for FY 2023-24 and FY 2024-25,
- Updating the COVID-19 increased FMAP adjustment for the phase-out over Calendar Year 2023, and
- Updating IGT funding for payment of SD/MC SMHS claims for dates of service in FY 2024-25.

Methodology:

1. The costs and clients are developed using 70 months of SD/MC and 70 months FFS/MC approved claims data, excluding disallowed claims. The SD/MC data is current as of June 30, 2023, with dates of service from June 2017 through March 2023. The FFS Inpatient data is current as of June 30, 2023, with dates of service from April 2017 through January 2023.

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

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

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

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2021-22	$2,226,215	$1,907,716	$318,499
FY 2022-23	$2,242,412	$1,915,742	$326,670
FY 2023-24	$2,247,222	$1,920,001	$327,221
FY 2024-25	$2,256,030	$1,924,259	$331,771

SMHS FOR ADULTS
BASE POLICY CHANGE NUMBER: 47

5. On a cash basis for FY 2023-24, the Department will be paying 0.3% of FY 2021-22 claims, 38.3% of FY 2022-23 claims, and 61.4% of FY 2023-24 SD/MC claims. For FFS Inpatient claims, the Department will be paying 2.5% of FY 2021-22 claims, 33.5% of FY 2022-23 claims, and 64.0% of FY 2023-24 claims. The cash amounts (rounded) for Adult's SMHS are:

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2021-22	$14,096	$6,042	$8,054
FY 2022-23	$843,545	$734,184	$109,361
FY 2023-24	$1,387,505	$1,178,104	$209,401
Total FY 2023-24	$2,245,146	$1,918,330	$326,816

6. On a cash basis for FY 2024-25, the Department will be paying 0.3% of FY 2022-23 claims, 38.3% of FY 2023-24 claims, and 61.4% of FY 2024-25 claims for SD/MC claims. For FFS Inpatient claims, the Department will be paying 2.5% of FY 2022-23 claims, and 33.5% of FY 2023-24 claims, and 64.0% of FY 2024-25 claims. The cash amounts (rounded) are:

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2022-23	$14,327	$6,067	$8,260
FY 2023-24	$845,362	$735,816	$109,546
FY 2024-25	$1,393,030	$1,180,717	$212,313
Total FY 2024-25	$2,252,719	$1,922,600	$330,119

7. The FY 2023-24 and FY 2024-25 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.

SMHS FOR ADULTS
BASE POLICY CHANGE NUMBER: 47

8. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023 for this policy change.

9. On a cash basis, the estimated costs for FY 2023-24 and FY 2024-25 are as follows:

(Dollars in Thousands)

Fiscal Year	TF	FF	ACA FF	COVID-19 FF	GF	*IGT	GF Abatement from Fund 613-0865	CF
FY 2023-24	$2,245,146	**$670,489**	**$802,601**	**$13,397**	**$102,181**	**$355,578**	$77,317	$223,583
FY 2024-25	$2,252,719	**$672,213**	**$806,408**	**$0**	**$102,496**	**$589,948**	$79,760	$1,894

Funding:
100% GF (4260-101-0001)
100% Title XIX FFP (4260-101-0890)
90% Title XIX FF / 10% GF (4260-101-0001/0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)
Medi-Cal County Behavioral Health Fund* (4260-601-3420)

SMHS FOR CHILDREN

BASE POLICY CHANGE NUMBER: 48
IMPLEMENTATION DATE: 7/2012
ANALYST: Elena Susbilla
FISCAL REFERENCE NUMBER: 1779

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$1,669,525,000	$1,960,124,000
- STATE FUNDS	$583,100,200	$886,345,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,669,525,000	$1,960,124,000
STATE FUNDS	$583,100,200	$886,345,200
FEDERAL FUNDS	$1,086,424,800	$1,073,778,800

Purpose:
This policy change estimates the base cost for specialty mental health services (SMHS) provided to children (birth through 20 years of age).

Authority:
Welfare & Institutions Code 14680-14685.1
California Constitution Article XIII Section 36
Medi-Cal Specialty Mental Health Services Consolidation (CA-17) Program 1915(b4) Waiver
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
The Medi-Cal SMHS program is “carved-out” of the broader Medi-Cal program and is administered by the Department under the authority of a 1915(b) waiver approved by the Centers for Medicare and Medicaid Services (CMS). The Department contracts with a Mental Health Plan (MHP) in each county to provide or arrange for the provision of Medi-Cal SMHS. All MHPs are county mental health departments.

SMHS are Medi-Cal entitlement services for adults and children who meet criteria for specialty mental health services. MHPs must certify that they incurred a cost before seeking reimbursement through claims to the State. MHPs are responsible for most of the non-federal share of Medi-Cal SMHS. Mental health services for Medi-Cal members who do not meet the criteria for SMHS are provided under the broader Medi-Cal program either through Medi-Cal managed care (MC) plans or the fee-for-service Medi-Cal (FFS/MC) program for members not enrolled in a MC plan.

Children’s SMHS are provided under the federal requirements of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which is available to full-scope members under age 21. The EPSDT benefit is designed to meet the special physical, emotional, and

SMHS FOR CHILDREN
BASE POLICY CHANGE NUMBER: 48

developmental needs of low income children. This policy change budgets the costs associated with SMHS for children. A separate policy change budgets the costs associated with SMHS for adults.

The following Medi-Cal SMHS are available for children:

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

*Children - Age 18 through 20

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

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 increased FMAP is effective January 1, 2020, and extended its availability through the last day of the calendar quarter of the national public health emergency (PHE).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

SMHS FOR CHILDREN
BASE POLICY CHANGE NUMBER: 48

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to:
- Updating projections based on additional actual SD/MC and FFS Inpatient paid claims data,
- Lower COVID-19 increased FMAP in FY 2023-24.

The change between FY 2023-24 and FY 2024-25, in the current estimate, is due to:
- Updating projections based on additional actual SD/MC and FFS Inpatient paid claims data and utilization;
- Updating the COVID-19 increased FMAP for the phase-out over Calendar Year 2023; and
- Updating IGT funding for payment of SD/MC SMHS claims for dates of service in FY 2024-25.

Methodology:
1. The costs and clients are developed using 70 months of SD/MC and 70 months FFS/MC approved claims data, excluding disallowed claims. The SD/MC data is current as of June 30, 2023, with dates of service from June 2017 through March 2023. The FFS Inpatient data is current as of June 30, 2023, with dates of service from April 2017 through January 2023.

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

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

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

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2021-22	$2,006,105	$1,864,042	$142,063
FY 2022-23	$2,014,153	$1,866,030	$148,123
FY 2023-24	$2,020,772	$1,868,385	$152,387
FY 2024-25	$2,029,391	$1,873,741	$155,650

5. On a cash basis for FY 2023-24, the Department will be paying 0.2% of FY 2021-22 claims, 34.4% of FY 2022-23 claims, and 65.5% of FY 2023-24 SD/MC claims. For FFS Inpatient claims, the Department will be paying 0.9% of FY 2021-22 claims, 25.6% of FY 2022-23 claims, and 73.5% of FY 2023-24 claims. The cash amounts (rounded) for Children's SMHS are:

SMHS FOR CHILDREN
BASE POLICY CHANGE NUMBER: 48

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2021-22	$4,475	$3,245	$1,230
FY 2022-223	$679,384	$641,429	$37,955
FY 2023-24	$1,334,914	$1,222,895	$112,019
Total FY 2023-24	$2,018,773	$1,867,569	$151,204

6. On a cash basis for FY 2024-25, the Department will be paying 0.2% of FY 2022-23 claims, 34.4% of FY 2023-24 claims, and 65.5% of FY 2024-25 claims for SD/MC claims. For FFS Inpatient claims, the Department will be paying 0.9% of FY 2022-23 claims, and 25.6% of FY 2023-24 claims, and 73.5% of FY 2024-25. The cash amounts (rounded) for Children's SMHS are:

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2022-23	$4,531	$3,248	$1,283
FY 2023-24	$681,285	$642,238	$39,047
FY 2024-25	$1,340,819	$1,226,400	$114,419
Total FY 2024-25	$2,026,635	$1,871,886	$154,749

7. The FY 2023-24 and FY 2024-25 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. The Title XIX and Title XXI COVID-19 increased FMAP is assumed for expenditures through December 31, 2023 for this policy change.

9. On a cash basis, the estimated costs for FY 2023-24 and FY 2024-25 are as follows:

SMHS FOR CHILDREN
BASE POLICY CHANGE NUMBER: 48

(Dollars in Thousands)

Fiscal Year	TF	GF	FF	MCHIP	ACA FF	*IGT	COVID-19 FF	GF Abatement from Fund 613-0865	County
FY 2023-24	$2,018,773	**$38,990**	**$800,572**	**$206,176**	**$61,445**	**$544,110**	**$18,232**	$62,112	$287,136
FY 2024-25	$2,026,635	**$39,413**	**$801,966**	**$207,029**	**$64,784**	**$846,932**	**$0**	$65,035	$1,476

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)
COVID-19 Title XIX Increased FFP (4260-101-0890)
COVID-19 Title XXI Increased FFP (4260-101-0890)
Medi-Cal County Behavioral Health Fund* (4260-601-3420)

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER: 64
IMPLEMENTATION DATE: 7/2000
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 56

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$31,539,443,000	$31,756,215,000
- STATE FUNDS	$12,702,886,750	$12,800,262,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$31,539,443,000	$31,756,215,000
STATE FUNDS	$12,702,886,750	$12,800,262,600
FEDERAL FUNDS	$18,836,556,250	$18,955,952,400

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

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

Interdependent Policy Changes:
Capitated Rate Adjustment for FY 2024-25
COVID-19 Increased FMAP - DHCS

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

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due to:

- The prior estimate assumed that enrollment would continue at the levels close to those observed in January 2023 (the most recent actual month at that time), with the incremental impact of further changes in enrollment due to COVID-19 accounted for in the COVID-19 Caseload Impact and COVID-19 Caseload Impact Base Adjustment policy changes. This estimate assumes that enrollment continue at levels close to those observed in July 2023 (the most recent actual month). The July 2023 caseload level is significantly higher than the January 2023 caseload level, leading to increased costs in this policy change. The incremental impact of redeterminations on managed care costs are accounted for separately in the COVID-19 Redeterminations Impact policy change.
- Updated CY 2023 rates, including separate rates for Unsatisfactory Immigration Status (UIS) and Satisfactory Immigration Status (SIS) populations, were used for this estimate.

TWO PLAN MODEL
BASE POLICY CHANGE NUMBER: 64

Estimating expenditures using these separate rates means that adjustments to shift federal spending to state spending for UIS populations previously budgeted in other policy changes are now reflected in this policy change. This leads to higher General Fund costs in this policy change compared to the prior estimate.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to an increase in eligibles.

Methodology:

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

2. On an accrual basis, the last six months of the CY 2023 rates and the first six months of the CY 2024 rates have been budgeted for FY 2023-24.

3. FY 2023-24 weighted rates have been updated from the previous estimate.

4. The difference from the FY 2023-24 weighted rates to the CY 2024 rates and the estimated adjustment anticipated for the CY 2025 rates, to occur in FY 2024-25 is captured in the Capitated Rate Adjustment for FY 2024-25 policy change as a percentage assumption applied to seven months of the CY 2024 rates and five months of the CY 2025 rates on a cash basis.

5. The eligibles in this PC are reflective of actuals through July 2023, inclusive of COVID-19 caseload impacts. The COVID-19 Redeterminations Impact PC adjusts these base projections to account for incremental impacts resuming eligibility redeterminations on the Medi-Cal caseload and managed care enrollment.

6. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of $282,000,000 for FY 2023-24 and $282,000,000 for FY 2024-25 were included in the rates.

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

8. The County Children's Health Insurance Program (CCHIP) transitioned to Medi-Cal Managed Care for Santa Clara and San Francisco counties on October 1, 2019. The costs associated with CCHIP are not currently reflected in this PC.

9. As of January 1, 2022, a regional rate model was implemented for certain managed care counties. Managed care plan rates in impacted counties reflect a weighted average blend of the county-specific rates. The following groupings of counties are consolidated into single rating regions:

    a. Fresno, Kings, and Madera
    b. Riverside and San Bernardino
    c. San Joaquin and Stanislaus

TWO PLAN MODEL
BASE POLICY CHANGE NUMBER: 64

10. As of January 1, 2022, the costs associated with HCBS High supplemental payments originally in CCI counties are reflected in this PC.

11. As of January 1, 2022, Rapid Whole Genome Sequencing was included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

12. As of January 1, 2022, Annual Cognitive Assessments (SB 48) was included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

13. As of January 1, 2022, Community Health Worker was included as a covered managed care benefit. The costs associated with these services are reflected in the rates as of January 1, 2023.

14. As of January 1. 2022, Dyadic Services were included as a covered managed care benefit. The costs associated with these services are reflected in the rates as of January 1, 2023.

15. As of January 1, 2022, Major Organ Transplant was included as a covered managed care benefit. The costs associated with these service are reflected in the rates as of January 1, 2023.

16. As of July 1, 2022, certain programs formerly funded by Proposition 56 are now funded by the General Fund through the managed care base capitation rates. These program are as follows:
    - Proposition 56 Intermediate Care Facilities for the Developmentally Disabled,
    - Proposition 56 Freestanding Pediatric Subacute Facilities,
    - Proposition 56 Community-Based Adult Services,
    - Proposition 56 Adverse Childhood Experiences Screening, and
    - Proposition 56 Developmental Screenings.

    These payments are no longer designated as Proposition 56 programs.

17. As of July 1, 2022, Routine Costs for Clinical Trials was included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

18. As of July 1, 2022, Cancer Biomarker Testing was included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

19. As of January 1, 2023, Doula Services are included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

20. As of January 1, 2023, Behavioral Health Treatment services transitioned from a supplemental rate payment approach to the base capitation rates. The remaining CY 2022 supplemental rate expenditures will continue to be budgeted in the Behavioral Health Treatment policy change.

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

TWO PLAN MODEL
BASE POLICY CHANGE NUMBER: 64

22. 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.

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

(Dollars in Thousands)

FY 2023-24	Member Months	Total
Alameda	5,397,650	$1,823,149
Contra Costa	3,694,891	$1,223,452
Fresno	6,170,299	$1,402,808
Kern	5,630,848	$1,372,817
Kings	786,055	$169,255
Los Angeles	47,242,675	$13,400,294
Madera	951,215	$187,825
Riverside	11,612,018	$3,013,292
San Bernardino	11,434,179	$3,031,550
San Francisco	2,715,698	$1,140,973
San Joaquin	3,745,756	$976,436
Santa Clara	5,119,832	$1,498,770
Stanislaus	3,025,229	$854,739
Tulare	3,266,057	$623,236
Total	110,792,401	$30,718,598
Maternity and ACA Maternity	*106,298	$823,775
Total with Maternity		$31,542,372

*Events

(Dollars in Thousands)

Included in the Above Dollars	FY 2023-24
Mental Health	$282,000

TWO PLAN MODEL
BASE POLICY CHANGE NUMBER: 64

(Dollars in Thousands)

FY 2024-25	Member Months	Total
Alameda	5,420,054	$1,835,200
Contra Costa	3,703,426	$1,227,925
Fresno	6,177,681	$1,405,771
Kern	5,637,684	$1,375,940
Kings	786,797	$169,504
Los Angeles	47,337,649	$13,445,400
Madera	951,643	$187,981
Riverside	11,625,641	$3,017,494
San Bernardino	11,442,625	$3,035,427
San Francisco	2,727,028	$1,146,099
San Joaquin	3,753,020	$979,561
Santa Clara	5,124,075	$1,500,680
Stanislaus	3,028,655	$856,287
Tulare	3,268,632	$623,928
Total	110,984,611	$30,807,197
Maternity and ACA Maternity	*111,612	$864,963
Total with Maternity		$31,672,160

*Events

(Dollars in Thousands)

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

TWO PLAN MODEL
BASE POLICY CHANGE NUMBER: 64

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

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$17,461,873	$8,730,937	$8,730,937
65% Title XXI / 35% GF (4260-101-0001/0890)	$1,569,623	$549,368	$1,020,255
ACA 90% FFP/10% GF (2020 and later)	$10,002,553	$1,000,255	$9,002,298
100% State GF (4260-101-0001)	$2,416,166	$2,416,166	$0
Title XIX 100% FFP	$27,619	$0	$27,619
90% Family Planning FFP / 10% GF (4260-101-0001/0890)	$61,609	$6,161	$55,448
Total	**$31,539,443**	**$12,702,887**	**$18,836,556**

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$17,617,711	$8,808,856	$8,808,856
65% Title XXI / 35% GF (4260-101-0001/0890)	$1,574,896	$551,214	$1,023,682
ACA 90% FFP/10% GF (2020 and later)	$10,042,376	$1,004,238	$9,038,138
100% State GF (4260-101-0001)	$2,429,795	$2,429,795	$0
Title XIX 100% FFP	$29,828	$0	$29,828
90% Family Planning FFP / 10% GF (4260-101-0001/0890)	$61,609	$6,161	$55,448
Total	**$31,756,215**	**$12,800,263**	**$18,955,952**

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 65
IMPLEMENTATION DATE: 12/1987
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 57

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$11,692,626,000	$11,706,227,000
- STATE FUNDS	$4,510,942,300	$4,516,875,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$11,692,626,000	$11,706,227,000
STATE FUNDS	$4,510,942,300	$4,516,875,200
FEDERAL FUNDS	$7,181,683,700	$7,189,351,800

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

Authority:
Welfare & Institutions Code 14087.3

Interdependent Policy Changes:
Capitated Rate Adjustment for FY 2024-25
COVID-19 Increased FMAP – DHCS

Background:
A COHS is a local agency created by a county board of supervisors to contract with the Medi-Cal program. There are 22 counties in the COHS Model: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, Santa Barbara, Santa Cruz, San Mateo, Shasta, Siskiyou, Solano, Sonoma, Trinity, Ventura, and Yolo.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due to:

- The prior estimate assumed that enrollment would continue at the levels close to those observed in January 2023 (the most recent actual month at that time), with the incremental impact of further changes in enrollment due to COVID-19 accounted for in the COVID-19 Caseload Impact and COVID-19 Caseload Impact Base Adjustment policy changes. This estimate assumes that enrollment continue at levels close to those observed in July 2023 (the most recent actual month). The July 2023 caseload level is significantly higher than the January 2023 caseload level, leading to increased costs in this policy change. The incremental impact of redeterminations on managed care costs are accounted for separately in the COVID-19 Redeterminations Impact policy change.
- Updated CY 2023 rates, including separate rates for Unsatisfactory Immigration Status (UIS) and Satisfactory Immigration Status (SIS) populations, were used for this estimate. Estimating expenditures using these separate rates means that adjustments to shift federal spending to state spending for UIS populations previously budgeted in other

COUNTY ORGANIZED HEALTH SYSTEMS
BASE POLICY CHANGE NUMBER: 65

policy changes are now reflected in this policy change. This leads to higher General Fund costs in this policy change compared to the prior estimate.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to an increase in eligibles.

Methodology:

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

2. On an accrual basis, the last six months of the CY 2023 rates and the first six months of the CY 2024 rates have been budgeted for FY 2023-24.

3. FY 2023-24 weighted rates have been updated from the previous estimate.

4. The difference from the FY 2023-24 weighted rates to the CY 2024 rates and the estimated rate adjustment anticipated for the CY 2025 rates to occur in FY 2024-25 is captured in the Capitated Rate Adjustment for FY 2024-25 policy change as a percentage assumption applied to seven months of the CY 2024 rates and five months of the CY 2025 rates on a cash basis.

5. Currently, all COHS plans have assumed risk for long term care services.

6. The eligibles in this PC are reflective of actuals through July 2023, inclusive of COVID-19 caseload impacts. The COVID-19 Redeterminations Impact PC adjusts these base projections to account for incremental impacts resuming eligibility redeterminations on the Medi-Cal caseload and managed care enrollment.

7. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of $157,600,000 for FY 2023-24 and $157,600,000 for FY 2024-25 were included in the rates.

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

9. The County Children's Health Insurance Program (CCHIP) transitioned to Medi-Cal Managed Care for San Mateo County on October 1, 2019. The costs associated with CCHIP are not currently reflected in this PC.

10. As of January 1, 2022, a regional rate model was implemented for certain managed care counties. Managed care plan (MCP) rates in impacted counties reflect a weighted average blend of the county-specific rates or are inclusive of the costs within a multi-county region. The following groupings of counties are consolidated into single rating regions:

    a. Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo
    b. Merced, Monterey, and Santa Cruz
    c. San Luis Obispo and Santa Barbara

COUNTY ORGANIZED HEALTH SYSTEMS
BASE POLICY CHANGE NUMBER: 65

11. As of January 1, 2022, the costs associated with HCBS High supplemental payments originally in CCI counties are reflected in this PC.

12. As of January 1, 2022, Rapid Whole Genome Sequencing was included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

13. As of January 1, 2022, Annual Cognitive Assessments (SB 48) was included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

14. As of January 1, 2022, Community Health Worker was included as a covered managed care benefit. The costs associated with these services are reflected in the rates as of January 1, 2023.

15. As of January 1, 2022, Dyadic Services were included as a covered managed care benefit. The costs associated with these services are reflected in the rates as of January 1, 2023.

16. As of January 1, 2022, Major Organ Transplant was included as a covered managed care benefit. The costs associated with these services are reflected in the rates as of January 1, 2023.

17. As of July 1, 2022, certain programs formerly funded by Proposition 56 are now funded by the General Fund through the managed care base capitation rates. These program are as follows:
    - Proposition 56 Intermediate Care Facilities for the Developmentally Disabled,
    - Proposition 56 Freestanding Pediatric Subacute Facilities,
    - Proposition 56 Community-Based Adult Services,
    - Proposition 56 Adverse Childhood Experiences Screening, and
    - Proposition 56 Developmental Screenings.

    These payments are no longer designated as Proposition 56 programs.

18. As of July 1, 2022, Routine Costs for Clinical Trials was included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

19. As of July 1, 2022, Cancer Biomarker Testing was included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

20. As of January 1, 2023, Doula services are included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

21. As of January 1, 2023, Behavioral Health Treatment services transitioned from a supplemental rate payment approach to the base capitation rates. The remaining CY 2022 supplemental rate expenditures will continue to be budgeted in the Behavioral Health Treatment policy change.

22. Effective July 1, 2023, the Specialty Mental Health Services (SMHS) benefits previously within the scope of certain MCPs, was carved out from their responsibilities and are now provided through the SMHS delivery system.

COUNTY ORGANIZED HEALTH SYSTEMS
BASE POLICY CHANGE NUMBER: 65

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

24. 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.

25. COHS dollars on an accrual basis are shown below, which excludes both WCM dollars and eligibles:

(Dollars in Thousands)

FY 2023-24	Member Months	Total
San Luis Obispo	837,446	$253,758
Santa Barbara	1,978,297	$599,779
San Mateo	1,801,818	$714,564
Solano	1,699,267	$664,484
Santa Cruz	977,772	$329,936
Orange	11,580,544	$3,452,037
Napa	432,916	$162,921
Monterey	2,301,007	$653,847
Yolo	768,203	$300,705
Marin	633,715	$247,294
Lake	430,743	$162,947
Mendocino	510,505	$182,291
Sonoma	1,620,091	$567,009
Merced	1,844,403	$517,550
Ventura	3,057,542	$1,006,244
Humboldt	750,074	$279,616
Lassen	110,854	$40,261
Modoc	51,221	$19,762
Shasta	882,041	$329,356
Siskiyou	238,215	$92,162
Trinity	70,517	$27,117
Del Norte	156,039	$61,187
Total FY 2023-24	32,733,231	$10,664,828
Maternity and ACA Maternity	*30,661	$277,375
Total with Maternity		**$10,942,203**

*Events

COUNTY ORGANIZED HEALTH SYSTEMS
BASE POLICY CHANGE NUMBER: 65

(Dollars in Thousands)

Included in Above Dollars	FY 2023-24
Mental Health	$157,600

(Dollars in Thousands)

FY 2024-25	Member Months	Total
San Luis Obispo	838,663	$254,610
Santa Barbara	1,981,968	$602,594
San Mateo	1,801,786	$714,580
Solano	1,702,293	$666,890
Santa Cruz	980,165	$331,372
Orange	11,596,214	$3,461,270
Napa	434,151	$163,897
Monterey	2,304,286	$656,026
Yolo	769,390	$301,651
Marin	634,526	$247,943
Lake	431,218	$163,245
Mendocino	511,727	$183,053
Sonoma	1,622,181	$568,356
Merced	1,846,179	$518,506
Ventura	3,060,228	$1,008,189
Humboldt	751,428	$280,475
Lassen	110,892	$40,302
Modoc	51,203	$19,761
Shasta	882,818	$329,928
Siskiyou	238,552	$92,388
Trinity	70,502	$27,114
Del Norte	156,058	$61,192
Total FY 2024-25	32,776,427	$10,693,341
Maternity and ACA Maternity	32,194	$291,244
Total with Maternity		**$10,984,585**

*Events

COUNTY ORGANIZED HEALTH SYSTEMS
BASE POLICY CHANGE NUMBER: 65

(Dollars in Thousands)

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

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

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$6,173,071	$3,086,536	$3,086,536
65% Title XXI / 35% GF (4260-101-0001/0890)	$690,100	$241,535	$448,565
ACA 90% FFP/10% GF (2020 and later)	$3,906,388	$390,639	$3,515,749
100% State GF (4260-101-0001)	$790,093	$790,093	$0
Title XIX 100% FFP	$111,574	$0	$111,574
90% Family Planning FFP / 10% GF (4260-101-0001/0890)	$21,400	$2,140	$19,260
Total	**$11,692,626**	**$4,510,942**	**$7,181,684**

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$6,188,477	$3,094,239	$3,094,239
65% Title XXI / 35% GF (4260-101-0001/0890)	$692,402	$242,341	$450,061
ACA 90% FFP/10% GF (2020 and later)	$3,894,770	$389,477	$3,505,293
100% State GF (4260-101-0001)	$788,679	$788,679	$0
Title XIX 100% FFP	$120,499	$0	$120,499
90% Family Planning FFP / 10% GF (4260-101-0001/0890)	$21,400	$2,140	$19,260
Total	**$11,706,227**	**$4,516,875**	**$7,189,352**

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 67
IMPLEMENTATION DATE: 4/1994
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 58

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$5,880,945,000	$5,917,714,000
- STATE FUNDS	$2,195,626,200	$2,211,171,850
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$5,880,945,000	$5,917,714,000
STATE FUNDS	$2,195,626,200	$2,211,171,850
FEDERAL FUNDS	$3,685,318,800	$3,706,542,150

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

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

Interdependent Policy Changes:
Capitated Rate Adjustment for FY 2024-25
COVID-19 Increased FMAP – DHCS

Background:
There are two counties in the GMC model: Sacramento and San Diego. In both counties, the Department contracts with several commercial plans providing more choices for the beneficiaries.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due to:

- The prior estimate assumed that enrollment would continue at the levels close to those observed in January 2023 (the most recent actual month at that time), with the incremental impact of further changes in enrollment due to COVID-19 accounted for in the COVID-19 Caseload Impact and COVID-19 Caseload Impact Base Adjustment policy changes. This estimate assumes that enrollment continue at levels close to those observed in July 2023 (the most recent actual month). The July 2023 caseload level is significantly higher than the January 2023 caseload level, leading to increased costs in this policy change. The incremental impact of redeterminations on managed care costs are accounted for separately in the COVID-19 Redeterminations Impact policy change.
- Updated CY 2023 rates, including separate rates for Unsatisfactory Immigration Status (UIS) and Satisfactory Immigration Status (SIS) populations, were used for this estimate. Estimating expenditures using these separate rates means that adjustments to shift

GEOGRAPHIC MANAGED CARE
BASE POLICY CHANGE NUMBER: 67

federal spending to state spending for UIS populations previously budgeted in other policy changes are now reflected in this policy change. This leads to higher General Fund costs in this policy change compared to the prior estimate.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to an increase in eligibles.

Methodology:

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

2. On an accrual basis, the last six months of the CY 2023 rates and the first six months of the CY 2024 rates have been budgeted for FY 2023-24.

3. FY 2023-24 weighted rates have been updated from the previous estimate.

4. The difference from the FY 2023-24 weighted rates to the CY 2024 rates and the estimated adjustment anticipated for the CY 2025 rates, to occur in FY 2024-25 is captured in the Capitated Rate Adjustment for FY 2024-25 policy change as a percentage assumption applied to seven months of the CY 2024 rates and five months of the CY 2025 rates on a cash on a cash basis.

5. The eligibles in this PC are reflective of actuals through July 2023, inclusive of COVID-19 caseload impacts. The COVID-19 Redeterminations Impact PC adjusts these base projections to account for incremental impacts resuming eligibility redeterminations on the Medi-Cal caseload and managed care enrollment.

6. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of $62,800,000 for FY 2023-24 and $62,800,000 for FY 2024-25 were included in the rates.

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

8. As of January 1, 2022, the costs associated with HCBS High supplemental payments originally in CCI counties are reflected in this PC.

9. As of January 1, 2022, Rapid Whole Genome Sequencing was included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

10. As of January 1, 2022, Annual Cognitive Assessments (SB 48) was included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

11. As of January 1, 2022, Community Health Worker was included as a covered managed care benefit. The costs associated with these services are reflected in the rates as of January 1, 2023.

GEOGRAPHIC MANAGED CARE
BASE POLICY CHANGE NUMBER: 67

12. As of January 1, 2022, Dyadic Services were included as a covered managed care benefit. The costs associated with these services are reflected in the rates as of January 1, 2023.

13. As of January 1, 2022, Major Organ Transplant was included as a covered managed care benefit. The costs associated with these services are reflected in the rates as of January 1, 2023.

14. As of July 1, 2022, certain programs formerly funded by Proposition 56 are now funded by the General Fund through the managed care base capitation rates. These programs are as follows:
    - Proposition 56 Intermediate Care Facilities for the Developmentally Disabled,
    - Proposition 56 Freestanding Pediatric Subacute Facilities,
    - Proposition 56 Community-Based Adult Services,
    - Proposition 56 Adverse Childhood Experiences Screening, and
    - Proposition 56 Developmental Screenings.

    These payments are no longer designated as Proposition 56 programs.

15. As of July 1, 2022, Routine Costs for Clinical Trials was included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

16. As of July 1, 2022, Cancer Biomarker Testing was included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

17. As of January 1, 2023, Doula services are included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

18. As of January 1, 2023, Behavioral Health Treatment services transitioned from a supplemental rate payment approach to the base capitation rates. The remaining CY 2022 supplemental rate expenditures will continue to be budgeted in the Behavioral Health Treatment policy change.

19. Effective July 1, 2023, the Specialty Mental Health Services (SMHS) benefit currently within the scope of certain managed care plans will be carved out from their responsibility and be provided through the SMHS delivery system.

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

21. 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.

GEOGRAPHIC MANAGED CARE
BASE POLICY CHANGE NUMBER: 67

22. GMC dollars on an accrual basis are:

(Dollars in Thousands)

FY 2023-24	Member Months	Total
Sacramento	7,347,168	$2,065,360
San Diego	11,876,554	$3,656,947
Total	19,223,722	$5,722,307
Maternity and ACA Maternity	*19,016	$159,009
Total with Maternity		**$5,881,317**

*Events

(Dollars in Thousands)

Included in Dollars Above	FY 2023-24
Mental Health	$62,800

(Dollars in Thousands)

FY 2024-25	Member Months	Total
Sacramento	7,360,562	$2,070,248
San Diego	11,890,868	$3,664,303
Total	19,251,429	$5,734,552
Maternity and ACA Maternity	*19,967	$166,960
Total with Maternity		**$5,901,511**

*Events

(Dollars in Thousands)

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

GEOGRAPHIC MANAGED CARE
BASE POLICY CHANGE NUMBER: 67

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

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$3,324,778	$1,662,389	$1,662,389
65% Title XXI / 35% GF (4260-101-0001/0890)	$283,680	$99,288	$184,392
ACA 90% FFP/10% GF (2020 and later)	$2,025,434	$202,543	$1,822,891
100% State GF (4260-101-0001)	$230,258	$230,258	$0
Title XIX 100% FFP	$5,317	$0	$5,317
90% Family Planning FFP / 10% GF (4260-101-0001/0890)	$11,478	$1,148	$10,330
Total	**$5,880,945**	**$2,195,626**	**$3,685,319**

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$3,351,246	$1,675,623	$1,675,623
65% Title XXI / 35% GF (4260-101-0001/0890)	$284,541	$99,589	$184,952
ACA 90% FFP/10% GF (2020 and later)	$2,033,216	$203,322	$1,829,894
100% State GF (4260-101-0001)	$231,490	$231,490	$0
Title XIX 100% FFP	$5,742	$0	$5,742
90% Family Planning FFP / 10% GF (4260-101-0001/0890)	$11,479	$1,148	$10,331
Total	**$5,917,714**	**$2,211,172**	**$3,706,542**

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

REGIONAL MODEL

BASE POLICY CHANGE NUMBER: 70
IMPLEMENTATION DATE: 11/2013
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1842

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$1,943,226,000	$1,963,772,000
- STATE FUNDS	$687,467,200	$692,304,650
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,943,226,000	$1,963,772,000
STATE FUNDS	$687,467,200	$692,304,650
FEDERAL FUNDS	$1,255,758,800	$1,271,467,350

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

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

Interdependent Policy Changes:
Capitated Rate Adjustment for FY 2024-25
COVID-19 Increased FMAP – DHCS

Background:
Managed care was previously in 30 counties. AB 1467 expanded managed care into the remaining 28 counties across the state. Expanding managed care into rural counties ensures that beneficiaries throughout the state receive health care through an organized delivery system that coordinates their care and leads to better health outcomes and lower costs.

There are 20 counties in the regional model: Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Imperial, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, San Benito, Sierra, Sutter, Tehama, Tuolumne, and Yuba.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due to:

- The prior estimate assumed that enrollment would continue at the levels close to those observed in January 2023 (the most recent actual month at that time), with the incremental impact of further changes in enrollment due to COVID-19 accounted for in the COVID-19 Caseload Impact and COVID-19 Caseload Impact Base Adjustment policy changes. This estimate assumes that enrollment continue at levels close to those observed in July 2023 (the most recent actual month). The July 2023 caseload level is significantly higher than the January 2023 caseload level, leading to increased costs in this policy change. The incremental impact of redeterminations on managed care costs are accounted for separately in the COVID-19 Redeterminations Impact policy change.

REGIONAL MODEL
BASE POLICY CHANGE NUMBER: 70

- Updated CY 2023 rates, including separate rates for Unsatisfactory Immigration Status (UIS) and Satisfactory Immigration Status (SIS) populations, were used for this estimate. Estimating expenditures using these separate rates means that adjustments to shift federal spending to state spending for UIS populations previously budgeted in other policy changes are now reflected in this policy change. This leads to higher General Fund costs in this policy change compared to the prior estimate.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to a slight increase in eligibles.

Methodology:

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

2. On an accrual basis, the last six months of the CY 2023 rates and the first six months of the CY 2024 rates have been budgeted for FY 2023-24.

3. FY 2023-24 weighted rates have been updated from the previous estimate.

4. The difference from the FY 2023-24 weighted rates to the CY 2024 rates and the estimated adjustment anticipated for the CY 2025 rates, to occur in FY 2024-25 is captured in the Capitated Rate Adjustment for FY 2024-25 policy change as a percentage assumption applied to seven months of the CY 2024 rates and five months of the CY 2025 rates on a cash basis.

5. The eligibles in this PC are reflective of actuals through July 2023, inclusive of COVID-19 caseload impacts. The COVID-19 Redeterminations Impact PC adjusts these base projections to account for incremental impacts resuming eligibility redeterminations on the Medi-Cal caseload and managed care enrollment.

6. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of $29,800,000 for FY 2023-24 and $29,800,000 for FY 2024-25 were included in the rates.

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

8. As of January 1, 2022, a regional rate model continued to be implemented for certain managed care counties. Managed care plan rates in impacted counties are inclusive of the costs within the multi-county region. The following counties are consolidated into a single rating region:

    a. Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba.

9. As of January 1, 2022, Rapid Whole Genome Sequencing was included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

REGIONAL MODEL
BASE POLICY CHANGE NUMBER: 70

10. As of January 1, 2022, Annual Cognitive Assessments (SB 48) was included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

11. As of January 1, 2022, Community Health Worker was included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

12. As of January 1, 2022, Dyadic Services were included as a covered managed care benefit. The costs associated with these services are reflected in the rates as of January 1, 2023.

13. As of January 1, 2022, Major Organ Transplant was included as a covered managed care benefit. The costs associated with these services are reflected in the rates as of January 1, 2023.

14. As of July 1, 2022, certain programs formerly funded by Proposition 56 are now funded by the General Fund through the managed care base capitation rates. These program are as follows:
    - Proposition 56 Intermediate Care Facilities for the Developmentally Disabled,
    - Proposition 56 Freestanding Pediatric Subacute Facilities,
    - Proposition 56 Community-Based Adult Services,
    - Proposition 56 Adverse Childhood Experiences Screening, and
    - Proposition 56 Developmental Screenings.

    These payments are no longer designated as Proposition 56 programs.

15. As of July 1, 2022, Routine Costs for Clinical Trials was included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

16. As of July 1, 2022, Cancer Biomarker Testing was included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

17. As of January 1, 2023, Doula services are included as a covered managed care benefit. The costs associated with these services are reflected in the rates.

18. As of January 1, 2023, Behavioral Health Treatment services transitioned from a supplemental rate payment approach to the base capitation rates. The remaining CY 2022 supplemental rate expenditures will continue to be budgeted in the Behavioral Health Treatment policy change.

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

20. 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.

REGIONAL MODEL
BASE POLICY CHANGE NUMBER: 70

21. Regional Model dollars on an accrual basis are:

(Dollars in Thousands)

FY 2023-24	Member Months	Total
Alpine	3,290	$865
Amador	110,881	$32,342
Butte	1,003,075	$319,788
Calaveras	163,453	$47,000
Colusa	130,107	$33,017
El Dorado	493,703	$146,338
Glenn	164,222	$44,145
Imperial	1,253,536	$259,441
Inyo	69,377	$21,589
Mariposa	71,453	$19,645
Mono	39,999	$9,245
Nevada	336,330	$103,925
Placer	901,853	$262,487
Plumas	77,103	$24,248
San Benito	160,215	$34,757
Sierra	8,877	$3,437
Sutter	526,226	$140,534
Tehama	361,373	$97,707
Tuolumne	185,291	$60,920
Yuba	435,732	$113,230
Total	6,496,096	$1,774,660
Maternity and ACA Maternity	6,575	$71,668
Total with Maternity		**$1,846,328**

*Events

(Dollars in Thousands)

Included in Dollars Above	FY 2023-24
Mental Health	$29,800

REGIONAL MODEL
BASE POLICY CHANGE NUMBER: 70

(Dollars in Thousands)

FY 2024-25	Member Months	Total
Alpine	3,295	$865
Amador	110,881	$32,341
Butte	1,004,067	$320,162
Calaveras	163,601	$47,074
Colusa	130,068	$33,007
El Dorado	494,136	$146,539
Glenn	164,384	$44,201
Imperial	1,258,770	$261,523
Inyo	69,386	$21,585
Mariposa	71,440	$19,643
Mono	40,010	$9,246
Nevada	336,418	$103,959
Placer	903,994	$263,311
Plumas	77,103	$24,246
San Benito	160,358	$34,839
Sierra	8,874	$3,436
Sutter	527,000	$140,832
Tehama	361,502	$97,746
Tuolumne	185,419	$60,976
Yuba	435,689	$113,219
Total	6,506,395	$1,778,748
Maternity and ACA Maternity	*6,904	$75,251
Total with Maternity		**$1,853,999**

*Events

(Dollars in Thousands)

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

REGIONAL MODEL
BASE POLICY CHANGE NUMBER: 70

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

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$1,116,493	$558,247	$558,247
65% Title XXI / 35% GF (4260-101-0001/0890)	$78,698	$27,544	$51,154
ACA 90% FFP/10% GF (2020 and later)	$604,993	$60,499	$544,494
100% State GF (4260-101-0001)	$40,821	$40,821	$0
Title XIX 100% FFP	$98,660	$0	$98,660
90% Family Planning FFP / 10% GF (4260-101-0001/0890)	$3,561	$356	$3,205
Total	**$1,943,226**	**$687,467**	**$1,255,759**

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$1,124,642	$562,321	$562,321
65% Title XXI / 35% GF (4260-101-0001/0890)	$79,095	$27,683	$51,412
ACA 90% FFP/10% GF (2020 and later)	$608,863	$60,886	$547,977
100% State GF (4260-101-0001)	$41,058	$41,058	$0
Title XIX 100% FFP	$106,553	$0	$106,553
90% Family Planning FFP / 10% GF (4260-101-0001/0890)	$3,561	$356	$3,205
Total	**$1,963,772**	**$692,305**	**$1,271,467**

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 72
IMPLEMENTATION DATE: 7/1992
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 62

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$1,439,529,000	$1,692,111,000
- STATE FUNDS	$719,296,800	$845,505,700
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,439,529,000	$1,692,111,000
STATE FUNDS	$719,296,800	$845,505,700
FEDERAL FUNDS	$720,232,200	$846,605,300

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:
COVID-19 Increase FMAP – DHCS

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

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

PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 72

Below is a list of PACE organizations:

New PACE Organizations	County	Operational
ConcertoHealth Los Angeles PACE	Los Angeles	July 1, 2023
ConcertoCare PACE	Kern	July 1, 2024
	Tulare	July 1, 2024
Loma Linda University Health	Riverside	January 1, 2024
	San Bernardino	January 1, 2024
WelbeHealth Bay Area	Santa Clara	January 1, 2024
	Alameda	January 1, 2024
AgeWell PACE	Sonoma	July 1, 2023
	Marin	July 1, 2023
Asian Heritage Healthcare	Los Angeles	January 1, 2024
Valley PACE	Fresno	January 1, 2024
	Madera	January 1, 2024
MyPlace Health	Los Angeles	January 1, 2024
Seen Health PACE	Los Angeles	July 1, 2024
Family Health care Network	Kings	July 1, 2024
	Tulare	July 1, 2024
High Desert PACE	San Bernardino	July 1, 2024
	Los Angeles	July 1, 2024
WelbeHealth Inland Empire	Riverside	July 1, 2024
	San Bernardino	July 1, 2024
Roze Room PACE	Los Angeles	July 1, 2024
Innovage-Downey	Los Angeles	July 1, 2024
Chinatown Services Center	Los Angeles	January 1, 2025
WelbeHealth Sierra PACE	Sacramento	January 1, 2025
Innercare	Imperial	January 1, 2025
MyPlace Health South LA PACE	Los Angeles	January 1, 2025
WelbeHealth San Bernardino PACE	Riverside	July 1, 2025
	San Bernardino	July 1, 2025
K-Day PACE	Los Angeles	July 1, 2024
Prime One Care	Los Angeles	January 1, 2025

Reason for Change:
The change from the prior estimate, for FY 2023-24, is a decrease due to lower estimated members. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a net increase due to a projected increase in enrollment and higher rates.

Methodology:
1. Assume the calendar year (CY) 2023, CY 2024, and CY 2025 rates will be calculated using plan specific experienced-based data to build actuarially sound prospective rates.

PACE (Other M/C)
BASE POLICY CHANGE NUMBER: 72

2. FY 2023-24 and FY 2024-25 estimated funding is based on CY 2023 rates and projected CY 2024 and CY 2025 rates.

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

4. Health care plans that began January 2023 or later are not in the total fund (TF) or general fund (GF) due to costs being recognized in other fee-for-service Medi-Cal plans or managed care plans. The new health care plans estimated costs are $25,705,000 TF in FY 2023-24 and $115,374,000 TF in FY 2024-25.

FY 2023-24	TF Cost (Rounded)	Eligible Months	Avg. Mo. Enrollment
Centers for Elders' Independence (Alameda & Contra Costa)	$88,673,000	13,469	1,122
Sutter Senior Care	$32,800,000	5,204	434
AltaMed Senior Care (Los Angeles & Orange)	$308,268,000	56,624	4,719
OnLok (San Francisco, Alameda & Santa Clara)	$170,359,000	21,623	1,802
St. Paul's PACE	$81,268,000	17,955	1,496
Los Angeles Jewish Homes	$22,658,000	3,938	328
CalOptima PACE	$33,278,000	5,229	436
InnovAge (San Bernardino & Riverside)	$79,211,000	15,248	1,271
Redwood Coast (Humboldt)	$17,461,000	2,974	248
Innovative Integrated Health (Fresno, Kern, Tulare & Orange)	$112,174,000	21,961	1,830
San Ysidro San Diego	$184,130,000	32,672	2,723
Stockton PACE (San Joaquin & Stanislaus)	$65,145,000	10,105	842
Gary & Mary West (San Diego)	$25,072,000	4,340	362
Family Health Centers of San Diego	$24,836,000	4,108	342
Central Valley (San Joaquin & Stanislaus)	$21,875,000	3,130	261
LA Coast (Los Angeles)	$36,934,000	5,398	450
Pacific PACE (Los Angeles)	$42,587,000	5,992	499
Sequoia (Fresno)	$56,290,000	9,325	777
InnovAge (Sacramento, Placer, El Dorado, Sutter, San Joaquin & Yuba)	$11,065,000	1,760	147
North East Medical Services (San Francisco)	$14,156,000	1,602	134
Neighborhood Health (Riverside & San Bernardino)	$11,289,000	2,142	179
Total FY 2023-24	**$1,439,529,000**	**244,799**	**20,402**

*Totals may differ due to rounding.

PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 72

FY 2024-25	TF Cost (Rounded)	Eligible Months	Avg. Mo. Enrollment
Centers for Elders' Independence (Alameda & Contra Costa)	$99,356,000	14,292	1,191
Sutter Senior Care	$34,024,000	5,112	426
AltaMed Senior Care (Los Angeles & Orange)	$362,225,000	62,508	5,209
OnLok (San Francisco, Alameda & Santa Clara)	$183,229,000	22,080	1,840
St. Paul's PACE	$94,690,000	19,764	1,647
Los Angeles Jewish Homes	$25,716,000	4,140	345
CalOptima PACE	$35,918,000	5,316	443
InnovAge (San Bernardino & Riverside)	$88,168,000	15,888	1,324
Redwood Coast (Humboldt)	$18,321,000	2,964	247
Innovative Integrated Health (Fresno, Kern, Tulare & Orange)	$132,097,000	24,384	2,032
San Ysidro San Diego	$218,791,000	37,056	3,088
Stockton PACE (San Joaquin & Stanislaus)	$84,772,000	12,588	1,049
Gary & Mary West (San Diego)	$30,419,000	5,052	421
Family Health Centers of San Diego	$32,705,000	5,136	428
Central Valley (San Joaquin & Stanislaus)	$27,630,000	3,756	313
LA Coast (Los Angeles)	$47,022,000	6,528	544
Pacific PACE (Los Angeles)	$53,923,000	7,152	596
Sequoia (Fresno)	$75,886,000	12,036	1,003
InnovAge (Sacramento, Placer, El Dorado, Sutter, San Joaquin & Yuba)	$12,528,000	1,884	157
North East Medical Services (San Francisco)	$19,613,000	2,100	350
Neighborhood Health (Riverside & San Bernardino)	$15,078,000	2,736	249
Total FY 2024-25	**$1,692,111,000**	**272,472**	**22,902**

*Totals may differ due to rounding.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2023-24	**$1,439,529**	**$719,297**	**$720,232**
FY 2024-25	**$1,692,111**	**$845,506**	**$846,605**

*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)
COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER: 76
IMPLEMENTATION DATE: 7/2004
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1029

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$173,593,000	$185,791,000
- STATE FUNDS	$67,893,250	$72,221,700
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$173,593,000	$185,791,000
STATE FUNDS	$67,893,250	$72,221,700
FEDERAL FUNDS	$105,699,750	$113,569,300

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

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

Interdependent Policy Changes:
COVID-19 Increased FMAP – DHCS

Background:
The DMC program provides a comprehensive approach to dental health care, combining clinical services and administrative procedures that are organized to provide timely access to primary care and other necessary services in a cost effective manner. The Department contracts with three Geographic Managed Care (GMC) plans and three Prepaid Health Plans (PHP). These plans provide dental services to Medi-Cal beneficiaries in Sacramento and Los Angeles counties.

DENTAL MANAGED CARE (Other M/C)
BASE POLICY CHANGE NUMBER: 76

Each dental plan receives a monthly per capita rate for every recipient enrolled in their plan. DMC program recipients enrolled in contracting plans are entitled to receive dental benefits from dentists within the plan's provider network.

AB 82 restored partial adult optional dental benefits, including full mouth dentures. Effective May 1, 2014, the scope of covered adult dental services offered at any dental service-rendering location that serves Medi-Cal beneficiaries, including Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), is limited to the adult optional benefits restored May 1, 2014, in addition to the adult dental benefits which include services for pregnant women, emergency services, Federally Required Adult Dental Services (FRADs), services provided at an Intermediate Care Facility/Skilled Nursing Facility, and services for Department of Developmental Services consumers. Effective January 1, 2018, the full restoration of adult dental benefits includes the remaining services which were not restored in 2014, such as restorative services (crowns), prosthodontic services (partial dentures), and endodontic services (root canals). The impact of the restoration of adult dental benefits is included in the capitation rates.

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

The CalAIM Dental Benefits and Pay-For-Performance initiatives (CalAIM Dental) began January 1, 2022. Components for these initiatives involve performance payments for preventive services rendered to adults and children, and statewide coverage for new benefits Caries Risk Assessment Bundle and Silver Diamine Fluoride.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due to updated rates and eligibles counts. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to updated rates and withhold releases for CY 2023.

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

2. Any portion of the rate attributable to Proposition 56 Supplemental Payments is captured in their respective policy changes.

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

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

DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER: 76

FY 2023-24	Total Member Months	Average Monthly Eligibles	Total Costs
Adult - GMC	3,975,798	331,317	$52,492,543
Child - GMC	3,031,854	252,655	$58,688,714
Adult - PHP	3,866,363	322,197	$43,325,613
Child - PHP	1,557,969	129,831	$25,498,161

FY 2024-25	Total Member Months	Average Monthly Eligibles	Total Costs
Adult - GMC	4,528,860	377,405	$52,492,543
Child - GMC	2,865,948	238,829	$58,688,714
Adult - PHP	4,039,680	336,640	$43,325,613
Child - PHP	1,533,840	127,820	$25,498,161

Funding:

FY 2023-24	TF	GF	FF
Regular FMAP T19	$96,510,000	$48,255,000	$48,255,000
ACA 90% FFP/10% GF (2020)	$55,969,000	$5,597,000	$50,372,000
Title 21 65% FFP/35% GF	$10,881,000	$3,808,000	$7,073,000
UIS 100% State GF	$10,233,000	$10,233,000	$0
Total	**$173,593,000**	**$67,893,000**	**$105,700,000**

FY 2024-25	TF	GF	FF
Regular FMAP T19	$103,696,000	$51,848,000	$51,848,000
ACA 90% FFP/10% GF (2020)	$60,135,000	$6,013,000	$54,122,000
Title 21 65% FFP/35% GF	$11,692,000	$4,092,000	$7,600,000
UIS 100% State GF	$10,268,000	$10,268,000	$0
Total	**$185,791,000**	**$72,221,000**	**$113,570,000**

*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)
COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

SENIOR CARE ACTION NETWORK (Other M/C)

BASE POLICY CHANGE NUMBER: 78
IMPLEMENTATION DATE: 2/1985
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 61

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$77,569,000	$82,869,000
- STATE FUNDS	$39,035,500	$41,706,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$77,569,000	$82,869,000
STATE FUNDS	$39,035,500	$41,706,000
FEDERAL FUNDS	$38,533,500	$41,163,000

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

Authority:
Welfare & Institutions Code 14200

Interdependent Policy Changes:
COVID-19 Increased FMAP – DHCS

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 2023-24, is an increase due to updated enrollment and rate growth estimates for Calendar Year (CY) 2024.The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to revised growth estimates for CY 2024 and CY 2025.

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

2. Assume an average monthly enrollment of 15,625 in FY 2023-24 and 16,094 in FY 2024-25.

SENIOR CARE ACTION NETWORK (Other M/C)
BASE POLICY CHANGE NUMBER: 78

3. The CY 2023 rates are estimated final rates.

4. CY 2024 and CY 2025 rates were projected by trending forward the CY 2023 estimated final rates.

5. Assume seven months of CY 2023 rating period payments and five months of CY 2024 rating period payments are paid in FY 2023-24.

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

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

(Dollars in Thousands)

FY 2023-24	Costs	Eligible Months	Avg. Monthly Enrollment
Los Angeles	$47,814	115,802	9,650
Riverside	$13,407	31,007	2,584
San Bernardino	$8,756	22,465	1,872
San Diego	$7,592	18,225	3,645
Total FY 2023-24	$77,569	187,499	15,625

(Dollars in Thousands)

FY 2024-25	Costs	Eligible Months	Avg. Monthly Enrollment
Los Angeles	$51,057	119,276	9,940
Riverside	$14,321	31,937	2,661
San Bernardino	$9,379	23,139	1,928
San Diego	$8,112	18,772	1,564
Total FY 2024-25	$82,869	193,124	16,094

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
50% Title XIX FF / 50% GF	$77,067	$38,534	$38,534
100% GF Title XIX	$502	$502	$0
Total FY 2023-24	**$77,569**	**$39,036**	**$38,534**

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
50% Title XIX FF / 50% GF	$82,326	$41,163	$41,163
100% GF Title XIX	$543	$543	$0
Total FY 2024-25	**$82,869**	**$41,706**	**$41,163**

SENIOR CARE ACTION NETWORK (Other M/C)

BASE POLICY CHANGE NUMBER: 78

Funding:
50% Title XIX / 50% GF (4260-101-0890/0001)
100% GF Title XIX (4620-101-0001)
COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL

BASE POLICY CHANGE NUMBER: 80
IMPLEMENTATION DATE: 7/2014
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 1837

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$31,080,000	$29,536,000
- STATE FUNDS	$12,707,000	$12,269,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$31,080,000	$29,536,000
STATE FUNDS	$12,707,000	$12,269,000
FEDERAL FUNDS	$18,373,000	$17,267,000

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

Authority:
AB 99 (Chapter 278, Statutes of 1991)
SB 800 (Chapter 448, Statutes of 2013)
SPA 17-043
SPA 17-044
SPA 18-0028
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

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

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

MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL
BASE POLICY CHANGE NUMBER: 80

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is slight decrease due to a reduction in anticipated delivery costs. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to lower caseload projections for FY 2024-25.

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

Program Forecast	FY 2023-24	FY 2024-25
Average Monthly Caseload	3,926	3,420
Average Expected Deliveries	227	174
Per Member Per Month (PMPM)	$254.12	$254.12

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 Title XXI COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change and is shown as a separate line item. The total estimated costs for MCAP mothers in FY 2023-24 and FY 2024-25 are:

MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL

BASE POLICY CHANGE NUMBER: 80

(Dollars in Thousands)

FY 2023-24	TF	SF	FF
65% Title XXI FFP / 35% Perinatal Insurance Fund	$27,965	$9,788	$18,177
100% Perinatal Insurance Fund	$3,114	$3,114	$0
COVID-19 Tile XXI Increased FMAP	$0	($196)	$196
Total	**$31,080**	**$12,706**	**$18,373**

FY 2024-25	TF	SF	FF
65% Title XXI FFP / 35% Perinatal Insurance Fund	$26,566	$9,298	$17,268
100% Perinatal Insurance Fund	$2,971	$2,971	$0
Total	**$29,536**	**$12,269**	**$17,268**

*Totals differ due to rounding.

Funding:
Perinatal Insurance Fund (4260-602-0309)
Title XXI FFP (4260-101-0890)
COVID-19 Title XXI Increased FFP (4260-101-0890)
COVID-19 Title XXI Increased FFP Perinatal Insurance Fund (4260-602-0309)

AIDS HEALTHCARE CENTERS (Other M/C)

BASE POLICY CHANGE NUMBER: 82
IMPLEMENTATION DATE: 5/1985
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 63

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$10,474,000	$11,055,000
- STATE FUNDS	$5,237,000	$5,527,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$10,474,000	$11,055,000
STATE FUNDS	$5,237,000	$5,527,500
FEDERAL FUNDS	$5,237,000	$5,527,500

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

Authority:
Welfare & Institutions Code 14088.85

Interdependent Policy Changes:
COVID-19 Increased FMAP – DHCS

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

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

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due to revised CY 2023 and CY 2024 enrollment and rate growth assumptions. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to rate growth assumptions for CY 2024 and CY 2025.

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

AIDS HEALTHCARE CENTERS (Other M/C)

BASE POLICY CHANGE NUMBER: 82

Member Months	Dual	Medi-Cal Only
CY 2023	3,741	5,840
CY 2024	3,507	5,924
CY 2025	3,458	5,927

2. Assume the following paid rates:

Paid Rates	Dual	Medi-Cal Only
CY 2023	$175.75	$1,637.30
CY 2024	$184.54	$1,719.17
CY 2025	$193.76	$1,805.12

An annual five percent growth factor is assumed to calculate CY 2024 and CY 2025 draft rates.

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

FY 2023-24	Paid Rate	MM	TF
Dual	$179.41	3,643	$653,000
Medi-Cal Only	$1,671.41	5,875	$9,821,000
Total	N/A	N/A	$10,474,000

FY 2024-25	Paid Rate	MM	TF
Dual	$188.38	3,486	$657,000
Medi-Cal Only	$1,754.98	5,925	$10,398,000
Total	N/A	N/A	$11,055,000

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

FY 2023-24	**TF**	**GF**	**FF**
Positive Healthcare	$10,474,000	$5,237,000	$5,237,000
Total FY 2023-24	**$10,474,000**	**$5,237,000**	**$5,237,000**

FY 2024-25	**TF**	**GF**	**FF**
Positive Healthcare	$11,055,000	$5,527,000	$5,528,000
Total FY 2024-25	**$11,055,000**	**$5,527,000**	**$5,528,000**

Funding:
50% Title XIX FF / 50% GF (4260-101-0001/0890)
COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM

BASE POLICY CHANGE NUMBER: 83
IMPLEMENTATION DATE: 7/2014
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 1823

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$9,617,000	$9,617,000
- STATE FUNDS	$3,298,950	$3,365,950
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$9,617,000	$9,617,000
STATE FUNDS	$3,298,950	$3,365,950
FEDERAL FUNDS	$6,318,050	$6,251,050

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 17-043
SPA 17-044
SB 184 (Chapter 47, Statutes of 2022)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
AB 495 created the CHIM fund, which funds the CCHIP, to provide health insurance coverage to low-income children under the age of 19.

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

COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM
BASE POLICY CHANGE NUMBER: 83

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 eligibles are still reflected in this policy change. Effective July 1, 2022, premium contribution amounts were reduced to $0.00.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 4.34 percentage points for certain expenditures in CCHIP. 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).

The Consolidated Appropriations Act of 2023 was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due to an increase in the estimated population and expenditures. There is no change in total funds from FY 2023-24 to FY 2024-25 in the current estimate. However, there is an increase in GF expenditures from FY 2023-24 to FY 2024-25, in the current estimate, due to the FFCRA increased FMAP funding phasing out for this policy change through December 2023.

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. Assume a multi-year reconciliation was completed in FY 2019-20.

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

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

COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM
BASE POLICY CHANGE NUMBER: 83

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

6. The Title XXI COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

7. Assume there will be approximately 7,701 CCHIP members in FY 2023-24 and FY 2024-25.

FY 2023-24	**TF**	**GF**	**FF**
Benefits Title XXI 65 FF/35 GF	$9,617,000	$3,366,000	$6,251,000
COVID-19 Tile XXI Increased FMAP	$0	($67,000)	$67,000
Total FY 2023-24	**$9,617,000**	**$3,299,000**	**$6,318,000**
FY 2024-25	**TF**	**GF**	**FF**
Benefits Title XXI 65 FF/35 GF	$9,617,000	$3,366,000	$6,251,000
Total FY 2024-25	**$9,617,000**	**$3,366,000**	**$6,251,000**

*Totals may differ due to rounding.

Funding:
65% Title XXI FF / 35% GF (4260-101-0890/0001)
COVID-19 Title XXI Increased FFP (4260-101-0890)
COVID-19 Title XXI GF (4260-101-0001)

MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL

BASE POLICY CHANGE NUMBER: 84
IMPLEMENTATION DATE: 11/2013
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 1797

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$5,170,000	$5,418,000
- STATE FUNDS	$1,773,500	$1,896,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$5,170,000	$5,418,000
STATE FUNDS	$1,773,500	$1,896,300
FEDERAL FUNDS	$3,396,500	$3,521,700

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 17-043
SPA 17-044
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

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.

MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL
BASE POLICY CHANGE NUMBER: 84

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is an increase due to higher projected per member, per month (PMPM) costs for both fee-for-service and Medi-Cal Managed Care.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to a projected growth in Medi-Cal Managed Care enrollment.

Methodology:
1. The Department estimates the average monthly FFS enrollment will be 202 in FY 2023-24 and 206 in FY 2024-25, and the average monthly Medi-Cal Managed Care enrollment will be 2,131 in FY 2023-24 and 2,138 in FY 2024-25.

2. The Department estimates the weighted average PMPM cost will be $747.00 in FY 2023-24 and $730.99 in FY 2024-25 for FFS infants, and $140.93 in FY 2023-24 and $140.76 in FY 2024-25 for Medi-Cal Managed Care infants.

3. The Title XXI COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change and is shown as a separate line item.

4. The total estimated costs for MCAIP infants in FY 2023-24 and FY 2024-25 are:

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
Benefits	$5,170	$1,810	$3,360
COVID-19 Tile XXI Increased FMAP	$0	($36)	$36
Net Total	**$5,170**	**$1,774**	**$3,396**

MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL

BASE POLICY CHANGE NUMBER: 84

FY 2024-25	TF	GF	FF
Benefits	$5,418	$1,896	$3,522
Net Total	**$5,418**	**$1,896**	**$3,522**

*Totals may differ due to rounding.

Funding:
65% Title XXI FFP/35% GF (4260-101-0890/0001)
COVID-19 Title XXI Increased FFP (4260-101-0890)
COVID-19 Title XXI GF (4260-101-0001)

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

BASE POLICY CHANGE NUMBER: 86
IMPLEMENTATION DATE: 7/2023
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 66

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$387,000	$0
- STATE FUNDS	$387,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$387,000	$0
STATE FUNDS	$387,000	$0
FEDERAL FUNDS	$0	$0

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

Authority:
Welfare & Institutions Code 14087.3

Interdependent Policy Changes:
Not Applicable

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

Family Mosaic has historically served a small population. Due to the small size of the population, actuarially sound capitation rates are unable to be developed pursuant to actuarial standards. In order to obtain federal funding, capitation rates must be actuarially sound and approved by the Centers for Medicare & Medicaid Services (CMS).

It was determined Family Mosaic Project capitation rates for calendar year (CY) 2014 to current were not compliant with actuarial standards, therefore, federal funding was unable to be claimed for this program retroactive back to CY 2014. The Department historically claimed federal funding for all capitation payments issued for this program, therefore, State General Fund was used to return the previously claimed federal funding back to CY 2014. It is the Department's intention to implement a system fix to ensure going forward capitation rates will be funded solely by State General Fund.

The Department will continue to calculate annual capitation rates for this program; however, annually developed rates will be unable to be actuarially certified and will not be submitted to CMS for review and approval. Due to the current contract expiration date of December 31, 2023, the last payment for this policy change is scheduled to be made in January 2024.

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

BASE POLICY CHANGE NUMBER: 86

Reason for Change:
The change from the prior estimate for FY 2023-24, and the change from FY 2023-24 to FY 2024-25 in the current estimate, is a decrease due to the contract expiration date of December 31, 2023. The last remaining payments, which includes retroactive payments, is anticipated to be made in January 2024.

Methodology:
1) The Family Mosaic member months are assumed to be the following:

- 111 in FY 2022-23
- 111 in FY 2023-24

2) The Family Mosaic capitation rate is assumed to be:

- $4,248.04 in CY 2023

3) Anticipated costs on a cash basis are:

Fiscal Year	TF	GF	FF
FY 2023-24	$387,000	$387,000	$0

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

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

BASE POLICY CHANGE NUMBER: 153
IMPLEMENTATION DATE: 7/1988
ANALYST: Genaro Rodriguez
FISCAL REFERENCE NUMBER: 76

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$4,499,413,000	$4,748,528,000
- STATE FUNDS	$2,652,562,000	$2,803,613,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$4,499,413,000	$4,748,528,000
STATE FUNDS	$2,652,562,000	$2,803,613,000
FEDERAL FUNDS	$1,846,851,000	$1,944,915,000

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:
COVID-19 Caseload Impact
COVID-19 Increased FMAP – DHCS

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 2023-24 were revised up 0.69% from the prior estimate:

- Based on six additional months of actual expenditures which include the effects of the Families First Coronavirus Response Act (FFCRA) continuous coverage requirement. Ongoing changes related to the FFCRA continuous coverage requirement are included in the COVID-19 Caseload Impact policy change.
- Partly offset by lower estimates for the 2024 premiums of $21.00 for Part A and $0.50 for Part B.

Expenditures are projected to grow 5.54% between FY 2023-24 and FY 2024-25 due to an estimated increase in the Part A premium of $27.00 and Part B premium of $10.20 between 2024 and 2025. Ongoing changes related to the FFCRA continuous coverage requirement are included in the COVID-19 Caseload Impact policy change.

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

BASE POLICY CHANGE NUMBER: 153

Premiums:

Calendar Year	2023	2024		2025
	Actual	May 2023 Estimate	Nov 2023 Estimate	Nov 2023 Estimate
Part A	$506.00	$530.00	$509.00	$536.00
Part B	$164.90	$175.30	$174.80	$185.00

Average Monthly Members:

FY	2022-23	2023-24		2024-25
	Actual	May 2023 Estimate	Nov 2023 Estimate	Nov 2023 Estimate
Part A	160,352	158,830	160,366	158,557
Part B	1,638,057	1,664,110	1,693,427	1,709,336

Methodology:

1. The Centers for Medicare and Medicaid set the following premiums for 2023.

Calendar Year	Part A	Part B
2023	$506.00	$164.90

2. For 2024 and 2025, the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance is projecting 0.6% and 5.3% respective growth in the Medicare Part A premium. Applying this growth to the prior year Part A premium calculates as $506.00 x 1.006 = $509.00, and $509.00 x 1.053 = $536.00 (rounded).

3. For 2024, and 2025 the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance is projecting 6.0% and 5.84% respective growth in the Medicare Part B premium. Applying this growth to the prior year Part B premium calculates as $164.90 x 1.06 = $174.80, and $174.80 x 1.0584 = $185.00. (rounded).

FY 2023-24	Part A	Part B
Average Monthly Members	160,366	1,693,427
Rate 07/2023-12/2023	$506.00	$164.90
Rate 01/2024-06/2024	$509.00	$174.80

FY 2024-25	Part A	Part B
Average Monthly Members	158,557	1,709,336
Rate 07/2024-12/2024	$509.00	$174.80
Rate 01/2025-06/2025	$536.00	$185.00

MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS
BASE POLICY CHANGE NUMBER: 153

4. The Families First Coronavirus Response Act (FFCRA) requires the department suspend eligibility redeterminations during the COVID-19 public health emergency (PHE) to receive a temporary increase in the federal medical assistance percentage (FMAP). The Consolidated Appropriations Act of 2023, passed on December 29, 2022, decouples the end of the FFCRA continuous coverage requirement from the end of the PHE; instead ending the continuous coverage requirement on March 31, 2023. The resumption of eligibility redeterminations began April 2023 for members due for renewal June 2023; those no longer determined eligible will be disenrolled effective July 2023. Ongoing eligibility redeterminations related to this population are expected to be completed in approximately twelve months. Projections are brought up to the last month of actuals and held at that level. Ongoing changes related to the FFCRA continuous coverage requirement are included in the COVID-19 Caseload Impact policy change.

   The Consolidated Appropriations Act of 2023 also established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023. Expenditures from the increased FMAP are budgeted in the COVID-19 Increased FMAP – DHCS policy change.

Funding:

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
Title XIX 50/50	$3,662,160	$1,831,080	$1,831,080
State GF 100%	$821,482	$821,482	$0
Title XIX 100% FFP	$15,771	$0	$15,771
Total	**$4,499,413**	**$2,652,562**	**$1,846,851**

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
Title XIX 50/50	$3,856,214	$1,928,107	$1,928,107
State GF 100%	$875,506	$875,506	$0
Title XIX 100% FFP	$16,808	$0	$16,808
Total	**$4,748,528**	**$2,803,613**	**$1,944,915**

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

MEDICARE PAYMENTS - PART D PHASED-DOWN

BASE POLICY CHANGE NUMBER: 154
IMPLEMENTATION DATE: 1/2006
ANALYST: Kathleen Dong
FISCAL REFERENCE NUMBER: 1019

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$3,234,728,000	$3,609,618,000
- STATE FUNDS	$3,234,728,000	$3,609,618,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,234,728,000	$3,609,618,000
STATE FUNDS	$3,234,728,000	$3,609,618,000
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates Medi-Cal's Medicare Part D expenditures.

Authority:
The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003

Interdependent Policy Changes:
COVID-19 Caseload Impact
COVID-19 Increased FMAP – DHCS

Background:
Medicare's Part D benefit began January 1, 2006. Part D provides a prescription drug benefit to all dual eligible beneficiaries and other Medicare eligible beneficiaries that enroll in Part D. Dual eligible beneficiaries had previously received drug benefits through Medi-Cal.

To help pay for this benefit, the federal government requires the states to contribute part of their savings for no longer providing the drug benefit to dual eligible beneficiaries. This is called the Phased-down Contribution or "clawback". In 2006, states were required to contribute 90% of their savings. This percentage decreased by 1 ⅔% each year until it reached 75% in 2015. The MMA of 2003 sets forth a formula to determine a state's "savings." The formula uses 2003 as a base year for states' dual eligible population drug expenditures and increases the average dual eligible drug costs by a growth factor to reach an average monthly phased-down contribution cost per dual eligible or the per member per month (PMPM) rate.

MEDICARE PAYMENTS - PART D PHASED-DOWN

BASE POLICY CHANGE NUMBER: 154

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

Calendar Year	PMPM rate
2020	$133.94
2021	$137.76
2022	$147.83
2023	$155.08
2024	$167.50 (estimated)
2025	$178.00 (estimated)

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

Fiscal Year	Total Payment	Ave. Monthly Beneficiaries
FY 2020-21	$2,009,620,969	1,479,629
FY 2021-22	$2,350,153,376	1,584,095
FY 2022-23	$2,622,797,792	1,656,292

Reason for Change:

Expenditures for FY 2023-24 were revised down by 0.39%% from the prior estimate:

- Caseload projections continue at the higher level with the historical growth trend, absent the FFCRA continuous coverage requirement. The ongoing changes related to the FFCRA continuous coverage requirement are included in the COVID-19 Caseload Impact – DHCS policy change.
- Projections lower with three months of reduced PMPM rate, resulting from the FFCRA increased FMAP in actuals. The projected reduction in payments from FFCRA that are not already reflected in expenditures are budgeted in the COVID-19 Increased FMAP – DHCS policy change.

Expenditures are projected to increase 11.6% between FY 2023-24 and FY 2024-25 because:

- The reduced PMPM rate, associated with the FFCRA continuous cover requirement, ends December 2023;
- An estimated increase in the PMPM rate of $10.50 for 2025, and
- Historical caseload growth, absent the FFCRA continuous coverage requirement.

Methodology:

1. The 2023 growth increased 4.90% over 2022 amounts per the *Centers for Medicare & Medicaid Services*. Medi-Cal's PMPM rate for 2023 is $155.08.

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

MEDICARE PAYMENTS - PART D PHASED-DOWN
BASE POLICY CHANGE NUMBER: 154

3. The 2025 growth is estimated to increase 6.27% over 2024 amounts per the *Centers for Medicare & Medicaid Services*. Medi-Cal's estimated PMPM rate for 2025 is $178.00.

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

5. The average monthly eligible beneficiaries are estimated using the growth trend in the monthly Part D enrollment data from May 2018 to July 2023.

6. The Families First Coronavirus Response Act (FFCRA) requires the department suspend eligibility redeterminations during the national public health emergency (PHE) to receive a temporary increase in the FMAP.

   The Consolidated Appropriations Act, 2023, approved on December 29, 2022, decoupled the end of the FFCRA continuous coverage requirement from the end of the national PHE. Instead of ending the continuous coverage requirement on March 31, 2023, the resumption of eligibility redeterminations began in April 2023 for beneficiaries due for renewal in June 2023; those no longer determined eligible would be disenrolled effective July 2023. Ongoing eligibility redeterminations related to this population are expected to be completed in approximately twelve months. Projections are brought up to the last month of actuals and historical growth absent the FFCRA continuous coverage requirement applied.

   The FFCRA increased the FMAP for certain expenditures in Medicaid through the last day of the calendar quarter of the national PHE. The Consolidated Appropriations Act of 2023 established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, 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.

   Projected expenditures from the increased FMAP are budgeted in the COVID-19 Increased FMAP – DHCS policy change.

7. The Phased-down Contribution is funded 100% by State General Fund.

MEDICARE PAYMENTS - PART D PHASED-DOWN

BASE POLICY CHANGE NUMBER: 154

	Payment Months	Est. Ave. Monthly Beneficiaries	Est. Ave. Monthly Cost	Total Cost
FY 2023-24	12	1,727,747	$269,561,500	**$3,234,728,000**
FY 2024-25	12	1,758,864	$300,801,500	**$3,609,618,000**

Funding:
100% GF (4260-101-0001)
COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

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

BASE POLICY CHANGE NUMBER: 155
IMPLEMENTATION DATE: 7/1990
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 23

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$3,423,496,000	$3,716,028,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,423,496,000	$3,716,028,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$3,423,496,000	$3,716,028,000

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

Authority:
Interagency Agreement 01-15834
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

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

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

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

BASE POLICY CHANGE NUMBER: 155

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is a net increase due to decreased estimate in current year expenditures and an increase in prior year expenditures that were expected to be paid in FY 2022-23 that occurred in FY 2023-24.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is a net increase due to increases in current year expenditures driven by estimated caseload growth and decreases in prior year expenditures due to no COVID increased FMAP that is included in FY 2024-25.

Methodology:
1. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023 for this policy change.

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

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	DHCS FFP	COVID-19 FF
FY 2023-24	$6,596,898	$3,173,402	**$3,298,449**	**$125,047**
FY 2024-25	$7,432,055	$3,716,027	**$3,716,028**	**$0**

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

PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 156
IMPLEMENTATION DATE: 4/1993
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 22

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$3,616,465,000	$3,893,201,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,616,465,000	$3,893,201,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$3,616,465,000	$3,893,201,000

Purpose:
This policy change provides Title XIX federal financial participation (FFP) to the California Department of Social Services (CDSS) for Medi-Cal beneficiaries participating in the In-Home Supportive Services (IHSS) programs: the Personal Care Services Program (PCSP) and the IHSS Plus Option (IPO) program administered by CDSS.

Authority:
Social Security Act (42 U.S.C., Section 1396, et. seq.)
PCSP Interagency Agreements (IA) 03-75676
IPO IA 09-86307
SB 1036 (Chapter 45, Statutes of 2012)
SB 1008 (Chapter 33, Statutes of 2012)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
Eligible services are authorized under Title XIX of the federal Social Security Act (42 U.S.C., Section 1396, et. seq.). The Department draws down and provides FFP to CDSS through IAs for the IHSS PCSP and the IPO program.

SB 1008 enacted the Coordinated Care Initiative (CCI) which required, in part, mandatory enrollment for dual eligibles into managed care for their Medi-Cal benefits. Those benefits included IHSS. Beginning April 1, 2014, some IHSS costs were paid through managed care capitation due to IHSS recipients transitioning into managed care. Effective January 1, 2018, IHSS are no longer included in the managed care capitation, thus all costs for IHSS eligible services are captured in this policy change.

FFP for the county cost of administering the PCSP is in the Personal Care Services policy change located in the Other Administration section of the Estimate.

PERSONAL CARE SERVICES (Misc. Svcs.)
BASE POLICY CHANGE NUMBER: 156

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 eligibles and integrating of long-term services and supports, except IHSS, into managed care. IHSS were removed from capitation rate payments effective January 1, 2018.

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change for FY 2023-24 from the prior estimate, and the change from FY 2023-24 to FY 2024-25 in the current estimate, is an increase due to updated expenditure data provided by CDSS that includes FFCRA increased FMAP costs for this policy change.

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

(Dollars in Thousands)

FY 2023-24	TF	FF	CDSS GF/ County Share
Title XIX 100% FFP	$6,807,430	$3,403,715	$3,403,715
COVID-19 Title XIX Increased FMAP	$0	$59,425	($59,425)
Total	$6,807,430	$3,463,140	$3,344,290
FY 2024-25	**TF**	**FF**	**CDSS GF/ County Share**
Title XIX 100% FFP	$7,328,342	$3,664,171	$3,664,171
COVID-19 Title XIX Increased FMAP	$0	$0	$0
Total	$7,328,342	$3,664,171	$3,664,171

*Totals may differ due to rounding.

PERSONAL CARE SERVICES (Misc. Svcs.)
BASE POLICY CHANGE NUMBER: 156

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

(Dollars in Thousands)

FY 2023-24	**TF**	**FF**	**CDSS GF/ County Share**
Title XIX 100% FFP	$6,985,991	$3,492,996	$3,492,995
COVID-19 Title XIX Increased FMAP	$0	$123,469	($123,469)
Total	$6,985,991	**$3,616,465**	$3,369,526
FY 2024-25	**TF**	**FF**	**CDSS GF/ County Share**
Title XIX 100% FFP	$7,785,733	$3,892,867	$3,892,866
COVID-19 Title XIX Increased FMAP	$0	$334	($334)
Total	$7,785,733	**$3,893,201**	$3,892,532

*Totals may differ due to rounding.

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

DENTAL SERVICES

BASE POLICY CHANGE NUMBER: 157
IMPLEMENTATION DATE: 7/1988
ANALYST: Louis Wollenberger
FISCAL REFERENCE NUMBER: 135

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$2,078,914,000	$2,078,914,000
- STATE FUNDS	$884,823,200	$884,823,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,078,914,000	$2,078,914,000
STATE FUNDS	$884,823,200	$884,823,200
FEDERAL FUNDS	$1,194,090,800	$1,194,090,800

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.

Delta Dental of California (Delta) was awarded a multi-year Administrative Services Organization (ASO) contract in 2016, which will expire in FY 2023-24. Gainwell Technologies LLC (GWT) was awarded a new multi-year Fiscal Intermediary-Dental Business Operations (FI-DBO) contract in 2022, and will succeed (replace) the ASO contract. The ASO/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 CD-MMIS.

The Medi-Cal Dental program covers a broad range of dental services for both children (0-20) and adults (21 and older) including, but not limited to the following dental service categories: diagnostic, preventive, restorative, endodontic, prosthodontic, and oral maxillofacial surgery services.

DENTAL SERVICES
BASE POLICY CHANGE NUMBER: 157

Reason for Change:
The change from the prior estimate for FY 2023-24 is due mainly to an increase in users and rates. In particular, this estimate includes additional caseload growth due to the continuous coverage requirement through June 2023.

There is no change from FY 2023-24 to FY 2024-25, in the current estimate, because this policy change assumes no impact from redeterminations. The impact of redeterminations is reflected in the COVID-19 Redeterminations Impact policy change.

Methodology:
1. Dental expenditures are estimated using 36 months of cash-basis expenditure data (July 2020-June 2023) and trending Users, Units/User, and Rate.

2. A portion of Proposition 56 Supplemental Payments, CalAIM - Dental Initiatives, and Evidence-Based Dental Practices estimates are included in this policy change.

3. Dental services estimates for the Breast and Cervical Cancer Treatment Program (BCCTP) are included in the BCCTP policy change.

4. The Families First Coronavirus Response Act (FFCRA) required the department suspend eligibility redeterminations during the national public health emergency, with the first impacts of resuming redeterminations beginning in July 2023. Projections include increases in user counts and costs related to this continuous coverage requirement. Changes in spending related to resuming redeterminations requirement are included in the COVID-19 Redeterminations policy change.

Funding:
(Dollars in Thousands)

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF	$1,322,898	$661,449	$661,449
ACA 90% FFP/10% GF (2020)	$395,858	$39,586	$356,273
65% Title XXI/35% GF (10/2020)	$271,224	$94,928	$176,295
100% GF	$88,860	$88,860	$0
Title XIX 100% FFP	$74	$0	$74
Total	**$2,078,914**	**$884,823**	**$1,194,091**

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF	$1,322,898	$661,449	$661,449
ACA 90% FFP/10% GF (2020)	$395,858	$39,586	$356,273
65% Title XXI/35% GF (10/2020)	$271,224	$94,928	$176,295
100% GF	$88,860	$88,860	$0
Title XIX 100% FFP	$74	$0	$74
Total	**$2,078,914**	**$884,823**	**$1,194,091**

Note: Totals may differ due to rounding.

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

BASE POLICY CHANGE NUMBER: 160
IMPLEMENTATION DATE: 7/1991
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 26

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$375,100,000	$371,123,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$375,100,000	$371,123,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$375,100,000	$371,123,000

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

Authority:
Interagency Agreement (IA) 03-75284
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

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

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

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

BASE POLICY CHANGE NUMBER: 160

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:

The change in FY 2023-24, from the prior estimate, is a net increase due to:

- Higher than expected prior year expenditures,
- New TCM rates were developed for FY 2023-24, and
- Decreased current year expenditures.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is net decrease due to:

- A slight growth in estimated caseload,
- New policy items in FY 2024-25, and
- No COVID-19 increased FMAP is included in FY 2024-25.

Methodology:

1. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023 for this policy change.

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

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	DHCS FFP	COVID-19 FF	Total FFP
FY 2023-24	$722,130	$347,030	**$361,065**	**$14,035**	**$375,100**
FY 2024-25	$742,246	$371,123	**$371,123**	**$0**	**$371,123**

Funding:

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

LAWSUITS/CLAIMS

BASE POLICY CHANGE NUMBER: 177
IMPLEMENTATION DATE: 7/2017
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2080

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$47,205,000	$1,350,000
- STATE FUNDS	$23,602,500	$675,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$47,205,000	$1,350,000
STATE FUNDS	$23,602,500	$675,000
FEDERAL FUNDS	$23,602,500	$675,000

Purpose:
This policy change estimates the cost of Medi-Cal lawsuit judgments, settlements, and attorney fees that are not shown in other policy changes.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
The State Legislature appropriates funds to pay the costs related to Medi-Cal lawsuits and claims. Larger lawsuit settlement amounts require both State Legislature and the Governor's approval for payment. Federal financial participation is claimed for all eligible lawsuit settlements approved by the Legislature and the Governor.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due to additional lawsuit settlement payments expected to be made. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to fewer lawsuit settlement payments expected to be made.

LAWSUITS/CLAIMS
BASE POLICY CHANGE NUMBER: 177

Methodology:

FY 2023-24	Total Amount
Attorney Fees	
Peter Moulinos v. Baass	$5,000
Total	**$5,000**
Other Attorney Fees	
Hinkle, et al. v. Kent, et al.	$2,200,000
Total	**$2,200,000**
Other Provider Settlements	
Blue Cross of CA dba Anthem Blue Cross (rate settlement)	$33,000,000
Molina Healthcare of CA	$12,000,000
Total	**$45,000,000**
FY 2023-24 Total (rounded)	**$47,205,000**

FY 2023-24			
	Committed	**Balance**	**Budgeted**
Attorney Fees <$30,000	$5,000	$195,000	$200,000
Provider Settlements <$100,000	$0	$1,000,000	$1,000,000
Beneficiary Settlements <$10,000	$0	$150,000	$150,000
Small Claims Court	$0	$0	$0
Other Attorney Fees	$2,200,000	N/A	$2,200,000
Other Provider Settlements	$45,000,000	N/A	$45,000,000
Other Beneficiary Settlements	$0	N/A	$0
Interest Paid	$0	$0	$0
Totals (Rounded)	**$47,205,000**	**$1,345,000**	**$48,550,000**

LAWSUITS/CLAIMS
BASE POLICY CHANGE NUMBER: 177

FY 2024-25	
	Budgeted
Attorney Fees<$30,000;Provider Settlements<$100,000; Beneficiary Settlements<$10,000	$0
Other Attorney Fees	$1,350,000
Other Provider Settlements	$0
Other Beneficiary Settlements	$0
Interest Paid	$0
Totals (Rounded)	**$1,350,000**

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

DEVELOPMENTAL CENTERS/STATE OP SMALL FAC

BASE POLICY CHANGE NUMBER: 182
IMPLEMENTATION DATE: 7/1997
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 77

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$19,954,000	$20,177,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$19,954,000	$20,177,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$19,954,000	$20,177,000

Purpose:
This policy change estimates the federal match provided to the California Department of Developmental Services (CDDS) for Developmental Centers (DCs) and State Operated Facilities (SOFs).

Authority:
Interagency Agreement (IA) 03-75282
IA 03-75283
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
The Department entered into an IA with CDDS to reimburse the Federal Financial Participation (FFP) for Medi-Cal clients served at DCs and SOFs. There are two DCs and one SOF statewide. The Budget Act of 2003 included the implementation of a quality assurance (QA) fee on the entire gross receipts of any intermediate care facility. DCs and SOFs are licensed as intermediate care facilities. This policy change also includes reimbursement for the federal share of the QA fee.

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

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).

DEVELOPMENTAL CENTERS/STATE OP SMALL FAC
BASE POLICY CHANGE NUMBER: 182

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is a net decrease due to the previous estimate incorrectly reflected the net billed amount instead of just the FFP (50%). The current estimate reflects the correct FFP and includes a higher billing rate that was effective July 1, 2023.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to consumer billing projected to increase in FY 2024-25.

Methodology:
1. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

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

(Dollars in Thousands)

Fiscal Year	Total Funds	CDDS GF	FFP Regular	COVID-19 FF
FY 2023-24	$39,077	$19,123	**$19,677**	**$277**
FY 2024-25	$40,562	$20,385	**$20,177**	**$0**

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

MEDI-CAL TCM PROGRAM

BASE POLICY CHANGE NUMBER: 187
IMPLEMENTATION DATE: 6/1995
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 27

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$15,121,000	$23,153,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$15,121,000	$23,153,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$15,121,000	$23,153,000

Purpose:
This policy change estimates the federal match provided to Local Government Agencies (LGAs) for the Targeted Case Management (TCM) program.

Authority:
Welfare & Institutions Code 14132.44
SB 910 (Chapter 1179, Statutes of 1991)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
The TCM program provides funding to LGAs based on certified public expenditures incurred for assisting Medi-Cal members in gaining access to needed medical, social, educational, and other services. TCM services include needs assessment, individualized service plans, referral, and monitoring/follow-up. Through rates established in the annual cost reports, LGAs submit invoices to the Department to claim federal financial participation (FFP) and receive interim payments. Counties are then required to submit annual cost reports that are audited by the Department and are used to reconcile those interim payments with a county's audited costs. Counties either receive additional funding if costs exceeded the interim payments or counties are required to reimburse the federal funds if interim payments exceeded their costs.

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).

MEDI-CAL TCM PROGRAM
BASE POLICY CHANGE NUMBER: 187

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is a net decrease, due to:

- Base Payment totals increasing $3,134,000 for both Affordable Care Act (ACA) and Regular payments due to an increase in claims during FY 2022-23.
- Estimated FFCRA FMAP decreasing $817,000 from the prior estimate, due to the phasing out of the Title XIX COVID-19 increased FMAP.
- Estimated reconciliation payments to the Department increasing from $2,158,000 in the prior estimate to $6,317,000 in the current estimate, for a net increase in $4,159,000 of reconciliation payments to the Department.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is a net increase, due to:

- Estimated FFCRA FMAP decreasing $449,000 from the FY 2023-24 to FY 2024-25, due to the phasing out of the Title XIX COVID-19 increased FMAP.
- Estimated reconciliation payments to the Department of $6,317,000 in the FY 2023-24 estimate shifting to estimated reconciliation payments to LGAs of $2,164,000 in the FY 2024-25 estimate.

Methodology:

1. State Plan Amendment 10-010, approved on December 19, 2013, and effective October 16, 2010, included interim and final reconciliations of LGAs costs for providing TCM.

2. The projected base payment amounts of $17,473,000 (Regular invoices) and $3,435,000 (ACA invoices) for FY 2023-24 and FY 2024-25, are based on FY 2022-23 payments for Regular and ACA payments.

3. In FY 2023-24 and FY 2024-25, the Department will complete reconciliations for FY 2013-14 through FY 2022-23. The Department expects to receive a net amount of $6,317,000 for actual/estimated audit reports during FY 2023-24. Additionally, the Department expects to pay a net amount of $2,164,000 for actual/estimated audit reports during FY 2024-25. The Department anticipates the recoupment/payment of these amounts based on previous invoice history, reimbursement history, and history of reconciliation payments.

4. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

5. On a cash basis, the FFCRA increased FMAP of $530,000 is expected to be paid in FY 2023-24.

MEDI-CAL TCM PROGRAM
BASE POLICY CHANGE NUMBER: 187

FY 2023-24	TF	FF	COVID-19 FF
Base (Average Expenditures)	$17,473,000	$17,473,000	$0
Base (ACA Expenditures)	$3,435,000	$3,435,000	$0
FFCRA FMAP Increase	$530,000	$0	$530,000
Reconciliation			
FFCRA Claims	($231,000)	$0	($231,000)
Regular Claims	($5,112,000)	($5,112,000)	$0
ACA Claims	($974,000)	($974,000)	$0
Total FY 2023-24	**$15,121,000**	**$14,822,000**	**$299,000**

FY 2024-25	TF	FF	COVID-19 FF
Base (Average Expenditures)	$17,473,000	$17,473,000	$0
Base (ACA Expenditures)	$3,435,000	$3,435,000	$0
FFCRA FMAP Increase	$81,000	$0	$81,000
Reconciliation			
FFCRA Claims	$439,000	$0	$439,000
Regular Claims	$1,519,000	$1,519,000	$0
ACA Claims	$206,000	$206,000	$0
Total FY 2024-25	**$23,153,000**	**$22,633,000**	**$520,000**

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.)

BASE POLICY CHANGE NUMBER: 200
IMPLEMENTATION DATE: 1/1993
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 91

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$369,000	$387,000
- STATE FUNDS	$184,500	$193,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$369,000	$387,000
STATE FUNDS	$184,500	$193,500
FEDERAL FUNDS	$184,500	$193,500

Purpose:
This policy change estimates the cost of the payouts for the Department's Health Insurance Premium Payment (HIPP) program.

Authority:
Welfare & Institutions Code 14124.91
Social Security Act 1905(a), 1906(a)(3), 1906A(e), and 1916(e)
Title 22 California Code of Regulations 50778 (Chapter 2, Article 15)
State Plan Amendment 21-0057

Interdependent Policy Changes:
COVID-19 Increased FMAP – DHCS

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 is 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.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to an increase on the FY 2022-23 actuals, which showed increasing premium and cost-sharing obligation amounts.

HIPP PREMIUM PAYOUTS (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 200

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to an increase based on actual costs and the assumption that premiums and cost sharing obligations increase, which is typically 5 percent each FY based on historical trends.

Methodology:

1. HIPP premium costs are determined by:
   - Actual premium and cost share obligation expenses for July 2022 through June 2023 for the current HIPP members,
   - 10 percent increase for growth of program to account for members that may be enrolled in FY 2023-24,
   - Using the actual amounts from FY 2022-23 to project premium and cost share obligation expenses for FY 2023-24 to derive;
     - The projected average PMPM cost multiplied by
     - The current member count due to:
       - The assumption that four HIPP members in foster youth aid code will continue their HIPP program eligibility,
       - The assumption that approximately 41 of the remaining HIPP members (less those four members in foster youth aid codes) will continue their HIPP program eligibility for a period of 12 months under a Medical Exemption Request.
   - To project FY 2024-25 costs, the projection is based upon the assumption that:
     - Premium costs and cost share obligation expenses will increase by 5 percent each fiscal year based on historical trends,
     - The population will remain stable as aforementioned.

2. The average PMPU cost including ancillary costs is estimated to be $749 in FY 2023-24 and $786 in FY 2024-25.

3. The average monthly HIPP enrollment is estimated to be 41 in both FY 2023-24 and FY 2024-25.

4. Costs for FY 2023-24 and FY 2024-25 are estimated to be:

FY 2023-24: $749 (average PMPM cost) x 41 (estimated member count) x 12 months = $369,000 TF (rounded).

FY 2024-25: $786 (average PMPM premium cost) x 41 (estimated member count) x 12 months = $387,000 TF (rounded).

Fiscal Year	TF	GF	FF
FY 2023-24	$369,000	$184,500	$184,500
FY 2024-25	$387,000	$193,500	$193,500

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)
COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

BASE RECOVERIES

BASE POLICY CHANGE NUMBER: 217
IMPLEMENTATION DATE: 7/1987
ANALYST: Allison Tamai
FISCAL REFERENCE NUMBER: 127

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	-$734,833,000	-$717,516,000
- STATE FUNDS	-$310,514,130	-$303,196,520
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$734,833,000	-$717,516,000
STATE FUNDS	-$310,514,130	-$303,196,520
FEDERAL FUNDS	-$424,318,870	-$414,319,480

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:
COVID-19 Increased FMAP – DHCS

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.

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.

BASE RECOVERIES
BASE POLICY CHANGE NUMBER: 217

The change in FY 2023-24, from the prior estimate, is due to:

- Personal Injury collections are higher than previously projected based on an overall increase in actuals for current year collections. Special Needs Trust collections received several high dollar payments and an increase in overall claim volume.
- Provider overpayments are higher due to catch-up collections from previously granted public health emergency waivers that deferred repayments for a limited period.
- There is a projected increase in health insurance collections due to the ongoing success of the Managed Care Plans and Fee-for-Service Pharmacy recoveries based on recent trends. Additional recoveries are also expected through new initiatives including recoveries on Dental Managed Care as well as the implementation of a pilot project to collect from health centers in rural counties.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to:

- For the health insurance collections, recoveries are expected to decrease as final health insurance claims are expected to be fully integrated into the regular recovery process.

Methodology:

1. The recoveries estimate uses the trend in monthly recoveries for July 2020 – July 2023.

(Dollars in Thousands)

Recovery Type	FY 2023-24	FY 2024-25
Personal Injury Collections	($174,017)	($174,101)
Workers' Comp. Collections	($4,355)	($4,590)
Health Insurance Collections	($248,600)	($230,000)
General Collections	($307,861)	($308,825)
TOTAL	**($734,833)**	**($717,516)**

BASE RECOVERIES
BASE POLICY CHANGE NUMBER: 217

Funding:

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	($589,309)	($294,654)	($294,655)
Title XIX 65 FF / 35 GF (4260-101-0890/0001)	($9,642)	($3,375)	($6,267)
Title XIX FFP (4260-101-0890)	($7,871)	$0	($7,871)
93% Title XIX ACA FF / 7% GF (4260-101-0890/0001)	($10,539)	($738)	($9,801)
90% Title XIX ACA FF / 10% GF (4260-101-0890/0001)	($117,472)	($11,747)	($105,725)
TOTAL	**($734,833)**	**($310,514)**	**($424,319)**

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	($575,421)	($287,711)	($287,710)
Title XIX 65 FF / 35 GF (4260-101-0890/0001)	($9,415)	($3,295)	($6,120)
Title XIX FFP (4260-101-0890)	($7,685)	$0	($7,685)
93% Title XIX ACA FF / 7% GF (4260-101-0890/0001)	($10,291)	($720)	($9,571)
90% Title XIX ACA FF / 10% GF (4260-101-0890/0001)	($114,704)	($11,470)	($103,234)
TOTAL	**($717,516)**	**($303,196)**	**($414,320)**

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

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 CHANGE INDEX

MEDI-CAL PROGRAM REGULAR
POLICY CHANGE INDEX

MEDI-CAL PROGRAM REGULAR
POLICY CHANGE INDEX

MEDI-CAL PROGRAM REGULAR
POLICY CHANGE INDEX

MEDI-CAL PROGRAM REGULAR
POLICY CHANGE INDEX

MEDI-CAL PROGRAM REGULAR
POLICY CHANGE INDEX

UNDOCUMENTED EXPANSION AGES 26 THROUGH 49

REGULAR POLICY CHANGE NUMBER: 1
IMPLEMENTATION DATE: 2/2024
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2385

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$1,436,027,000	$3,315,909,000
- STATE FUNDS	$1,228,010,000	$2,857,395,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,436,027,000	$3,315,909,000
STATE FUNDS	$1,228,010,000	$2,857,395,000
FEDERAL FUNDS	$208,017,000	$458,514,000

Purpose:
This policy change estimates the benefit costs to expand full scope Medi-Cal benefits to adults 26 through 49 years of age, regardless of immigration status.

Authority:
AB 184, (Chapter 47, Statutes of 2022)

Interdependent Policy Changes:
Not Applicable

Background:
California provides restricted-scope Medi-Cal coverage for emergency and pregnancy related services only to low-income adults, including undocumented immigrants who do not have a satisfactory immigration status, or are unable to verify their citizenship or immigration status, and who are otherwise Medi-Cal eligible.

Full-scope coverage expanded to eligible individuals, ages 19 through 25, regardless of citizenship or immigration status beginning January 1, 2020. Full-scope coverage expanded to eligible individuals, 50 years of age or older, regardless of citizenship or immigration status on May 1, 2022. Full scope coverage expanded to eligible individuals, ages 26 through 49, regardless of citizenship or immigration status on January 1, 2024. Federal financial participation (FFP) is available, regardless of immigration status, for emergency and pregnancy related services.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due to an increase in the expected population and costs. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to a full year of costs occurring in FY 2024-25.

UNDOCUMENTED EXPANSION AGES 26 THROUGH 49

REGULAR POLICY CHANGE NUMBER: 1

Methodology:

1. Assume the transition occurred on January 1, 2024.

2. Assume UIS specific rates for emergency and pregnancy-related services, which are eligible for FFP.

3. Assume UIS specific rates for state-only full scope services, which are ineligible for FFP.

4. Assume offsetting cost savings for current restricted-scope Medi-Cal expenditures.

5. In-Home Supportive Services are not budgeted in this policy change as they are included in the budget for the Department of Social Services.

6. On a cash basis, net expenditures are estimated to be:

(Dollars in Thousands)

Fiscal Years	TF	GF	FF
FY 2023-24	$1,436,027	$1,228,010	$208,017
FY 2024-25	$3,315,909	$2,857,395	$458,514

Funding:

100% GF (4260-101-0001)
100% Title XIX FFP (4260-101-0890)

POSTPARTUM CARE EXTENSION

REGULAR POLICY CHANGE NUMBER: 2
IMPLEMENTATION DATE: 7/2023
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2276

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$255,889,000	$264,796,000
- STATE FUNDS	$125,840,000	$130,230,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$255,889,000	$264,796,000
STATE FUNDS	$125,840,000	$130,230,000
FEDERAL FUNDS	$130,049,000	$134,566,000

Purpose:
This policy change estimates the benefit costs of extending postpartum care to individuals who are currently pregnant and receiving Medi-Cal pregnancy-related services, from the last day of their pregnancy for an additional 12 months.

Authority:
American Rescue Plan (ARP) Act (2021)
SPA 21-032

Interdependent Policy Changes:
COVID-19 Redeterminations Impact

Background:
Medi-Cal provides coverage for pregnancy and pregnancy-related services, including postpartum care for individuals who are pregnant. Prior to SB 104 (Chapter 67, Statues of 2019), postpartum care was terminated 60 days after the last day of pregnancy. SB 104 extended postpartum care for up to 12 months after the last day of pregnancy specifically for beneficiaries who receive pregnancy-related services and are diagnosed with a mental health condition.

The passage of ARP allows a Medicaid eligible individual who is receiving pregnancy-related services to remain eligible for Medi-Cal postpartum care for an additional 12 months after the last day of their pregnancy.

Medi-Cal temporarily suspended the annual renewal process to meet the Families First Coronavirus Response Act continuous coverage requirements and to receive a temporary increase in the federal medical assistance percentage. As such, the COVID-19 Redeterminations Impact policy change captures individuals who would have otherwise been disenrolled during the public health emergency (PHE) after their postpartum care coverage ended. The federal PHE continued through May 11, 2023. These individuals will maintain their current coverage beyond the end of the PHE.

POSTPARTUM CARE EXTENSION

REGULAR POLICY CHANGE NUMBER: 2

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due to an increase in projected eligibles and costs. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a slight increase due to an increase in projected eligible costs.

Methodology:
1. Assume this population would have otherwise not been eligible to receive services after the 60 day postpartum period.

2. Assume an April 1, 2022, effective date for this policy.

3. Assume the Coronavirus Disease 2019 PHE period continued through May 11, 2023, and costs for this program could not be captured during the PHE period.

FY 2023-24	TF	GF	SF	FF
50% Title XIX FF / 50% GF	$231,132,000	$115,566,000	$0	$115,566,000
100% Title XXI	$14,483,000	$0	$0	$14,483,000
100% Perinatal Insurance Fund	$10,274,000	$0	$10,274,000	$0
Total	**$255,889,000**	**$115,566,000**	**$10,274,000**	**$130,049,000**

FY 2024-25	TF	GF	SF	FF
50% Title XIX FF / 50% GF	$239,296,000	$119,648,000	$0	$119,648,000
100% Title XXI	$14,918,000	$0	$0	$14,918,000
100% Perinatal Insurance Fund	$10,582,000	$0	$10,582,000	$0
Total	**$264,796,000**	**$119,648,000**	**$10,582,000**	**$134,566,000**

Funding:
50% Title XIX FF / 50% GF (4260-101-0890/0001)
Perinatal Insurance Fund (4260-602-0309)
Title XXI FFP (4260-101-0890)

MEDI-CAL STATE INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 3
IMPLEMENTATION DATE: 12/2016
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 1569

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$43,024,000	$43,024,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$43,024,000	$43,024,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$43,024,000	$43,024,000

Purpose:
This policy change estimates the federal financial participation (FFP) provided to the California Department of Corrections and Rehabilitation (CDCR)/California Correctional Health Care Services (CCHCS) for the costs of providing inpatient services for adult inmates who are enrolled in Medi-Cal. This includes health care services to former inmates who have been granted medical parole.

Authority:
AB 1628 (Chapter 729, Statutes of 2010)
SB 1399 (Chapter 405, Statutes of 2010)
SB 184 (Chapter 47, Statutes of 2022)

Interdependent Policy Changes:
COVID-19 Increased FMAP – DHCS

Background:
AB 1628 (Chapter 729, Statutes of 2010) authorizes the Department and the CDCR to:

- Claim FFP for inpatient hospital services to Medi-Cal enrolled adult inmates in State correctional facilities when these services are provided off the grounds of the facility. Previously these services were paid by the CDCR with 100% General Fund (GF). Effective April 1, 2011, the Department began accepting Medi-Cal applications from the CCHCS for eligibility determinations for State inmates, retroactive to November 1, 2010. The Department will budget the FFP for services and CCHCS administrative costs and the CCHCS will continue to budget the GF.

SB 1399 (Chapter 405, Statutes of 2010) authorizes the Board of Parole Hearings to:

- Grant medical parole to permanently medically incapacitated State inmates. State inmates granted medical parole are potentially eligible for Medi-Cal. When a State inmate is granted medical parole, the CCHCS submits a Medi-Cal application to the Department to determine eligibility. Previously this service was funded through the CDCR with 100% GF.

MEDI-CAL STATE INMATE PROGRAMS
REGULAR POLICY CHANGE NUMBER: 3

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.

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 in FY 2023-24, from the prior estimate, is a decrease due to updated actuals based on current invoices from FY 2022-23. There is no change from FY 2023-24 to FY 2024-25 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. The Medical Parole program began in June 2011 with claiming beginning in April 2013.

2. Estimated costs for FY 2023-24 and FY 2024-25 are annualized projections primarily based on actual claims data for FY 2022-23. An average of the highest two quarters was used as the basis for the projection.

3. The Department will continue to pay ACA payments based on the Federal Medical Assistance Percentage of 90% for calendar year 2020 and beyond.

4. Assume a six-month lag in ongoing payments.

5. The Non-Federal share for this policy change is budgeted in the CDCR's budget. Included below is the total estimated FFP for the Medi-Cal Inpatient Hospital Costs for all eligible (Non-ACA and ACA) adult inmates in FY 2023-24 and FY 2024-25.

FY 2023-24	TF	FF
Adults - Non ACA	$13,504,000	$6,752,000
Adults - ACA	$39,696,000	$36,087,000
Medical Parole – Non ACA	$253,000	$126,000
Medical Parole – ACA	$65,000	$59,000
Total FY 2023-24	$53,518,000	**$43,024,000**

MEDI-CAL STATE INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 3

FY 2024-25	TF	FF
Adults - Non ACA	$13,504,000	$6,752,000
Adults - ACA	$39,696,000	$36,087,000
Medical Parole – Non ACA	$253,000	$126,000
Medical Parole – ACA	$65,000	$59,000
Total FY 2024-25	$53,518,000	**$43,024,000**

*Totals may differ due to rounding.

Funding:
100% Title XIX FFP (4260-101-0890)
100% Title XIX ACA FF (4260-101-0890)
COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

BREAST AND CERVICAL CANCER TREATMENT

REGULAR POLICY CHANGE NUMBER: 4
IMPLEMENTATION DATE: 1/2002
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 3

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$39,356,000	$39,356,000
- STATE FUNDS	$15,247,750	$15,252,750
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$39,356,000	$39,356,000
STATE FUNDS	$15,247,750	$15,252,750
FEDERAL FUNDS	$24,108,250	$24,103,250

Purpose:
This policy change estimates the fee-for-service (FFS) costs of the Breast and Cervical Cancer Treatment Program (BCCTP).

Authority:
AB 430 (Chapter 171, Statutes of 2001)
AB 1810 (Chapter 34, Statutes of 2018)
AB 133 (Chapter 143, Statutes of 2021)
Senate Bill (SB) 184 (Chapter 47, Statutes of 2022)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
AB 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 beneficiaries.

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 beneficiaries now have other coverage options available through Covered California and the Individual Insurance Market.

BREAST AND CERVICAL CANCER TREATMENT
REGULAR POLICY CHANGE NUMBER: 4

Effective July 1, 2018, Health Omnibus Trailer Bill, AB 1810 (Chapter 34, Statutes of 2018) signed June 27, 2018, appropriated funding to the General Fund for the elimination of the 18 and 24-month treatment limitations.

Effective May 1, 2022, AB 133, Chapter 143, granted full-scope Medi-Cal to adults who are 50 years of age and older.

Effective January 1, 2024, SB 184, Chapter 47, grants full-scope Medi-Cal to adults who are 26-49 years of age.

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change from the prior estimate for FY 2023-24, is an increase due to an increase in projected benefit costs. There is no change in total funds from FY 2023-24 to FY 2024-25. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a slight General Fund increase due to the FFCRA increased FMAP funding ending in FY 2023-24.

Methodology:
1. The Title XXI COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

2. Assume a total of 4,882 beneficiaries, of which 1,578 were in FFS and 3,304 were in managed care. Additionally, approximately 1,260 of the FFS beneficiaries were eligible for State-Only services.

3. Due to SB 184, of the 4,882 individuals currently in BCCTP coverage, 1,800 individuals will transfer to county Medi-Cal from BCCTP. Project a total of 3,082 active individuals in BCCTP coverage effective January 1, 2024, with 1,000 individuals in FFS and 2,082 individuals in managed care. Additionally, approximately 800 of the FFS individuals are eligible for State-Only services.

4. Assume none of the FFS beneficiaries were in accelerated enrollment.

BREAST AND CERVICAL CANCER TREATMENT
REGULAR POLICY CHANGE NUMBER: 4

5. Assume the State will pay Medicare and other health coverage premiums for an average of 173 beneficiaries monthly in FY 2023-24 and FY 2024-25. Assume an average monthly premium cost per beneficiary of $111.66.

6. Assume 45% of beneficiaries will require a third year of treatment, and 20% of those beneficiaries will require a fourth year of treatment.

7. Managed Care costs associated with the BCCTP are budgeted in the Two-Plan, County Organized Health Systems, Geographic Managed Care, and Regional Model policy changes.

8. FFS costs are estimated as follows:

FY 2023-24	**TF**	**GF**	**FF**
Full Scope FFS Costs	$37,261,000	$13,153,000	$24,108,000
FFS State-Only Services	$1,863,000	$1,863,000	$0
FFS State-Only Premiums	$232,000	$232,000	$0
Total	**$39,356,000**	**$15,248,000**	**$24,108,000**
FY 2024-25	**TF**	**GF**	**FF**
Full Scope FFS Costs	$37,261,000	$13,158,000	$24,103,000
FFS State-Only Services	$1,863,000	$1,863,000	$0
FFS State-Only Premiums	$232,000	$232,000	$0
Total	**$39,356,000**	**$15,253,000**	**$24,103,000**

* Totals differ due to rounding.

Funding:

FY 2023-24	**TF**	**GF**	**FF**
100% General Fund 4260-101-0001	$2,095,000	$2,095,000	$0
50% Title XIX FFP / 50% GF (4260-101-0890/0001)	$776,000	$388,000	$388,000
65% Title XIX FFP/ 35% GF (4260-101-0890/0001)	$36,485,000	$12,770,000	$23,715,000
COVID-19 Title XIX Increased FFP (4260-101-0890)	$0	($5,000)	$5,000
Total	**$39,356,000**	**$15,248,000**	**$24,108,000**
FY 2024-25	**TF**	**GF**	**FF**
100% General Fund 4260-101-0001	$2,095,000	$2,095,000	$0
50% Title XIX FFP / 50% GF (4260-101-0890/0001)	$776,000	$388,000	$388,000
65% Title XIX FFP/ 35% GF (4260-101-0890/0001)	$36,485,000	$12,770,000	$23,715,000
Total	**$39,356,000**	**$15,253,000**	**$24,103,000**

* Totals differ due to rounding.

PHASING IN THE MEDI-CAL ASSET LIMIT REPEAL

REGULAR POLICY CHANGE NUMBER: 5
IMPLEMENTATION DATE: 7/2022
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2324

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$101,050,000	$195,400,000
- STATE FUNDS	$50,525,000	$97,700,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	61.09 %	61.09 %
APPLIED TO BASE		
TOTAL FUNDS	$39,318,600	$76,030,100
STATE FUNDS	$19,659,280	$38,015,070
FEDERAL FUNDS	$19,659,280	$38,015,070

Purpose:
This policy change estimates the benefit and program costs to disregard countable assets in their entirety when determining eligibility for Non-Modified Adjusted Gross Income (Non-MAGI) Medi-Cal, Medicare Savings Programs, and Long-term Care.

Authority:
AB 133 (Chapter 143, Statutes of 2021)
SPA 23-0012

Interdependent Policy Change:
COVID-19 Increased FMAP – DHCS

Background:
California has asset limits for each Non-MAGI Medi-Cal program, which are outlined in State statute for the various coverage groups subject to such asset limits. The methodologies for asset treatment are set forth in the Medicaid State Plan and the limits are established in both State statute and regulations. Prior to July 1, 2022, to be eligible for Non-MAGI Medi-Cal, including Long-term Care, the countable assets for one person could not exceed $2,000, or $3,000 for two people. These amounts had not been changed since 1989. The asset limits for the Medicare Savings Programs were $7,970 for an individual and $11,960 for two people.

AB 133 required a two-phased approach to eliminating the asset limits for Non-MAGI programs, Medicare Savings Programs, and Long-term Care. Phase I of this approach, which increased asset limits to $130,000 for one person and $65,000 for each additional person, implemented on July 1, 2022.

Phase II of this approach required the elimination of the asset limits for Non-MAGI programs, Medicare Savings Programs, and Long-term Care effective January 1, 2024. The Centers for Medicare and Medicaid Services approved California's State Plan Amendment to implement Phase II, effective January 1, 2024.

PHASING IN THE MEDI-CAL ASSET LIMIT REPEAL

REGULAR POLICY CHANGE NUMBER: 5

Reason for Change:
The change from the prior estimate, for FY 2023-24, is a slight decrease due to a decrease in projected benefit costs. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to a full year of costs in FY 2024-25 for the population impacted by the asset repeal.

Methodology:
1. Assume the asset limit increase implemented July 1, 2022.

2. Assume the asset repeal implements no sooner than January 1, 2024.

3. Assume there will be impacts to the Non-MAGI Medi-Cal, Medicare Savings Programs, and Long-term Care populations.

4. Assume the Department will pay Medicare Part B premiums for dual eligibles.

5. Assume the Department will pay Medicare Part A premiums for individuals enrolled into Medicare Savings Programs.

6. Federal Funds for In-Home Supportive Services are budgeted in the Personal Care Services (Misc. Svcs.) policy change and the General Fund share is included in the budget for the California Department of Social Services.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2023-24	$101,050	$50,525	$50,525
FY 2024-25	$195,400	$97,700	$97,700

Funding:
50% Title XIX FF / 50% GF (4260-101-0890/0001)
COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

HEALTH ENROLLMENT NAVIGATORS FOR CLINICS

REGULAR POLICY CHANGE NUMBER: 6
IMPLEMENTATION DATE: 7/2023
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2422

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$20,000,000	$0
- STATE FUNDS	$10,000,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$20,000,000	$0
STATE FUNDS	$10,000,000	$0
FEDERAL FUNDS	$10,000,000	$0

Purpose:
This policy change estimates the funding provided specifically to Community Health Centers (CHCs) 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 play a vital role in assisting counties to reach out to marginalized populations and help eligible individuals apply and successfully complete the health coverage enrollment process, retain coverage, navigate the health care system, and gain timely access to medical care through community-based care management.

This funding for outreach, enrollment, retention, and community-based assistance with utilization and care management will help Medi-Cal eligible individuals enroll or maintain enrollment in health care coverage and have access to the care they need.

Reason for Change:
There is no General Fund (GF) change from the prior estimate for FY 2023-24. The Total Fund change in the current estimate, for FY 2023-24, is an increase as the policy now assumes a federal fund match. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to all funding being expended in FY 2023-24.

Methodology:
1. A prime contractor implementation occurred on October 1, 2023.

HEALTH ENROLLMENT NAVIGATORS FOR CLINICS
REGULAR POLICY CHANGE NUMBER: 6

2. Assume local CHCs will conduct outreach, enrollment, and retention activities in their applicable area and will receive supplemental funding.

3. 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***
Estimated in FY 2023-24	$20,000	$10,000	$10,000
Estimated in FY 2024-25	$0	$0	$0
Total Estimated Remaining	$0	$0	$0

*Federal funds authority is newly requested for the fiscal year in which funds are anticipated to be expended.

4. Total estimated costs for FY 2023-24 and FY 2024-25 are:

(Dollars in Thousands)

FY 2023-24	**TF**	**GF**	**FF***
Appropriation Year 2023-24	$20,000	$10,000	$10,000
Total FY 2023-24	**$20,000**	**$10,000**	**$10,000**

FY 2024-25	**TF**	**GF**	**FF***
Appropriation Year 2023-24	$0	$0	$0
Total FY 2024-25	**$0**	**$0**	**$0**

*Federal funds authority is newly requested for the fiscal year in which funds are anticipated to be expended.

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

CALAIM - INMATE PRE-RELEASE PROGRAM

REGULAR POLICY CHANGE NUMBER: 7
IMPLEMENTATION DATE: 10/2024
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2332

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$47,916,000
- STATE FUNDS	$0	$16,291,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$47,916,000
STATE FUNDS	$0	$16,291,000
FEDERAL FUNDS	$0	$31,625,000

Purpose:
This policy change estimates the cost for the development, implementation, ongoing maintenance, and operation, of certain California Advancing & Innovating Medi-Cal (CalAIM) initiatives involving justice-involved populations.

Authority:
Penal Code Section 4011.11
Welfare & Institutions Code Sections 14011.10, 14132.275, 14184.800, and 14186
AB 133 (Chapter 143, Statutes of 2021)

Interdependent Policy Change:
Not Applicable

Background:
California is requesting federal authority necessary to implement CalAIM, a framework that encompasses broad-based delivery system, program and payment reform across the Medi-Cal program. CalAIM recognizes the opportunity to move California's whole-person care approach – first authorized by the Medi-Cal 2020 Section 1115 demonstration – to a statewide level, with a clear focus on improving health and reducing health disparities and inequities. Collectively, the Section 1115 CalAIM demonstration and Section 1915(b) waiver, along with related contractual and Medi-Cal State Plan changes, will enable California to fully execute the CalAIM initiative, providing benefits to certain high needs, hard-to-reach populations, with the objective of improving health outcomes for Medi-Cal beneficiaries and other low-income people in the state.

Inmates leaving correctional facilities are at extremely high risk of poor outcomes due to high rates of mental illness, substance use disorders, complex medical conditions, and unmet social needs such as housing insecurity, unemployment, and inadequate social connections. CalAIM proposes to improve outcomes for this population by mandating county inmate pre-release application processes, allowing Medi-Cal reimbursement for services in the 90-day time period prior to release, and to ensure a facilitated referral and linkage ("warm hand-off") to behavioral health services, both to providers in managed care networks and to county behavioral health departments.

CALAIM - INMATE PRE-RELEASE PROGRAM

REGULAR POLICY CHANGE NUMBER: 7

This policy change estimates costs for CalAIM Pre-Release Services up-to-90 days prior to release:

- To provide targeted Medi-Cal services to eligible justice-involved populations up to 90-days pre-release no sooner than October 1, 2024, which includes: care management/care coordination; community-based physical and behavioral health clinical consultation services provided via telehealth or, optionally, in-person as needed, including behavioral health referrals/linkages; medications for addiction treatment (also known as medication-assisted treatment or MAT), medications for mental health diagnoses; and other medications to stabilize chronic and significant conditions, associated laboratory/radiology services; and for use post-release into the community a supply of medication (according to the applicable Medi-Cal policy duration for individual medications) and necessary Durable Medical Equipment.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is a decrease due to a shift in program implementation from April 1, 2024, to October 1, 2024. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to the program implementing in FY 2024-25.

Methodology:
1. Assume Pre-Release Services up-to-90 days prior to release (including Behavioral Health Referrals/Linkages) policies implement no sooner than October 1, 2024.

2. Total estimated costs for FY 2024-25 are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2024-25	$47,916	$16,291	$31,625

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

REFUGEE MEDICAL ASSISTANCE

REGULAR POLICY CHANGE NUMBER: 8
IMPLEMENTATION DATE: 11/2020
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2237

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the refugees' medical expenditures to be reimbursed by the California Department of Public Health (CDPH).

Authority:
Interagency Agreement (IA) 22-20415

Interdependent Policy Changes:
Not Applicable

Background:
Full federal funding is available through the Refugee Resettlement Program (RRP) for medical services provided to refugees in Refugee Medical Assistance (aid code 02) during their first 12 months in the United States. This is an increase from the 8 month limit that was previously in effect. Due to a change in federal rules, the extension of the RMA eligibility period to 12 months is now required for individuals whose period of RMA eligibility began on or after October 1, 2021. The Department implemented this change after the public health emergency ended. The RRP federal grant is administered by CDPH, which has program responsibility through the Refugee Health Assessment Program. The federal Office of Refugee Resettlement allows only one grant award for refugee health services in the state. The Department invoices the CDPH through an IA for refugee expenditure reimbursement, which is originally paid with General Fund (GF) dollars. There is a $600,000 annual reimbursement cap under the grant for these services.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is a decrease due to updated actuals that are lower than previously estimated. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to a projected decrease in reimbursement of claims as a result of actuals that are lower than previously estimated.

REFUGEE MEDICAL ASSISTANCE

REGULAR POLICY CHANGE NUMBER: 8

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.

2. The total reimbursable amounts are estimated to be:

Fiscal Year	TF	GF	GF Reimbursement
FY 2023-24	$0	($136,000)	$136,000
FY 2024-25	$0	($120,000)	$120,000

Funding:

100% GF (4260-101-0001)
Reimbursement GF (4260-601-0995)

NON-OTLICP CHIP

REGULAR POLICY CHANGE NUMBER: 9
IMPLEMENTATION DATE: 12/1998
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 13

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$123,270,450	-$122,167,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$123,270,450	-$122,167,200
FEDERAL FUNDS	$123,270,450	$122,167,200

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:
COVID-19 Increased FMAP – DHCS

Background:
Medi-Cal has multiple CHIP eligibility categories. The largest is OTLICP which is budgeted throughout the Estimate. The other CHIP eligibility categories are budgeted in this policy change.

- Resource Disregard Program: Prior to the implementation of the Affordable Care Act (ACA), Medi-Cal had asset limitations where families that exceeded it were eligible through the CHIP Resource Disregard Program. However, the ACA requires that states raise the minimum income level to at least 133 percent of the federal poverty level (FPL) and remove the Medicaid asset test for children, effective January 1, 2014. These changes allow certain children who would not have been eligible for Medicaid under the State Plan in effect on March 31, 1997, to now be eligible for Medicaid. Until these children transition out of the associated aid codes, the Department continues to budget the adjustment in this policy change (aid codes 8N, 8P, 8R, 8T).

- Medicaid Expansion: This CHIP population exceeds the Medicaid FPL limit and are below the OTLICP FPL (aid codes M5, M6).

NON-OTLICP CHIP
REGULAR POLICY CHANGE NUMBER: 9

- Hospital Presumptive Eligibility (HPE): Effective January 1, 2016, the ACA requires the Department to give hospitals the option to determine HPE for Medicaid. The HPE Program offers qualified individuals immediate access to temporary Medi-Cal while applying for permanent Medi-Cal coverage or other health coverage. CHIP coverage extends to a portion of HPE (aid codes H0, H6, H9).

Reason for Change:
The change from the prior estimate, for FY 2023-24, is a General Fund (GF) savings increase due to an increase in estimated expenditures for the Medicaid Expansion population. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a slight GF savings decrease due to a decrease in estimated expenditures.

Methodology:
1. It is assumed the estimated costs of the HPE, Medicaid Expansion, and Resource Disregard aid codes will be $821,803,000 TF in FY 2023-24 and $814,448,000 TF in FY 2024-25.

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 2023-24 and FY 2024-25 are:

(Dollars in Thousands)

FY 2023-24	TF	GF
Resource Disregard	$79	($12)
HPE	$4,880	($732)
Medicaid Expansion	$816,844	($122,527)
Total Cost	**$821,803**	**($123,271)**

FY 2024-25	TF	GF
Resource Disregard	$79	($12)
HPE	$4,819	($723)
Medicaid Expansion	$809,550	($121,432)
Total Cost	**$814,448**	**($122,167)**

Funding:
(Dollars in Thousands)

FY 2023-24	Fund Number	TF	GF	FF
50% Title XIX FF / 50% GF	4260-101-0890/0001	($821,803)	($410,902)	($410,901)
65% Title XXI FF / 35% GF	4260-101-0890/0001	$821,803	$287,631	$534,172
Net Impact (rounded)		**$0**	**($123,271)**	**$123,271**

NON-OTLICP CHIP
REGULAR POLICY CHANGE NUMBER: 9

FY 2024-25	Fund Number	TF	GF	FF
50% Title XIX FF / 50% GF	4260-101-0890/0001	($814,448)	($407,224)	($407,224)
65% Title XXI FF / 35% GF	4260-101-0890/0001	$814,448	$285,057	$529,391
Net Impact (rounded)		**$0**	**($122,167)**	**$122,167**

* COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

NON-EMERGENCY FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 10
IMPLEMENTATION DATE: 12/1997
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 15

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$1,610,512,300	$1,610,512,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$1,610,512,300	$1,610,512,300
FEDERAL FUNDS	-$1,610,512,300	-$1,610,512,300

Purpose:
This policy change is a technical adjustment to shift funds from Title XIX and Title XXI federal financial participation (FFP) to 100% General Fund (GF) because the Department cannot claim FFP for non-emergency health care expenditures for nonexempt New Qualified Immigrants (NQI) subject to the five-year bar, Permanent Residence Under the Color of Law (PRUCOL), undocumented children and adults.

Authority:
HR 3734 (1996), Personal Responsibility and Work Opportunity Act (PRWORA)
Welfare & Institutions Code 14007.5
SB 75 (Chapter 18, Statutes of 2015)
SB 104 (Chapter 67, Statutes of 2019)

Interdependent Policy Changes:
COVID-19 Increased FMAP – DHCS

Background:
HR 3734 (1996), PRWORA, specifies that FFP is not available for full-scope Medi-Cal services for qualified, nonexempt immigrants who have resided in the United States for less than five years. Currently, FFP is only available for emergency and pregnancy services. California provides full scope Medi-Cal services to eligible, nonexempt, qualified immigrants; however, non-emergency services that are not pregnancy related are 100% State funded.

Previously, California provided restricted-scope Medi-Cal coverage (emergency and pregnancy related services only) to many low-income undocumented children and young adults. FFP was available, regardless of immigration status, for emergency and pregnancy related services. Full scope Medi-Cal benefits became available for individuals who did not have satisfactory immigration status or were unable to verify satisfactory immigration status or citizenship effective:

- May 16, 2016, for individuals under the age of 19.
- January 1, 2020, for individuals 19 through 25 years of age.
- May 1, 2022, for individuals over 50 years of age or older.

NON-EMERGENCY FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 10

California will continue to receive FFP for the emergency and pregnancy related services; however, any non-emergency services provided will be ineligible for FFP and funded solely by the State's GF.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is a decrease due to managed care costs shifting out of this policy change and into the managed care base policy changes beginning in FY 2023-24. There is no change from FY 2023-24 to FY 2024-25 in the current estimate.

Methodology:
1. Based on updated January 2023 through June 2023 FFS expenditure reports of non-emergency services provided to this population, the Department estimates the following non-emergency FFS costs will be $2,425,315,000 TF in FY 2023-24 and FY 2024-25.

2. Managed care costs shifted into the managed care base policy changes beginning FY 2023-24.

3. The impact of the State Children's Health Insurance Program (SCHIP) funding for prenatal care for new qualified immigrants is included in the SCHIP Funding for the Prenatal Care policy change.

4. The estimated FFP Repayment in FY 2023-24 and FY 2024-25:

(Dollars in Thousands)

FFS and MC costs	FY 2023-24		FY 2024-25	
	TF	FF Repayment	TF	FF Repayment
All Others (50% FF / 50% GF)	$1,389,933	$694,966	$1,389,933	$694,966
All Others (65% FF / 35% GF)	$6,385	$4,150	$6,385	$4,150
All Others (Title XXI)	$58,807	$38,225	$58,807	$38,225
ACA	$970,190	$873,171	$970,190	$873,171
Total	$2,425,315	**$1,610,512**	$2,425,315	**$1,610,512**

Funding:
50% Title XIX FF / 50% GF (4260-101-0890/0001)
65% Title XIX FF / 35% GF (4260-101-0890/0001)
100% GF (4260-101-0001)
90% Title XIX ACA / 10% GF (4260-101-0890/0001)
COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

SCHIP FUNDING FOR PRENATAL CARE

REGULAR POLICY CHANGE NUMBER: 11
IMPLEMENTATION DATE: 7/2005
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 1007

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$79,960,900	-$78,895,050
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$79,960,900	-$78,895,050
FEDERAL FUNDS	$79,960,900	$78,895,050

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

Authority:
AB 131 (Chapter 80, Statutes of 2005)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

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 undocumented women 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.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) 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). National public health emergencies are effective for 90 days unless extended or terminated.

The Consolidated Appropriations Act of 2023 was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;

SCHIP FUNDING FOR PRENATAL CARE

REGULAR POLICY CHANGE NUMBER: 11

- 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:
The change from the prior estimate, for FY 2023-24, is an increase in general fund savings due to an increase in prenatal costs.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is a general fund savings decrease due to the FFCRA increased FMAP funding ending in FY 2023-24 as well as a projected decrease in prenatal costs.

Methodology:
1. Assume the FMAP for Title XXI is 65% FF and 35% GF beginning October 1, 2020.

2. The Title XXI COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

3. The total fund cost of prenatal care for undocumented and legal immigrant women is estimated to be:

(Dollars in Thousands)

FY 2023-24	**$121,706**
FY 2024-25	**$121,377**

Funding:
(Dollars in Thousands)

FY 2023-24	**Fund Number**	**TF**	**GF**	**FF**
100% State GF	4260-101-0001	($121,706)	($121,706)	$0
Title XXI 65% FF / 35% GF	4260-101-0890/0001	$121,706	$42,597	$79,109
COVID-19 Tile XXI Increased FMAP	4260-101-0890/0001	$0	($852)	$852
Net Impact		**$0**	**($79,961)**	**$79,961**
FY 2024-25	**Fund Number**	**TF**	**GF**	**FF**
100% State GF	4260-101-0001	($121,377)	($121,377)	$0
Title XXI 65% FF / 35% GF	4260-101-0890/0001	$121,377	$42,482	$78,895
Net Impact		**$0**	**($78,895)**	**$78,895**

MEDI-CAL COUNTY INMATE REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 12
IMPLEMENTATION DATE: 2/2018
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2029

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the reimbursement from counties for the General Fund (GF) share of the medical costs associated with the Medi-Cal County Inmate Program (MCIP).

Authority:
AB 1628 (Chapter 729, Statutes of 2010)
AB 396 (Chapter 394, Statutes of 2011)
SB 1462 (Chapter 837, Statutes of 2012)
AB 720 (Chapter 646, Statutes of 2013)
AB 80 (Chapter 12, Statutes of 2020)
SB 184 (Chapter 47, Statutes of 2022)

Interdependent Policy Changes:
Not Applicable

Background:
AB 1628 (Chapter 729, Statutes of 2010) authorizes the Department and counties to:

- Claim FFP for inpatient hospital services for Medi-Cal enrolled adult inmates in county correctional facilities when these services are provided off the grounds of the facility. Previously these services were paid by the county.

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

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

SB 1462 (Chapter 837, Statutes of 2012) authorizes a county sheriff, or his/her designee, to:

- Release certain prisoners (compassionate release) from a county correctional facility and request that a court grant medical probation, or resentencing in lieu of jail time, to certain county inmates. Counties are responsible for paying the non-federal share of costs associated with providing care to inmates compassionately released or granted

MEDI-CAL COUNTY INMATE REIMBURSEMENT
REGULAR POLICY CHANGE NUMBER: 12

medical probation. Counties are responsible for determining Medi-Cal eligibility for county inmates seeking medical probation or compassionate release.

AB 720 (Chapter 646, Statutes of 2013) authorizes the board of supervisors in each county, in consultation with the county sheriff, to:

- Designate an entity or entities to assist county jail inmates to apply for a health insurance affordability program.
- Authorize this entity to act on behalf of a county jail inmate for the purpose of applying for, or determinations of, Medi-Cal eligibility for acute inpatient hospital services as specified.

AB 80 (Chapter 12, Statutes of 2020) conforms the suspension of benefits for juveniles, as defined under state law, with the existing federal law, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act). The definition of juvenile has changed (both State and County) to include individuals under the age of 21 or individuals enrolled in the former foster youth group under the age of 26. “Eligible Juveniles”, as defined by the SUPPORT Act, only impacts Medi-Cal suspension of benefits policies and does not impact eligibility age restrictions or age requirements for general Medi-Cal programs.

SB 184 (Chapter 47, Statutes of 2022) requires County Welfare Departments to suspend Medi-Cal benefits for all inmates of a public institution for the duration of their incarceration. State law requires the suspension of Medi-Cal benefits for any individual, regardless of age, who is a Medi-Cal 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.

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 2023-24, is a decrease due to capturing recent paid claims data.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to utilizing recent claims data and due to the Coronavirus Disease 2019 (COVID-19) Increased Federal Medical Assistance Percentage (FMAP) phasing out in FY 2023-24. The FY 2023-24 reimbursements are reduced by the availability of the COVID-19 increased FMAP which reduces the GF liability in the Medi-Cal County Inmate Programs.

MEDI-CAL COUNTY INMATE REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 12

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.

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. Assume there will be reduced reimbursement due to COVID-19 increased FMAP being available.

6. The total estimated GF reimbursement in FY 2023-24 and FY 2024-25 will be:

FY 2023-24	GF	Reimbursement
Non ACA	$632,000	$641,000
ACA	$894,000	$882,000
Juvenile	$16,000	$20,000
Compassionate Release – Non ACA	$3,000	$4,000
Compassionate Release - ACA	$3,000	$4,000
Total	$1,548,000	**$1,551,000**

FY 2024-25	GF	Reimbursement
Non ACA	$670,000	$662,000
ACA	$939,000	$928,000
Juvenile	$17,000	$17,000
Compassionate Release – Non ACA	$4,000	$4,000
Compassionate Release - ACA	$3,000	$3,000
Total	$1,633,000	**$1,614,000**

*Totals may differ due to rounding.

Funding:

100% GF (4260-101-0001)
Reimbursement GF (4260-610-0995)

CS3 PROXY ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 13
IMPLEMENTATION DATE: 4/2017
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2155

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$127,946,000	-$99,363,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$127,946,000	-$99,363,500
FEDERAL FUNDS	$127,946,000	$99,363,500

Purpose:
This policy change estimates the technical adjustment in funding for the Non-Optional Targeted Low Income Children's Program (OTLICP) population of the Children's Health Insurance Program (CHIP) as described below. Expenditures are adjusted from Title XIX 50% federal financial participation (FFP) to enhanced Title XXI FFP.

Authority:
SB 903 (Chapter 624, Statutes of 1997)
42 CFR 435.907(e)

Interdependent Policy Changes:
COVID-19 Increased FMAP – DHCS

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 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 2023-24, from the prior estimate, is a General Fund (GF) savings increase due to updated actuals based on recent memos. The change from FY 2023-24 to FY 2024-2025, in the current estimate, is a GF savings decrease due to projecting lower adjustment memos in FY 2024-25.

Methodology:
1. Effective FY 2020-21, assume a two quarter adjustment lag.

CS3 PROXY ADJUSTMENT
REGULAR POLICY CHANGE NUMBER: 13

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. Previously, the CS3 Proxy adjustments were budgeted in the Non-OTLICP CHIP policy change.

4. Total estimated costs for FY 2023-24 and FY 2024-25 are:

(Dollars in Thousands)

Fiscal Years	TF	GF	FF
FY 2023-24	**$0**	**($127,947)**	**$127,947**
FY 2024-25	**$0**	**($99,364)**	**$99,364**

Funding:
(Dollars in Thousands)

FY 2023-24	Fund Number	TF	GF	FF
50% Title XIX /50% GF	4260-101-0890/0001	($709,600)	($354,800)	($354,800)
65% Title XXI / 35% GF	4260-101-0890/0001	$709,600	$248,359	$461,241
Title XIX FF	4260-101-0890	($71,686)	$0	($71,686)
Title XIX GF	4260-101-0001	$71,686	$71,686	$0
Title XXI FF	4260-101-0890	$93,192	$0	$93,192
Title XXI GF	4260-101-0001	($93,192)	($93,192)	$0
Net Impact (rounded)		**$0**	**($127,947)**	**$127,947**

* Totals may differ due to rounding

(Dollars in Thousands)

FY 2024-25	Fund Number	TF	GF	FF
50% Title XIX /50% GF	4260-101-0890/0001	($509,250)	($254,625)	($254,625)
65% Title XXI / 35% GF	4260-101-0890/0001	$509,250	$178,237	$331,013
Title XIX FF	4260-101-0890	($76,588)	$0	($76,588)
Title XIX GF	4260-101-0001	$76,588	$76,588	$0
Title XXI FF	4260-101-0890	$99,564	$0	$99,564
Title XXI GF	4260-101-0001	($99,564)	($99,564)	$0
Net Impact (rounded)		**$0**	**($99,364)**	**$99,364**

* Totals may differ due to rounding
** COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

COMMUNITY FIRST CHOICE OPTION

REGULAR POLICY CHANGE NUMBER: 14
IMPLEMENTATION DATE: 12/2012
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 1595

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$8,010,345,000	$8,687,097,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$8,010,345,000	$8,687,097,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$8,010,345,000	$8,687,097,000

Purpose:
This policy change budgets Title XIX federal funding for the Department of Social Services (CDSS) associated with the Community First Choice Option (CFCO).

Authority:
Welfare & Institutions Code 14132.956
Affordable Care Act (ACA) 2401
Interagency Agreement 11-88407
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
The ACA established a new State Plan option, which became available to states on October 1, 2010, to provide home and community-based attendant services and supports through CFCO. CFCO allows States to receive a 6% increase in federal match for expenditures related to this option. The state submitted a State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) which proposed moving federally eligible Personal Care Services Program (PCSP) and In-Home Supportive Services (IHSS) Plus Option program participants into CFCO. The Department budgets Title XIX Federal Financial Participation (FFP) for the provision of IHSS Plus Option and PCSP services to Medi-Cal beneficiaries.

The SPA was approved on August 31, 2012, with an effective date of December 1, 2011. In addition, CMS approved SPA 13-007, effective July 1, 2013, which updated eligibility language for compliance with the Social Security Act section 1915(k)(1) and 42 CFR section 441.510.

The CFCO generates new federal funds and creates General Fund savings to the State and counties who provide matching funds. The anticipated savings would be offset by cost increases to administer CFCO.

COMMUNITY FIRST CHOICE OPTION
REGULAR POLICY CHANGE NUMBER: 14

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change from the prior estimate for FY 2023-24, as well as the change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to updated expenditure data provided by CDSS that includes FFCRA increased FMAP costs for this policy change.

Methodology:
1. Costs for Medi-Cal beneficiaries 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 2023-24 and FY 2024-25 are in the table below.

(Dollars in Thousands)

FY 2023-24	TF	FF	CDSS GF/ County Share
Title XIX 100% FFP	$16,208,768	$8,104,384	$8,104,384
COVID-19 Tile XIX Increased FMAP	$0	$141,493	($141,493)
Total	$16,208,768	$8,245,877	$7,962,891
FY 2024-25	**TF**	**FF**	**CDSS GF/ County Share**
Title XIX 100% FFP	$17,578,248	$8,789,124	$8,789,124
COVID-19 Tile XIX Increased FMAP	$0	$0	$0
Total	$17,578,248	$8,789,124	$8,789,124

3. The estimated costs CDSS provided on a cash basis for FY 2023-24 and FY 2024-25 are in the table below.

COMMUNITY FIRST CHOICE OPTION

REGULAR POLICY CHANGE NUMBER: 14

(Dollars in Thousands)

FY 2023-24	**TF**	**FF**	**CDSS GF/ County Share**
100% Title XIX FFP	$15,554,425	$7,777,213	$7,777,212
COVID-19 Tile XIX Increased FMAP	$0	$233,132	($233,132)
Total	$15,554,425	**$8,010,345**	$7,544,080
FY 2024-25	**TF**	**FF**	**CDSS GF/ County Share**
100% Title XIX FFP	$17,373,417	$8,686,708	$8,686,709
COVID-19 Tile XIX Increased FMAP	$0	$389	($389)
Total	$17,373,417	**$8,687,097**	$8,686,320

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

HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS

REGULAR POLICY CHANGE NUMBER: 15
IMPLEMENTATION DATE: 2/2016
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 1967

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$21,774,000	$16,016,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$21,774,000	$16,016,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$21,774,000	$16,016,000

Purpose:
This policy change estimates the payment and technical adjustment in funding from Title XIX 50/50 Federal Medical Assistance Percentage (FMAP) to the enhanced Title XIX Affordable Care Act (ACA) FMAP for services provided at Designated Public Hospitals (DPHs) for Hospital Presumptive Eligibility (HPE) to the ACA Optional Expansion Population. HPE is a required provision of the ACA.

Authority:
Title 42, CFR, Section 435.1110
Social Security Act 1902(a)(47)
SB 28 (Chapter 442, Statutes of 2013)
California State Plan Amendment 13-0027-MM7

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2014, the ACA requires the Department to give hospitals the option to determine HPE for Medicaid. The HPE program offers qualified individuals immediate access to temporary Medi-Cal while applying for permanent Medi-Cal coverage or other health coverage. Individuals complete the HPE application on-line with a qualified HPE provider at a participating, qualified hospital. Eligibility is determined in real-time.

Individuals granted temporary HPE must complete the Medi-Cal application process in order to enroll in a permanent Medi-Cal program.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is an increase due to adding one quarter of actuals higher than previously projected. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to FY 2023-24 including one quarter of higher actuals, while FY 2024-25 is four quarters of projections that utilize the lower expenditure trends from FY 2019-20 and FY 2020-21.

HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS

REGULAR POLICY CHANGE NUMBER: 15

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 beneficiaries receiving services in DPHs and makes payments to DPHs for the enhanced FFP. The Department generates reports six months after the last day of the quarter to allow for lagged claims submission. The estimated average quarterly payment for enhanced Title XIX ACA FFP is $4,004,000 for FY 2023-24 and FY 2024-25 based on the average expenditures of the most recent eight quarters of data available (FY 2020-21 Q1-4, and FY 2021-22 Q1-4).

3. The Department will also claim the enhanced Title XIX ACA FMAP for beneficiaries receiving services in DPHs and estimates to pay DPHs $21,774,000 in FY 2023-24 and $16,016,000 in FY 2024-25. The estimated pass-through costs are included in the chart below.

(Dollars in Thousands)

FY 2023-24	**TF**	**FF**
FY 2022-23 Q2	$5,758	$5,758
FY 2022-23 Q3	$4,004	$4,004
FY 2022-23 Q4	$4,004	$4,004
FY 2023-24 Q1	$4,004	$4,004
FY 2023-24 Q2	$4,004	$4,004
Net Impact	**$21,774**	**$21,774**

FY 2024-25	**TF**	**FF**
FY 2023-24 Q3	$4,004	$4,004
FY 2023-24 Q4	$4,004	$4,004
FY 2024-25 Q1	$4,004	$4,004
FY 2024-25 Q2	$4,004	$4,004
Net Impact	**$16,016**	**$16,016**

Funding:

ACA 100% FFP (4260-101-0890)

1% FMAP INCREASE FOR PREVENTIVE SERVICES

REGULAR POLICY CHANGE NUMBER: 16
IMPLEMENTATION DATE: 1/2016
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 1791

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$9,748,000	-$5,807,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$9,748,000	-$5,807,000
FEDERAL FUNDS	$9,748,000	$5,807,000

Purpose:
This policy change estimates an additional 1% in federal medical assistance percentage (FMAP) for specified preventive services.

Authority:
Affordable Care Act (ACA), Section 4106

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2013, the ACA provides states with the option to receive an additional 1% in FMAP for providing specified preventive services. Eligible preventive services are those assigned Grade A or B by the United States Preventive Services Task Force (USPSTF), and approved adult vaccines and their administration as recommended by the Advisory Committee on Immunization Practices (ACIP). To be eligible to receive the enhanced FMAP, States must cover the specified preventive services in their standard Medicaid benefit package and cannot impose cost sharing for these services. States may only claim the 1% FMAP on services that adhere to the USPSTF Grade A and B recommendations on age, gender, periodicity and other criteria as indicated in the summary of recommendations. The Department previously incorporated, and continues to provide USPSTF recommended Grade A and B preventative services and ACIP approved adult vaccines as part of the Medi-Cal benefit package without cost-sharing.

The majority of the USPSTF Grade A and B recommendations include preventive screening services for adults only. The 1% FMAP policy does not apply to family planning services that are eligible for 90% match and prescription drugs (including over-the-counter).

For Fee-for-Service (FFS) members, many of the 1% FMAP eligible services for children, such as those for newborns prior to discharge from the hospital, cannot be pulled from the bundled rate. Additionally, the 1% FMAP can only be claimed if the primary purpose of the visit is the delivery of preventive services under USPSTF and ACIP.

1% FMAP INCREASE FOR PREVENTIVE SERVICES

REGULAR POLICY CHANGE NUMBER: 16

Reason for Change:
The change in FY 2023-24, from the prior estimate, is a net increase in managed care savings based on updated actual data from fourth quarter of Calendar Year (CY) 2022 savings that is used to project the savings in FY 2023-24 and FY 2024-25. The projected FFS savings increased based on updated actual data through December 2022.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease in estimated managed care savings due to two years (CY 2021 & CY 2023) of savings being claimed in FY 2023-24 as opposed to only one year (CY 2024) of savings claimed in FY 2024-25.

Methodology:
1. The 1% FMAP savings will include the following periods of savings in FY 2023-24:
    - FFS – July 1, 2022 through June 30, 2023
    - Managed care – January 1, 2021 through December 31, 2021
    - Managed care – January 1, 2023 through December 31, 2023

2. FY 2024-25 will include the following periods of savings:
    - FFS – July 1, 2023 through June 30, 2024
    - Managed care – January 1, 2024 through December 31, 2024

3. Due to a request from the CMS (Centers for Medicare & Medicaid Services), the Department has recalculated its Bridge Period savings and will be paying back the portion of those funds tied to members with unsatisfactory immigration status.

1% FMAP INCREASE FOR PREVENTIVE SERVICES
REGULAR POLICY CHANGE NUMBER: 16

4. Total savings for the 1% FMAP increase for preventive services are as follows:

FY 2023-24	TF	GF	FF
FFS:			
FY 2022-23 Savings	$0	($200,000)	$200,000
Total FFS	$0	($200,000)	$200,000
Managed Care:			
FY 2020-21 Savings	$0	($2,060,000)	$2,060,000
FY 2021-22 Savings	$0	($2,061,000)	$2,061,000
FY 2022-23 Savings	$0	($2,803,000)	$2,803,000
FY 2023-24 Savings	$0	($2,804,000)	$2,804,000
Bridge Period FFP UIS Payback	$0	$180,000	($180,000)
Total Managed Care	$0	($9,548,000)	$9,548,000
Total FY 2023-24	**$0**	**($9,748,000)**	**$9,748,000**

FY 2024-25	TF	GF	FF
FFS:			
FY 2023-24 Savings	$0	($200,000)	$200,000
Total FFS	$0	($200,000)	$200,000
Managed Care:			
FY 2023-24 Savings	$0	($2,803,000)	$2,803,000
FY 2024-25 Savings	$0	($2,804,000)	$2,804,000
Total Managed Care	$0	($5,607,000)	$5,607,000
Total FY 2024-25	**$0**	**($5,807,000)**	**$5,807,000**

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

HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.

REGULAR POLICY CHANGE NUMBER: 17
IMPLEMENTATION DATE: 1/2014
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 1821

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$33,281,200	-$32,817,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$33,281,200	-$32,817,600
FEDERAL FUNDS	$33,281,200	$32,817,600

Purpose:
This policy change estimates the technical adjustment in funding from Title XIX 50/50 Federal Medical Assistance Percentage (FMAP) to the enhanced Title XIX Affordable Care Act (ACA) FMAP for providing Hospital Presumptive Eligibility (HPE) to the ACA Optional Expansion Population. HPE is a required provision of the ACA.

Authority:
Title 42, CFR, Section 435.1110
Social Security Act 1902(a)(47)
SB 28 (Chapter 442, Statutes of 2013)
California State Plan Amendment 13-0027-MM7
State Plan Amendment (SPA) 20-0024

Interdependent Policy Changes:
COVID-19 Increased FMAP – DHCS

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 March 24, 2023, the Centers for Medicare & Medicaid Services approved SPA 20-0024, which expanded the HPE Program to include the aged (65 years of age and older), disabled, and blind population, or the HPE Expansion Group.

HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.

REGULAR POLICY CHANGE NUMBER: 17

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase in GF due to adding two additional quarter of actuals lower than previously projected.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase in GF due to FY 2023-24 utilizing three quarters of actuals while FY 2024-25 utilizes four quarters of projections with lowered expenditure 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. Using claims from FY 2022 Q1-3, and a projected average from claims in FY 2021 Q4 and FY 2022 Q1-3 for FY 2022 Q4, the estimate average quarterly adjustment for FY 2023-24 is $21,316,000. Using a projected average from claims in FY 2021 Q4 and FY 2022 Q1-3 for FY 2023 Q1-4, the estimate average quarterly adjustment for FY 2024-25 is $20,801,000.

4. The Department estimates to adjust $85,263,000 TF claims from Title XIX 50/50 FMAP to claim the enhanced Title XIX ACA FMAP in FY 2023-24 and $83,203,000 TF in FY 2024-25. The estimated funding adjustment is included in the chart below.

(Dollars in Thousands)

FY 2023-24	**TF**	**GF**	**FF**
50% Title XIX FF / 50% GF	($83,203)	($41,602)	($41,601)
90% Title XIX FF / 10% GF	$83,203	$8,320	$74,883
Net Impact	**$0**	**($33,282)**	**$33,282**

FY 2024-25	**TF**	**GF**	**FF**
50% Title XIX FF / 50% GF	($82,044)	($41,022)	($41,022)
90% Title XIX FF / 10% GF	$82,044	$8,204	$73,840
Net Impact	**$0**	**($32,818)**	**$32,818**

*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)
COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

ACA DSH REDUCTION

REGULAR POLICY CHANGE NUMBER: 18
IMPLEMENTATION DATE: 10/2023
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 2105

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	-$837,844,000	-$1,199,552,000
- STATE FUNDS	-$371,398,000	-$540,730,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$837,844,000	-$1,199,552,000
STATE FUNDS	-$371,398,000	-$540,730,000
FEDERAL FUNDS	-$466,446,000	-$658,822,000

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

Authority:
Affordable Care Act (ACA), HR 3590, Section 2551
HR 2 (2015)
HR 1892 (2018)
HR 4378 (2019)
HR 3055 (2019)
HR 1865 (2019)
HR 748 (2020)
HR 8337 (2020)
HR 133 (2020)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
The federal DSH allotment is available for uncompensated Medi-Cal and uninsured costs incurred by DSHs. The ACA requires the aggregate, nationwide reduction of DSH allotments in the amount of $8 billion annually Federal Fiscal Year (FFY) 2024 through FFY 2027, for a total aggregate reduction of $32 billion. The distribution of the aggregate reductions is determined by the Centers for Medicare & Medicaid Services (CMS).

The original effective date of the reduction was October 1, 2013; however, HR 2 (2015) delayed the start date of the reduction until October 1, 2017. HR 1892 (2018) was enacted on February 9, 2018, which postponed the reduction until October 1, 2019. Subsequently, HR 4378 (2019) and HR 3055 (2019) were enacted, postponing the reduction until November 22, 2019, and December 21, 2019, respectively. On December 20, 2019, HR 1865 further delayed the ACA DSH reduction until May 23, 2020. On March 27, 2020, HR 748 (2020) was enacted which

ACA DSH REDUCTION
REGULAR POLICY CHANGE NUMBER: 18

eliminated the FFY 2020 reduction and postponed the start of the FFY 2021 reduction until December 1, 2020. On October 1, 2020, HR 8337 postponed the start of the FFY 2021 reduction until December 12, 2020. On December 27, 2020, HR 133 eliminated DSH reductions for FFYs 2021-2023, lowered the overall national reduction to $32 billion, and postponed implementation until FFY 2024.

In October 2017, CMS released a simulated California DSH reduction amount of $166 million, which represented 8.35% of the total national reduction. In October 2019, CMS released a preliminary California DSH reduction amount of $389.5 million for FFY 2020, representing 9.74% of that year's total national reduction of $4 billion. In October 2020, CMS released a preliminary California DSH reduction amount of $266 million for FFY 2021, representing 6.66% of that year's total national reduction. Based on the FFY 2021 amounts released from CMS and updates to the national aggregate total of $8 billion per year, for estimation purposes for all DSH years impacted by the reduction (FFY 2024-2027), California's percent share of the national reduction is assumed to be 6.66%.

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

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to:

- Utilization of updated program year data, which resulted in an increased reduction absorption for Private DSH Replacement.
- An updated Non-Designated Public Hospital (NDPH) DSH allotment allocation estimate which resulted in a decreased reduction absorption.
- A change to the UC Designated Public Hospital (DPH) DSH and GPP DSH allotment allocations. The Department will continue to budget for and pay the UCLA hospitals through DSH rather than GPP until CMS has approved the UCLA transition to GPP.

ACA DSH REDUCTION
REGULAR POLICY CHANGE NUMBER: 18

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to:

- A larger DSH allotment estimate. The Department estimated FY 2024-25 DSH allotment will not be subject to American Rescue Plan (ARP) adjustments and is derived by trending forward the estimated non-ARP adjusted FY 2023-24 allotment by 2%.

Methodology:

1. California's DSH allotment is estimated to be $1.49 billion for FY 2023-24 and $1.50 billion for FY 2024-25.

2. California's anticipated reduction results in a total reduction of $533 million federal funds (FF) for FY 2023-24 and FY 2024-25, for NDPHs and DPHs. The DSH allotment reduction will offset DSH payments for NDPHs and University of California (UC) DPHs in the DSH Payment policy change, and the remaining DPHs in the GPP policy change.

3. The DSH allotment amount is applied in the DSH payment methodology to determine the reduction amount for the estimated aggregate Private DSH Replacement funding. The total reduction amount is estimated to be $127 million FF for FY 2023-24 and $126 million FF for FY 2024-25. The Private DSH replacement reduction will offset Private DSH replacement payments in the Private Hospital DSH Replacement policy change.

4. The Title XIX COVID-19 increased FMAP is assumed for savings through December 31, 2023, for this policy change.

5. Assume the following DSH reduction on an accrual basis:

(Dollars in Thousands)

FY 2023-24	TF	GF	IGT	FF	COVID-19 FF
Private DSH Replacement	($251,018)	($123,940)	$0	($125,509)	($1,569)
DSH NDPH	($17,610)	($8,695)	$0	($8,805)	($110)
DSH UC	($114,669)	$0	$0	($114,669)	$0
GPP	($808,961)	$0	($399,930)	($409,031)	$0
Total Reduction FY 2023-24	**($1,192,258)**	**($132,635)**	**($399,930)**	**($658,014)**	**($1,679)**

ACA DSH REDUCTION
REGULAR POLICY CHANGE NUMBER: 18

(Dollars in Thousands)

FY 2024-25	TF	GF	IGT	FF
Private DSH Replacement	($252,598)	($126,299)	$0	($126,299)
DSH NDPH	($17,698)	($8,849)	$0	($8,849)
DSH UC	($114,684)	$0	$0	($114,684)
GPP	($818,164)	$0	($409,082)	($409,082)
Total Reduction FY 2024-25	**($1,203,144)**	**($135,148)**	**($409,082)**	**($658,914)**

6. For Private Hospital DSH Replacement and DSH NDPH:
   - Assume 11/12 of the FY 2023-24 DSH payment reduction will occur in FY 2023-24 and 1/12 will occur in FY 2024-25.

7. For UC DSH:
   - Assume 3/4 of the FY 2023-24 DSH payment reduction will occur in FY 2023-24 and 1/4 will occur in FY 2024-25.

8. For GPP:
   - Assume 5/8 of the FY 2023-24 GPP payment reduction will occur in FY 2023-24 and 3/8 will occur in FY 2024-25.

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

(Dollars in Thousands)

FY 2023-24	TF	GF***	IGT	FF	COVID-19 FF
FY 2023-24 Private DSH Replacement	($230,100)	($113,481)	$0	($115,050)	($1,569)
FY 2023-24 DSH NDPH	($16,142)	($7,961)	$0	($8,071)	($110)
FY 2023-24 DSH UC*	($86,002)	$0	$0	($86,002)	$0
FY 2023-24 GPP**	($505,600)	$0	($249,956)	($255,644)	$0
Total Reduction FY 2023-24	**($837,844)**	**($121,442)**	**($249,956)**	**($464,767)**	**($1,679)**

ACA DSH REDUCTION

REGULAR POLICY CHANGE NUMBER: 18

(Dollars in Thousands)

FY 2024-25	TF	GF***	IGT	FF
FY 2023-24 Private DSH Replacement	($20,918)	($10,459)	$0	($10,459)
FY 2023-24 DSH NDPH	($1,468)	($734)	$0	($734)
FY 2023-24 DSH UC*	($28,667)	$0	$0	($28,667)
FY 2023-24 GPP**	($303,360)	$0	($149,974)	($153,386)
FY 2024-25 Private DSH Replacement	($231,550)	($115,775)	$0	($115,775)
FY 2024-25 DSH NDPH	($16,224)	($8,112)	$0	($8,112)
FY 2024-25 DSH UC*	($86,013)	$0	$0	($86,013)
FY 2024-25 GPP**	($511,352)	$0	($255,676)	($255,676)
Total Reduction FY 2024-25	**($1,199,552)**	**($135,080)**	**($405,650)**	**($658,822)**

Funding:
100% Demonstration DSH Fund (4260-601-7502)*
100% Title XIX FFP (4260-101-0890)**
100% Global Payment Program Special Fund (4260-601-8108)**
50% Title XIX/ 50% GF (4260-101-0001/0890)***
COVID-19 Title XIX Increased FFP (4260-101-0890)
COVID-19 Title XIX GF (4260-101-0001)

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

REGULAR POLICY CHANGE NUMBER: 19
IMPLEMENTATION DATE: 7/2000
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 25

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$578,033,000	$845,986,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$578,033,000	$845,986,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$578,033,000	$845,986,000

Purpose:
This policy change estimates the federal match provided to Local Educational Agencies (LEAs) for Medi-Cal eligible services through the LEA Medi-Cal Billing Option Program (LEA BOP).

Authority:
Welfare & Institutions Code 14132.06 and 14115.8
State Plan Amendment (SPA) 15-021
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023
AB 483 (Chapter 527, Statutes of 2023)

Interdependent Policy Changes:
Not Applicable

Background:
Local Educational Agencies, which consist of school districts, county offices of education, charter schools, community colleges, and university campuses, may enroll as Medi-Cal providers through the LEA BOP. Through the program, LEAs receive federal reimbursement for certified public expenditures (CPEs) incurred while providing specific eligible health services to Medi-Cal enrolled students to the extent federal financial participation (FFP) is available. LEAs receive interim reimbursement through claims payments and then calculate their total cost of providing these services to Medi-Cal-enrolled students using a Cost and Reimbursement Comparison Schedule (CRCS) that is submitted to the Department annually for the preceding fiscal year (FY). Final payment settlements based on actual CPEs for a given year are considered completed when the Department has audited the LEA's CRCS.

- If interim reimbursements exceed the audited CPE settlement, the Department collects the overpayment and returns the excess federal match from the LEA to the federal government by means of withholding funds from future interim claims until the LEA's account is reconciled.
- If interim claims reimbursements are less than the audited CPE settlement, the Department draws additional federal funds to reimburse the LEA. These additional draws have not previously been reported on any estimate.

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

REGULAR POLICY CHANGE NUMBER: 19

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. 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 for direct services, and final settlements are estimated to start in FY 2023-24.

SPA 15-021 also requires the Department to issue 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 will be 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 is the first year that LEA BOP will report the final settlement amounts.

Because LEA BOP is a CPE program, the total cost of providing the covered services to Medi-Cal members is reflected on the CRCS. The federal medical assistance program (FMAP) is then broken down as components of the total reported cost: The interim claims submitted by the LEAs are reimbursed at 50 percentage points FFP. However, some of the services or members are eligible for increased or enhanced Title XIX and Title XXI FMAP, which is reflected for the first time on the CRCS for FY 2020-21.

The FFCRA provides increased federal funding by increasing the 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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

LOCAL EDUCATION AGENCY (LEA) PROVIDERS
REGULAR POLICY CHANGE NUMBER: 19

Reason for Change:
The change in FY 2023-24, from the prior estimate, is a net increase due to:

- The Consolidated Appropriations Act of 2023 FFCRA enhanced FMAP is applicable during the first six months of FY 2023-24.

- Program growth from SPA 15-021 for the interim payments is now anticipated to be a 10 percentage point increase, instead of 20% from the previous estimate from FY 2022-23. This growth is applied to the calculations for interim reimbursement for the new services and practitioners which is then used develop the estimated amount for interim payments in FY 2023-24.

- The calculation that was used to develop the interim payment estimate for FY 2023-24 uses an average of the paid claims from the past two fiscal years, instead of three. This is due to the decremental impact of COVID-19 on paid claims in FY 2020-21. By using the past two FYs, the average will be more in alignment with what was paid out in interim payments for FY 2022-23.

- The number and timing of final and back-casting settlements in FY 2023-24 have been updated based on Audits and Investigations' (A&I) revised timeline for auditing current CRCS reports and back-casted reports.

    - A majority of the FY 2020-21 CRCS reports were finalized in FY 2022-23, therefore the final settlement amount for this CRCS period was paid out primarily in FY 2022-23 rather than in FY 2023-24 as previously anticipated.

    - Additionally, the previous estimate for the interim settlement amount was based on what was submitted to DHCS. However, since the last estimate, more CRCS reports were received for FY 2020-21, which now reflects the increase in the interim settlement amount.

- The rate inflation increased to 8.6621%.

- The System Development Notice (SDN) to remove the Unsatisfactory Immigration Status (UIS) Blank Indicator is expected to reduce the overall interim payments made by $2.8 million. Base estimate moving forward for future estimates will include UIS impact.

- Final settlement amounts for back-casted FYs 2015-16, FY 2016-17, and FY 2017-18 are included in the estimate. This estimate is based upon the amounts identified in the CRCS reports for FY 2015-16 as it is the only data available.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is a net increase due to:

- Overall interim reimbursement estimate decreased due to a reduced rate inflation point percentage and removal of the FFCRA enhanced FMAP percentages.

- No longer anticipating program growth from State Plan Amendment 15-021.

- Assembly Bill 483 was signed into law. This bill states that 2% will be withheld from the interim reimbursement starting in FY 2024-25. This is reflected as a decrease in the interim reimbursement.

LOCAL EDUCATION AGENCY (LEA) PROVIDERS
REGULAR POLICY CHANGE NUMBER: 19

- Currently, 3% of the interim reimbursement is withheld, and that amount is reflected in the actual and estimated interim reimbursement amounts and not identified separately.

- The SDN to remove the UIS Blank Indicator is expected to reduce the overall interim payments made by $2.8 million. In future estimates, the base estimate will incorporate the impact of UIS.

- Additional payouts projected to increase final settlement amounts due to A&I's updated audit schedule for final settlements for back-casting (FYs 2015-16, 2016-17, 2017-18, and 2018-19), and regular CRCS reports (FY 2019-20) to be paid out in FY 2024-25.

- The estimate for final and interim settlement amounts is based upon FY 2021-22 CRCS reported amounts and will be updated with final settlement amounts when FY 2018-19 and FY 2019-20 are received.

Methodology:

1. For FY 2023-24, the estimated interim reimbursement is based on the average of the preceding two FYs of actual paid claims data.

2. For FY 2024-25, the estimated interim reimbursement is based on the average of the preceding two FYs of paid and estimated claims data.

3. Assume a 10% program growth increase in FY 2023-24 only based upon analysis of the submitted amended CRCSs for FY 2015-16 that includes CPEs for the SPA expansion, and the interim claims received in FY 2022-23 that are captured in the cash management drill.

4. The FYs 2023-24 and 2024-25 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.

5. SDN 23005 was implemented on June 26, 2023, to disallow UIS claims for FFP. Assume a $2,769,920 decrease to LEA reimbursements in FY 2023-24 for the exclusion of claims for members with a UIS. A reduction has been included in the FY 2023-24 estimate to reflect an overall reduction of interim claims. The UIS impact is factored into the FY 2024-25 estimate by inclusion in the estimated interim reimbursement from FY 2023-24.

6. Approximately 66% of the FY 2021-22 CRCS will receive an interim settlement, in FY 2023-24 and 66% of the FY 2022-23 CRCS will receive an interim settlement in FY 2024-25. This amount is calculated using A&I's most recently completed final settlement percentage (79%) and is calculated as payments at 60% of the reported amount, which is the amount LEA BOP will be paying LEAs for the interim settlement.

7. Two-thirds of the FY 2020-21 CRCS will receive a final settlement in FY 2022-23 Q3 and Q4. Final settlements anticipated in FY 2023-24 will include 33% of FY 2020-21 and 33% of FY 2021-22. For this estimate, this amount is calculated using A&I's most recently completed final settlement percentage.

LOCAL EDUCATION AGENCY (LEA) PROVIDERS
REGULAR POLICY CHANGE NUMBER: 19

8. Back-casting for expansion services is based upon 38% of the participating LEAs who filed timely amended CRCS reports for FY 2015-16. These demonstrate median program growth of 155 percentage points. This was reduced to 20% assuming that not all LEAs will submit the required forms timely and that those who had the most to gain were those who submitted timely. The first batch of back-casting payments begin in FY 2023-24 for 66.6% of FY 2015-16, FY 2016-17, and FY 2017-18, and the remaining 33.3% paid FY 2024-25 Q1 and Q2. Back-casting payments for FY 2018-19 are expected to be completed in FY 2024-25.

9. Assume the enhanced FMAPs proportionately for the estimated interim reimbursements, interim settlements, and final settlements. Enhanced FMAPs are not part of the back-casting settlements. They are based by LEA upon the aid codes of members for when claims are submitted.

10. The Title XIX and Title XXI COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

FY 2023-24	TF	Title XIX FFP	Title XXI FFP	COVID-19 FF
Estimated Interim Reimbursement	$136,031,000	$125,954,000	$0	$10,077,000
Rate Inflation (8.6621%)	$11,783,000	$10,910,000	$0	$873,000
SPA 15-021 Impact (10% growth)	$14,781,000	$13,686,000	$0	$1,095,000
Reduction of UIS Blank Indicator	($2,770,000)	($2,565,000)	$0	($205,000)
Interim Settlements for SFY 2021-22	$65,866,000	$50,657,000	$14,606,000	$603,000
Final Settlements for SFY 2020-21	$44,118,000	$33,931,000	$9,783,000	$404,000
Back-casting (66% of SFYs 2015-16, 2016-17, 2017-18, 2018-19; 50% of SFY 2019-20)	$308,224,000	$239,397,000	$68,827,000	$0
Total	**$578,033,000**	**471,970,000**	**$93,216,000**	**12,847,000**

FY 2024-25	TF	Title XIX FFP	Title XXI FFP	COVID-19 FF
FY 2024-25 Estimated Interim Reimbursement	$150,005,000	$150,005,000	$0	$0
Rate Inflation (8.2254%)	$12,590,000	$12,590,000	$0	$0
Interim Settlements for SFY 2020-21	$24,725,000	$19,351,000	$5,374,000	$0
Final Settlements for SFY 2020-21	$348,885,000	$273,053,000	$75,832,000	$0
Back-casting (66% of SFYs 2015-16, 2016-17, 2017-18, 2018-19; 50% of SFY 2019-20)	$309,781,000	$309,781,000	$0	$0
Total	**$845,986,000**	**$764,780,000**	**$81,206,000**	**$0**

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

FAMILY PACT PROGRAM

REGULAR POLICY CHANGE NUMBER: 20
IMPLEMENTATION DATE: 1/1997
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 1

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$225,304,000	$290,328,000
- STATE FUNDS	$54,708,800	$70,498,700
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$225,304,000	$290,328,000
STATE FUNDS	$54,708,800	$70,498,700
FEDERAL FUNDS	$170,595,200	$219,829,300

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:
COVID-19 Increased FMAP – DHCS

Background:
Effective January 1, 1997, family planning services expanded under the Family PACT program to provide contraceptive services to persons in need of such services with incomes under 200% of the Federal Poverty Level. The Centers for Medicare & Medicaid Services (CMS) approved a Section 1115 demonstration project waiver, effective December 1, 1999.

On March 24, 2011, CMS approved a State Plan Amendment (SPA), in accordance with the Affordable Care Act, to transition the current Family PACT waiver into the State Plan. Under the SPA, eligible family planning services and supplies, formerly reimbursed exclusively with 100% State General Fund, receive a 90% federal financial participation (FFP), and family planning-related services receive reimbursement at Title XIX 50/50 FFP.

This policy change is inclusive of CMS approved, time-limited supplemental payments, at a rate equal to 150 percent of the current Family PACT rates, to Family PACT providers for specific family planning services. Expenditures for these services are delineated in the Proposition 56-Women's Health Supplemental Payments policy change.

Drug rebates for Family PACT drugs are included in the Family PACT Drug Rebates policy change.

FAMILY PACT PROGRAM
REGULAR POLICY CHANGE NUMBER: 20

Reason for Change:
The change from the prior estimate, for FY 2023-24, is decrease due to updated actual expenditure data and a reduction in users projected to drop off during caseload redeterminations. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to higher projected users of Family PACT services in FY 2024-25.

Methodology:
1. The Department used linear regressions based upon the most recent 36 months of actual data for users, units per user, and dollars per unit.

2. Family planning services and testing for sexually transmitted infections (STIs) are eligible for 90% FFP.

3. The treatment of STIs and other family planning-related services are eligible for Title XIX 50/50 FFP.

4. It is assumed that 13.95% of the Family PACT population are undocumented persons and are budgeted at 100% GF.

(Dollars in Thousands)

Fiscal Years	TF	GF	FF
FY 2023-24	**$225,304**	**$54,709**	**$170,595**
FY 2024-25	**$290,328**	**$70,498**	**$219,830**

*Totals may differ due to rounding.

Funding:
(Dollars in Thousands)

FY 2023-24	TF	GF	FF
90% Family Planning / 10% GF (4260-101-0890/0001)	$184,143	$18,414	$165,729
50% Title XIX / 50% GF (4260-101-0890/0001)	$9,733	$4,866	$4,867
100% GF (4260-101-0001)	$31,428	$31,428	$0
Total	**$225,304**	**$54,708**	**$170,596**

FY 2024-25	TF	GF	FF
90% Family Planning / 10% GF (4260-101-0890/0001)	$237,287	$23,729	$213,558
50% Title XIX / 50% GF (4260-101-0890/0001)	$12,542	$6,271	$6,271
100% GF (4260-101-0001)	$40,499	$40,499	$0
Total	**$290,328**	**$70,499**	**$219,829**

*Totals may differ due to rounding.
** COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

MULTIPURPOSE SENIOR SERVICES PROGRAM

REGULAR POLICY CHANGE NUMBER: 21
IMPLEMENTATION DATE: 7/2019
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 28

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$63,951,000	$63,951,000
- STATE FUNDS	$31,335,500	$31,975,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$63,951,000	$63,951,000
STATE FUNDS	$31,335,500	$31,975,500
FEDERAL FUNDS	$32,615,500	$31,975,500

Purpose:
This policy change estimates the cost of the Multipurpose Senior Services Program (MSSP).

Authority:
Welfare & Institutions Code 9560-9568
Welfare & Institutions Code 14132.275
Welfare & Institutions Code 14186
SB 1008 (Chapter 33, Statutes of 2012)
American Rescue Plan (ARP) Act (2021)
Families First Coronavirus Response Act (FFCRA)
AB 128 (Chapter 21, Statutes of 2021)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
The MSSP provides social and health care management and purchases supplemental services to assist persons aged 65 and older who are "at risk" of needing nursing facility placement but who wish to remain in the community. The program provides services under a federal 1915(c) home and community-based services waiver. The Coordinated Care Initiative (CCI) was previously scheduled to transition MSSP to a managed care benefit effective January 1, 2023; however, effective January 1, 2022, MSSP was carved-out of CCI. 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 October 2015, Health Plan of San Mateo (HPSM) successfully transitioned to a full managed care benefit and has fully integrated MSSP services into health plan operations.

Effective January 1, 2022, the total MSSP reimbursement is budgeted in this policy change as a result of AB 128.

MULTIPURPOSE SENIOR SERVICES PROGRAM
REGULAR POLICY CHANGE NUMBER: 21

The ARP provides additional Coronavirus Disease 2019 (COVID-19) relief to states. Section 9817 of the ARP provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS). Increased FMAP is available from April 1, 2021, through March 31, 2022. States must use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021, and states must use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. State funds equivalent to the amount of federal funds attributable to the increased FMAP are deposited in the Home and Community-Based Services American Rescue Plan Fund.

The FFCRA provides increased federal funding by increasing the 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. 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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
There is no change for FY 2023-24 from the prior estimate. There is no change in total funds from FY 2023-24 to FY 2024-25 in the current estimate. There is a General Fund increase from FY 2023-24 to FY 2024-25 in the current estimate due to the FFCRA increased FMAP ending on December 31, 2023.

Methodology:
1. Assume the MSSP has 11,940 slots at a rate of $5,356 per slot.

2. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

3. The estimates below were provided on a cash basis.

MULTIPURPOSE SENIOR SERVICES PROGRAM

REGULAR POLICY CHANGE NUMBER: 21

FY 2023-24	TF	GF	FF
50% Title XIX FFP / 50% GF	$63,951,000	$31,975,000	$31,976,000
COVID-19 Title XIX Increased FMAP	$0	($640,000)	$640,000
Total	**$63,951,000**	**$31,336,000**	**$32,615,000**
FY 2024-25	**TF**	**GF**	**FF**
50% Title XIX FFP / 50% GF	$63,951,000	$31,975,000	$31,976,000
Total	**$63,951,000**	**$31,975,000**	**$31,976,000**

*Totals may differ due to rounding.

Funding:
50% Title XIX FF / 50% GF (4260-101-0890/0001)
COVID-19 FFCRA Title XIX Increased FFP (4260-101-0890)
COVID-19 FFCRA Title XIX GF (4260-101-0001)

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER: 22
IMPLEMENTATION DATE: 12/2008
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 1228

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$48,808,000	$62,090,000
- STATE FUNDS	$10,854,000	$17,686,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$48,808,000	$62,090,000
STATE FUNDS	$10,854,000	$17,686,000
FEDERAL FUNDS	$37,954,000	$44,404,000

Purpose:
This policy change estimates the costs of providing demonstration services to Medi-Cal eligible members enrolled in the California Community Transitions (CCT) Demonstration Project who will transition to the community and receive qualified home and community-based services for up to 365 days following their transition.

Authority:
Federal Deficit Reduction Act (DRA) of 2005 (P.L. 109-171), Section 6071
Affordable Care Act (ACA) (P.L. 111-148), Section 2403
Medicaid Extenders Act of 2019 (P.L. 116-3), Section 2
Families First Coronavirus Response Act (FFCRA), (P.L. 116-127), Section 6008
California Welfare and Institutions Code, Chapter 300, Section 14196.2
Consolidated Appropriations Act, 2021 (P.L. 108-361), Section 204
California Welfare and Institutions Code, Section14196.6
Consolidated Appropriations Act, 2023 (P.L. 117-328), Section 5114

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.

CALIFORNIA COMMUNITY TRANSITIONS COSTS
REGULAR POLICY CHANGE NUMBER: 22

The Extenders Act provided the Centers for Medicare & 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.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid; however, MFP expenditures are only able to draw down an additional 3.1%. 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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 3.1% increased FMAP for Title XIX from Jan 2020 to March 2023;
- 2.5% increased FMAP for Title XIX from April 2023 to June 2023;
- 1.25% increased FMAP for Title XIX from July 2023 to Sept 2023;
- 0.75% increased FMAP for Title XIX from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

On December 27, 2020, the President signed the Consolidated Appropriations Act, 2021 into law, which includes an extension of the MFP grant through FFY 2023 and appropriates funding through 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. The Act also reduced the number of days a member had to reside in a facility to be eligible for MFP from 90 to 60 days.

Beginning January 1, 2021, SB 214 created a temporary program that revised the requirement for members residing in an inpatient facility from 90 days and longer to less than 90 days. The temporary program required the Department to end enrolling specified members by the end of December 31, 2022, and end providing services at the end of December 31, 2023. However, SB 214 was invalidated due to federal legislation that modified criteria for the MFP grant. As a result, the Department proposed amendments to the statute through trailer bill language to align the state-funded CCT population with the new federal requirements.

On July 27, 2021, AB 133 was approved and resulted in necessary changes to state law to align with federal MFP requirements, which removed barriers to the Department's implementation of the state-only CCT program. AB 133 aligned state statute with the amended federal statute, by reducing the required period of residence in an inpatient facility from 90 days to 60 days. The state-funded, CCT-like program allows CCT Lead Organizations to provide transition services to Medi-Cal members who have not yet met the federal, MFP residency eligibility criteria, as a way to help reduce the amount of time members are required to remain in an institution during the COVID-19 public health emergency.

On March 31, 2022, CMS issued a Memorandum to MFP grantees informing it is increasing the reimbursement rate for MFP supplemental services. These services are now 100% federally funded with no state share. Effective January 1, 2022, supplemental services are fully covered by MFP grant funds at a federal reimbursement rate of 100%. Implementation of CCT supplemental services is pending.

CALIFORNIA COMMUNITY TRANSITIONS COSTS
REGULAR POLICY CHANGE NUMBER: 22

On September 30, 2022, California Welfare and Institutions Code, Section 14196.6 was amended to extend the CCT-like program's end date from December 31, 2023, to December 31, 2026.

On December 29, 2022, the President signed the Consolidated Appropriations Act of 2023 into law, which appropriates additional funding for each fiscal year 2024 through 2027. Unexpended grant funds awarded for any fiscal year can continue to be spent for up to four additional years, through September 30, 2031.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is a decrease due to the cost per member being lower than previously estimated based on additional actuals data through June 2023. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to additional enrollments from the CCT members.

Methodology:
1. Assume estimated costs of waiver impacted services for members residing year-round in Nursing Facility (NF)-Bs would be $124,189 in FY 2023-24 and $123,642 in FY 2024-25. The savings from moving members from NF-Bs to the waiver are 50% FFP 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. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

3. The state-funded CCT members transitioned to the CCT program in October 2021.

4. 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.

5. Assume 1,127 members will transition from an inpatient facility to the CCT program in FY 2023-24 and 1,590 in FY 2024-25.

6. Assume 754 ALW members who transitioned from an institution to a community setting qualify to draw down $28,500 per year in post-transition Qualified Home and Community-Based Services.

7. Assume $27,403,000 was awarded for CY 2022, which allowed CCT transitions to continue through December 31, 2022.

8. The federal government issued a new grant award in CY 2023 at least equal to the current grant awarded, which allowed CCT transitions to continue through December 31, 2023.

9. Below is the overall impact of the CCT Demonstration project in FY 2023-24 and FY 2024-25.

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER: 22

FY 2023-24	TF	GF	FF
CCT Costs PC:			
GF costs and Total FFP	$27,259,000	$5,480,000	$21,779,000
State-Funded CCT Population	$3,000	$2,000	$1,000
ALW Transition Costs	$21,546,000	$5,576,000	$15,970,000
COVID-19 Title XIX Increased FFP	$0	($205,000)	$205,000
Total Costs	**$48,808,000**	**$10,853,000**	**$37,955,000**
CCT Savings:			
Total GF savings and Total FFP	($103,791,000)	($51,895,000)	($51,896,000)
CCT Fund Transfer to CDSS PC:			
CCT Fund Transfer Costs	$287,000	$0	$287,000
COVID-19 Title XIX Increased FFP	$8,000	$0	$8,000
Total Costs	$295,000	$0	$295,000
CCT Outreach - Admin costs PC:	$340,000	$0	$340,000
Total of CCT PCs including savings	($54,348,000)	($41,042,000)	($13,306,000)

*The savings are included in the total, however, they are fully reflected in the base estimates.

FY 2024-25	TF	GF	FF
CCT Costs PC:			
GF costs and Total FFP	$40,541,000	$8,151,000	$32,390,000
State-Funded CCT Population	$3,000	$2,000	$1,000
ALW Transition Costs	$21,546,000	$9,533,000	$12,013,000
Total Cost	**$62,090,000**	**$17,686,000**	**$44,404,000**
CCT Savings:			
Total GF savings and Total FFP	($133,348,000)	($66,674,000)	($66,674,000)
CCT Fund Transfer to CDSS PC:	$391,000	$0	$391,000
CCT Outreach - Admin costs PC:	$340,000	$0	$340,000
Total of CCT PCs including savings	($70,527,000)	($48,988,000)	($21,539,000)

*The savings are included in the total, however, they are fully reflected in the base estimates.

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER: 22

Funding:
100% GF (4260-101-0001)
MFP Federal Grant (4260-106-0890)
COVID-19 Title XIX GF (4260-101-0001)
COVID-19 Title XIX Increased FFP (4260-106-0890)
50% Title XIX FFP / 50% GF (4260-101-0890/0001)

BEHAVIORAL HEALTH TREATMENT

REGULAR POLICY CHANGE NUMBER: 23
IMPLEMENTATION DATE: 10/2016
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 1855

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$19,667,000	$12,078,000
- STATE FUNDS	$9,107,950	$5,727,900
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$19,667,000	$12,078,000
STATE FUNDS	$9,107,950	$5,727,900
FEDERAL FUNDS	$10,559,050	$6,350,100

Purpose:
This policy change estimates the costs for providing Behavioral Health Treatment (BHT) services for children under age 21 with a diagnosis of autism spectrum disorder (ASD), 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
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
SB 870 added Welfare & Institutions Code (WIC), Section 14132.56 to direct the Department to implement BHT services to the extent it is required by the federal government to be covered by Medi-Cal for individuals under 21 years of age. On July 7, 2014, the Centers for Medicare and Medicaid Services (CMS) released guidance for states to cover BHT services for Medicaid beneficiaries 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

BEHAVIORAL HEALTH TREATMENT
REGULAR POLICY CHANGE NUMBER: 23

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).

The Department, in collaboration with DDS, began transitioning responsibility for BHT services starting February 1, 2016 in both Medi-Cal Fee-for-Service (FFS) and managed care. The transition was completed in September 2016. Medi-Cal beneficiaries age 21 and over receiving BHT services from RCs will continue to receive those services from the RCs pursuant to the 1915(c) and (i) waivers.

Additional RC clients, without an ASD diagnosis, have been receiving BHT Behavioral Intervention Services (BIS) through the RCs. On March 1, 2018, the Department transitioned these additional RC clients enrolled in FFS Medi-Cal 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.

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due to a portion of FY 2021-22 and FY 2022-23 claims for FFS, previously budgeted in FY 2022-23, is now expected to be paid in FY 2023-24.

The change in the current estimate, from FY 2023-24 to FY 2024-25, is due to the following:

- FFS - The decrease is due to more prior year payments estimated for FY 2023-24.
- Managed care – Base capitation rates, effective January 1, 2023, are captured fully in the Capitated Rate Adjustment policy change.

Methodology:
1. Coverage for BHT began on September 15, 2014.

Fee-for-Service
2. A total of 1,683 FFS beneficiaries transitioned from DDS on February 1, 2016.

BEHAVIORAL HEALTH TREATMENT
REGULAR POLICY CHANGE NUMBER: 23

3. The IA contract between the Department and DDS was executed in July 2017, with a retroactive effective date of February 1, 2016.

4. 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.

5. The FFS cost reimbursement estimates were provided by DDS. The estimated annual cost on an accrual basis is $11,481,000 TF for FY 2023-24 and FY 2024-25 claims.

6. On a cash basis, FFS reimbursements are estimated to be paid as follows:

Fee-for-Service Claims	Accrual	FY 2023-24	FY 2024-25
FY 2021-22 claims	$13,501,000	$2,106,000	$0
FY 2022-23 claims	$11,834,000	$5,604,000	$596,000
FY 2023-24 claims	$11,481,000	$9,568,000	$1,914,000
FY 2024-25 claims	$11,481,000	$0	$9,568,000
Total		**$17,278,000**	**$12,078,000**

Managed Care

7. Managed care payments began in October 2016 for BHT services based on a supplemental capitation payment methodology, retroactive to the implementation date.

8. Beginning January 2021, managed care rates are updated on a calendar year basis. Starting January 1, 2023, BHT transitioned to the base capitation rates. The CY 2023 BHT PMPM expenditures will be captured in the managed care base costs whilst any remaining CY 2022 supplemental expenditures will continue to be budgeted in this policy change.

9. The Title XIX and Title XXI COVID-19 increased FMAP is assumed for expenditures through December 31, 2023 for this policy change.

Rate Year	Accrual	FY 2023-24	FY 2024-25
FY 2021-22 - FFS	$13,501,000	$2,106,000	$0
FY 2022-23 - FFS	$11,834,000	$5,604,000	$596,000
FY 2022-23 - MC	$1,252,640,000	$2,389,000	$0
FY 2023-24 - FFS	$11,481,000	$9,568,000	$1,914,000
FY 2024-25 - FFS	$11,481,000	$0	$9,568,000
Total		$19,667,000	$12,078,000

FY 2023-24	TF	GF	FF	COVID-19 FF
Fee-for-Service	$17,278,000	$8,030,000	$9,084,000	$164,000
Managed Care	$2,289,000	$1,078,000	$1,256,000	$55,000
Total	**$19,667,000**	**$9,108,000**	**$10,340,000**	**$219,000**

BEHAVIORAL HEALTH TREATMENT

REGULAR POLICY CHANGE NUMBER: 23

FY 2024-25	TF	GF	FF	COVID-19 FF
Fee-for-Service	$12,078,000	$5,728,000	$6,350,000	$0
Managed Care	$0	$0	$0	$0
Total	**$12,078,000**	**$5,728,000**	**$6,350,000**	**$0**

Funding:

FY 2023-24	TF	GF	FF
65% Title XXI / 35% GF (4260-101-0001/0890)	$3,377,000	$1,182,000	$2,195,000
50% Title XIX / 50% GF (4260-101-0001/0890)	$16,290,000	$8,145,000	$8,145,000
COVID-19 Title XIX (4260-101-0001/0890)	$0	($191,000)	$191,000
COVID-19 Title XXI (4260-101-0001/0890)	$0	($28,000)	$28,000
Total	**$19,667,000**	**$9,108,000**	**$10,559,000**

FY 2024-25	TF	GF	FF
65% Title XXI / 35% GF (4260-101-0001/0890)	$2,074,000	$726,000	$1,348,000
50% Title XIX / 50% GF (4260-101-0001/0890)	$10,004,000	$5,002,000	$5,002,000
Total	**$12,078,000**	**$5,728,000**	**$6,350,000**

CYBHI - DYADIC SERVICES

REGULAR POLICY CHANGE NUMBER: 24
IMPLEMENTATION DATE: 1/2023
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2328

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$128,012,000	$170,579,000
- STATE FUNDS	$52,167,950	$70,717,050
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	97.40 %	99.76 %
APPLIED TO BASE		
TOTAL FUNDS	$3,328,300	$409,400
STATE FUNDS	$1,356,370	$169,720
FEDERAL FUNDS	$1,971,940	$239,670

Purpose:
This policy change estimates the costs of adding dyadic services as a Medi-Cal benefit for children under 21 years old and their parents/guardians.

Authority:
AB 133 (Chapter 143, Statutes of 2021)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
The Children and Youth Behavioral Health Initiative (CYBHI) is a multiyear package of investments as part of the FY 2021-22 budget agreement. The CYBHI is intended to transform California's behavioral health system for children and youth aged 0-25 into a world-class, innovative, up-stream focused, ecosystem where all children and young adults are routinely screened, supported, and served for emerging behavioral health needs. Dyadic services are included in the CYBHI package.

Effective January 1, 2023, the Department added dyadic services as a covered outpatient benefit in both fee-for-service (FFS) and managed care delivery systems for members under 21 years old. Children typically see medical providers over a dozen times during infancy and early childhood, but routine visits do not always surface issues that could lead to behavioral health problems later in the child's life. Dyadic services allow medical and behavioral health providers to work as teams, treating both the child and the parent/caregiver. The behavioral health provider screens the family for trauma and stress, interpersonal safety, tobacco and substance use, mental health symptoms, and social determinants of health (such as food or housing insecurity), and is able to provide timely support, referrals, and coordination. Dyadic services have been proven to improve outcomes for children by addressing issues early, before they lead to serious health problems.

CYBHI - DYADIC SERVICES
REGULAR POLICY CHANGE NUMBER: 24

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is a decrease due to the following:

- Reflecting costs after FFS payment lags are applied.
- Managed care costs for dyadic services are now fully included in base capitation rates.

The change in the current estimate, from FY 2023-24 to FY 2024-25, is an increase due to FY 2024-25 including a full years' expenditure and ramp up of benefits.

Methodology:
1. The dyadic services benefit began on January 1, 2023.

2. The Title XIX and Title XXI COVID-19 increased FMAP is assumed for expenditures through December 31, 2023 for this policy change.

3. Total estimated costs for dyadic services, on a cash basis, is as follows.

Dyadic Services	TF	GF	FF	COVID-19 FF
FY 2023-24 (Lagged)	$128,012,000	$52,168,000	$75,037,000	$807,000
FY 2024-25 (Lagged)	$170,579,000	$70,717,000	$99,862,000	$0

CYBHI - DYADIC SERVICES
REGULAR POLICY CHANGE NUMBER: 24

Funding:

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$86,600,000	$43,300,000	$43,300,000
65% Title XXI FF / 35% GF (4260-101-0001/0890)	$22,135,000	$7,748,000	$14,387,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	$19,277,000	$1,927,000	$17,350,000
COVID-19 Title XIX (4260-101-0001/0890)	$0	($688,000)	$688,000
COVID-19 Title XXI (4260-101-0001/0890)	$0	($119,000)	$119,000
Total	**$128,012,000**	**$52,168,000**	**$75,844,000**

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$115,826,000	$57,913,000	$57,913,000
65% Title XXI FF / 35% GF (4260-101-0001/0890)	$29,315,000	$10,260,000	$19,055,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	$25,438,000	$2,544,000	$22,894,000
Total	**$170,579,000**	**$70,717,000**	**$99,862,000**

MEDICAL INTERPRETER PILOT PROJECT

REGULAR POLICY CHANGE NUMBER: 25
IMPLEMENTATION DATE: 2/2022
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 1989

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$2,005,000	$969,000
- STATE FUNDS	$2,005,000	$969,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,005,000	$969,000
STATE FUNDS	$2,005,000	$969,000
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the costs for establishing a medical interpreter pilot project.

Authority:
SB 165 (Chapter 365, Statutes of 2019)
AB 118 (Chapter 42, Statutes of 2023)

Interdependent Policy Changes:
Not Applicable

Background:
SB 165 appropriated $5 million General Fund (GF) for the support of medical interpreter pilot project. Funding will be awarded for pilot projects in up to four pilot sites to deliver language assistance services to patients/clients who are unserved or underserved because they are limited English proficient (LEP).

Reason for Change:
The change in FY 2023-24, from the prior estimate, is a net decrease due to:
- Minor changes in interpreter needs identified by pilot site clinics;
- Language expansion at Contra Costa clinic did not progress as anticipated;
- A reduced need for interpretation services during university summer vacations;
- The Pilot Project Evaluator estimate decreased due to allocating the funds to FY 2024-25; and
- Pilot Site Clinic estimate increased due to additional staff needed to coordinate the program through its sunset date of June 30, 2025.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to the cost declining due to the sunset date of the program in June 30, 2025.

MEDICAL INTERPRETER PILOT PROJECT
REGULAR POLICY CHANGE NUMBER: 25

Methodology:
1. The Medical Interpreter Pilot Project was effective October 1, 2021.

2. Assume a delay in the pilot project launch in FY 2021-22, resulting in a rollover of funds to FY 2022-23. The remaining dollars of the $5,000,000 budget will be used in FY 2023-24 and FY 2024-25.

3. A one-time $60,000 GF start-up cost for pilot site contractors was paid in February 2022.

4. SB 165 in FY 2019-20 provided $5 million GF, available for expenditure through June 30, 2024. Availability has been extended due to approval of AB 118 which extends the program through June 30, 2025, with no other programmatic changes. The table below displays the estimated spending and remaining funds by Appropriation Year:

	TF	GF
Appropriation Year 2019-20		
Prior Years	$2,026,000	$2,026,000
Estimated in FY 2023-24	$2,005,000	$2,005,000
Estimated in FY 2024-25	$969,000	$969,000
Total Estimated Remaining	$0	$0

5. Total estimated reimbursement for FY 2023-24 and FY 2024-25 are as follows:

FY 2023-24	**TF**	**GF**
Appropriation Year 2019-20	$2,005,000	$2,005,000
Total FY 2023-24	**$2,005,000**	**$2,005,000**

FY 2024-25	**TF**	**GF**
Appropriation Year 2019-20	$969,000	$969,000
Total FY 2024-25	**$969,000**	**$969,000**

MEDICAL INTERPRETER PILOT PROJECT
REGULAR POLICY CHANGE NUMBER: 25

6. Total estimated reimbursement for FY 2023-24 and FY 2024-25, on a cash basis, are:

FY 2023-24	TF	GF
Interpret Services Contractors	$1,260,000	$1,260,000
Pilot Project Evaluator	$525,000	$525,000
Pilot Site Clinics Compensation	$220,000	$220,000
Total	**$2,005,000**	**$2,005,000**

FY 2024-25	TF	GF
Interpret Services Contractors	$315,000	$315,000
Pilot Project Evaluator	$434,000	$434,000
Pilot Site Clinics Compensation	$220,000	$220,000
Total	**$969,000**	**$969,000**

Funding:
100% General Fund (4260-101-0001)

CCS DEMONSTRATION PROJECT

REGULAR POLICY CHANGE NUMBER: 26
IMPLEMENTATION DATE: 4/2013
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1775

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$1,730,000	$0
- STATE FUNDS	$807,550	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,730,000	$0
STATE FUNDS	$807,550	$0
FEDERAL FUNDS	$922,450	$0

Purpose:
This policy change estimates additional payments to or recoveries from organized health care delivery systems for the California Children's Services (CCS) Medi-Cal beneficiaries as determined by the two-sided risk corridor the Department entered into for the three and a half years of the program.

Authority:
ABX4 6 (Chapter 6, Statutes of 2009)
SB 208 (Chapter 714, Statutes of 2010)
California Bridge to Reform (BTR), Section 1115(a) Medicaid Demonstration
California Medi-Cal 2020, Section 1115(a) Demonstration

Interdependent Policy Changes:
COVID-19 Increased FMAP – DHCS

Background:
The BTR, approved by the Centers for Medicare and Medicaid Services effective November 1, 2010, and the Medi-Cal 2020 extension, allows the Department to develop and implement organized health care delivery models to provide comprehensive health care services to CCS Medi-Cal eligible children. This includes both primary preventive care and services specific to the child's CCS eligible health condition.

Rady Children's Hospital – San Diego (RCHSD) demonstration project was implemented effective July 1, 2018. RCHSD acts as an Accountable Care Organization in providing services to CCS-eligible Medi-Cal beneficiaries with any one or more of the following acute conditions: cystic fibrosis, acute lymphoid leukemia, sickle cell disease, hemophilia, and diabetes. Participating members must be under the age of 21. Due to the 1115 Waiver expiring on December 31, 2020, the demonstration project was expected to sunset no sooner than December 31, 2020. However, due to the COVID-19 impact, CMS granted an extension of one year on the 1115 Waiver. The RCHSD demonstration project ended on December 31, 2021. The Department entered into a two-sided risk corridor arrangement for all three and a half years of the program.

CCS DEMONSTRATION PROJECT
REGULAR POLICY CHANGE NUMBER: 26

Reason for Change:
The change for FY 2023-24, from the prior estimate, is a decrease due to updated CY 2021 risk corridor calculations. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to the sunset of the RCHSD demonstration project and completion of CY 2021 risk corridor in FY 2023-24.

Methodology:
1. The RCHSD demonstration project implemented in July 2018.

2. The final capitation payment occurred in FY 2022-23.

3. Risk corridor calculations for CY 2021 are estimated to result in a payment of $1,730,000 in FY 2023-24.

4. Total estimated costs for FY 2023-24 and FY 2024-25 on a cash basis are:

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$1,347,000	$674,000	$673,000
65% Title XXI / 35%GF (4260-101-0001/0890)	$383,000	$134,000	$249,000
Total	**$1,730,000**	**$808,000**	**$922,000**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
65% Title XXI / 35% GF (4260-101-0001/0890)
COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

HEARING AID COVERAGE FOR CHILDREN PROGRAM

REGULAR POLICY CHANGE NUMBER: 27
IMPLEMENTATION DATE: 12/2021
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 2189

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$1,515,000	$2,607,000
- STATE FUNDS	$1,515,000	$2,607,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	10.40 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,357,400	$2,607,000
STATE FUNDS	$1,357,440	$2,607,000
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the cost of providing hearing aids and associated services to children ages 20 and under, who are otherwise not eligible for Medi-Cal, do not have health insurance coverage for hearing aids and related services or have qualifying partial other health coverage for hearing aids, and are at or below 600% Federal Poverty Level (FPL).

Authority:
AB 89 (Chapter 7, Statutes of 2020)
Budget Act of 2022 [AB 179 (Chapter 249, Statutes of 2022)]

Interdependent Policy Changes:
Not Applicable

Background:
The Department introduced a new California state-only benefit for children, ages 0-17, who are otherwise not eligible for Medi-Cal, and with a household income up to 600% of the federal poverty level, effective July 1, 2021. This benefit is available to children with no health insurance or whose existing health insurance does not cover hearing aids and related services. Valid hearing aid prescription from an otolaryngologist or physician, or referral from a hearing-related professional or medical provider will be required for program enrollment. This program is funded with 100% General Fund (GF).

Without this benefit, eligible children are at a high risk for developmental and educational delays. It is especially important to make this benefit available, given the current pandemic that has resulted in school closures and distance learning. Children who are deaf and hard of hearing must be able to utilize every medical assistance/device available to ensure continued learning.

HEARING AID COVERAGE FOR CHILDREN PROGRAM

REGULAR POLICY CHANGE NUMBER: 27

Effective January 1, 2023, the eligibility criteria of Hearing Aid Coverage for Children Program (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.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to updated payment lag assumptions.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to the continuation of enrollment ramp-up in FY 2024-25.

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 2023-24 and $2,738,000 in FY 2024-25.

3. FY 2023-24 and FY 2024-25 lagged payments for HACCP claims are estimated to be:

Hearing Aid Coverage for Children Program	TF	GF
FY 2023-24	$1,515,000	$1,515,000
FY 2024-25	$2,607,000	$2,607,000

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

CCT FUND TRANSFER TO CDSS

REGULAR POLICY CHANGE NUMBER: 28
IMPLEMENTATION DATE: 10/2011
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 1562

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$295,000	$391,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$295,000	$391,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$295,000	$391,000

Purpose:
This policy change estimates the enhanced federal funding associated with providing the California Department of Social Services (CDSS) additional Title XIX for waiver services provided to Medi-Cal members who participate in the California Community Transitions (CCT) project.

Authority:
Federal Deficit Reduction Act (DRA) of 2005 (P.L. 109-171), Section 6071
Affordable Care Act (ACA) (P.L. 111-148), Section 2403)
Medicaid Extenders Act of 2019 (P.L. 116-3), Section 2
IA 10-87274 (CDSS)
Families First Coronavirus Response Act (FFCRA) (P.L. 116–127), Section 6008
Consolidated Appropriations Act, 2021 (P.L. 108-361), Section 204
Consolidated Appropriations Act, 2023 (P.L. 117-328), Section 5114

Interdependent Policy Changes:
Families First Coronavirus Response Act (FFCRA)

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 & 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.

CCT FUND TRANSFER TO CDSS
REGULAR POLICY CHANGE NUMBER: 28

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid; however, MFP expenditures are only able to draw down an additional 3.1%. 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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 3.1% increased FMAP for Title XIX from Jan 2020 to March 2023;
- 2.5% increased FMAP for Title XIX from April 2023 to June 2023;
- 1.25% increased FMAP for Title XIX from July 2023 to Sept 2023;
- 0.75% increased FMAP for Title XIX from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

On December 27, 2020, the President signed the Consolidated Appropriations Act, 2021 into law, which includes an extension of the MFP grant through FFY 2023 and appropriates funding through 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. The Act also reduced the number of days a member had to reside in a facility to be eligible for MFP from 90 to 60 days.

On December 29, 2022, the President signed the Consolidated Appropriations Act of 2023 into law, which appropriates additional funding for each fiscal year 2024 through 2027. Unexpended grant funds awarded for any fiscal year can continue to be spent for up to four additional years, through September 30, 2031.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due to higher CCT enrollment than previously estimated based on additional actuals data through June 2023. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to increased CCT enrollment.

Methodology:
1. The Department provides HCBS to CCT members who are receiving IHSS. The Department provides federal funding to CDSS as the base federal match through HCBS policy changes.

2. CCT services are reimbursed at 75% FFP and 25% GF. The GF for CDSS is provided by CDSS and is budgeted in the Personal Care Services (Misc. Svcs.) policy change.

3. The Department established IA 10-87274 with CDSS. The IA transfers the additional 25% FFP for HCBS provided to CCT members who are receiving IHSS services during their 365 days of participation in the CCT demonstration.

4. It is assumed that 12% of all members utilize IHSS under CCT. Assume each case costs $6,017 in FY 2023-24 and $6,359 in FY 2024-25. The Department will provide 25% of these costs to CDSS. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

CCT FUND TRANSFER TO CDSS
REGULAR POLICY CHANGE NUMBER: 28

5. Assume 1,127 members will transition in FY 2023-24 and 1,590 in FY 2024-25.

6. Assume $27,120,000 TF was awarded for calendar year (CY) 2022, which allowed CCT transitions to continue through December 31, 2022.

7. The federal government issued a new grant award of $35,718,000 in CY 2023, which allowed CCT transitions to continue through December 31, 2023.

8. Below is the overall impact of the CCT Demonstration project in FY 2023-24 and FY 2024-25.

FY 2023-24	**TF**	**GF**	**FF**
CCT Costs (PC 28):			
GF costs and Total FFP	$27,259,000	$5,480,000	$21,779,000
State-Funded CCT Population	$3,000	$2,000	$1,000
ALW Transition Costs	$21,546,000	$5,576,000	$15,970,000
COVID-19 Title XIX Increased FFP	$0	($205,000)	$205,000
Total Costs	$48,808,000	$10,853,000	$37,955,000
CCT Savings:			
Total GF savings and Total FFP	($103,791,000)	($51,895,000)	($51,896,000)
CCT Fund Transfer to CDSS PC:			
CCT Fund Transfer Costs	$287,000	$0	$287,000
COVID-19 Title XIX Increased FFP	$8,000	$0	$8,000
Total Costs	**$295,000**	**$0**	**$295,000**
CCT Outreach - Admin costs PC:	$340,000	$0	$340,000
Total of CCT PCs including savings	($54,348,000)	($41,042,000)	($13,306,000)

*The savings are included in the total, however, they are fully reflected in the base estimates.

CCT FUND TRANSFER TO CDSS

REGULAR POLICY CHANGE NUMBER: 28

FY 2024-25	TF	GF	FF
CCT Costs PC:			
GF costs and Total FFP	$40,541,000	$8,151,000	$32,390,000
State-Funded CCT Population	$3,000	$2,000	$1,000
ALW Transition Costs	$21,546,000	$9,533,000	$12,013,000
Total Cost	$62,090,000	$17,686,000	$44,404,000
CCT Savings:			
Total GF savings and Total FFP	($133,348,000)	($66,674,000)	($66,674,000)
CCT Fund Transfer to CDSS PC:	**$391,000**	**$0**	**$391,000**
CCT Outreach - Admin costs PC:	$340,000	$0	$340,000
Total of CCT PCs including savings	($70,918,000)	($48,988,000)	($21,930,000)

*The savings are included in the total, however, they are fully reflected in the base estimates.

Funding:
MFP Federal Grant (4260-106-0890)
COVID-19 Title XIX Increased FFP (4260-106-0890)

DOULA BENEFIT

REGULAR POLICY CHANGE NUMBER: 29
IMPLEMENTATION DATE: 1/2023
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2279

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$565,000	$1,132,000
- STATE FUNDS	$228,650	$458,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	52.55 %	35.10 %
APPLIED TO BASE		
TOTAL FUNDS	$268,100	$734,700
STATE FUNDS	$108,500	$297,440
FEDERAL FUNDS	$159,600	$437,230

Purpose:
This policy change estimates the cost of adding doula services as a covered Medi-Cal benefit in Fee-for-Service (FFS) and managed care delivery systems.

Authority:
Budget Act of 2021 [SB 129 (Chapter 69, Statutes of 2021)]

Interdependent Policy Changes:
COVID-19 Increased FMAP – DHCS

Background:
The Department added doula services to the list of preventive services effective January 1, 2023. Doula services include personal support to women and families throughout a woman's pregnancy, childbirth and postpartum experience. This includes emotional and physical support, provided during pregnancy, labor, birth and the postpartum period. Pursuant to 42 Code of Federal Regulations (CFR) Section 440.130(c), doula services must be recommended by a physician or other licensed practitioner.

Medi-Cal's standard doula benefit will include maternity and labor support visits, which can be at the beneficiary's home, or part of a beneficiary's office visit, and during delivery. Currently, there is no certification requirement to operate as a doula in the state of California. For doulas who choose to go through a certification process, the requirements vary based on the organization.

Positive health outcomes as a result of doula services are expected during the pregnancy through childbirth. Research suggests that the doula benefit also results in offsetting savings, due to situations where higher costs for preterm births and cesarean deliveries may be avoided. More positive health outcomes are also expected during the pregnancy through to childbirth. However, no offsetting savings are assumed in this policy change. Such savings will accrue as reductions in base expenditures as they materialize.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is a decrease due to reflecting costs after

DOULA BENEFIT
REGULAR POLICY CHANGE NUMBER: 29

FFS payment lags are applied and updating the portion of first year costs that are reflected in the FFS base estimate.

The change in the current estimate, from FY 2023-24 to FY 2024-25, is due to an increase in the estimated phased-in utilization for FY 2024-25.

Methodology:
1. The doula benefit was implemented in January 2023 in both Medi-Cal FFS and managed care delivery systems for beneficiaries with full scope Medi-Cal or pregnancy-only coverage.

2. Managed care costs for doula benefit are included in base capitation rates, and currently budgeted in the following policy changes: County Organized Health Systems, Two Plan Model, Regional Model, and Geographic Managed Care.

3. An estimated 14,868 births occur in Medi-Cal FFS. Assume 10% of those births will utilize doula services.

4. The estimated cost for doula per labor is $1,094.00. Assume the annual cost for doula benefit is $1,627,000 TF.

5. Assume the doula benefit utilization will occur on a phase in basis with 25% utilization in the first year, 50% in the second year, and full phase-in occurring in the third year.

6. Total estimated costs for the doula benefit, on a cash basis, is as follows:

Doula Benefit	TF	GF	FF
FY 2023-24 (Lagged)	**$565,000**	**$229,000**	**$336,000**
FY 2024-25 (Lagged)	**$1,132,000**	**$458,000**	**$674,000**

Funding:

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$426,000	$213,000	$213,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	$132,000	$14,000	$118,000
65% Title XXI FF / 35% GF (4260-101-0001/0890)	$7,000	$2,000	$5,000
Total	**$565,000**	**$229,000**	**$336,000**

DOULA BENEFIT

REGULAR POLICY CHANGE NUMBER: 29

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$854,000	$427,000	$427,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	$264,000	$26,000	$238,000
65% Title XXI FF / 35% GF (4260-101-0001/0890)	$14,000	$5,000	$9,000
Total	**$1,132,000**	**$458,000**	**$674,000**

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

COMMUNITY HEALTH WORKER

REGULAR POLICY CHANGE NUMBER: 30
IMPLEMENTATION DATE: 2/2022
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2269

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$91,871,000	$91,871,000
- STATE FUNDS	$32,393,300	$32,393,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	100.00 %	100.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the cost for adding Community Health Workers (CHWs) to the class of skilled and trained individuals who are able to provide clinically appropriate Medi-Cal covered benefits and services in both Fee-for-Service (FFS) and managed care delivery systems.

Authority:
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
CHWs are skilled and trained health educators who work directly with individuals who may have difficulty understanding and/or interacting with providers due to cultural and/or language barriers. CHWs can assist those individuals by helping them to navigate the relationship with their health care providers, assist them in accessing health care services, and provide key linkages with other similar and related community-based resources. As a result, CHWs help to extend the reach of providers into underserved communities, reduce health disparities, enhance provider communication, and improve health outcomes and overall quality measures. Working in conjunction with health care providers, CHWs can bridge gaps in communication and instill lasting health knowledge to individuals within their communities to reduce health and mental health disparities experienced by vulnerable communities in California.

Effective July 1, 2022, the Department added CHWs as another class of skilled and trained individuals who are able to provide clinically appropriate Medi-Cal covered benefits and services. CHWs render Medi-Cal covered benefits and services, and operate under the supervision of a licensed, enrolled Medi-Cal provider. The Department also added violence prevention services (VPS) as part of the CHW state plan amendment (SPA). These services are available under both the FFS and managed care delivery system.

COMMUNITY HEALTH WORKER
REGULAR POLICY CHANGE NUMBER: 30

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to

- Managed care costs for CHW are now fully included in base capitation rates.
- FFS costs are now fully reflected in the FFS base estimate.

There is no change from FY 2023-24 to FY 2024-25 in the current estimate.

Methodology:
1. CHWs began providing Medi-Cal benefits and services beginning July 1, 2022 for both FFS and managed care.

2. The Title XIX and Title XXI COVID-19 increased FMAP is assumed for expenditures through December 31, 2023 for this policy change.

3. Total estimated costs for CHWs, on a cash basis, is as follows:

FY 2023-24	TF	GF	FF	COVID-19 FF
Fee-for-Service	$9,201,000	$4,120,000	$4,999,000	$82,000
Managed Care	$82,670,000	$28,273,000	$54,009,000	$388,000
Total	**$91,871,000**	**$32,393,000**	**$59,008,000**	**$470,000**

FY 2024-25	TF	GF	FF	COVID-19 FF
Fee-for-Service	$9,201,000	$4,120,000	$4,999,000	$82,000
Managed Care	$82,670,000	$28,273,000	$54,009,000	$388,000
Total	**$91,871,000**	**$32,393,000**	**$59,008,000**	**$470,000**

COMMUNITY HEALTH WORKER
REGULAR POLICY CHANGE NUMBER: 30

Funding:

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$57,778,000	$28,889,000	$28,889,000
65% Title XXI FF / 35% GF (4260-101-0001/0890)	$31,833,000	$3,183,000	$28,650,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	$2,260,000	$791,000	$1,469,000
COVID-19 Title XIX (4260-101-0001/0890)	$0	($458,000)	$458,000
COVID-19 Title XXI (4260-101-0001/0890)	$0	($12,000)	$12,000
Total	**$91,871,000**	**$32,393,000**	**$59,478,000**

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$57,778,000	$28,889,000	$28,889,000
65% Title XXI FF / 35% GF (4260-101-0001/0890)	$31,833,000	$3,183,000	$28,650,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	$2,260,000	$791,000	$1,469,000
COVID-19 Title XIX (4260-101-0001/0890)	$0	($458,000)	$458,000
COVID-19 Title XXI (4260-101-0001/0890)	$0	($12,000)	$12,000
Total	**$91,871,000**	**$32,393,000**	**$59,478,000**

FPACT HPV VACCINE COVERAGE

REGULAR POLICY CHANGE NUMBER: 31
IMPLEMENTATION DATE: 7/2023
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 2311

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$5,092,000	$0
- STATE FUNDS	$2,901,500	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	100.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the costs of providing the human papillomavirus (HPV) vaccination as a covered benefit under the Family Planning, Access, Care and Treatment (Family PACT) Program.

Authority:
State Plan Amendment 10-014

Interdependent Policy Changes:
Not Applicable

Background:
HPV is a common virus that can cause deadly cancers. Effective July 1, 2022, the Department expanded the Family PACT program to include the HPV vaccine as a covered benefit for females and males, ages 19 through 45. This policy increases access to the HPV vaccine, which prevents genital tract, oropharyngeal cancers, and pre-cancers.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is decrease due to updated actuals being lower than previously projected. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to the HPV benefit costs being budgeted in the Family PACT Program policy change beginning in FY 2023-24.

Methodology:
1. Implementation began on July 1, 2022.

2. Assume 10,830 Family PACT clients will get a 3 dose HPV vaccine at the medical reimbursement rate of $742.38.

FPACT HPV VACCINE COVERAGE

REGULAR POLICY CHANGE NUMBER: 31

Fiscal Years	TF	GF	FF
FY 2023-24	**$5,092,000**	**$2,901,000**	**$2,191,000**

Funding:

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890/0001)	$4,381,000	$2,191,000	$2,190,000
100% GF (4260-101-0001)	$710,000	$710,000	$0
Total	**$5,092,000**	**$2,901,000**	**$2,191,000**

CALAIM - LTC BENEFIT TRANSITION

REGULAR POLICY CHANGE NUMBER: 32
IMPLEMENTATION DATE: 1/2023
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2196

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	-$175,788,000	$4,318,000
- STATE FUNDS	-$80,826,100	$1,985,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$175,788,000	$4,318,000
STATE FUNDS	-$80,826,100	$1,985,300
FEDERAL FUNDS	-$94,961,900	$2,332,700

Purpose:
This policy change estimates the impact of adding the long-term care (LTC) as a covered benefit through Medi-Cal Managed Care through the California Advancing and Innovating Medi-Cal (CalAIM) demonstration waiver.

Authority:
California Advancing and Innovating Medi-Cal (CalAIM) 1915(b) Waiver Amendment and Renewal
Welfare & Institutions Code Section 14184.201

Interdependent Policy Changes:
COVID-19 Increased FMAP – DHCS

Background:
Under CalAIM, all Medi-Cal Managed Care Plans (MCP) are required to authorize and cover LTC services in institutional settings as required by state and federal law in an appropriate LTC facility. Specialty LTC provider types include skilled nursing facilities (SNFs), intermediate care facilities (ICFs), or facilities that furnish sub-acute (SA) care. The Medi-Cal program currently sets different reimbursement rates for the following LTC providers: Skilled Nursing Facilities Level-B (FS/NF-B) (SNFs), Adult Freestanding Subacute Facilities Level-B (FSSA/NF-B), Distinct Part Subacute Facilities Level-B (DP/NF-B), Adult Distinct Part Subacute Facilities Level-B (DPSA/NF-B), NF-Bs designated as Institutions for Mental Diseases (IMD), Distinct Part Pediatric Subacute (DP/PSA), Freestanding Pediatric Subacute Facilities (FS/PSA), Intermediate Care Facility for Developmentally Disabled (ICF/DD), Intermediate Care Facility for Developmentally Disabled with Habilitative (ICF/DD-H), and Intermediate Care Facility for Developmentally Disabled with Nursing (ICF/DD-N).

Prior to CalAIM, LTC services were a full managed care benefit in County Organized Health Systems (COHS) and/or Coordinated Care Initiative (CCI) plans. In non-COHS managed care counties, MCPs are responsible for the month of admission and the month following.

CALAIM - LTC BENEFIT TRANSITION

REGULAR POLICY CHANGE NUMBER: 32

Under CalAIM, all MCPs are required to cover LTC facility services. This means that members who are admitted into a LTC facility in non-COHS counties and would otherwise have been disenrolled from the MCP will remain enrolled in managed care. The LTC benefit transition standardizes and reduces the complexity of the varying models of care delivery in California. Populations moving between counties will have the same experience when it comes to receiving services through a managed care plan.

In addition, under CalAIM, LTC members would be enrolled in mandatory managed care enrollment, allowing for Medi-Cal MCPs to provide more coordinated and integrated care and provide members with a network of primary care providers and specialists.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to:

- Removing the January 1, 2023 FFS and managed care SNF transition impacts from this policy change as they are fully captured in the FFS base and managed care base capitation rates.
- FY 2023-24 only reflects the impact of the ICF/DD and subacute care facilities transition and the CY 2023 ICF/DD and subacute care facility managed care recoupment.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to:

- FY 2024-25 capturing a full 12 months' worth of FFS impacts, whereas FY 2023-24 only captures a partial year of impacts.
- Managed care recoupments for CY 2023 rates paid for the ICF/DD and subacute care transition were completed in FY 2023-24.

Methodology:

1. The LTC benefit and enrollment transition to managed care for skilled nursing facility services is effective January 1, 2023; and the managed care transitions for services provided in intermediate care facilities for the developmentally disabled (ICF/DDs) and subacute (SA) care facilities will be effective January 1, 2024.

2. The FFS and managed care impact of the January 1, 2023 skilled nursing facility transition is fully captured in the FFS base projections and managed care base capitation rates.

3. FY 2023-24 and FY 2024-25 include the FFS and managed care impact of the ICF/DDs and subacute care facilities which shift to managed care. The annual value of benefits, for ICF/DDs and subacute care facilities, estimated to shift from FFS to managed care is $949.2 million TF.

4. A total of $474.6 million TF from the CY 2023 rates were paid for ICF/DD and subacute care facilities transition. Due to the delay of the ICF/DD and subacute care facilities to January 2024, the $474.6 million TF will be recouped in FY 2023-24.

CALAIM - LTC BENEFIT TRANSITION
REGULAR POLICY CHANGE NUMBER: 32

5. The impacts of the transition in FFS and managed care are shown below:

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
FFS (Lagged)	($373,547)	($171,754)	($201,793)
Managed Care	$197,759	$90,928	$106,831
Total	**($175,788)**	**($80,826)**	**($94,962)**

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
FFS (Lagged)	($944,926)	($434,470)	($510,456)
Managed Care	$949,244	$436,455	$512,789
Total	**$4,318**	**$1,985**	**$2,333**

Funding:
50% Title XIX FF/ 50% GF (4260-101-0001/0890)
90%Title XIX FF / 10% GF (4260-101-0001/0890)
65% Title XXI FF / 35% GF (4260-101-0001/0890)
COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

MEDICATION THERAPY MANAGEMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 33
IMPLEMENTATION DATE: 7/2022
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 2263

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$2,448,000	$3,861,000
- STATE FUNDS	$794,750	$1,253,700
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	4.40 %	2.79 %
APPLIED TO BASE		
TOTAL FUNDS	$2,340,300	$3,753,300
STATE FUNDS	$759,780	$1,218,720
FEDERAL FUNDS	$1,580,510	$2,534,560

Purpose:
This policy change estimates the costs for providing medication management payments to Medi-Cal enrolled pharmacies who, by means of signed contracts with the Department, provide a list of specialized services to high-risk and medically complex populations with certain disease states by implementing a new Medication Therapy Management (MTM) program.

Authority:
AB 133 (Chapter 143, Statutes of 2021)
SPA 21-0028

Interdependent Policy Change:
COVID-19 Increased FMAP – DHCS

Background:
In February 2019, following implementation of the new Fee-For-Service (FFS) Actual Acquisition Cost (AAC)-based pharmacy reimbursement methodology, independent pharmacy providers and the California Pharmacists Association (CPhA), notified the Department that the new methodology, and associated reduced reimbursement could cause certain pharmacies to cease providing specialized medication management services. These specialized services are designed to ensure “at risk” populations remain adherent and compliant with their drug treatment regimens. Characteristics of the “at risk” population receiving medication management services may include homelessness, mental illness, and/or history/evidence of non-compliance or non-adherence with medications.

The Department authorized a survey to determine acquisition costs and identify specialized services provided by those pharmacies in the dispensing of specific drugs. The survey confirmed the AAC methodology resulted in a potential for member access issues with respect to certain drugs, while being an appropriate reimbursement methodology overall. The drug therapy categories surveyed were identified through direct communications from Medi-Cal providers to the Department including reports from stakeholders and CPhA.

MEDICATION THERAPY MANAGEMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 33

The Department has implemented a separate specific reimbursement methodology for FFS pharmacy services provided in conjunction with certain complex chronic medical conditions including but not limited to, Severe Mental Illness (SMI), Human Immunodeficiency Virus (HIV), Hepatitis C Virus (HCV), cancer, cystic fibrosis and other genetic diseases, Multiple Sclerosis (MS), Hemophilia, Cardio-vascular diseases, lung and respiratory diseases, severe/progressive nervous system disorders, chronic Kidney Disease, Alzheimer's disease or other dementia, End Stage Renal Disease, Osteoporosis and Diabetes. Such services were formerly not reimbursable in Medi-Cal. To participate in this program, Medi-Cal enrolled pharmacies are required to enter into a contract with the Department. The contract will outline the specific requirements and guidelines necessary to receive reimbursement under this methodology. The Department has adopted nationally recognized MTM billing codes, as well as the associated rates paid for each. A review of literature, and other state's MTM programs, suggests an aggregated average of six MTM encounter sessions per member annually is typical (prior authorization requests will be considered for the medical necessity of additional sessions).

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to slightly lower pharmacy enrollment than previously estimated.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to continued monthly projection of additional pharmacy enrollment.

Methodology:
1. Assume provider payment per encounter is $75.00 based on the rate paid for the medication therapy management code in the marketplace.

2. Since January 2022, approximately 125 pharmacies have contracted with the Department to provide MTM services. The Department anticipates pharmacies will continue to enter into MTM contracts.

3. Based on trained staff time and resources necessary to provide MTM sessions, the Department estimates an average of 15 members will receive MTM sessions each month (assuming an average total caseload of thirty (30) clients per pharmacy at any point in time annually). Each of these members is assumed to have an average of six encounters per year.

4. Claims submission began July 1, 2022.

5. Assume by the end of FY 2023-24, 240 pharmacies will be providing MTM services. The FFS costs are estimated to be:

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF	$1,308,000	$654,000	$654,000
90% Title XIX / 10% GF	$1,033,000	$103,000	$930,000
65% Title XXI / 35%	$107,000	$38,000	$69,000
Total	**$2,448,000**	**$795,000**	**$1,653,000**

MEDICATION THERAPY MANAGEMENT PROGRAM
REGULAR POLICY CHANGE NUMBER: 33

6. Assume by the end of FY 2024-25, 300 pharmacies will be providing MTM services. The FFS costs are estimated to be:

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF	$2,064,000	$1,032,000	$1,032,000
90% Title XIX / 10% GF	$1,629,000	$163,000	$1,466,000
65% Title XXI / 35%	$168,000	$59,000	$109,000
Total	**$3,861,000**	**$1,254,000**	**$2,607,000**

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)
COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

MEDI-CAL DRUG REBATE FUND

REGULAR POLICY CHANGE NUMBER: 34
IMPLEMENTATION DATE: 11/2019
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 2124

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the transfer of drug rebate collections from the Medi-Cal Drug Rebate Fund to the General Fund (GF).

Authority:
SB 78 (Chapter 38, Statues of 2019)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
COVID-19 Redeterminations Impact

Background:
SB 78 established the Medi-Cal Drug Rebate Fund, effective July 1, 2019. The non-federal share of federal and state supplemental Medi-Cal rebate collections will be deposited into the Medi-Cal Drug Rebate Fund. Transfers will occur from the Medi-Cal Drug Rebate Fund to offset the GF.

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;

MEDI-CAL DRUG REBATE FUND
REGULAR POLICY CHANGE NUMBER: 34

- 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..

For information on the federal share of the rebate collections, see the Federal Drug Rebates, State Supplemental Drug Rebates, Family PACT Drug Rebates, and BCCTP Drug Rebates policy changes.

On January 7, 2019, the Governor issued Executive Order N-01-19 which required the Department to transition Medi-Cal pharmacy services from Managed Care (MC) to the Fee-For-Service (FFS) delivery system. Additional state supplemental rebates are being collected as a result of the MC population shift to Medi-Cal Rx.

Reason for Change:
The change in FY 2023-24, from the prior estimate is an increase in the GF transfer due to:
- Estimating an increase in rebate collections, and
- The actual ending balance in the Medi-Cal Drug Rebate Fund for FY 2022-23 was higher than estimated.

The change from FY 2023-24 to FY 2024-25 in the current estimate, is a decrease in the GF transfer due to:
- The actual ending balance in the Medi-Cal Drug Rebate Fund for FY 2022-23 was included in the FY 2023-24 transfer, and
- Lower rebate collections in FY 2024-25.

Methodology:
1. In FY 2023-24, it is estimated that $2.87 billion will be transferred from the Medi-Cal Drug Rebate Fund to the GF and $2.48 billion will be transferred from the Medi-Cal Drug Rebate Fund to the GF in FY 2024-25.

2. A balance of $386.83 million was in the Medi-Cal Drug Rebate Fund as of July 2023. In FY 2023-24 and FY 2024-25 all rebate collections will be transferred to the GF leaving no reserve in the Medi-Cal Drug Rebate Fund as a budget solution.

3. The Title XIX COVID-19 Increased FMAP and Title XXI COVID-19 increased FMAP is assumed for drug rebates for claims paid through December 31, 2023, for this policy change.

MEDI-CAL DRUG REBATE FUND
REGULAR POLICY CHANGE NUMBER: 34

4. The summary of the non-federal share and federal share of the estimated FY 2023-24 and FY 2024-25 rebates and the estimated reserve for each respective fiscal year are:

(Dollars in Thousands)

FY 2023-24 Summary of Drug Rebates	**TF**	**Fund 3331**	**FF**
Federal Drug Rebates	($6,518,749)	($2,408,249)	($4,110,500)
State Supplemental Drug Rebates	($273,709)	($74,953)	($198,756)
Family PACT Drug Rebates	($3,864)	($473)	($3,391)
BCCTP Drug Rebates	($4,780)	($1,562)	($3,218)
Subtotal Rebates	($6,801,102)	($2,485,237)	($4,315,865)
FY 2022-23 Fund Balance		($386,834)	
Medi-Cal Drug Rebate Fund Transfer		**($2,872,071)**	

(Dollars in Thousands)

FY 2024-25 Summary of Drug Rebates	**TF**	**Fund 3331**	**FF**
Federal Drug Rebates	($6,484,885)	($2,404,968)	($4,079,917)
State Supplemental Drug Rebates	($277,885)	($75,917)	($201,968)
Family PACT Drug Rebates	($6,199)	($762)	($5,437)
BCCTP Drug Rebates	($4,999)	($1,665)	($3,334)
Subtotal Rebates	($6,773,968)	($2,483,312)	($4,290,656)
Medi-Cal Drug Rebate Fund Transfer		**($2,483,312)**	

5. The estimated transfers from the Medi-Cal Drug Rebate Fund to GF are:

(Dollars in Thousands)

FY 2023-24	**TF**	**GF**	**SF**
Drug Rebates Transfer	**$0**	**($2,872,071)**	**$2,872,071**

(Dollars in Thousands)

FY 2024-25	**TF**	**GF**	**SF**
Drug Rebates Transfer	**$0**	**($2,483,312)**	**$2,483,312**

MEDI-CAL DRUG REBATE FUND
REGULAR POLICY CHANGE NUMBER: 34

Funding:

(Dollars in Thousands)

FY 2023-24	TF	GF	SF
Medi-Cal Drug Rebate Fund (4260-601-3331)	$2,872,071	$0	$2,872,071
100% GF (4260-101-0001)	($2,918,379)	($2,918,379)	$0
COVID-19 Title XIX GF (4260-101-0001)	$44,944	$44,944	$0
COVID-19 Title XXI GF (4260-101-0001)	$1,333	$1,333	$0
COVID-19 BCCTP GF (4260-101-0001)	$31	$31	$0
Total	**$0**	**($2,872,071)**	**$2,872,071**

(Dollars in Thousands)

FY 2024-25	TF	GF	SF
Medi-Cal Drug Rebate Fund (4260-601-3331)	$2,483,312	$0	$2,483,312
100% GF (4260-101-0001)	($2,483,312)	($2,483,312)	$0
Total	**$0**	**($2,483,312)**	**$2,483,312**

LITIGATION SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 35
IMPLEMENTATION DATE: 8/2009
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 1449

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	-$8,000	$0
- STATE FUNDS	-$8,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$8,000	$0
STATE FUNDS	-$8,000	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the settlement amounts expected to be received by the Department from pharmaceutical and other companies due to illegal promotion of drugs, kickbacks and overcharges.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
The Department works collaboratively with the Office of the Attorney General to pursue charges related to Qui-Tam lawsuits (civil lawsuits filed under the False Claims Act by individuals not affiliated with the government, that result in a recovery of funds due to the Department), illegal promotion of drugs, kickbacks, and overcharging of Medicaid.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due to a settlement payment from FY 2022-23 now expected to be received in FY 2023-24. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to only being able to budget for current year settlement amounts.

LITIGATION SETTLEMENTS
REGULAR POLICY CHANGE NUMBER: 35

Methodology:
The following settlements are expected to be received in FY 2023-24:

Settlement Name	FY 2023-24
Progenity Inc.	($8,000)
Total GF Savings	**($8,000)**

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

BCCTP DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 36
IMPLEMENTATION DATE: 1/2010
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1433

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	-$3,218,000	-$3,334,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$3,218,000	-$3,334,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$3,218,000	-$3,334,000

Purpose:
This policy change estimates the revenues collected from the Breast and Cervical Cancer Treatment Program (BCCTP) drug rebates.

Authority:
Social Security Act, section 1927 [42 U.S.C. 1396r–8]
Omnibus Budget Reconciliation Act (OBRA) of 1990, Title IV, sec. 4401(a)(3), 104 Stat.
Welfare & Institutions Code 14105.33
SB 78 (Chapter 38, Statues of 2019)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

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).

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).

BCCTP DRUG REBATES
REGULAR POLICY CHANGE NUMBER: 36

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is an increase in savings due to:

- Including two additional quarters of actual rebate collection data through the quarter ending June 2023, and
- An increase in estimated BCCTP pharmacy expenditures for the applicable expenditure period.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is increase in rebate savings due to an increase in estimated BCCTP pharmacy expenditures from FY 2023-24 to FY 2024-25.

Methodology:

1. Payments began in January 2010.

2. Rebates are invoiced quarterly.

3. The 4.34% Title XIX COVID-19 increased FMAP is assumed for drug rebates through December 31, 2023.

4. The estimated rebates to collect are $4,780,000 in FY 2023-24 and $4,999,000 in FY 2024-25.

5. Assume, of the total BCCTP rebates collected, the ACA offset for BCCTP is $230,000 TF in FY 2023-24 and $241,000 in FY 2024-25.

BCCTP DRUG REBATES
REGULAR POLICY CHANGE NUMBER: 36

6. The Department estimates $1,562,000 and $1,665,000 BCCTP drug rebates to be collected and transferred to the Medi-Cal Drug Rebate Fund in FY 2023-24 and FY 2024-25, respectively.

FY 2023-24	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	($2,957,000)	($2,957,000)	($1,593,000)
ACA Offset	($230,000)	($230,000)	$0
COVID-19 Title XIX BCCTP Increased FMAP	($31,000)	($31,000)	$31,000
Total	**($3,218,000)**	**($3,218,000)**	($1,562,000)

FY 2024-25	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	($3,093,000)	($3,093,000)	($1,665,000)
ACA Offset	($241,000)	($241,000)	$0
Total	**($3,334,000)**	**($3,334,000)**	($1,665,000)

*The Fund 3331 Transfer column is for informational purposes only. See Methodology #6.

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

FAMILY PACT DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 37
IMPLEMENTATION DATE: 12/1999
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 51

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	-$3,391,000	-$5,437,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$3,391,000	-$5,437,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$3,391,000	-$5,437,000

Purpose:
This policy change estimates the revenues collected from the Family Planning Access, Care and Treatment (FPACT) drug rebates.

Authority:
Social Security Act, section 1927 [42 U.S.C. 1396r–8]
Omnibus Budget Reconciliation Act (OBRA) of 1990, Title IV, sec. 4401(a)(3), 104 Stat.
Welfare & Institutions Code 14105.33
SB 78 (Chapter 38, Statues of 2019)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Medi-Cal Drug Rebate Fund

Background:
Rebates for drugs covered through the FPACT program are obtained by the Department from the drug companies involved. Rebates are estimated by using the actual Fee-for-Service (FFS) trend data for drug expenditures, and applying a historical percentage of the actual amounts collected to the trend projection.

In October 2008, the Department discontinued the collection of rebates for drugs that are not eligible for federal financial participation (FFP), which the Centers for Medicare & Medicaid Services (CMS) determined to be 24% of the FPACT drug costs. Effective July 2009, it is assumed 13.95% of the FPACT drug costs are not eligible for rebates.

SB 78 established the Medi-Cal Drug Rebate Fund (Fund 3331), effective July 1, 2019. The non-federal share of Medi-Cal federal and state supplemental drug rebates will be deposited into Fund 3331. See the Medi-Cal Drug Rebate Fund policy change for the estimated total transfers from Fund 3331 to the General Fund (GF).

FAMILY PACT DRUG REBATES
REGULAR POLICY CHANGE NUMBER: 37

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is a decrease in rebates savings due to:

- Including two additional quarters of actual rebate collection data through quarter ending June 2023, and
- Decreased estimated FPACT pharmacy expenditures for the applicable expenditure period.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase in rebate savings due to an estimated increase in FPACT pharmacy expenditures from FY 2023-24 to FY 2024-25.

Methodology:

1. The regular Federal Medical Assistance Percentage (FMAP) percentage is applied to 7.96% of the FPACT rebates to account for the purchase of non-family planning drugs, and the family planning percentage (90% FFP) is applied to 92.04% of the FPACT rebates.

2. The Title XIX COVID-19 increased FMAP is assumed for drug rebates through December 31, 2023 for this policy change.

3. Assume the ACA offset is $257,000 TF for FY 2023-24 and $412,000 TF for FY 2024-25.

4. Actual data from July 2013 to June 2023 is used to project rebates.

5. The Department estimates $473,000 and $762,000 FPACT rebate collections to be collected and transferred to the Medi-Cal Drug Rebate Fund in FY 2023-24 and FY 2024-25, respectively.

FAMILY PACT DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 37

FY 2023-24	TF	FF	Fund 3331 Transfer
100% Title XIX FF	($3,132,000)	($3,132,000)	($475,000)
ACA Offset	($257,000)	($257,000)	$0
COVID-19 Title XIX Increased FMAP	($2,000)	($2,000)	$2,000
Total	**($3,391,000)**	**($3,391,000)**	($473,000)

FY 2024-25	TF	FF	Fund 3331 Transfer
100% Title XIX FF	($5,025,000)	($5,025,000)	($762,000)
ACA Offset	($412,000)	($412,000)	$0
Total	**($5,437,000)**	**($5,437,000)**	($762,000)

*The Fund 3331 Transfer column is for informational purposes only. See Methodology #5.

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

PHARMACY RETROACTIVE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 38
IMPLEMENTATION DATE: 10/2023
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 2194

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	-$80,859,000	$0
- STATE FUNDS	$23,237,050	$17,396,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$80,859,000	$0
STATE FUNDS	$23,237,050	$17,396,000
FEDERAL FUNDS	-$104,096,050	-$17,396,000

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. The retroactive adjustments resumed in FY 2023-24.

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 COD's be billed at the AAC.

Providers continued to be paid using the Average Wholesale Price reimbursement methodology until the AAC methodology was implemented on February 23, 2019. Retroactive adjustments for the 23-month period, from April 1, 2017, to February 23, 2019 were to be implemented. The initial retroactive adjustment was for one month of claims (April 2017) and installed on May 23, 2019.

PHARMACY RETROACTIVE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 38

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 applies to all pharmacy claims billed through the Medi-Cal Fee-for-Service Fiscal Intermediary. Recoupments for the retroactive adjustments resumed in October 2023.

The Budget Act of 2022 cancelled the retroactive recoupments for independent pharmacy providers.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to a shift in the recoupment timing.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to the completion of recoupments.

Methodology:
1. Assume the retroactive recoupments for independent pharmacy providers will not be collected, and the General Fund will be used to repay CMS the federal funds amount of the cancelled pharmacy recoupments.

2. Assume the retroactive adjustments for chain pharmacy providers and the federal repayment for independent pharmacies resumed in August 2023 and recoupments began in October 2023.

3. Assume any net payments to independent and chain pharmacies occurs in FY 2023-24.

4. On a cash basis, the net impact in FY 2023-24 is estimated to be:

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
Remaining payments	$49,010	$17,547	$31,463
Federal repayment	$0	$52,187	($52,187)
Pharmacy recoupments	($129,868)	($46,495)	($83,373)
Total	**($80,859)**	**($23,237)**	**($104,096)**

5. On a cash basis, the net impact in FY 2024-25 is estimated to be:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
Federal repayment	$0	$17,396	($17,396)
Total	**$0**	**$17,396**	**($17,396)**

PHARMACY RETROACTIVE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 38

Funding:

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$30,068	$15,034	$15,034
90% Title XIX/ 10% GF (4260-101-0001/0890)	$16,468	$1,647	$14,821
65% Title XXI / 35% GF (4260-101-0001/0890)	$2,475	$866	$1,609
100% Title XXI GF (4260-101-001)	$287	$287	$0
100% Title XXI FFP (4260-101-0890)	($6,846)	$0	($6,846)
100% Title XIX GF (4260-101-0001)	$5,403	$5,403	$0
100% Title XIX FFP (4260-101-0890)	($128,714)	$0	($128,714)
Total	**($80,859)**	**$23,237**	**($104,096)**

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
100% Title XXI GF (4260-101-001)	$878	$878	$0
100% Title XXI FFP (4260-101-0890)	($878)	$0	($878)
100% Title XIX GF (4260-101-0001)	$16,518	$16,518	$0
100% Title XIX FFP (4260-101-0890)	($16,518)	$0	($16,518)
Total	**$0**	**$17,396**	**($17,396)**

MEDICAL SUPPLY REBATES

REGULAR POLICY CHANGE NUMBER: 39
IMPLEMENTATION DATE: 10/2006
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1181

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	-$173,120,000	-$129,840,000
- STATE FUNDS	-$86,560,000	-$64,920,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$173,120,000	-$129,840,000
STATE FUNDS	-$86,560,000	-$64,920,000
FEDERAL FUNDS	-$86,560,000	-$64,920,000

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:
COVID-19 Increased FMAP – DHCS

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. The Department establishes the reimbursement rates for the specific medical supplies based on 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.

The medical supply rebate contract time periods are:

- Diabetic test strips, lancets, self-monitoring blood glucose (SMBG) monitors, control solution for SMBG monitors, and lancing devices: January 1, 2022, to December 31, 2024.
- Pen needles: January 1, 2021 to December 31, 2023 and January 1, 2024 to December 31, 2026.
- Disposable insulin delivery systems (DiDD) (Omnipods and V-Go): January 1, 2022, to December 31, 2024.
- Continuous Glucose Monitors (CGMs): January 1, 2022, to December 31, 2024.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is an increase in savings due to the incorporation of CGM rebates into this policy change. The CGM rebate savings were previously

MEDICAL SUPPLY REBATES
REGULAR POLICY CHANGE NUMBER: 39

included in the Continuous Glucose Monitoring System Benefit policy change in the May 2023 Estimate

The change from FY 2023-24 to FY 2024-25 in the current estimate, is a decrease in savings due to a one-time shift in the timing of rebate collections as a result of switching from a manual system to an automated system causing only three quarters of rebates to be collected in FY 2024-25.

Methodology:

1. Assume the average FFS quarterly collections are for medical supply rebates are $43,280,000.

2. The January 1, 2022 transition of pharmacy benefits from MC to the FFS delivery system, Medi-Cal Rx, increased the FFS medical supply rebates.

3. There is a one quarter lag for medical supply rebate collections under the current manual process.

4. In FY 2024-25, medical supply rebate collections will transition to an automated system with a two quarter lag in rebate collections. This one-time adjustment will result in three quarter of rebates collected in FY 2024-25.

5. Assume the total rebates collected are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2023-24	($173,120)	($86,560)	($86,560)
FY 2024-25	($129,840)	($64,920)	($64,920)

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

STATE SUPPLEMENTAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 40
IMPLEMENTATION DATE: 1/1991
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 54

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	-$198,756,000	-$201,968,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$198,756,000	-$201,968,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$198,756,000	-$201,968,000

Purpose:
This policy change estimates the revenues collected from the State Supplemental Drug rebates.

Authority:
Welfare & Institutions Code 14105.33
SB 78 (Chapter 38, Statues of 2019)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Medi-Cal Drug Rebate Fund
COVID-19 Redeterminations Impact

Background:
State supplemental drug rebates for drugs provided through Fee-for-Service (FFS) and County Organized Health Systems are negotiated by the Department with drug manufacturers to provide additional drug rebates over and above the federal rebate levels (see the Federal Drug Rebate policy change).

SB 78 established the Medi-Cal Drug Rebate Fund (Fund 3331) effective July 1, 2019. The non-federal share of Medi-Cal federal and state supplemental drug rebates will be deposited into Fund 3331. See the Medi-Cal Drug Rebate Fund policy change for the estimated total transfers from Fund 3331 to the General Fund (GF).

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).

STATE SUPPLEMENTAL DRUG REBATES
REGULAR POLICY CHANGE NUMBER: 40

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is a decrease in rebate savings due to:

- Including two additional quarters of actual rebate collection data through the quarter ending June 2023, and
- Projections for state supplemental rebates are based on trends from actual rebate collection data to FFS drug expenditures.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is increase in rebate savings due to estimating an increase in pharmacy expenditures from FY 2023-24 to FY 2024-25.

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. The Title XIX COVID-19 increased FMAP and Title XXI COVID-19 increased FMAP is assumed for drug rebates for claims paid through December 31, 2023, for this policy change.

4. CHIP rebates are funded at 65% FF / 35% GF beginning October 1, 2020. Assume CHIP drug rebates collections are $4,356,000 FF and $4,615,000 FF in FY 2023-24 and FY 2024-25, respectively.

5. The optional expansion ACA population collections are estimated to be $148,976,000 TF for FY 2023-24, of which $134,078,000 FF is budgeted in this policy change. The amount of $14,898,000 SF is the estimated non-federal share in the Medi-Cal Drug Rebate Fund. For FY 2024-25, the ACA collections are estimated to be $154,657,000 TF, of which $139,191,000 FF is budgeted in this policy change. The amount of $15,466,000 SF is the estimated non-federal share in the Medi-Cal Drug Rebate Fund.

6. The Department estimates to transfer $74,953,000 and $75,917,000 state supplemental rebates to be collected and transferred to the Medi-Cal Drug Rebate Fund in FY 2023-24 and FY 2024-25, respectively.

STATE SUPPLEMENTAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 40

FY 2023-24	TF	FF	Fund 3331 Transfer
100% Title XIX FF	($59,114,000)	($59,114,000)	($61,263,000)
100% Title XIX ACA FF	($134,078,000)	($134,078,000)	($14,898,000)
100% Title XXI FF	($4,356,000)	($4,356,000)	$0
COVID-19 Title XIX Increased FMAP	($1,166,000)	($1,166,000)	$1,166,000
COVID-19 Title XXI Increased FMAP	($42,000)	($42,000)	$42,000
Total	**($198,756,000)**	**($198,756,000)**	($74,953,000)

FY 2024-25	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	($58,162,000)	($58,162,000)	($60,451,000)
100% Title XIX ACA FF	($139,191,000)	($139,191,000)	($15,466,000)
100% Title XXI FF	($4,615,000)	($4,615,000)	$0
Total	**($201,968,000)**	**($201,968,000)**	($75,917,000)

*The Fund 3331 Transfer column is for informational purposes only. See Methodology #6.

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

FEDERAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 41
IMPLEMENTATION DATE: 7/1990
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 55

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	-$4,110,500,000	-$4,079,917,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$4,110,500,000	-$4,079,917,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$4,110,500,000	-$4,079,917,000

Purpose:
This policy change estimates the revenues collected from the Federal Drug rebates.

Authority:
Social Security Act, section 1927 [42 U.S.C. 1396r–8]
Omnibus Budget Reconciliation Act (OBRA) of 1990, Title IV, sec. 4401(a)(3), 104 Stat.
SB 78 (Chapter 38, Statues of 2019)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Medi-Cal Drug Rebate Fund
COVID-19 Redeterminations Impact

Background:
The Medicaid Drug Rebate Program, created by OBRA 1990, allows the Department to obtain price discounts for drugs. The 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).

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).

FEDERAL DRUG REBATES
REGULAR POLICY CHANGE NUMBER: 41

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is an increase in rebate savings due to:

- Including two additional quarters of actual rebate collection data through the quarter ending June 2023, and
- An increase in estimated pharmacy expenditures for the applicable expenditure period.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease in rebate savings due to no COVID-19 increased FMAP in FY 2024-25.

Methodology:

1. Rebates are invoiced quarterly and payments occur six months after the conclusion of each quarter.

2. Fee-for-Service (FFS) rebates are estimated by using actual FFS trend data for drug expenditures and applying a historical percentage of actual rebates collected to the FFS trend projection.

3. MC rebates are estimated by using the actual trend data for MC eligibles and applying a historical percentage of actual rebates collected to the trend projection.

4. Assume family planning drugs account for 0.21% of the regular federal drug rebates and are funded with 90% federal funds (FF) and 10% GF.

5. The Title XIX COVID-19 increased FMAP and Title XXI COVID-19 increased FMAP is assumed for drug rebates for claims paid through December 31, 2023.

6. CHIP rebates are funded at 65% FF / 35% GF beginning October 1, 2020. Assume CHIP drug rebate collections are $135,376,000 FF and $143,388,000 FF in FY 2023-24 and FY 2024-25, respectively.

7. The optional expansion ACA population collections are estimated to be $1,577,053,000 TF for FY 2023-24, of which $1,419,348,000 FF is budgeted in this policy change. The amount of $157,705,000 SF is the estimated non-federal share in the Medi-Cal Drug Rebate Fund. For FY 2024-25, a total of $1,631,053,000 TF is estimated for the optional expansion population, of which $1,467,947,000 FF is budgeted in this policy change. The amount of $163,106,000 SF is the estimated non-federal share in the Medi-Cal Drug Rebate Fund.

FEDERAL DRUG REBATES
REGULAR POLICY CHANGE NUMBER: 41

8. The ongoing additional FF claimed by CMS (ACA Offset) is reflected in this policy change. The additional FF is $290,069,000 TF for FY 2023-24 and $287,087,000 TF for FY 2024-25.

9. The Department estimates $2,408,249,000 and $2,404,968,000 federal drug rebates to be collected and transferred to the Medi-Cal Drug Rebate Fund in FY 2023-24 and FY 2024-25, respectively.

(Dollars in Thousands)

FY 2023-24	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	($2,220,640)	($2,220,640)	($2,295,611)
100% Title XIX ACA FF	($1,419,348)	($1,419,348)	($157,705)
100% Title XXI FF	($135,376)	($135,376)	$0
ACA Offset	($290,069)	($290,069)	$0
COVID-19 Title XIX Increased FMAP	($43,776)	($43,776)	$43,776
COVID-19 Title XXI Increased FMAP	($1,291)	($1,291)	$1,291
Total	**($4,110,500)**	**($4,110,500)**	($2,408,249)

FY 2024-25	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	($2,181,495)	($2,181,495)	($2,241,862)
100% Title XIX ACA FF	($1,467,947)	($1,467,947)	($163,106)
100% Title XXI FF	($143,388)	($143,388)	$0
ACA Offset	($287,087)	($287,087)	$0
Total	**($4,079,917)**	**($4,079,917)**	($2,404,968)

*The Fund 3331 Transfer column is for informational purposes only. See Methodology #7.

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

HCBS SP - CONTINGENCY MANAGEMENT

REGULAR POLICY CHANGE NUMBER: 43
IMPLEMENTATION DATE: 5/2022
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2278

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$21,562,000	$82,682,000
- STATE FUNDS	$5,015,000	$19,510,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$21,562,000	$82,682,000
STATE FUNDS	$5,015,000	$19,510,000
FEDERAL FUNDS	$16,547,000	$63,172,000

Purpose:
This policy change estimates the cost of adding Contingency Management (CM) in select Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver counties as an optional evidence-based Medi-Cal benefit under the federally approved CalAIM Section 1115(a) Waiver Program using enhanced federal funding from the American Rescue Plan Act of 2021 (ARP).

Authority:
American Rescue Plan (ARP) Act (2021)
Budget Act of 2021 [SB 129 (Chapter 69, Statutes of 2021)]
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
The ARP Act of 2021 provides additional Coronavirus Disease 2019 (COVID-19) relief to states. Section 9817 of the ARP provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS). Increased FMAP is available from April 1, 2021, through March 31, 2022. States must use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021, and states must use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. State funds equivalent to the amount of federal funds attributable to the increased FMAP are deposited in the Home and Community-Based Services American Rescue Plan (HCBS ARP) Fund pursuant to Section 11.95 of the 2021 Budget Act. Section 11.95 appropriates this funding to eligible HCBS activities identified in the HCBS Spending Plan.

The Centers for Medicare and Medicaid Services (CMS) approved the addition of CM as an optional benefit in DMC-ODS counties as part of the 1115 Demonstration Waiver renewal, as a

HCBS SP - CONTINGENCY MANAGEMENT
REGULAR POLICY CHANGE NUMBER: 43

pilot, beginning July 1, 2022 through March 2024. Contingency management 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. Contingency management was approved in the 2021 Budget Act, funded from the HCBS ARP Fund.

Effective April 1, 2024, the Department will extend the Recovery Incentives Program as an optional CM benefit for all DMC-ODS counties who opt-in to cover CM as a DMC-ODS service in alignment with the timeline of the CalAIM 1115 Demonstration waiver (through December 31, 2026). Funding for the non-federal share for services will be with county funds beginning April 1, 2024, after the currently assumed end of the HCBS Spending Plan which is authorized through March 31, 2024. Counties would voluntarily opt-in to provision of this benefit and use of county funds for the non-federal share of payments.

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is a decrease due to updated roll-out and cost assumptions based on revised rollout of providers and updated rate assumptions.

The change in the current estimate, from FY 2023-24 to FY 2024-25, is an increase due to a higher projected ramp up of benefit.

Methodology:
1. Contingency management was added as an optional service to the CalAIM 1115 Demonstration Waiver effective January 1, 2022, and services began in April 2023.

2. Prior to implementation of the benefit, $3,535,000 in initial start-up funding was provided to counties in FY 2021-22 and distributed through the Behavioral Health Quality Improvement Program (BH-QIP).

3. Ongoing services for Contingency Management include the following costs:
    - Incentive costs for members averaging $300 per year (up to a maximum of $599)
    - Contingency management services costs

HCBS SP - CONTINGENCY MANAGEMENT
REGULAR POLICY CHANGE NUMBER: 43

4. The Title XIX and Title XXI COVID-19 increased FMAP is assumed for expenditures through December 31, 2023 for this policy change.

5. 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 before FF can be used for payment.

6. Total estimated costs for contingency management, on a cash basis, is as follows:

FY 2023-24	TF	HCBS ARP Fund	IGT*	FF	COVID-19 FF
CM Incentive Costs	$2,148,000	$373,000	$127,000	$1,641,000	$7,000
CM Services Costs	$19,414,000	$3,370,000	$1,145,000	$14,833,000	$66,000
Total	**$21,562,000**	**$3,743,000**	**$1,272,000**	**$16,474,000**	**$73,000**

FY 2024-25	TF	IGT*	FF
CM Incentive Costs	$7,585,000	$1,790,000	$5,795,000
CM Services Costs	$75,097,000	$17,720,000	$57,377,000
Total	**$82,682,000**	**$19,510,000**	**$63,172,000**

Funding:
100% Title XIX (4260-101-0890)
100% Title XXI (4260-101-0890)
100% ACA Title XIX FF (4260-101-0890)
Medi-Cal County Behavioral Health Fund (4260-601-3420)*
COVID-19 Title XIX Increased FFP (4260-101-0890)
COVID-19 Title XXI Increased FFP (4260-101-0890)
Home and Community-Based Services American Rescue Plan Fund (4260-101-8507)

DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 44
IMPLEMENTATION DATE: 7/2021
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 1724

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$14,999,000	$20,478,000
- STATE FUNDS	$4,003,150	$5,552,750
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$14,999,000	$20,478,000
STATE FUNDS	$4,003,150	$5,552,750
FEDERAL FUNDS	$10,995,850	$14,925,250

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)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
The DMC program currently covers the following Substance Use Disorder (SUD) services under the State Plan: Outpatient Drug-Free Treatment Services (ODF), Intensive Outpatient Treatment Services (IOT), Residential Treatment Services (RTS) for pregnant and postpartum women, and the Narcotic Treatment Program (NTP).

Prior to FY 2023-24, on an annual basis, the Department adjusted the DMC rates based on the cumulative growth in the Implicit Price (CIP) Deflator for the Costs of Goods and Services to Governmental Agencies reported by the Department of Finance. The proposed DMC rates were based either on the developed rates using annual cost report settlement data, or the FY 2009-10 Budget Act rates adjusted for the CIP deflator, whichever was lower.

Under the of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the Department has developed rates for DMC services using new methodologies which are more specific to the provider type providing the service and/or to each county's costs. DMC rates using these methodologies were implemented on July 1, 2023. Annually, the Department will adjust the DMC rates by the percentage change in the four-quarter average Home Health Agency Market Basket Index.

DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 44

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
- MAT Dosing – Regular and Perinatal

The proposed DMC rates for RTS – Regular and Perinatal are based on county specific, daily rates developed under the CalAIM initiative.

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is an increase due to higher rates for DMC services using the new rate setting methodologies.

The change in the current estimate, from FY 2023-24 to FY 2024-25, is due to FY 2024-25 reflecting changes for FY 2023-24 and FY 2024-25 rates, and FY 2024-25 rate adjustments fully reflecting in this policy change.

DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 44

Methodology:

1. The FY 2022-23 developed rates, FY 2023-24 estimated rates, and FY 2024-25 estimated rates for regular and perinatal services are:

Regular Services	FY 2022-23 Developed Rates	FY 2023-24 Developed Rates	FY 2024-25 Estimated Rates
NTP Methadone	$16.20	$21.44	$22.09
NTP Individual Counseling	$19.01	$75.72	$77.99
NTP Group Counseling	$4.49	$16.83	$17.33
Intensive Outpatient Treatment	$87.24	$340.74	$350.96
Residential Treatment - EPSDT	$128.47	$111.58	$114.93
ODF Individual Counseling	$95.07	$378.60	$389.96
ODF Group Counseling	$40.40	$151.44	$155.98

Perinatal Services	FY 2022-23 Developed Rates	FY 2023-24 Developed Rates	FY 2024-25 Estimated Rates
NTP Methadone	$17.45	$32.94	$33.92
NTP Individual Counseling	$27.21	$75.72	$77.99
NTP Group Counseling	$9.09	$16.83	$17.33
Intensive Outpatient Treatment	$104.37	$340.74	$350.96
Residential Treatment Services	$128.47	$111.58	$114.93
ODF Individual Counseling	$136.08	$378.60	$389.96
ODF Group Counseling	$81.82	$151.44	$155.98

2. The incremental rate changes for FY 2023-24 and FY 2024-25 are shown below:

Incremental Difference	FY 2023-24 Regular	FY 2023-24 Perinatal	FY 2024-25 Regular	FY 2024-25 Perinatal
NTP Methadone	$5.24	$15.49	$0.64	$0.99
NTP Individual Counseling	$56.71	$48.51	$2.27	$2.27
NTP Group Counseling	$12.34	$7.74	$0.50	$0.50
Intensive Outpatient Treatment	$253.50	$236.37	$10.22	$10.22
Residential Treatment Services	($16.89)	($16.89)	$3.35	$3.35
ODF Individual Counseling	$283.53	$242.52	$11.36	$11.36
ODF Group Counseling	$111.04	$69.62	$4.54	$4.54

DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 44

3. The cost estimate for FY 2023-24, based on the incremental rate changes for FY 2022-23 and FY 2023-24 are:

FY 2023-24 - Regular	Total Number of Units	Incremental Difference	Total Rate Adj. Cost
NTP Methadone	426,671	$5.24	$2,238,000
NTP Individual Counseling	211,627	$56.71	$12,001,000
Intensive Outpatient Treatment	2,138	$253.50	$542,000
ODF Individual Counseling	8,073	$283.53	$2,289,000
ODF Group Counseling	23,178	$111.04	$2,574,000
Total for Regular Services			$19,644,000

FY 2023-24 - Perinatal	Total Number of Units	Incremental Difference	Total Rate Adj. Cost
Intensive Outpatient Treatment	377	$236.37	$89,000
Residential Treatment Services	241	($16.89)	($4,000)
ODF Individual Counseling	15	$242.52	$4,000
ODF Group Counseling	34	$69.62	$2,000
Total for Perinatal Services			$91,000

4. The cost estimate for FY 2024-25, based on the incremental rate changes for FY 2023-24 and FY 2024-25 are:

FY 2024-25 - Regular	Total Number of Units	Incremental Difference	Total Rate Adj. Cost	FY 2024-25 Rate Adj.
NTP Methadone	426,671	$0.64	$274,000	$2,512,000
NTP Individual Counseling	211,627	$2.27	$481,000	$12,482,000
Intensive Outpatient Treatment	2,138	$10.22	$22,000	$564,000
ODF Individual Counseling	8,073	$11.36	$92,000	$2,381,000
ODF Group Counseling	23,178	$4.54	$105,000	$2,679,000
Total for Regular Services			$974,000	$20,618,000

FY 2024-25 – Perinatal	Total Number of Units	Incremental Difference	Total Rate Adj. Cost	FY 2024-25 Rate Adj.
Intensive Outpatient Treatment	377	$10.22	$4,000	$93,000
Residential Treatment Services	241	$3.35	$1,000	($3,000)
ODF Individual Counseling	15	$11.36	$0	$4,000
ODF Group Counseling	34	$4.54	$0	$2,000
Total for Perinatal Services			$5,000	$96,000

DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT
REGULAR POLICY CHANGE NUMBER: 44

5. Total estimated costs for the annual rate adjustments are:

Annual Rate Adj. Cost	FY 2023-24 Rates	FY 2024-25 Rates	FY 2023-24 (Lagged)	FY 2024-25 (Lagged)
NTP	$14,239,000	$14,994,000	$10,822,000	$14,813,000
ODF	$4,869,000	$5,066,000	$3,700,000	$5,018,000
IOT	$631,000	$657,000	$480,000	$650,000
RTS	($4,000)	($3,000)	($3,000)	($3,000)
Total	**$19,735,000**	**$20,714,000**	**$14,999,000**	**$20,478,000**

FY 2023-24	TF	GF	IGT*	FF	COVID-19 FF
Regular					
Current	$6,366,000	$86,000	$3,029,000	$3,187,000	$64,000
ACA Optional	$8,564,000	$856,000	$0	$7,708,000	$0
Perinatal					
Current	$65,000	$0	$32,000	$32,000	$1,000
ACA Optional	$4,000	$0	$0	$4,000	$0
Total	$14,999,000	**$942,000**	**$3,061,000**	**$10,931,000**	**$65,000**

FY 2024-25	TF	GF	IGT*	FF
Regular				
Current	$8,691,000	$119,000	$4,220,000	$4,352,000
ACA Optional	$11,693,000	$1,169,000	$0	$10,524,000
Perinatal				
Current	$88,000	$0	$44,000	$44,000
ACA Optional	$6,000	$1,000	$0	$5,000
Total	$20,478,000	**$1,289,000**	**$4,264,000**	**$14,925,000**

6. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023 for this policy change.

7. Effective July 1, 2023, non-federal share of costs that was initially funded with county funds (CF), is funded through an inter-governmental transfer (IGT).

8. Assume DMC claims are paid 76% in the same year the services occur and the remaining 24% in the following year.

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)
COVID-19 Title XIX Increased FFP (4260-101-0890)

DRUG MEDI-CAL PROGRAM COST SETTLEMENT

REGULAR POLICY CHANGE NUMBER: 46
IMPLEMENTATION DATE: 7/2021
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 1723

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	-$1,727,000	-$1,594,000
- STATE FUNDS	-$320,000	-$303,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,727,000	-$1,594,000
STATE FUNDS	-$320,000	-$303,000
FEDERAL FUNDS	-$1,407,000	-$1,291,000

Purpose:
This policy change estimates the cost settlements to counties and contracted providers for payments related to Drug Medi-Cal (DMC) services.

Authority:
Welfare & Institutions Code 14124.24 (g)(1)
Title 22, California Code of Regulations 51516.1

Interdependent Policy Changes:
Not Applicable

Background:
The DMC program currently covers the following Substance Use Disorder (SUD) services under the State Plan: Outpatient Drug-Free Treatment Services (ODF), Intensive Outpatient Treatment Services (IOT), Residential Treatment Services (RTS) for pregnant and postpartum women, and Narcotic Treatment Program (NTP).

The DMC program initially pays a claim for SUD services at a provisional rate, not to exceed the State's maximum allowance. At the end of each fiscal year, providers for non-NTP services must submit actual cost information. The DMC program completes a final settlement after receipt and review of the provider's cost report. The cost settlement is based on the county's certified public expenditures (CPE). The Department has the authority to audit the cost reports within three years of the cost settlement.

Cost settlements for non-NTP services is limited to the lowest of the following costs:

- Provider's usual and customary charge to the general public for the same or similar services,
- Provider's allowable costs of providing the service, or
- DMC statewide maximum allowance for the service.

DRUG MEDI-CAL PROGRAM COST SETTLEMENT

REGULAR POLICY CHANGE NUMBER: 46

Cost settlements for NTP services is limited to the lowest of the following costs:

- Provider's usual and customary charge to the general public for the same or similar services, or
- DMC statewide maximum allowance for the service.

Starting July 1, 2014, as instructed by the Centers for Medicare & Medicaid Services (CMS), the Department changed its cost settlement process to counties for their administrative expenses through a quarterly claims and cost settlement process. Prior to that, counties were paid for their DMC expenses (services and administration) through CPE as part of an all-inclusive rate. Starting from the FY 2014-15 annual cost report settlement, all amounts for administrative cost reimbursements or recoupments will be included in the Drug Medi-Cal County Administration policy change.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to a change in timing for the processing of the cost and audit settlements which has shifted some prior year settlements from FY 2022-23 to FY 2023-24.

The change in the current estimate, from FY 2023-24 to FY 2024-25, is due to less audit settlements and cost settlement recoupments occurring in FY 2024-25.

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 2023-24 and FY 2024-25:

FY 2023-24	TF	GF	Title XIX	Title XXI	CF
FY 2017-18 Audit Settlements	($531,000)	($40,000)	($267,000)	($1,000)	($223,000)
FY 2018-19 Audit Settlements	($1,366,000)	($104,000)	($686,000)	($2,000)	($574,000)
FY 2017-18 Cost Settlements	($14,000)	($4,000)	($11,000)	$1,000	$0
FY 2018-19 Cost Settlements	($583,000)	($164,000)	($448,000)	$29,000	$0
FY 2019-20 Cost Settlements	($30,000)	($8,000)	($23,000)	$1,000	$0
Total	($2,524,000)	**($320,000)**	**($1,435,000)**	**$28,000**	($797,000)

DRUG MEDI-CAL PROGRAM COST SETTLEMENT

REGULAR POLICY CHANGE NUMBER: 46

FY 2024-25	TF	GF	Title XIX	Title XXI	CF
FY 2018-19 Audit Settlements	($152,000)	($12,000)	($76,000)	$0	($64,000)
FY 2019-20 Audit Settlements	($1,518,000)	($115,000)	($763,000)	($2,000)	($638,000)
FY 2018-19 Cost Settlements	($253,000)	($71,000)	($195,000)	$13,000	$0
FY 2019-20 Cost Settlements	($373,000)	($105,000)	($287,000)	$19,000	$0
Total	($2,296,000)	**($303,000)**	**($1,321,000)**	**$30,000**	($702,000)

Funding:
100% General Fund
100% Title XIX (4260-101-0890)
100% Title XXI (4260-101-0890)

BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE

REGULAR POLICY CHANGE NUMBER: 49
IMPLEMENTATION DATE: 7/2022
ANALYST: Elena Susbilla
FISCAL REFERENCE NUMBER: 2262

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$300,030,000	$239,600,000
- STATE FUNDS	$300,030,000	$239,600,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$300,030,000	$239,600,000
STATE FUNDS	$300,030,000	$239,600,000
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the funding available for competitive grants to qualified entities to construct, acquire and rehabilitate real estate assets or to invest in infrastructure, including mobile crisis services, to expand the community continuum of behavioral health treatment resources.

Authority:
SB 129 (Chapter 69, Statutes of 2021)
AB 179 (Chapter 249, Statutes of 2022)
American Rescue Plan (ARP) Act (2021)

Interdependent Policy Changes:
Not Applicable

Background:
The Department aims to reduce homelessness, incarceration, unnecessary hospitalizations, and inpatient days and improve outcomes for people with behavioral health conditions by expanding access to community-based treatment. The Department also seeks to ensure Medi-Cal beneficiaries have access to sufficient treatment resources across the behavioral health continuum of care, prioritizing community-based, non-institutional treatment options to address needs in crisis and for longer-term residential treatment. To support these efforts, the Behavioral Health Continuum Infrastructure Program (BHCIP) expands the community continuum of behavioral health treatment resources by providing grants to qualified entities to construct, acquire, and rehabilitate real estate assets or to invest in mobile crisis infrastructure. The investment in real estate assets expands the continuum of services by increasing capacity for short-term crisis stabilization, acute and sub-acute care, crisis residential, community-based mental health residential treatment, substance use disorder residential treatment, peer respite, community and outpatient behavioral health services, and other clinically enriched longer-term treatment and rehabilitation opportunities for persons with behavioral health disorders in the least restrictive and least costly setting.

BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE
REGULAR POLICY CHANGE NUMBER: 49

The BHCIP grant funds will be awarded in the rounds focused on the following: mobile crisis infrastructure, county and tribal planning grants, new launch-ready infrastructure projects, infrastructure focused on children and youth 25 years of age and younger (which is part of the Children and Youth Behavioral Health Initiative (CYBHI)), and infrastructure to address gaps in the state's behavioral health continuum.

Behavioral treatment resources funded pursuant the program may qualify for an exemption from the California Environmental Quality Act and automatic zoning compliance requirements.

The American Rescue Plan Act (ARPA) includes funding to state and local governments. The funds are distributed to states, tribes, and territories based on a formula that considers the state's share of the nation's unemployment. The ARPA funds can be used for specific purposes including addressing public health impacts, negative economic impacts, and water, sewer, and broadband. State and local governments have until December 31, 2024, to encumber the funds and until December 31, 2026, to liquidate the funds. Given that the DHCS Medi-Cal Estimate is budgeted on a cash basis, DHCS has until December 31, 2026, to expend of the State Fiscal Recovery Fund (SFRF) funds.

The CYBHI augments the BHCIP funding for FY 2021-22 and FY 2022-23. The CYBHI is a multiyear package of investments as part of the 2021 Budget Act. The CYBHI is intended to transform California's behavioral health system for children and youth aged 0-25 into a world-class, innovative, up-stream focused, ecosystem where all children and young adults are routinely screened, supported, and served for emerging behavioral health needs. BHCIP infrastructure grants targeted to children and youth aged 25 or younger are part of the CYBHI, however, costs are reflected solely in this policy change.

Reason for Change:
The change for FY 2023-24 from the prior estimate is an increase due to adjusting the FY 2023-24 payments to include payments to new awardees from additional rounds that have started.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is a net decrease due to including payments estimated for additional awardees in FY 2024-25 and a delay in funding available for FY 2024-25.

Methodology:
1. The 2021-22 Budget Act amount of $743,499,000 TF in local assistance funding is included in the Medi-Cal Estimate. The approved local assistance funding included $300 million from SFRF available for expenditure through December 31, 2026, and $443,499,000 from the General Fund available for expenditure through June 30, 2026. The 2022-23 Budget Act appropriated $1,163,750,000 GF in local assistance funding available for expenditure through June 30, 2027, and $218,500,000 from SFRF, available for expenditure through December 31, 2026.
   - Of the GF funding, $480,500,000 is available to support the Children and Youth RFA, $430,049,000 for the Crisis and Behavioral Health Continuum RFA, and $480,700,000 for the Outstanding Needs Remaining After Rounds 3 through 5 RFA.
   - The $218,500,000 SFRF will be allocated to the Launch Ready RFA (progress payments.

2. Of the funds appropriated in the 2021 Budget Act, assume $466,000,000 TF will be expended for qualified entities to expand resources. This includes:

BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE
REGULAR POLICY CHANGE NUMBER: 49

- $166,000,000 GF including, $150,000,000 to support mobile crisis infrastructure and $16,000,000 for County and Tribal Planning Grants.
- $300,000,000 SFRF will be allocated to the Launch Ready RFA (initial payments).

3. Assume $300,030,000 TF will be paid in FY 2023-24 from the 2021-22 and 2022-23 Budget Act amounts. Funding would be made available via a competitive application process.

4. Assume $239,600,000 TF will be paid in FY 2024-25.

5. The table below displays the estimated spending and remaining funds by Appropriation Years:
(Dollars in Thousands)

	TF	GF	SFRF
Appropriation Year 2021-22	$743,499	$443,499	$300,000
Prior Years	$455,152	$155,152	$300,000
Estimated in FY 2023-24	$155,439	$155,439	$0
Estimated in FY 2024-25	$132,908	$132,908	$0
Total Estimated Remaining	$0	$0	$0
Appropriation Year 2022-23	$1,382,250	$1,163,750	$218,500
Prior Years	$268,500	$50,000	$218,500
Estimated in FY 2023-24	$144,591	$144,591	$0
Estimated in FY 2024-25	$106,692	$106,692	$0
Total Estimated Remaining	$862,467	$862,467	$0

6. The estimated costs in FY 2023-24 and FY 2024-25 are as follows:

(Dollars in Thousands)

FY 2023-24	**TF**	**GF**
Appropriation Year 2021-22	$155,439	$155,439
Appropriation Year 2022-23	$144,591	$144,591
Total FY 2023-24	**$300,030**	**$300,030**

(Dollars in Thousands)

FY 2024-25	**TF**	**GF**
Appropriation Year 2021-22	$132,908	$132,908
Appropriation Year 2022-23	$106,692	$106,692
Total FY 2024-25	**$239,600**	**$239,600**

Funding:
General Fund (4260-101-0001)

MHP COSTS FOR FFPSA

REGULAR POLICY CHANGE NUMBER: 50
IMPLEMENTATION DATE: 10/2021
ANALYST: Elena Susbilla
FISCAL REFERENCE NUMBER: 2252

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$47,538,000	$43,195,000
- STATE FUNDS	$19,782,000	$21,418,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	8.61 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$43,445,000	$43,195,000
STATE FUNDS	$18,078,770	$21,418,000
FEDERAL FUNDS	$25,366,210	$21,777,000

Purpose:
This policy change estimates the reimbursement to mental health plans (MHPs) for expenditures related to pre and post care of foster children and youth treated in Short-Term Residential Therapeutic Programs (STRTPs). Beginning October 1, 2021, MHPs implemented a Qualified Individual (QI) to provide specific intensive case management prior to or within 30 days of an admission to a STRTP. Beginning October 1, 2021, MHPs began providing six months of intensive aftercare treatment to foster children and youth for six months after being discharged from a STRTP to a family-based setting.

Authority:
Family First Prevention Services Act (Public Law 115-123)
AB 153 (Chapter 86, Statutes of 2021)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
FFPSA – Qualified Individual
The federal Family First Prevention Services Act (FFPSA) was signed into law on February 9, 2018. Prior to enactment of FFPSA, MHPs were only required to provide Medi-Cal beneficiaries, including those in the Foster Care system, all medically necessary specialty mental health services (SMHS). Current law provides for an Interagency Placement Committee (IPC), representing Child Welfare, Probation and County Mental Health (at a minimum), to determine eligibility for STRTP placement. However, historically there had been no specified criteria or process for making the determination. The MHP's only obligation was to determine medical necessity for the mental health services provided within the facility (e.g., group therapy), not for the need for a residential level of care.

MHP COSTS FOR FFPSA
REGULAR POLICY CHANGE NUMBER: 50

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 placement and services are more appropriate than residential care and if not, that the placement in a STRTP provides the most effective and appropriate level of care setting in the least restrictive environment, and the placement is consistent with the short-term and long-term mental and behavioral health goals and permanency plan for the child. The QI must engage with the CFTs and mental health providers, and if the STRTP is not medically necessary, must provide intensive care coordination (ICC) and make recommendations for more appropriate services. This is a much higher level of care coordination and care management than was provided prior to FFPSA and is expected to require at least 10 hours per client.

FFPSA – After Care

FFPSA also requires states to provide discharge planning and family-based after care support for at least 6 months after a foster child or youth is discharged from an STRTP. Discharge planning with a focus on family-based support for 6 months post-discharge is expected to result in an increase in utilization of medically necessary SMHS during the 6 months after discharge. The California Department of Social Services (CDSS) and the Department will utilize the High-Fidelity Wraparound (HFW) model to meet the aftercare requirement of FFPSA, as its substantial research base demonstrates improved outcomes in children and youth in foster care with complex mental health needs.

Funding

The State realigned the responsibility for Specialty Mental Health Services (SMHS) to the counties in 2011 as part of 2011 Public Safety Realignment. Pursuant to Proposition 30, state requirements enacted after September 30, 2012, that have an overall effect of increasing the costs already borne by a local agency for programs or levels of service mandated by 2011 Realignment shall apply to local agencies only to the extent that the state provides funding for the cost increase.

The requirements for FFPSA - QI are beyond what is currently required for medical necessity determinations, and therefore would trigger Proposition 30. For FFPSA - After Care, the Department has created a process for HFW services to ensure the enhanced match rate only applies to aftercare services meeting criteria for the HFW model and meeting medical necessity criteria for SMHS. SMHS provided to beneficiaries that are not part of a HFW model are considered existing county obligations and are not expected to prompt additional state funding requests pursuant to Proposition 30.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid. The FFCRA increased FMAP is effective January 1, 2020 and extended its availability through the last day of the calendar quarter of the national public health emergency (PHE).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;

MHP COSTS FOR FFPSA
REGULAR POLICY CHANGE NUMBER: 50

- 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:
The change from the prior estimate for FY 2023-24 is due to updated lags.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to projected lower caseloads and CFT meetings. In addition, the COVID-19 increased FMAP is phased out after FY 2023-24 dates of service and less COVID-19 increased FMAP is included in FY 2024-25.

Methodology:

FFPSA Qualified Individual
Standardized Assessments
1. Assume 5,914 children and youth will be placed in an STRTP in FY 2022-23, 3,850 in FY 2023-24, and 3,531 in FY 2024-25.

2. Assume Standardized Assessment by a QI began on October 1, 2021.

3. Assume a total of 5,914 receive a standardized assessment by a QI in FY 2022-23, 3,850 children and youth will receive a standardized assessment by a QI in FY 2023-24 and 3,531 in FY 2024-25. Each standardized assessment will take 10 total hours to complete.

4. Assume children and youth placed in an STRTP will receive, on average, 1.37 assessments per year in FY 2022-23. Assume children and youth placed in an STRTP will receive, on average, 1.41 assessments per year for FY 2023-24 and FY 2024-25.

5. Assume MHPs will spend, on average, $283.20 per hour for a qualified individual to complete an assessment. The Department estimates MHPs will spend $22,945,374 for a QI to complete standardized assessments in FY 2022-23 and $15,373,512 in FY 2023-24, and $14,099,707 in FY 2024-25.

Fiscal Year	STRTP Caseload	Assessment Hours	Assessments Per Year	Cost Per Hour (QI)	Assessment Cost
FY 2022-23	5,914	10	1.37	$283.20	$22,945,374
FY 2023-24	3,850	10	1.41	$283.20	$15,373,512
FY 2024-25	3,531	10	1.41	$283.20	$14,099,707

Child and Family Team (CFT)
6. Assume the children and youth placed in an STRTP will receive, on average, 3.03 CFT meetings during placement evaluation for an STRTP in FY 2022-23 and 3.10 CFT meetings in FY 2023-24, and 3.09 CFT meetings in FY 2024-25.

MHP COSTS FOR FFPSA
REGULAR POLICY CHANGE NUMBER: 50

7. Assume the QI spends 2 hours providing a reimbursable SMHS in each CFT. Assume MHPs will spend, on average, $283.20 per hour for a QI to participate in CFT meetings while children and youth are placed in an STRTP. The Department estimates MHPs will spend $10,149,559 for QI participation in CFTs in FY 2022-23 and $6,759,984 in FY 2023-24, and $6,179,871 in FY 2024-25.

Fiscal Year	STRTP Caseload	CFT Hours	CFTs Per Year	Cost Per Hour (QI)	CFT Cost
FY 2022-23	5,914	2	3.03	$283.20	$10,149,559
FY 2023-24	3,850	2	3.10	$283.20	$6,759,984
FY 2024-25	3,531	2	3.09	$283/20	$6,179,871

FFPSA – After Care

8. CDSS estimates the total cost of providing services pursuant to the HFW model to be $54,450,000 in FY 2022-23, $44,733,000 in FY 2023-24, and $38,259,000 in FY 2024-25.

9. Analysis of the set of services contained in the HFW model show that, on average, 45% of these services are likely to be billable to child welfare departments and 55% are estimated to meet medical necessity criteria for SMHS.

10. The Department projects the total cost of providing SMH aftercare services will be $29,947,500 in FY 2022-23, $24,603,150 in FY 2023-24, and $21,042,450 in FY 2024-25.

11. The Title XIX FFCRA COVID-19 increased FMAP is assumed for expenditures through December 31, 2023 for this policy change. The FFCRA funding will be offset equally between the GF and the county funds (CF).

12. 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

13. Assume on a cash basis for FY 2023-24, the Department will pay 0.2% of FY 2021-22, 34.4% of FY 2022-23 claims and 65.5% of FY 2023-24 claims. On a cash basis for FY 2024-25, the Department will pay 0.2% of FY 2022-23 claims, 34.4% of FY 2023-24 claims, and 65.5% of FY 2024-25 claims. The estimated costs, on a cash basis, are:

MHP COSTS FOR FFPSA

REGULAR POLICY CHANGE NUMBER: 50

(Dollars in Thousands)

	TF	GF	FF	COVID-19 FF	IGT	CF
FY 2021-22						
Assessments	$31	$7	$15	$2	$0	$7
CFTs	$10	$2	$5	$1	$0	$2
After care	$33	$7	$17	$2	$0	$7
Total	$74	$16	$37	$5	$0	$16
FY 2022-23						
Assessments	$7,887	$1,739	$3,944	$465	$0	$1,739
CFTs	$3,488	$769	$1,744	$206	$0	$769
After care	$10,294	$2,270	$5,147	$607	$0	$2,270
Total	$21,669	$4,778	$10,835	$1,278	$0	$4,778
FY 2023-24						
Assessments	$10,062	$2,465	$5,031	$101	$2,465	$0
CFTs	$4,424	$1,084	$2,212	$44	$1,084	$0
After care	$16,103	$3,945	$8,052	$161	$3,945	$0
Total	$30,589	$7,494	$15,295	$306	$7,494	$0
Total FY 2023-24	$52,332	**$12,288**	**$26,167**	**$1,589**	**$7,494**	$4,794

MHP COSTS FOR FFPSA

REGULAR POLICY CHANGE NUMBER: 50

(Dollars in Thousands)

	TF	GF	FF	COVID-19 FF	IGT*	CF
FY 2022-23						
Assessments	$40	$9	$20	$2	$0	$9
CFTs	$18	$4	$9	$1	$0	$4
After care	$51	$11	$26	$3	$0	$11
Total	$109	$24	$55	$6	$0	$24
FY 2023-24						
Assessments	$5,285	$1,295	$2,642	$53	$1,295	$0
CFTs	$2,323	$569	$1,162	$23	$569	$0
After care	$8,458	$2,072	$4,229	$85	$2,072	$0
Total	$16,066	$3,936	$8,033	$161	$3,936	$0
FY 2024-25						
Assessments	$9,228	$2,307	$4,614	$0	$2,307	$0
CFTs	$4,044	$1,011	$2,022	$0	$1,011	$0
After care	$13,772	$3,443	$6,886	$0	$3,443	$0
Total	$27,044	$6,761	$13,522	$0	$6,761	$0
TOTAL FY 2024-25	$43,219	**$10,721**	**$21,610**	**$167**	**$10,697**	$24

Funding:
100% Title XIX FFP (4260-101-0890)
100% Title XIX GF (4260-101-0001)
COVID-19 Title XIX Increased FFP (4260-101-0890)
Medi-Cal County Behavioral Health Fund* (4260-601-3420)

CALAIM - BH QUALITY IMPROVEMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 51
IMPLEMENTATION DATE: 9/2021
ANALYST: Elena Susbilla
FISCAL REFERENCE NUMBER: 2187

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$21,347,000	$0
- STATE FUNDS	$21,347,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$21,347,000	$0
STATE FUNDS	$21,347,000	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the payments to counties under the Behavioral Health Quality Improvement Program (BH-QIP).

Authority:
Budget Act of 2021 [SB 129 (Chapter 69, Statutes of 2021)]

Interdependent Policy Changes:
Not Applicable

Background:
The California Advancing and Innovating Medi-Cal (CalAIM) BH-QIP is an incentive payment program to support Mental Health Plans (MHP), Drug Medi-Cal State Plans (DMC) and Drug Medi-Cal Organized Delivery Systems (DMC-ODS) as they prepare for changes in the CalAIM initiative and other approved administration priorities. The three CalAIM BH-QIP goals are:

1. **Payment Reform**
   - Implement new Current Procedural Technology/Healthcare Common Procedure Coding System (CPT/HCPCS) procedure codes, modifiers, place of service codes, and taxonomy codes.
   - Update county claiming systems to successfully submit 837 transactions to the Short-Doyle Medi-Cal (SD/MC) claiming system.
   - Implement new Intergovernmental Transfer (IGT) agreement protocol.

2. **Implementation of CalAIM Behavioral Health Policy Changes**
   - Implement standardized screening tools in compliance with the Department of Health Care Services' (The Department) guidance.
   - Implement standardized transition of care tools in compliance with the Department's guidance.
   - For DMC Only: Assist providers to implement American Society of Addiction Medicine (ASAM) criteria to determine level of care in compliance with the Department's guidance.

CALAIM - BH QUALITY IMPROVEMENT PROGRAM
REGULAR POLICY CHANGE NUMBER: 51

- Implement revised documentation standards, including but not limited to, assessment domains, problem lists, progress notes, and applicable timeliness standards.
- Provide guidance and training to county-operated and county-contracted providers on all new behavioral health policies, as outlined by the Department in Behavioral Health Information Notices.

3. Data Exchange
- Promote bi-directional data exchange between MHP, DMC, DMC-ODS and MCPs in order to improve health outcomes and health equity through enhanced coordination of care.

Each participating county earns incentive payments in the CalAIM BHQIP by achieving certain milestones as outlined in the program's implementation plan and instructions. The Department anticipates incentive payments continuing into FY 2023-24.

Reason for Change:
There is no change in FY 2023-24, from the prior estimate.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to final payments are expected to be made in FY 2023-24.

Methodology:
1. Assume all 57 counties apply for this funding (Sutter/Yuba operate jointly).

2. Start-up payments were made in FY 2021-22 to provide for billing code conversion, technical assistance, and county IT infrastructure changes including incorporating managed care and other utilization data from the Department into county IT systems.

3. Initial incentive payments to counties began in the third quarter of FY 2021-22.

4. Assume additional payments will be made based on counties achieving deliverable milestones in FY 2022-23 and FY 2023-24.

5. The estimated payments in FY 2023-24 are:

(Dollars in Thousands)

Incentive Payments	TF	GF
FY 2023-24	$21,347	$21,347

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

MHP COSTS FOR CONTINUUM OF CARE REFORM

REGULAR POLICY CHANGE NUMBER: 52
IMPLEMENTATION DATE: 1/2017
ANALYST: Elena Susbilla
FISCAL REFERENCE NUMBER: 1957

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$3,639,000	$3,919,000
- STATE FUNDS	$2,687,150	$2,842,450
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,639,000	$3,919,000
STATE FUNDS	$2,687,150	$2,842,450
FEDERAL FUNDS	$951,850	$1,076,550

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
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

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 beneficiaries under the age of 21 (Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)). Either a CFT or an interagency placement committee (IPC) must decide that a STRTP is the appropriate level of care for the child or youth.

MHP COSTS FOR CONTINUUM OF CARE REFORM
REGULAR POLICY CHANGE NUMBER: 52

- 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.

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change from the prior estimate for FY 2023-24 is due to a decrease based on actual claims data.

The change from FY 2023-24 to FY 2024-25 in the current estimate is due to a slight increase based on actual claims data showing a general increase in claims each fiscal year.

Methodology:
1. The FY 2023-24 and FY 2024-25 estimated costs are forecasted based on actual claims data.

2. The CFT costs are estimated by using actual claims data from FY 2017-18 through FY 2021-22.

3. The Placement Assessments costs are estimated by using actual claims data from FY 2018-19 through FY 2021-22.

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 2023-24 and FY 2024-

MHP COSTS FOR CONTINUUM OF CARE REFORM
REGULAR POLICY CHANGE NUMBER: 52

25, 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 2023-24: Federal Share: $3,000,000 x 0.75 x 0.53 = $1,192,000 (Rounded)
FY 2024-25: Federal Share: $3,000,000 x 0.75 x 0.53 = $1,192,000 (Rounded)
FY 2023-24: General Fund Match: $3,000,000 x (1-(0.75 x 0.53)) = $1,808,000 (Rounded)
FY 2024-25: General Fund Match: $3,000,000 x (1-(0.75 x 0.53)) = $1,808,000 (Rounded)

Funding Summary

5. The estimate and lag are based on Short Doyle/Medi-Cal Children paid claims data. On a cash basis for FY 2023-24, the Department will pay 0.20% of FY 2021-22 claims, 34.4% of FY 2022-23 claims and 65.5% of FY 2023-24 claims. On a cash basis For FY 2024-25, the Department will pay 0.20% of FY 2022-23 claims, 34.4% of FY 2023-24 claims, and 65.5% of FY 2024-25 claims. There is no lag in payment for training costs.

6. The Title XIX and Title XXI COVID-19 increased FMAP is assumed for expenditures through December 31, 2023 for this policy change.

7. The FY 2023-24 estimate and FY 2024-25 estimate, on a cash basis, is:

(Dollars in Thousands)

FY 2023-24	TF	GF	FF	COVID-19 FF
CFT	$455	$219	$231	$5
Placement Assessments	$1,377	$660	$703	$13
Training	$1,808	$1,808	$0	$0
Total	**$3,639**	**$2,687**	**$934**	**$18**

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
CFT	$525	$258	$267
Placement Assessments	$1,588	$776	$810
Training	$1,808	$1,808	$0
Total	**$3,919**	**$2,842**	**$1,077**

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)
COVID-19 Title XIX Increased FMAP (4260-101-0001/0890)
COVID-19 Title XXI Increased FMAP (4260-101-0001/0890)

OUT OF STATE YOUTH - SMHS

REGULAR POLICY CHANGE NUMBER: 53
IMPLEMENTATION DATE: 1/2021
ANALYST: Elena Susbilla
FISCAL REFERENCE NUMBER: 2268

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$2,112,000	$2,163,000
- STATE FUNDS	$1,056,000	$1,081,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,112,000	$2,163,000
STATE FUNDS	$1,056,000	$1,081,500
FEDERAL FUNDS	$1,056,000	$1,081,500

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:
COVID-19 Increased FMAP – DHCS

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
REGULAR POLICY CHANGE NUMBER: 53

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:
There is no change, for FY 2023-24, from the prior estimate.

The change from FY 2023-24 to FY 2024-25, in the current estimate is a slight increase due to adding estimated claims to be paid in FY 2024-25.

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 beneficiaries.

2. Based on actual claims incurred in FY 2021-22 and the adjustment for payment lag, the FY 2021-22 accrual is estimated to be $2,030,000 for the 130 youth returned to California.

3. 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.

4. The estimated growth of costs from FY 2022-23 to FY 2023-24 and FY 2023-24 to FY 2024-25 is 2.42%, based on the forecasted increase of SMHS children’s services approved claims.

5. The accrual estimates for FY 2022-23, FY 2023-24, and FY 2024-25 are:

(Dollars in Thousands)

Fiscal Year	Accrual	FY 2023-24	FY 2024-25
FY 2022-23	$2,079	$728	$0
FY 2023-24	$2,129	$1,384	$745
FY 2024-25	$2,181	$0	$1,418
Total		$2,112	$2,163

OUT OF STATE YOUTH - SMHS
REGULAR POLICY CHANGE NUMBER: 53

6. The cash estimates for FY 2023-24 and FY 2024-25 are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2023-24	$2,112	$1,056	$1,056
FY 2024-25	$2,163	$1,082	$1,081

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

CALAIM - BH - CONNECT DEMONSTRATION

REGULAR POLICY CHANGE NUMBER: 54
IMPLEMENTATION DATE: 1/2025
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2394

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$39,043,000
- STATE FUNDS	$0	$13,227,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$39,043,000
STATE FUNDS	$0	$13,227,000
FEDERAL FUNDS	$0	$25,816,000

Purpose:
This policy change estimates the cost of the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration, previously referred to as the California Behavioral Health Community-Based Continuum (CalBH-CBC) Demonstration, to expand access and strengthen the continuum of mental health services for Medi-Cal members living with significant behavioral health needs.

Authority:
Medicaid Section 1115 Demonstration Waiver
Welfare & Institutions Code 14184.400(c)

Interdependent Policy Changes:
Not Applicable

Background:
California is facing a growing mental health crisis exacerbated by the COVID-19 pandemic. Since the pandemic, California hospitals are reporting 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 already making many investments in expanding behavioral health services. The BH-CONNECT Demonstration was designed to expand on these investments, complement existing major behavioral health initiatives, and strengthen the continuum of care for Medi-Cal members.

The Department will apply for a new Medicaid Section 1115 demonstration, titled the BH-CONNECT Demonstration, to expand access to and strengthen the continuum of mental health

CALAIM - BH - CONNECT DEMONSTRATION
REGULAR POLICY CHANGE NUMBER: 54

services for Medi-Cal members living with significant behavioral health needs. The disparities addressed in the demonstration are based largely off California's 2022 Assessment, titled Assessing the Continuum of Care for Behavioral Health Services in California.

The proposed BH-CONNECT Demonstration approach includes five key components:
- Strengthening the statewide continuum of community-based services and evidence-based practices available through Medi-Cal for individuals living with significant behavioral health needs.
- Supporting statewide practice transformations and improvements in the county-administered behavioral health system.
- Improving statewide county accountability for meeting service improvement requirements and implementing new benefits through incentives, robust technical assistance, and oversight.
- Establishing a county option to provide enhanced community-based services.
- Establishing a county option to receive Federal Funds Participation (FFP) for services provided during short-term stays in Institutes of Mental Disease (IMDs), contingent on counties meeting robust accountability requirements.

If counties opt-in to participate, counties will be required to reinvest the FFP they receive through the demonstration into expanding Medi-Cal behavioral health service provision and capacity.

Counties participating in the demonstration will be required to submit an implementation plan, which among other requirements, is expected to outline how the county intends to reinvest the FFP received.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to:
- A delay of the implementation from January 1, 2024 to January 1, 2025.
- The Department previously assumed FACT, Supported Employment, Activity Stipends, Initial Child Welfare-Mental Health Plan Assessment and Rent/Temporary Housing would be implemented at the end of year one of implementation. The Department now assumes these benefits will go live at the beginning of year one.
- Removing bed tracker costs from the Medi-Cal Local Assistance Estimate as this will now be in State Operations.

The change in the current estimate, from FY 2023-24 to FY 2024-25, is due to no BH-CONNECT Demonstration costs in FY 2023-24.

Methodology:
1. Assume the BH-CONNECT Demonstration will be implemented in January 2025.

2. The demonstration relies upon updated guidance from Centers for Medicare & Medicaid Services and the new availability of FFP for services in IMDs. Milestones must be met to qualify for this FFP.

3. Some features of the demonstration will be available starting FY 2024-25, however, features that require more lead-in time will be phased in over FY 2025-26 and FY 2026-27.

4. The Department and counties will partner to provide the non-federal share of the demonstration features. The share differs between features of the demonstration. The

CALAIM - BH - CONNECT DEMONSTRATION
REGULAR POLICY CHANGE NUMBER: 54

Department will need to submit a demonstration application and implementation plan in order the secure the FFP.

5. Total estimated costs for the BH-CONNECT Demonstration, on a cash basis, is as follows:

FY 2024-25	TF	GF	FFP	IGT*
SMHS – Statewide	$1,310,000	$655,000	$655,000	$0
SMHS – Opt-in	$37,733,000	$0	$25,161,000	$12,572,000
Total	**$39,043,000**	**$655,000**	**$25,816,000**	**$12,572,000**

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

SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS

REGULAR POLICY CHANGE NUMBER: 55
IMPLEMENTATION DATE: 2/2022
ANALYST: Elena Susbilla
FISCAL REFERENCE NUMBER: 2247

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$158,000	$159,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$158,000	$159,000
FEDERAL FUNDS	-$158,000	-$159,000

Purpose:
This proposal estimates the ongoing costs resulting from ancillary Medi-Cal services (that is, services other than specialty mental health services) provided to Medi-Cal members while in Short-Term Residential Therapeutic Programs (STRTPs) that are classified as Institutions for Mental Diseases (IMDs). This proposal estimates the amount of federal reimbursement the Department may need to return to the Centers for Medicare and Medicaid Services (CMS) in response to CMS guidance that STRTPs cannot be exempted from IMD determination.

Authority:
P.L. 115-123; 42 CFR 435.1009

Interdependent Policy Changes:
Not Applicable

Background:
The Families First Prevention Services Act (FFPSA) was enacted on February 9, 2018. The intent of the FFPSA is to restrict the use of congregate care, unless absolutely necessary, by limiting Title IV-E maintenance payments to specific congregate care settings meeting defined requirements. The FFPSA added Qualified Residential Treatment Programs (QRTPs) as a congregate care setting that may be used for children and youth requiring a therapeutic placement when specific criteria are met. In California, STRTPs regulatory requirements are similar to QRTPs and the California Department of Social Services (CDSS) is working to ensure STRTPs' current licensing standards meet the requirements of QRTPs. The definition of a QRTP in Title IV-E overlaps with the criteria used by a state to determine if a facility operates as an IMD, as defined in Title XIX. Title XIX prohibits federal reimbursement for covered services provided to beneficiaries who are residents of an IMD.

SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS

REGULAR POLICY CHANGE NUMBER: 55

On July 3, 2020, the Department sent a letter to CMS explaining why STRTPs do not meet the criteria to be classified as an IMD. CMS responded to the Department on July 30, 2020, and was unable to provide the Department with a blanket assurance that all STRTPs are not IMDs. As a result, the Department assessed each STRTP to determine whether or not the STRTP meets the criteria to be considered an IMD. As federal regulations prohibit federal reimbursement for covered services provided to Medi-Cal members who are residents of an IMD, the Department will no longer receive federal reimbursement for services provided to children and youth residing in STRTPs that meet IMD criteria and would have been qualified for federal funds prior to the IMD determination, including medically necessary services for physical health, mental health, dental, and substance use disorders. Since the IMD exclusion pre-dates realignment, specialty mental health costs for Medi-Cal members in STRTP IMDs would be the responsibility of county mental health plans.

Ancillary services are the state's responsibility. The Department will establish a process to repay federal funds on an ongoing basis for ancillary services provided to beneficiaries while a resident of an STRTP that is identified to be an IMDs.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to an increase in actual claims in FY 2020-21 and FY 2021-22 which informs the estimate for FY 2023-24.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to the forecasted percentage change in claims costs which was taken from the May 2023 Specialty Mental Health Services Budget Supplement.

Methodology:
1. As of December 31, 2022, the Department have completed assessments of the STRTP facilities and determined three facilities are classified as IMDs.

2. This policy change estimates the cost of providing services to beneficiaries while residing in an STRTP that would have been Medicaid reimbursable prior to the IMD determination, beginning July 1, 2022 and December 31, 2022.

3. All Medi-Cal costs, other than specialty mental health costs, are included in this estimate (managed care, fee-for-service, and dental).

4. The Department determined the total cost of all ancillary Medi-Cal services provided to children and youth, and not claimed through the Short-Doyle Medi-Cal claiming system, while residing in an STRTP that could meet the criteria of an IMD. The estimates for FY 2023-24 and FY 2024-25 are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2023-24	$0	$158	($158)
FY 2024-25	$0	$159	($159)

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

SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT

REGULAR POLICY CHANGE NUMBER: 56
IMPLEMENTATION DATE: 1/2012
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1660

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the cost of federal fund (FF) repayments made to the Centers for Medicare and Medicaid Services (CMS) for improper claims for Medi-Cal services made by Siskiyou County Mental Health Plan. In addition, Siskiyou County General Fund (GF) reimbursements are also included in this policy change.

Authority:
Title 42, United States Code (USC) 1396b (d)(2)(C)

Interdependent Policy Changes:
Not Applicable

Background:
During the audit and cost settlement processes, the Department identified overpayments to the Siskiyou County Mental Health Plan from improper Medi-Cal billing practices. Pursuant to federal statute, the Department must remit the overpaid FF to CMS within a year of the discovery date. While the county acknowledged its Medi-Cal billing problems, it is unable to repay the amounts owed in a significant or timely manner. Consequently, the County will reimburse the Department $200,000 per year until it fulfills its obligation for repayment. The County repayments began August 2012. The County has submitted eleven payments totaling $2,200,000.

Reason for Change:
There is no change from the prior estimate for FY 2023-24.

There is no change from FY 2023-24 and FY 2024-25, in the current estimate.

Methodology:
1. The Department began making repayments to CMS in January 2012 and repaid CMS overpayments discovered during cost settlements for FY 2006-07 through FY 2010-11 and audit settlements for FY 2005-06 through FY 2010-11.

SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT

REGULAR POLICY CHANGE NUMBER: 56

2. Siskiyou County reimburses the GF $200,000 annually. The county has submitted payments totaling $2,200,000.

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	($2,200,000)	$0	$0
Recoupments	($381,000)	$0	$0
Total	$9,408,000	$11,989,000	$0

3. The estimate for FY 2023-24 and FY 2024-25 is as follows:

Fiscal Year	TF	GF	FF	Reimbursement
FY 2023-24	**$0**	**($200,000)**	**$0**	**$200,000**
FY 2024-25	**$0**	**($200,000)**	**$0**	**$200,000**

Funding:
100% GF (4260-101-0001)
Reimbursement GF (4260-601-0995)

CHART REVIEW

REGULAR POLICY CHANGE NUMBER: 57
IMPLEMENTATION DATE: 7/2012
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1714

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	-$74,000	-$10,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$74,000	-$10,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$74,000	-$10,000

Purpose:
This policy change estimates the recoupments due to the Department from disallowed claims. The disallowed claims are the result of the on-site chart reviews of inpatient and outpatient mental health providers (MHPs).

Authority:
Title 9, California Code of Regulations 1810.380

Interdependent Policy Changes:
Not Applicable

Background:
Since January 2005, the Department has been conducting on-site chart reviews of MHPs by comparing claims to the corresponding patient chart entries. The Department recoups the disallowed claims.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is an increase due to updating the amounts from estimated inpatient recoupments to actual inpatient recoupments. The outpatient recoupments remains unchanged.

The change in FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to less inpatient recoupments and no outpatient recoupment during the FY 2023-24 review cycle for the FY 2024-25 cost estimate.

Methodology:
1. The FY 2023-24 estimate includes estimated and actual recoupments from inpatient and outpatient Chart Reviews to be conducted for FY 2022-23. The Department focused predominately on technical assistance reviews, without imposing additional outpatient review recoupments for FY 2022-23.

CHART REVIEW
REGULAR POLICY CHANGE NUMBER: 57

2. The FY 2024-25 estimate is the estimated recoupments from only inpatient Chart Reviews to be conducted for FY 2023-24.

Fiscal Year	TF	FF
FY 2023-24	($74,000)	($74,000)
FY 2024-25	($10,000)	($10,000)

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

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 58
IMPLEMENTATION DATE: 7/2015
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1713

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	-$61,458,000	-$62,921,000
- STATE FUNDS	$42,000	$42,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$61,458,000	-$62,921,000
STATE FUNDS	$42,000	$42,000
FEDERAL FUNDS	-$61,500,000	-$62,963,000

Purpose:
This policy change estimates interim and final cost 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
State Plan Amendment (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. Final settlements are completed within three years of the last amended county cost report the MHPs submit to the Department.

The reconciliation process for each fiscal year may result in an overpayment or underpayment to the county and will be handled as follows:

- For counties that have been determined to be overpaid, the Department will recoup any overpayments.
- For counties that have been determined to be underpaid, the Department will make a payment equal to the difference between the counties cost report and the Medi-Cal payments.

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 58

In addition to any reimbursements determined through the interim cost 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 2023-24, from the prior estimate, is due to the lower than expected actual number of interim and audit settlements that were received resulting in a lower projected settlement.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is a slight increase due to a higher cost per settlement.

Methodology:

1. Interim cost settlements are based on the difference between each county MHP's filed cost report and the payments they received from the Department.

2. Final cost settlements are based on the difference between each county MHP's final audited cost report and the payments they received from the Department.

3. Cost settlements for services, administration, utilization review, quality assurance, and mental health Medi-Cal administrative activities are each determined separately.

4. Cost settlements prior to 2011 realignment may consist of General Fund (GF).

5. To estimate expected expenditures for FY 2023-24 and FY 2024-25 for interim and audit settlements not yet received, the following procedures are used:

    - The average expenditure of $1,605,000 per interim settlement is determined by dividing the actual net inflow of $121,964,000 from FY 2020-21 by 76, the number of interim settlements processed in FY 2020-21. The average expenditure of $419,000 per audit settlement is determined by dividing the net inflow, $11,732,000, by 28, the number of audit settlements processed in FY 2020-21. This amount was then reduced by $406,000 to account for a reduction in recoupable amounts resulting from the narrowing of final audits by Audits and Investigations. The resulting recoupment amount per audit settlement is $13,000 per settlement.

    - The average expenditure per settlement is increased by 3% for fiscal years not yet received and which were not present in calculating the averages in prior step.

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 58

- 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.

- The percentage of each fund type of settlements processed in FY 2020-21 was used to determine the estimated amounts of Title XIX and Title XXI for the interim and audit settlement types for FY 2023-24 and FY 2024-25. Assuming that FY 2023-24 and FY 2024-25 estimated settlements will follow the same funding trends, the total estimated amount for each settlement type per fiscal year were multiplied by the percentages representing the Title XIX and Title XXI funding splits.

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 2023-24 and FY 2024-25.

7. The net FF to be reimbursed and/or recouped in FY 2023-24 for interim settlements and audit settlements are as shown:

(Dollars in Thousands)

Interim Settlements	**TF**	**GF**	**Title XIX**	**Title XXI**
FY 2015-16	($23,141)	$9	($20,316)	($2,834)
FY 2016-17	($30,645)	$12	($26,904)	($3,753)
FY 2018-19	($3,612)	$1	($3,171)	($442)
FY 2019-20	($3,721)	$1	($3,267)	($456)
Subtotal	($61,119)	$24	($52,268)	($7,485)

(Dollars in Thousands)

Audit Settlements	**TF**	**GF**	**Title XIX**	**Title XXI**
FY 2015-16	($293)	$15	($292)	($16)
FY 2018-19	($30)	$2	($30)	($2)
FY 2019-20	($16)	$1	($16)	($1)
Subtotal	($339)	$18	($338)	($19)
Total FY 2023-24	**($61,458)**	**$42**	**($53,996)**	**($7,504)**

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 58

8. The net FF to be reimbursed and/or recouped in FY 2024-25 for interim settlements and audit settlements are as shown:

(Dollars in Thousands)

Interim Settlements	TF	GF	Title XIX	Title XXI
FY 2015-16	($26,446)	$11	($23,218)	($3,239)
FY 2016-17	($3,405)	$1	($2,989)	($417)
FY 2018-19	($25,287)	$10	($22,200)	($3,097)
FY 2019-20	($7,441)	$3	($6,533)	($911)
Subtotal	($62,579)	$25	($54,941)	($7,663)

(Dollars in Thousands)

Audit Settlements	TF	GF	Title XIX	Title XXI
FY 2015-16	($279)	$14	($278)	($15)
FY 2018-19	($47)	$2	($46)	($3)
FY 2019-20	($16)	$1	($16)	($1)
Subtotal	($341)	$17	($339)	($19)
Total FY 2024-25	**($62,921)**	**$42**	**($55,280)**	**($7,683)**

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

GLOBAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 59
IMPLEMENTATION DATE: 12/2015
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 1951

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$3,195,419,000	$2,778,489,000
- STATE FUNDS	$1,564,311,000	$1,389,246,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,195,419,000	$2,778,489,000
STATE FUNDS	$1,564,311,000	$1,389,246,000
FEDERAL FUNDS	$1,631,108,000	$1,389,243,000

Purpose:
This policy change estimates the payments to fund California's remaining uninsured population.

Authority:
California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)
SB 815 (Chapter 111, Statutes of 2016)
Families First Coronavirus Response Act (FFCRA)
American Rescue Plan (ARP) Act (2021)
California Advancing and Innovating Medi-Cal (CalAIM) Section 1115(a) Medicaid Demonstration
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
ACA DSH Reduction

Background:
Since 2005, the Designated Public Hospital and Clinic systems (DPH systems) have received partial support for health expenditures made on behalf of the uninsured through a combination of California's 1115 Waivers' Safety Net Care Pool (SNCP), now known as Uncompensated Care Pool (UC Pool), and Medicaid Disproportionate Share Hospital (DSH) funding. These two funding sources have been provided through a cost-based system. The Medi-Cal 2020's redesigned Global Payment Program (GPP) includes funding from the UC Pool and the State's DSH allotment (related to the DPHs), and is designed with preset reductions to the overall funding amounts in the latter demonstration years to coincide with the Medicaid DSH reductions required in the Affordable Care Act (ACA).This safety net stabilization program provides an innovative approach to financing care to California's remaining uninsured population served by DPH systems by unifying the DSH and UC Pool funding streams into a DPH-specific global payment system. The GPP incentive and utilization based program steers funding to those who are providing actual inpatient and/or outpatient services to uninsured Californians who are most in need. Rather than continue payments to inpatient facilities based upon the prior UC Pool and DSH system that provides funding based on the volume of hospitalizations, the GPP promotes

GLOBAL PAYMENT PROGRAM
REGULAR POLICY CHANGE NUMBER: 59

the right care, at the right time, in the right setting for uninsured Californians served by the DPH systems.

On August 3, 2020, the Centers for Medicare and Medicaid Services (CMS) approved a six-month GPP extension through December 31, 2020. An additional one-year extension of the Medi-Cal 2020 waiver was approved on December 29, 2020, which extended the GPP program from January 1, 2021 through December 31, 2021.

On December 29, 2021, CMS approved CalAIM, a multi-year initiative focused on system, program, and payment reform that will allow California to take a population health, person-centered approach to provided services, with the goal of improving health outcomes for Medi-Cal and other low-income populations. CalAIM is effective from January 1, 2022, through December 31, 2026. A key change to the GPP is the incorporation of equity-enhancing services.

Effective July 1, 2015, DPHs, except State Government-operated University of California (UC) hospitals, receive their allocation of the federal DSH payments through the Global Payment Program. Beginning January 1, 2022, UC Hospitals may participate in GPP after obtaining CMS approval.

Beginning January 1, 2023, pending CMS approval, University of California Los Angeles (UCLA) will be participating in the Global Payment Program rather than the DSH program. Accordingly, beginning with Program Year (PY) 9, the proposed percentage of the Designated Public Hospital (DPH) DSH Allotment FFP allocated to DSH DPH hospitals will be adjusted to 20.371% rather than 21.896%. Until CMS approves the transition, UCLA will continue to be paid through DSH based on the 21.896% DPH DSH allocation. Once the transition is approved, the DPH DSH allocation percentage will be adjusted, DSH funds will be recouped, and a payment will be issued through GPP.

The ACA requires a reduction in the DSH allotments and was previously scheduled to go into effect on October 1, 2013. Most recently, on December 27, 2020, HR 133 (2020) was enacted with eliminated the DSH reductions for Federal Fiscal Year (FFY) 2021 through FFY 2023, lowered the overall aggregate national reduction to $32 billion, and postponed the implementation until FFY 2024. See the ACA DSH Reduction policy change for more information.

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;

GLOBAL PAYMENT PROGRAM
REGULAR POLICY CHANGE NUMBER: 59

- 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

On March 11, 2021, HR 1319 (2021), ARP, was enacted. ARP requires that for the federal fiscal years in which the FFCRA increased FMAP is applicable, the states' annual DSH allotments be recalculated such that the total computable DSH expenditures for a state is equal to the total computable DSH expenditures that would have resulted in the absence of the FFCRA increased FMAP. The result is an increase in the DSH allotments for the impacted fiscal years. This policy change reflects the revised preliminary ARP-adjusted FFY 2022 allotment and the preliminary FFY 2023 ARP-adjusted allotment released by CMS on September 26, 2022, as well as the Department estimated FFY 2024 and 2025 non-ARP-adjusted allotments.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to:

- The inclusion of PY 8 Quarter 4B (10% threshold reduction) payment pending CMS approval.
- The inclusion of the PY 8 Final Reconciliation payment, which is pending the receipt of final data from Public Health Care Systems (PHCS) and is subject to reductions in order to maintain compliance with the DSH allotment Total Computable (TC) cap, since it is anticipated that the entire unclaimable GPP DSH FFP amount can be absorbed by the PY 8 Final Reconciliation payment.
- An increase in PY 9 payments. Because the entire unclaimable GPP DSH FFP amount due to the TC cap should be absorbed by the PY 8 Final Reconciliation payment, fewer GPP PY 9 payments must be reduced.
- An updated Non-Designated Public Hospitals (NDPH) DSH allotment for FFY 2023 which resulted in a decreased GPP DSH allotment allocation for PY 8 and PY 9.
- An updated NDPH allotment estimate for FFY 2024 through 2026 which allows for an increased GPP DSH allotment allocation for PY 10 through PY 11.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to a larger DSH allotment estimate in FY 2024-25. The Department estimated FY 2024-25 DSH allotment will not be subject to ARP adjustments and is derived by trending forward the estimated non-ARP-adjusted FY 2023-24 allotment by 2%.

Methodology:

1. The PY for the GPP was originally established as July 1 to June 30, to align with the state fiscal year for PY 1 through PY 5. PY 6 (formerly 6A) is a six-month extension aligning with the fiscal period of July 1, 2020, to December 31, 2020. Starting with PY 7 (formerly 6B) on January 1, 2021, the GPP will align with the calendar year period of January 1 to December 31. The calendar year program format will continue for subsequent GPP program years.

2. On July 14, 2016, CMS approved $472 million in UC Pool funding for PY 2 through PY 5. The $472 million is subject to 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.

GLOBAL PAYMENT PROGRAM
REGULAR POLICY CHANGE NUMBER: 59

3. The total federal funding for the GPP for PY 1 through PY 12 is estimated at:

(Dollars in Thousands)

Program Year	DPH 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)	$903,395	$236,000	$1,139,395
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)	$1,141,602	$265,264	$1,406,866
PY 8 (1/1/22-12/31/22)	$1,203,416	$263,848	$1,467,264
PY 9 (1/1/23-12/31/23)	$1,193,690	$246,620	$1,440,310
PY 10(1/1/24-12/31/24)	$1,148,506	$236,000	$1,384,506
PY 11 (1/1/25-12/31/25)	$1,167,459	$236,000	$1,403,459
PY 12 (1/1/26-12/31/26)	$1,191,199	$236,000	$1,427,199

4. For PY 1 through PY 5, payments are made on a quarterly basis where three quarters are paid in the current state fiscal year and the fourth quarter is paid the following state fiscal year. For PY 6 (formerly 6A), two quarterly payments were made in the current state fiscal year. Beginning with PY 7 (formerly 6B), payments will be made on a quarterly basis, where one quarter is paid in the current state fiscal year, and the remaining three quarters are paid in the subsequent state fiscal year.

5. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023 for this policy change.

6. 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. Instead, the non-federal share is reduced according to the Consolidated Appropriations Act of 2023, reducing the overall TF, while keeping FFP the same that would have been paid at 50% federal share / 50% non-federal share. The FFP does not change, while the non-federal share is reduced.

7. The FY 2023-24 DSH allotment is subject to ARP adjustments for three months (October-December 2023), and therefore assumes a 2% annual increase from the preliminary non-ARP adjusted FFY 2023 allotment with three months of COVID-19 increased FMAP phase-out consistent with the Consolidated Appropriations Act of 2023.

GLOBAL PAYMENT PROGRAM
REGULAR POLICY CHANGE NUMBER: 59

8. The estimated GPP payments on a cash basis are:

(Dollars in Thousands)

FY 2023-24	TF	IGT	FF	COVID-19 FF
PY 8 (1/1/22-12/31/22)	$404,698	$196,585	$208,113	$0
PY 9 (1/1/23-12/31/23)	$2,098,468	$1,021,599	$1,072,149	$4,720
PY 10 (1/1/24-12/31/24)	$692,253	$346,127	$346,126	$0
Total	**$3,195,419**	**$1,564,311**	**$1,626,388**	**$4,720**

FY 2024-25	TF	IGT	FF
PY 10 (1/1/24-12/31/24)	$2,076,759	$1,038,381	$1,038,378
PY 11 (1/1/25-12/31/25)	$701,730	$350,865	$350,865
Total	**$2,778,489**	**$1,389,246**	**$1,389,243**

Funding:
100% Title XIX FFP (4260-101-0890)
100% Global Payment Program Special Fund (4260-601-8108)
COVID-19 Title XIX Increased FFP (4260-101-0890)

CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES

REGULAR POLICY CHANGE NUMBER: 60
IMPLEMENTATION DATE: 2/2022
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2245

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$1,829,376,000	$1,590,844,000
- STATE FUNDS	$748,822,250	$621,263,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,829,376,000	$1,590,844,000
STATE FUNDS	$748,822,250	$621,263,000
FEDERAL FUNDS	$1,080,553,750	$969,581,000

Purpose:
This policy change estimates the costs to implement a statewide Enhanced Care Management (ECM) benefit, Community Supports, and plan incentives to build infrastructure linked to reform within the Medi-Cal managed care delivery system.

Authority:
California Advancing and Innovating Medi-Cal (CalAIM) Initiative

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2022, the Department implemented a new ECM benefit and 14 Community Supports in the Medi-Cal managed care delivery system and established Medi-Cal managed care health plan (MCP) incentives linked to delivery system reform through investments in Community Supports and ECM. Medi-Cal MCPs in counties without Whole Person Care pilots and/or Health Homes Programs implemented the new ECM benefit on July 1, 2022, for certain mandated populations of focus.

The new 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 beneficiaries.

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

CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES
REGULAR POLICY CHANGE NUMBER: 60

statewide within the managed care delivery system effective January 1, 2022. Community Supports provide for flexible wrap-around services that Medi-Cal MCPs would be able to offer as a part of their overall population health management strategy as viable substitutes to more costly services such as hospital inpatient and long-term institutional care. Medium to high-risk and/or high-cost Medi-Cal beneficiaries who experience, or are at risk of experiencing, poor health outcomes may benefit from accessing non-traditional alternatives to State Plan benefits.

The Community Supports are:

- Housing Transition/Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities
- Nursing Facility Transition to a Home
- Personal Care (beyond In-Home Supportive Services) and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

Incentive payments complement Community Supports and ECM and are intended to incentivize Medi-Cal MCPs to invest in voluntary Community Supports delivery and partner with community-based organizations and on-the-ground providers such as Federally Qualified Health Centers, Rural Health Clinics, Indian Health Service clinics, public hospital safety net systems, and county behavioral health systems and providers. The time-limited incentive funding (January 1, 2022, through June 30, 2024, program period) is focused on building a pathway for Medi-Cal MCPs and providers to invest in the necessary delivery and systems infrastructure, building appropriate and sustainable care management and Community Supports capacity, and achieving improvements in quality performance that can inform future policy decisions to align with the goal of managed long-term services and supports by 2026.

Reason for Change:
There is no change from the prior estimate for FY 2023-24. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to funding for the incentive payments expiring June 30, 2024.

CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES

REGULAR POLICY CHANGE NUMBER: 60

Methodology:
Costs are estimated to be:

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
Community Supports	$236,960	$74,408	$162,552
Plan Incentives	$600,000	$300,000	$300,000
Enhanced Care Management	$992,416	$374,415	$618,001
Total for FY 2023-24	**$1,829,376**	**$748,822**	**$1,080,554**

*Totals may differ due to rounding.

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
Community Supports	$248,808	$78,128	$170,680
Plan Incentives	$300,000	$150,000	$150,000
Enhanced Care Management	$1,042,037	$393,135	$648,902
Total for FY 2024-25	**$1,590,844**	**$621,263**	**$969,581**

*Totals may differ due to rounding.

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

UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

REGULAR POLICY CHANGE NUMBER: 61
IMPLEMENTATION DATE: 7/2013
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 1769

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$712,000	$601,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$712,000	$601,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$712,000	$601,000

Purpose:
This policy change estimates the federal fund (FF) payments for uncompensated care services provided by Indian Health Service (IHS) tribal health facilities.

Authority:
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)
California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)
California Advancing and Innovating Medi-Cal Section 1115(a) Medicaid Demonstration (CalAIM)

Interdependent Policy Changes:
Not Applicable

Background:
In April 2013, CMS approved an amendment to the BTR to establish an uncompensated care pool to reimburse Tribal health programs for the cost of providing services to American Indian and Alaska Native patients who had been eliminated from Medi-Cal coverage due to previous State budget shortfalls. The amendment was intended to maintain IHS and Tribal facilities' financial viability and provide services to eligible individuals. Tribal uncompensated care payments were subsequently authorized under the Medi-Cal 2020 Demonstration through December 31, 2021. Notably, these services have since been restored in the Medi-Cal program, with the exception of chiropractic services.

On December 29, 2021, CMS approved California's Section 1115 Demonstration, named CalAIM. With this approval, Tribal uncompensated care payments for chiropractic services will be provided 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 (CPE) under this demonstration. For services provided to IHS eligible individuals, claims will be reimbursed with 100% FFP.

UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

REGULAR POLICY CHANGE NUMBER: 61

Reason for Change:
The change from FY 2023-24, from the prior estimate, is due to the delay in receiving and paying January–December 2022 and January–March 2023 invoices.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to using the actual calendar year (CY) 2023 encounter rate and using an estimated CY 2024 encounter rate, along with the delayed invoices for January–December 2022 and January–March 2023.

Methodology:
1. Assume IHS payments will continue until December 31, 2026.

2. The IHS global encounter rate is updated on the Federal Register for each calendar year. For CY 2022 the rate is $640, for CY 2023 the rate is $654. The projected CY 2024 rate is $708, and the CY 2025 projected rate is $767.

3. IHS claims are paid for each encounter. Assume IHS payments will be made as follows on a cash basis:

FY 2023-24	TF	FF
Calendar Year 2022	$28,000	$28,000
Calendar Year 2023	$544,000	$544,000
Calendar Year 2024	$140,000	$140,000
Total	**$712,000**	**$712,000**

FY 2024-25	TF	FF
Calendar Year 2024	$450,000	$450,000
Calendar Year 2025	$151,000	$151,000
Total	**$601,000**	**$601,000**

Funding:
100% Health Care Support Fund (4260-601-7503)

MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE

REGULAR POLICY CHANGE NUMBER: 62
IMPLEMENTATION DATE: 1/2017
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1954

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$687,000	$0
- STATE FUNDS	$687,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$687,000	$0
STATE FUNDS	$687,000	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the dental-related costs for the Medi-Cal 2020 Waiver. These costs include the estimated incentive payments for the provision of preventive services, caries risk assessment and disease management, continuity of care, and funding for the Local Dental Pilot Projects (LDPPs).

Authority:
California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not applicable

Background:
Through the Medi-Cal 2020 Waiver, the Department implemented and oversaw four dental efforts (domains), which were collectively referred to as the Dental Transformation Initiative (DTI) program.

The four domains of the DTI program were as follows:

(1) Increase Preventive Services Utilization for Children,
(2) Caries Risk Assessment and Disease Management,
(3) Increase the Continuity of Care, and
(4) LDPPs

The Increase Preventive Services Utilization for Children domain aimed to increase the statewide proportion of children ages one through twenty enrolled in Medi-Cal who receive a preventive dental service in a given year. The Department offered incentive payments to dental provider service office locations that provided preventive services to an increased number of Medi-Cal children, as determined by the Department. A reassessment of this Domain and the

MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE
REGULAR POLICY CHANGE NUMBER: 62

applicable benchmarks took place between years two and three in order to evaluate program effectiveness.

The Caries Risk Assessment and Disease Management domain enabled eligible Medi-Cal Dental program enrolled dentists to receive incentive payments for performing caries risk assessments and for each service performed under a pre-identified treatment plan for children ages six and under, based upon the beneficiary's risk level as determined by the dentist via the caries risk assessment. The key elements of this program were to formally assess and manage caries risk, and to emphasize the provision of preventive services in lieu of more invasive and costly procedures. This domain was implemented on a pilot basis in select counties based on the percentage of restorative to preventive services, representative sampling across the state, and likelihood of provider participation. As of January 1, 2019, this domain expanded to eighteen additional counties. The attributes considered when selecting these counties for expansion were ratio of restorative to preventive services (greater than 45%), provider populations, and robust eligible beneficiary count.

The Increase the Continuity of Care domain aimed to encourage the continuity of care among Medi-Cal beneficiaries age 20 and under. This domain was implemented on a pilot basis in select counties based on the ratio of service office locations to beneficiaries, current levels of continuity of care at, above and below the statewide continuity of care baseline, and representation throughout the state. As of January 1, 2019, this domain expanded to include 19 counties and a rate increase of $60. The Department hoped to increase utilization and participation with the expansion efforts.

The Department required the selected LDPPs to have broad-based provider and community support and collaboration, including Tribes and Indian health programs, with incentives related to goals and metrics that contribute to the overall goals of any one of the three abovementioned programs. The Department issued payments to pilot providers (i.e. the entity or entities providing the pilot proposal application) only on the basis of an approved application. Fifteen LDPPs were approved; however, two LDPP were unable to execute their contracts.

Under the Special Terms and Conditions (STCs) of the Medi-Cal 2020 Waiver, the DTI Program was allocated $148 million annually for each of the five program years (calendar years (CY) 2016-2020), equating to a total pool of $740 million for the entirety of the program. During the demonstration of the DTI, the Department met performance goals, and was authorized an additional $5 million. With the COVID-19 pandemic, an additional $148 million was allocated to DTI during the extension of the Medi-Cal 2020 Waiver for CY 2021. The DTI Program projected to surpass its total allotment of $893 million in FY 2022-23 and the remainder will be backfilled from the general fund.

Reason for Change:
The change from the previous estimate, for FY 2023-24, is a decrease due to updated projections for program close out costs and a pending invoice. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to program ending in December 2021 and runout costs ending in FY 2023-24.

Methodology:
Domain 1: Increase Preventive Services Utilization for Children
1. This domain has ended and does not have expenditures in FY 2023-24.

MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE
REGULAR POLICY CHANGE NUMBER: 62

Domain 2: Caries Risk Assessment and Disease Management

2. This domain has ended and does not have expenditures in FY 2023-24.

Domain 3: Increase the Continuity of Care

3. The implementation date for Domain 3 was July 1, 2016; however, claims data from January 1, 2016, through June 30, 2016, count towards the domain's performance metrics and incentive payments as compared to prior year's data. Payments are made once a year starting in July 2017. Therefore, FY 2022-23 includes incentive payments for CY 2021 and runout for CY 2020, while FY 2023-24 includes runout incentive payments for FY 2021.

4. This incentive program was available to service office locations that provided examinations to an enrolled Medi-Cal beneficiary for two, three, four, five, and six year continuous periods.

5. This incentive program was only available for services performed on child beneficiary participants age 20 and under. The Department assumed that the beneficiaries from the baseline year for the county would return to the same provider at the same rates in subsequent years.

6. Incentive payment amounts were made available in tiers based on the length of time a beneficiary maintains continuity of care with the same service office location. In each subsequent year of continuity, the dollar amount of the incentive payment for an exam of the same child within that period was increased.

Total Domain 3 costs are estimated to be:

Fiscal Year	TF	GF	FF
FY 2023-24	**$62,000**	**$62,000**	**$0**

Domain 4: Local Dental Pilot Projects

7. The estimated expenditures for FY 2023-24 is an invoice pending a settlement decision.

Fiscal Year	TF	GF	FF
FY 2023-24	**$625,000**	**$625,000**	**$0**

For all domains:

8. The DTI program is projected to surpass the amount originally authorized under the Medi-Cal 2020 waiver's STCs. The DTI program ended with an approximate deficit of $30.2 million and will be backfilled from the GF. $687,000 will be paid in FY 2023-24.

9. On a cash basis, the FY 2023-24 total demonstration costs are:

FY 2023-24	TF	GF	FF
100% GF	$687,000	$687,000	$0
Total	**$687,000**	**$687,000**	**$0**

*Totals may not add due to rounding

MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE

REGULAR POLICY CHANGE NUMBER: 62

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

2023 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.

REGULAR POLICY CHANGE NUMBER: 66
IMPLEMENTATION DATE: 3/2024
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2408

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$9,649,139,000	$9,914,615,000
- STATE FUNDS	$3,746,111,500	$3,967,767,050
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$9,649,139,000	$9,914,615,000
STATE FUNDS	$3,746,111,500	$3,967,767,050
FEDERAL FUNDS	$5,903,027,500	$5,946,847,950

Purpose:
This policy change estimates the cost of capitation rate increases that are offset by managed care organization (MCO) tax proceeds. The tax proceeds will be used for the non-federal share of capitation rate increases.

Authority:
AB 119 (Chapter 13, Statutes of 2023)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
2023 MCO Enrollment Tax Mgd. Care Plans
2023 MCO Enrollment Tax Mgd. Care Plans-Funding Adj.

Background:
Effective April 1, 2023, the Department enacted a multi-year renewal of the MCO provider tax that provides for a statewide tax on managed care plans based on reported enrollment into these plans during the 12-month calendar year (CY) 2022 period. The tax is tiered based on whether the enrollee is a Medi-Cal enrollee or other enrollee.

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. 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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;

2023 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.

REGULAR POLICY CHANGE NUMBER: 66

- 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:
There is no total fund change from the prior estimate for FY 2023-24. However, due to updated funding splits and FFCRA calculations, there was a decrease in General Funds (GF). The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to updated capitation amounts.

Methodology:
1. The 2023 MCO Enrollment Tax proceeds are required to be used to offset the capitation rate development process and payments made to the State that result directly from the imposition of the tax.

2. Enrollment for managed care plans is based on the number of Medi-Cal enrollees and "all-other" enrollees.

3. The enrollee count is multiplied by a tiered rate to determine total tax revenue.

4. Increased capitation rates due to the 2023 MCO Enrollment Tax are initially paid from the GF. The GF is then reimbursed by 2023 MCO Enrollment Tax revenue through a funding adjustment. The reimbursement is budgeted in the 2023 MCO Enrollment Tax Mgd. Care Plans-Funding Adjustment policy change.

5. Retroactive payments for CY 2023 will all occur in FY 2023-24.

6. Starting CY 2024, assume a one-month payment lag for all plans subject to MCO tax.

7. The Title XIX and Title XXI COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

8. 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 (MCO Tax)	FF
FY 2023-24	**$9,649,139**	$3,746,111	$5,903,028
FY 2024-25	**$9,914,615**	$3,967,767	$5,946,848

Funding:

2023 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.

REGULAR POLICY CHANGE NUMBER: 66

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

MANAGED CARE HEALTH CARE FINANCING PROGRAM

REGULAR POLICY CHANGE NUMBER: 68
IMPLEMENTATION DATE: 5/2020
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2061

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$2,163,690,000	$2,163,690,000
- STATE FUNDS	$727,820,600	$764,365,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,163,690,000	$2,163,690,000
STATE FUNDS	$727,820,600	$764,365,600
FEDERAL FUNDS	$1,435,869,400	$1,399,324,400

Purpose:
This policy change estimates increased payments to managed care plans (MCPs) designed to provide additional support for counties and/or public entities serving Medi-Cal beneficiaries.

Authority:
Welfare & Institutions Code 14087.3
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Managed Care Reimbursements to the General Fund

Background:
Effective July 1, 2018, the Department implemented a new voluntary Managed Care Health Care Financing Program which increases payments to MCPs to provide additional support for counties and/or public entities servicing Medi-Cal beneficiaries. Participation is voluntary and the increased payment levels will be evaluated annually.

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. 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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;

MANAGED CARE HEALTH CARE FINANCING PROGRAM
REGULAR POLICY CHANGE NUMBER: 68

- 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:
The change from the prior estimate, for FY 2023-24, is an increase due to updated enrollment and rates. There is no change from FY 2023-24 to FY 2024-25 in the current estimate.

Methodology:
1. The Managed Care Health Care Financing Program began with the FY 2018-19 rating period.

2. Payments for the CY 2022 rating period are anticipated to occur in FY 2023-24. Based on preliminary participation levels for the twelve months of CY 2022, the total payments are estimated to be $2,163,690,000 TF.

3. Payments for the CY 2023 rating period are anticipated to occur in FY 2024-25. However, participation levels for the CY 2023 rating period are not known at this time, pending anticipated updates to the CY 2023 rates. Therefore, the estimated total payments for the CY 2023 rating period are assumed to be $2,163,690,000 TF, consistent with the CY 2022 rating period.

4. The Title XIX and Title XXI COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

5. Anticipated costs on a cash basis are:

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
CY 2022 Title XIX 50/50	$1,104,194	$552,097	$552,097
CY 2022 Title XXI 65/35	$126,774	$44,371	$82,403
CY 2022 ACA 90/10	$715,982	$71,598	$644,384
100% State GF	$102,231	$102,231	$0
UIS Emergency Title XIX 50/50	$54,084	$27,042	$27,042
UIS Pregnancy Title XXI 65/35	$6,583	$2,304	$4,279
ACA UIS Emergency 90/10	$51,933	$5,193	$46,740
ACA UIS Pregnancy 65/35	$1,909	$668	$1,241
COVID-19 Tile XXI Increased FMAP	$0	($5,871)	$5,871
COVID-19 Tile XIX Increased FMAP	$0	($71,813)	$71,813
Total FY 2023-24	**$2,163,690**	**$727,820**	**$1,435,870**

*Totals may differ due to rounding.

MANAGED CARE HEALTH CARE FINANCING PROGRAM

REGULAR POLICY CHANGE NUMBER: 68

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
CY 2023 Title XIX 50/50	$1,104,194	$552,097	$552,097
CY 2023 Title XXI 65/35	$126,774	$44,371	$82,403
CY 2023 ACA 90/10	$715,982	$71,598	$644,384
100% State GF	$102,231	$102,231	$0
UIS Emergency Title XIX 50/50	$54,084	$27,042	$27,042
UIS Pregnancy Title XXI 65/35	$6,583	$2,304	$4,279
ACA UIS Emergency 90/10	$51,933	$5,193	$46,740
ACA UIS Pregnancy 65/35	$1,909	$668	$1,241
COVID-19 Tile XXI Increased FMAP	$0	($3,109)	$3,109
COVID-19 Tile XIX Increased FMAP	$0	($38,030)	$38,030
Total FY 2024-25	**$2,163,690**	**$764,365**	**$1,399,325**

*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% State GF (4260-101-0001)
SCHIP GF (4260-101-0001/0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)
COVID-19 Title XIX GF (4260-101-0001)
COVID-19 Title XXI Increased FFP (4260-101-0890)
COVID-19 Title XXI GF (4260-101-0001)

MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER: 69
IMPLEMENTATION DATE: 9/2019
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2062

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$2,058,008,000	$2,121,737,000
- STATE FUNDS	$560,524,650	$609,610,900
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,058,008,000	$2,121,737,000
STATE FUNDS	$560,524,650	$609,610,900
FEDERAL FUNDS	$1,497,483,350	$1,512,126,100

Purpose:
This policy change estimates managed care directed payments to fund Quality Incentive Pool (QIP) payments by managed care plans (MCPs) to Designated Public Hospitals (DPHs) including the University of California Health Systems (UCs), and District and Municipal Public Hospitals (DMPHs) based on their performance on designated performance metrics.

Authority:
SB 171 (Chapter 768, Statutes of 2017)
AB 205 (Chapter 768, Statutes of 2017)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Managed Care Reimbursements to the General Fund

Background:
The Centers for Medicare & Medicaid Services (CMS) instituted the final rule which modernized Medicaid managed care regulations. Title 42, Code of Federal Regulations, section 438.6 (c) provides states flexibility to implement delivery system and provider payment initiatives under MCP contracts based on allowable directed payments.

Effective July 1, 2017, for the FY 2017-18 rating period, the Department has directed MCPs to make QIP payments to DPHs tied to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. To receive QIP payments the DPHs must achieve specified improvement targets, which grow more difficult through year-over-year improvement or sustained high performance requirements. The total funding available for the QIP payments are limited to a predetermined amount (pool).

Prior to implementation of a directed payment program, CMS requires states seek pre-approval of any requested directed payment program through the standard CMS “pre-print” form.

MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL
REGULAR POLICY CHANGE NUMBER: 69

Effective July 1, 2020, the Department transitioned the existing Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program for DPHs and DMPHs to the QIP directed payment framework. The goal was to enable hospitals to continue quality improvement efforts that have been underway following the June 30, 2020, expiration of the PRIME program.

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. 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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
There is no change from the prior estimate for FY 2023-24. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to the larger pooled amounts for CY 2023.

Methodology:
1. The maximum value of the CY 2022 QIP is $2.058 billion total fund. Subject to actual performance on measures, this amount is anticipated to pay out in FY 2023-24.

2. The maximum value of the CY 2023 QIP is $2.122 billion total fund. Subject to actual performance on measures, this amount is anticipated to pay out in FY 2024-25.

3. The Title XIX and Title XXI COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

4. On a cash basis, the estimated QIP payments are:

(Dollars in Thousands)

FY 2023-24	TF	GF	FF	ACA FF
CY 2022 Title XIX	$1,010,409	$505,205	$505,205	$0
CY 2022 ACA 90/10	$983,682	$98,368	$0	$885,314
CY 2022 Title XXI 65/35	$63,917	$22,371	$41,546	$0
COVID-19 Tile XIX Increased FMAP	$0	($62,645)	$62,645	$0
COVID-19 Tile XXI Increased FMAP	$0	($2,774)	$2,774	$0
Total FY 2023-24	**$2,058,008**	**$560,525**	**$612,170**	**$885,314**

*Difference due to rounding.

MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER: 69

(Dollars in Thousands)

FY 2024-25	TF	GF	FF	ACA FF
CY 2023 Title XIX	$1,041,698	$520,849	$520,849	$0
CY 2023 ACA 2021 90/10	$1,014,143	$101,414	$0	$912,729
CY 2023 Title XXI 65/35	$65,896	$23,063	$42,832	$0
COVID-19 Tile XIX Increased FMAP	$0	($34,202)	$34,202	$0
COVID-19 Tile XXI Increased FMAP	$0	($1,514)	$1,514	$0
Total FY 2024-25	**$2,121,737**	**$609,610**	**$599,397**	**$912,729**

*Difference due to rounding.

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX ACA FF / 10% GF (4260-101-0001/0890)
65% Title XXI FF / 35% GF (4260-101-0001/0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)
COVID-19 Title XIX GF (4260-101-0001)
COVID-19 Title XXI Increased FFP (4260-101-0890)
COVID-19 Title XXI GF (4260-101-0001)

MANAGED CARE PUBLIC HOSPITAL EPP

REGULAR POLICY CHANGE NUMBER: 71
IMPLEMENTATION DATE: 9/2019
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2060

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$1,853,760,000	$1,913,968,000
- STATE FUNDS	$477,618,750	$510,841,350
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,853,760,000	$1,913,968,000
STATE FUNDS	$477,618,750	$510,841,350
FEDERAL FUNDS	$1,376,141,250	$1,403,126,650

Purpose:
This policy change estimates Managed Care Enhanced Payment Program (EPP) Directed Payments for Designated Public Hospitals (DPHs) including University of California Health Systems (UCs).

Authority:
SB 171 (Chapter 768, Statutes of 2017)
Title 42, Code of Federal Regulations (CFR), Section 438.6(c)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Managed Care Reimbursements to the General Fund

Background:
The Centers for Medicare & Medicaid Services (CMS) instituted the final rule which modernized Medicaid managed care regulations. The result is changes in the usage of managed care delivery systems, CFR section 438.6(c) provides states flexibility to implement delivery system and provider payment initiatives under Medicaid managed care plan (MCP) contracts based on allowable directed payments.

Effective July 1, 2017, with the FY 2017-18 rating period, the Department directed MCPs to make enhanced network contracted payments to California's DPHs. The total funding available for the enhanced network contracted payments is limited to a predetermined amount (pool). The EPP Directed Payment Program is divided into two primary sub-pools:

- Capitated sub-pool value is based on a pre-determined pool amount. Actual payments will be increased by a uniform percentage based on actual monthly DPH member assignment for network contracted services.

- Fee-For-Service (FFS) sub-pool value is based on a pre-determined pool amount. Actual payments will be increased by a uniform dollar amount based on actual utilization of network contracted services.

MANAGED CARE PUBLIC HOSPITAL EPP
REGULAR POLICY CHANGE NUMBER: 71

Prior to implementation of a directed payment program, 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.

On January 20 and February 2, 2022, the Department received CMS pre-print approval to continue the EPP Directed Payment program for the rating period covering January 1, 2021, through December 31, 2021. On July 14, 2022, the Department received CMS pre-print approval to continue the EPP Directed Payment program for the rating period covering January 1, 2022, through December 31, 2022. On December 31, 2022, the Department submitted a pre-print requesting program continuation and approval for the January 1, 2023, through December 31, 2023, rating period.

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. 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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
There is no total fund change from the prior estimate for FY 2023-24. However, due to updated funding splits, there was an increase in General Funds. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to the larger pooled amounts for CY 2022 and CY 2023.

Methodology:
1. The value of the entire public hospital EPP pool is $1,792,530,000 TF for the CY 2021 rating period on an accrual basis.

2. The value of the entire public hospital EPP pool is $1,878,640,000 TF for the CY 2022 rating period on an accrual basis.

3. The value of the entire public hospital EPP pool is $1,982,550,000 TF for the CY 2023 rating period on an accrual basis.

4. The July 1, 2021, through December 31, 2021, FFS sub-pool payments were made in September 2023. The January 1, 2022, through June 30, 2022, FFS sub-pool payments are anticipated to be made in March 2024. The July 1, 2022, through December 31, 2022, FFS sub-pool payments are anticipated to be made in September 2024. The January 1, 2023, through June 30, 2023, FFS sub-pool payments are anticipated to be made in March 2025.

MANAGED CARE PUBLIC HOSPITAL EPP
REGULAR POLICY CHANGE NUMBER: 71

5. The January 1, 2022, through June 30, 2022, Capitated sub-pool payments were made in September 2023. The July 1, 2022, through December 31, 2022, Capitated sub-pool payments are anticipated to be made in March 2024. The January 1, 2023, through June 30, 2023, Capitated sub-pool payments are anticipated to be made in September 2024. The July 1, 2023, through December 31, 2023, Capitated sub-pool payments are anticipated to be made in March 2025.

6. The Title XIX and Title XXI COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

7. On a cash basis, the estimated payments are:

(Dollars in Thousands)

FY 2023-24	TF	GF	FF	ACA FF
Title XIX	$617,084	$308,542	$308,542	$0
Title XXI 65/35	$62,005	$21,702	$40,303	$0
UIS State Only	$78,731	$78,731	$0	$0
ACA 2020 90/10	$1,095,940	$109,594	$0	$986,346
COVID-19 Tile XIX Increased FMAP	$0	($38,259)	$38,259	$0
COVID-19 Tile XXI Increased FMAP	$0	($2,691)	$2,691	$0
Total FY 2023-24	**$1,853,760**	**$477,619**	**$389,795**	**$986,346**

*Totals may differ due to rounding.

(Dollars in Thousands)

FY 2024-25	TF	GF	FF	ACA FF
Title XIX	$657,096	$328,548	$328,548	$0
Title XXI 65/35	$66,327	$23,215	$43,112	$0
UIS State Only	$81,826	$81,826	$0	$0
ACA 2020 90/10	$1,108,719	$110,872	$0	$997,847
COVID-19 Tile XIX Increased FMAP	$0	($31,370)	$31,370	$0
COVID-19 Tile XXI Increased FMAP	$0	($2,249)	$2,249	$0
Total FY 2024-25	**$1,913,968**	**$510,842**	**$405,279**	**$997,847**

*Totals may differ due to rounding.

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX ACA FF / 10% GF (4260-101-0001/0890)
65% Title XXI FF / 35% GF (4260-101-0001/0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)
COVID-19 Title XIX GF (4260-101-0001)
COVID-19 Title XXI Increased FFP (4260-101-0890)
COVID-19 Title XXI GF (4260-101-0001)
100% GF (4260-101-0001)

HCBS SP - HOUSING AND HOMELESSNESS INCENTIVE PROG

REGULAR POLICY CHANGE NUMBER: 73
IMPLEMENTATION DATE: 7/2023
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 2325

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$557,414,000	$0
- STATE FUNDS	$249,984,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$557,414,000	$0
STATE FUNDS	$249,984,000	$0
FEDERAL FUNDS	$307,430,000	$0

Purpose:
This policy change estimates payments to Medi-Cal managed care plans (MCP) made through the Housing and Homelessness Incentive Program (HHIP) using enhanced federal funding under Section 9817 of the American Rescue Plan Act (ARPA) of 2021. The estimated payments are intended to incentivize investments and progress in addressing homelessness and keeping people housed within the Medi-Cal Managed Care program.

Authority:
American Rescue Plan Act (2021)
Section 11.95, Budget Act of 2021
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
American Rescue Plan Increased FMAP for HCBS

Background:
The ARPA of 2021 provides additional COVID-19 relief to states. Section 9817 of the ARPA provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS). Increased FMAP is available from April 1, 2021, through March 31, 2025. States must use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021, and states must use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. State funds equivalent to the amount of federal funds attributable to the increased FMAP are deposited in the Home and Community-Based Services American Rescue Plan Fund pursuant to Section 11.95 of the Budget Act of 2021. Section 11.95 appropriates this funding to eligible HCBS activities identified in the HCBS Spending Plan.

HCBS SP - HOUSING AND HOMELESSNESS INCENTIVE PROG

REGULAR POLICY CHANGE NUMBER: 73

The HHIP allows MCPs to earn incentive funds, up to $1.288 billion TF over the duration of the program, for achieving progress in addressing homelessness and keeping people housed and developing the necessary capacity and partnerships to connect their members to needed housing service. The MCPs submitted plans to the Department that map the continuum of services with a focus on homelessness prevention, interim housing (particularly for the aging and/or disabled population), rapid re-housing (families and youth), and permanent supportive housing. Funds are made available based on point in time counts of homeless individuals and other factors determined by the Department. MCPs must meet specified metrics to earn available funds. The program offers a way for MCPs that did not achieve enough points on select measures in Submissions 1 and 2 to earn back some or all of those points by performing over and above the thresholds on select Priority Measures in the same reporting period or by way of High-Performance Pool.

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is a decrease to reflect a revision in the estimated amount of incentive payments that will be earned. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to all payments being paid out in FY 2023-24.

Methodology:
1. Phase I of HHIP (Planning phase) began effective January 1, 2022. Plans were able to earn incentive payments for completion of Local Homelessness Plans (LHP) and Investment Plans for their respective counties, which were subject to review and acceptance by the Department.
2. In Phase II of HHIP (Outcome/Performance phase), plans may earn incentive payments based on achievement of specified metrics and measures.
3. Incentive payments began on October 2022.
4. The Title XIX FFCRA increased FMAP is assumed for expenditures through October 31, 2023, for this policy change.
5. The last payment for this program is expected to be paid out in FY 2023-24.
6. The costs for this PC on a cash basis for FY 2023-24 are expected to be:

HCBS SP - HOUSING AND HOMELESSNESS INCENTIVE PROG

REGULAR POLICY CHANGE NUMBER: 73

(Dollars in Thousands)

FY 2023-24	TF	SF	FF
50% Title XXI FF (4260-101-0890)	$278,707	$0	$278,707
HCBS ARP Fund	$278,707	$278,707	$0
COVID-19 Title XIX Increased FMAP	$0	($28,723)	$28,723
Total FY 2023-24	**$557,414**	**$249,984**	**$307,430**

Funding:
100% Title XIX FF (4260-101-0890)
Home and Community-Based Services American Rescue Plan Fund (4260-101-8507)
COVID-19 Title XIX Increased FFP (4260-101-0890)
COVID-19 Title XIX GF (4260-101-0001)

RETRO MC RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 74
IMPLEMENTATION DATE: 1/2016
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1788

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$629,178,000	$287,132,000
- STATE FUNDS	$343,924,600	$156,707,750
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$629,178,000	$287,132,000
STATE FUNDS	$343,924,600	$156,707,750
FEDERAL FUNDS	$285,253,400	$130,424,250

Purpose:
This policy change estimates retroactive managed care capitation rate adjustments.

Authority:
Welfare & Institutions Code, section 14087.3

Interdependent Policy Changes:
COVID-19 Increased FMAP – DHCS

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 2023-24, is a Total Fund decrease due to the updated retroactive managed care rate adjustments and recoupments mainly related to MCO tax CY 2022 rate adjustments. The additional decrease in the General Fund (GF) is attributed to the SB 78 MCO tax reconciliation, which resulted in a reimbursement to the GF.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to lower estimated retroactive managed care rate adjustments in FY 2024-25.

Methodology:
1. The Department estimates the following retroactive managed care capitation rate adjustments and retroactive pass-through payments in FY 2023-24 and FY 2024-25:

RETRO MC RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 74

(Dollars in Thousands)

FY 2023-24	TF	GF	Fund 3156	State-Only	FF
Retro MC Rate Adjustments Payments	$564,767	$275,311	$0	$45,082	$244,374
Retro Pass-Through Payments	$64,411	$22,849	$0	$683	$40,879
SB 78 MCO Tax Reconciliation	$0	($175,439)	$175,439	$0	$0
Total FY 2023-24	**$629,178**	**$122,721**	**$175,439**	**$45,765**	**$285,253**

(Dollars in Thousands)

FY 2024-25	TF	GF	State-Only	FF
Retro MC Rate Adjustment Payments	$209,514	$80,353	$48,804	$80,357
Retro Pass-Through Payments	$77,618	$26,834	$717	$50,067
Total FY 2024-25	**$287,132**	**$107,187**	**$49,521**	**$130,424**

Funding:
50% Title XIX FF / 50% GF (4260-101-0001/0890)
65% Title XXI FF / 35% GF (4260-101-0001/0890)
ACA 90/10 (2019) (4260-101-0890)
100% GF (4260-101-0001)
3156 MCO Tax (Non-GF) (4260-601-3156 MCO Tax)
COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

WORKFORCE & QUALITY INCENTIVE PROGRAM

REGULAR POLICY CHANGE NUMBER: 75
IMPLEMENTATION DATE: 2/2024
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2388

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$280,000,000	$296,845,000
- STATE FUNDS	$139,605,500	$148,004,100
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$280,000,000	$296,845,000
STATE FUNDS	$139,605,500	$148,004,100
FEDERAL FUNDS	$140,394,500	$148,840,900

Purpose:
This policy change estimates the cost providing Workforce & Quality Incentive Program (WQIP) directed payments to Freestanding Skilled Nursing Facilities, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facilities, Level-B (FSSA/NF-B).

Authority:
AB 186 (Chapter 46, Statutes of 2022)

Interdependent Policy Changes:
COVID-19 Increased FMAP – DHCS

Background:
AB 186 established the WQIP for calendar years 2023 through 2026 to provide nursing facilities which meet workforce and quality benchmarks directed payments through the Medi-Cal managed care delivery system. The WQIP succeeds the former Quality & Accountability Supplemental Payment program. AB 186 requires the Department to develop the methodology, parameters and eligibility criteria for receipt of WQIP directed payments in consultation with stakeholders.

Statute requires the Department to set the amount of performance-based directed payments to target an aggregate amount of $280 million for the 2023 calendar year (CY) and to increase the targeted amount in subsequent years by an amount equal to one percent of facilities' non-labor costs.

Reason for Change:
There is no change in the total fund projections for FY 2023-24 from the prior estimate.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to FY 2024-25 reflecting increased CY 2024 costs inclusive of one percent of facilities' non-labor costs in CY 2023.

WORKFORCE & QUALITY INCENTIVE PROGRAM

REGULAR POLICY CHANGE NUMBER: 75

Methodology:

1. Assume that WQIP directed payments will be $280 million for calendar year 2023 will be paid in FY 2023-24.

2. Assume that the WQIP directed payments in calendar year 2024 will be $280 million in base funding plus one percent of calendar year 2023 non-labor costs which equals $16.845 million, for a total payment of $296.8 million to be paid in FY 2024-25.

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
WQIP Directed Payments	$280,000	$139,605	$140,395
Total	**$280,000**	**$139,605**	**$140,395**

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
WQIP Directed Payments	$296,845	$148,004	$148,841
Total	**$296,845**	**$148,004**	**$148,841**

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)
COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

CYBHI - STUDENT BH INCENTIVE PROGRAM

REGULAR POLICY CHANGE NUMBER: 77
IMPLEMENTATION DATE: 1/2022
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2260

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$85,422,000	$85,422,000
- STATE FUNDS	$42,711,000	$42,711,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$85,422,000	$85,422,000
STATE FUNDS	$42,711,000	$42,711,000
FEDERAL FUNDS	$42,711,000	$42,711,000

Purpose:
This policy change estimates expenditures related to implementing an incentive program through Medi-Cal managed care plans, in coordination with county behavioral health departments and schools, to build infrastructure, partnerships, and capacity statewide to increase access to preventive and early intervention behavioral health services for students.

Authority:
AB 133 (Chapter 143, Statutes of 2021)
SB 154 (Chapter 43, Statutes of 2022)

Interdependent Policy Changes:
COVID-19 Increased FMAP – DHCS

Background:
The Children and Youth Behavioral Health Initiative (CYBHI) is a multiyear package of investments as part of the FY 2021-22 budget agreement. The CYBHI is intended to transform California's behavioral health system for children and youth aged 0-25 into a world-class, innovative, up-stream focused, ecosystem where all children and young adults are routinely screened, supported, and served for emerging behavioral health needs.

Schools are a critical point of access for preventive and early intervention behavioral health services, as children are in school for many hours a day, for approximately half the days of the year. The consequences of not addressing child and adolescent mental health conditions often extend to adulthood. Early identification and treatment through school-based or school-linked services can reduce emergency room visits, crisis situations, inpatient stays and placement in high-cost special education settings and/or out of home placement. Schools often lack on-campus behavioral health resources and find it challenging to recognize and respond appropriately to children's mental health needs, particularly in the absence of school-based mental health professionals.

In order to build infrastructure, partnerships, and capacity statewide, the Department implemented incentive payments to qualifying Medi-Cal managed care plans for a variety of

CYBHI - STUDENT BH INCENTIVE PROGRAM
REGULAR POLICY CHANGE NUMBER: 77

interventions for a maximum period of three calendar years commencing with the rating period beginning January 1, 2022. The initial Student Behavioral Health Incentive assessment funds were paid out to plans within Program Year 1 (Calendar Year 2022). For Program Years 2 (CY 2023) and 3 (CY 2024), Medi-Cal managed care plans receive incentive payments from the Department based on achieving the outlined milestones and performance metrics.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is a slight increase due to revised projections for the remaining Targeted Intervention Allocation Pool payments. There is no change in the current estimate from FY 2023-24 to FY 2024-25.

Methodology:
1. Assume expenditures of $85,422,000 TF ($42,711,000 GF) in FY 2023-24 and $85,422,000 TF ($42,711,000 GF) in FY 2024-25.

2. A total of $388,986,000 TF ($194,493,000 GF) is available for the local assistance portion of this program, available for expenditure through June 30, 2025. The table below displays the estimated spending and remaining funds by Appropriation Year:

	TF	GF	FF
Appropriation Year 2021-22			
Prior Years	$218,142,000	$109,071,000	$109,071,000
Estimated in FY 2023-24	$85,422,000	$42,711,000	$42,711,000
Estimated in FY 2024-25	$85,422,000	$42,711,000	$42,711,000
Total Estimated Remaining	$0	$0	$0

3. The estimated costs in FY 2023-24 and FY 2024-25 are as follows:

FY 2023-24	TF	GF	FF
50% Title XIX / 50%GF	$85,422,000	$42,711,000	$42,711,000
Total	**$85,422,000**	**$42,711,000**	**$42,711,000**

.

FY 2024-25	TF	GF	FF
50% Title XIX / 50%GF	$85,422,000	$42,711,000	$42,711,000
Total	**$85,422,000**	**$42,711,000**	**$42,711,000**

*Totals may differ due to rounding

Funding:
Title XIX 50 FF/50 GF (4260-101-0890/0001)
COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

MANAGED CARE DP-NF PASS-THROUGH PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 79
IMPLEMENTATION DATE: 2/2025
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 2448

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$62,638,000
- STATE FUNDS	$0	$29,145,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$62,638,000
STATE FUNDS	$0	$29,145,000
FEDERAL FUNDS	$0	$33,493,000

Purpose:
This policy change estimates costs for the distinct part nursing facility (DP-NF) pass-through payment program that transitions supplemental payments for DP-NF days formerly covered in the Medi-Cal fee-for-service (FFS) delivery system.

Authority:
Welfare & Institutions Code 14184.201(b)(c)
42, Code of Federal Regulations 438.6(d)(6)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Change:
Not Applicable

Background:
DP-NFs are currently 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 beneficiaries. These supplemental payments are currently covered in the Medi-Cal FFS delivery system.

Effective January 1, 2023, the managed care delivery system will include a temporary DP-NF pass-through payment program that will transition supplemental payments for DP-NF days formerly covered under FFS. This program will apply 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.

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

MANAGED CARE DP-NF PASS-THROUGH PAYMENT PROGRAM
REGULAR POLICY CHANGE NUMBER: 79

- 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:
This is a new policy change.

Methodology:
1. The total value of the funding for the district hospital directed payment pool on an accrual basis is $62.6 million total fund for the CY 2023 rating period and is anticipated to pay in a lump sum in FY 2024-25.

2. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

3. On a cash basis, the estimated payments are:

FY 2024-25	TF	GF	FF	ACA FF	FFCRA
Title XIX 50/50	$58,900,000	$29,450,000	$29,450,000	$0	$0
ACA 2020 90/10	$2,320,000	$232,000	$0	$2,088,000	$0
100% State GF	$1,378,000	$1,378,000	$0	$0	$0
Title XIX 50/50 - UIS	$40,000	$20,000	$20,000	$0	$0
COVID-19 Title XIX Increased FMAP	$0	($1,935,000)	$0	$0	$1,935,000
Total FY 2024-25	**$62,638,000**	**$29,145,000**	**$29,470,000**	**$2,088,000**	**$1,935,000**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX ACA FF / 10% GF (4260-101-0001/0890)
100% State GF (4260-101-0001)
COVID-19 Title XIX Increased FFP (4260-101-0890)

CCI-QUALITY WITHHOLD REPAYMENTS

REGULAR POLICY CHANGE NUMBER: 81
IMPLEMENTATION DATE: 5/2017
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2031

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$29,976,000	$16,676,000
- STATE FUNDS	$14,988,000	$8,338,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$29,976,000	$16,676,000
STATE FUNDS	$14,988,000	$8,338,000
FEDERAL FUNDS	$14,988,000	$8,338,000

Purpose:
This policy change estimates the repayment of the quality withholds for the Coordinated Care Initiative (CCI).

Authority:
SB 1008 (Chapter 33, Statutes of 2012)
SB 1036 (Chapter 45, Statutes of 2012)

Interdependent Policy Changes:
Not Applicable.

Background:
In coordination with Federal and State Government, the CCI provided the benefits of coordinated care models to persons eligible for Medi-Cal. By enrolling these eligibles into coordinated care delivery models, the CCI aligned financial incentives, streamlined beneficiary-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 withhold started at 1% in CY 2014 and CY 2015, increased to 2% in CY

CCI-QUALITY WITHHOLD REPAYMENTS
REGULAR POLICY CHANGE NUMBER: 81

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 has been removed from capitation rate payments effective January 1, 2018.

As part of the CalAIM Initiative's standardized mandatory enrollment of dual eligibles and statewide integration of long-term care into managed care, the CCI pilot program sunset December 31, 2022.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due to the repayment of withhold amounts for CY 2021 in addition to the withhold amounts for CY 2020. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to FY 2024-25 being based on the withhold amounts for only CY 2022.

Methodology:
1. Withheld amounts are repaid subject to performance consistent with established quality thresholds. Thresholds are based on a combination of certain core quality withhold measures as well as state-specified quality measures.

2. The CMS and the State evaluate plan performance according to the specified metrics in order to determine how much of the withheld amount a plan will be repaid for a given year.

3. Assume quality withholds for CY 2020 and CY 2021 will be repaid in FY 2023-24.

4. Assume quality withholds for CY 2022 will be repaid in FY 2024-25.

FY 2023-24	TF	GF	FF
Quality Withhold Repayment (CY 2020 & CY 2021)	$29,976,000	$14,988,000	$14,988,000

FY 2024-25	TF	GF	FF
Quality Withhold Repayment (CY 2022)	$16,676,000	$8,338,000	$8,338,000

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

PROP 56 - BEHAVIORAL HEALTH INCENTIVE PROGRAM

REGULAR POLICY CHANGE NUMBER: 85
IMPLEMENTATION DATE: 7/2022
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 2254

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$2,156,000	$0
- STATE FUNDS	$171,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,156,000	$0
STATE FUNDS	$171,000	$0
FEDERAL FUNDS	$1,985,000	$0

Purpose:
This policy change estimates payments to providers made through the Behavioral Health Integration (BHI) Incentive program intended to incentivize physical and behavioral health outcomes within the Medi-Cal Managed Care program and improve evidence-based medical and behavioral health integration practices.

Authority:
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023
Budget Act of 2021

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 limited-term Proposition 56 funding for the BHI program.

The BHI Incentive program implemented on January 1, 2021, was intended to incentivize physical and behavioral health outcomes within the Medi-Cal Managed Care program and improve evidence-based medical and behavioral health integration practices.

Proposition 56 funding, along with federal funds, were used to make these payments. This policy change identified the interim 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.

PROP 56 - BEHAVIORAL HEALTH INCENTIVE PROGRAM

REGULAR POLICY CHANGE NUMBER: 85

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due to updated actuals from the re-evaluation of BHI health plans' milestone achievements. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to the final payment for the BHI program having completed in September 2023.

Methodology:

1. On a cash basis, the total directed payments are $2,156,000 in FY 2023-24.

2. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

3. Below is the payment table for FY 2023-24, by funding type.

FY 2023-24	TF	GF	FF
50% Title XIX FF/ 50% GF	$2,156,000	$1,078,000	$1,078,000
COVID-19 Title XIX Increased FMAP	$0	($907,000)	$907,000
Total	**$2,156,000**	**$171,000**	**$1,985,000**

Funding:
50% Title XIX FF / 50% GF (4260-101-0890/0001)
COVID-19 Title XIX Increased FFP (4260-101-0890)
COVID-19 Title XIX GF (4260-101-0001)

CAPITATED RATE ADJUSTMENT FOR FY 2024-25

REGULAR POLICY CHANGE NUMBER: 87
IMPLEMENTATION DATE: 7/2024
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1338

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$1,657,764,000
- STATE FUNDS	$0	$634,798,400
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$1,657,764,000
STATE FUNDS	$0	$634,798,400
FEDERAL FUNDS	$0	$1,022,965,600

Purpose:
The policy change estimates the increase for the Managed Care capitation rates for fiscal year (FY) 2024-25.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
Managed care capitation rates are typically rebased each rating period. After actuarial analysis, upward/downward adjustments are applied to historical data to develop a reasonable “base” for rate development. Additional adjustments such as trends and program changes are applied to the base data in order to inform the final capitated rates. This policy change shows the increase in capitation rates from FY 2023-24 to FY 2024-25.

Reason for Change:
The change in capitation rates from FY 2023-24 to FY 2024-25 is a 3.83% average rate increase on a cash basis, primarily due to:

- Updated Calendar Year (CY) 2024 rate growth and draft CY 2025 rate growth projections in the range of 3.6% to 4.7% annually, depending on Managed Care model and year.

CAPITATED RATE ADJUSTMENT FOR FY 2024-25

REGULAR POLICY CHANGE NUMBER: 87

Methodology:

1. Assume the following dollars per managed care model:

Managed Care Models	FY 2023-24 Estimated Cost	Rate Adjustment	Dollar Adjustment
Two Plan	$27,037,541,811	3.60%	$973,369,832
GMC	$5,011,885,622	3.50%	$175,410,711
Regional	$1,612,898,429	3.60%	$58,068,847
COHS	$9,594,159,232	4.70%	$450,914,602
Total	$43,256,485,096	3.83%	$1,657,763,991

Funding:

FY 2024-25	Two Plan	COHS	GMC	REGIONAL	Total
SIS Title XIX 50/50	$478,238,000	$221,849,000	$90,230,000	$32,356,000	$822,673,000
SIS Title XXI 65/35	$41,524,000	$19,256,000	$7,949,000	$2,410,000	$71,139,000
ACA SIS 90/10	$329,731,000	$152,926,000	$65,620,000	$20,779,000	$569,056,000
UIS 100% State GF	$75,466,000	$32,465,000	$6,879,000	$1,287,000	$116,097,000
UIS Pregnancy 65/35	$3,219,000	$1,695,000	$334,000	$84,000	$5,332,000
UIS Emergency Title XIX 50/50	$24,193,000	$11,674,000	$2,202,000	$596,000	$38,665,000
ACA UIS Emergency 90/10	$16,680,000	$8,857,000	$1,601,000	$383,000	$27,521,000
UIS Emergency 65/35	$2,101,000	$1,188,000	$194,000	$44,000	$3,527,000
Family Planning 90/10	$2,218,000	$1,006,000	$402,000	$128,000	$3,754,000
TF	$973,370,000	$450,916,000	$175,411,000	$58,067,000	**$1,657,764,000**
GF	$377,939,800	$173,254,050	$62,824,250	$20,780,300	**$634,798,000**
FF	$595,430,200	$277,661,950	$112,586,750	$37,286,700	**$1,022,966,000**

MANAGED CARE DISTRICT HOSPITAL DIRECTED PAYMENTS

REGULAR POLICY CHANGE NUMBER: 88
IMPLEMENTATION DATE: 3/2025
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 2437

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$100,000,000
- STATE FUNDS	$0	$29,215,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$100,000,000
STATE FUNDS	$0	$29,215,000
FEDERAL FUNDS	$0	$70,785,000

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:
The Centers for Medicare & Medicaid Services (CMS) instituted the final rule which modernized Medicaid managed care regulations. The result is changes in the usage of managed care delivery systems. 42 CFR 438.6(c) provides states flexibility to implement delivery system and provider payment initiatives under Medicaid MCPs contracts based on allowable directed payments that focus on delivery system reform.

The 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.

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on

MANAGED CARE DISTRICT HOSPITAL DIRECTED PAYMENTS
REGULAR POLICY CHANGE NUMBER: 88

the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
This is a new policy change.

Methodology:
1. The total value of the funding for the district hospital directed payment pool on an accrual basis is $200 million total fund for CY 2023 rating period.

2. Within this managed care rating period, the payment is issued in a lump sum for each 6-month service period.

3. Payment for the January through June 2023 service period is anticipated to occur in March 2025.

4. The Title XIX and Title XXI COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

5. On a cash basis, the estimated payments are:

(Dollars in Thousands)

FY 2024-25	TF	IGT*	FF	ACA FF
Title XIX 50/50	$52,551	$26,275	$26,276	$0
Title XXI 65/35	$3,785	$1,325	$2,460	$0
ACA 2020 90/10	$43,664	$4,366	$0	$39,298
COVID-19 Title XIX Increased FMAP	$0	($2,619)	$2,619	$0
COVID-19 Title XXI Increased FMAP	$0	($132)	$132	$0
Total FY 2024-25	**$100,000**	**$29,215**	**$31,487**	**$39,298**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX ACA FF / 10% GF (4260-101-0001/0890)
65% Title XXI FF / 35% GF (4260-101-0001/0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)
COVID-19 Title XXI Increased FFP (4260-101-0890)
*Reimbursement GF (4260-601-0995)

2023 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ

REGULAR POLICY CHANGE NUMBER: 89
IMPLEMENTATION DATE: 3/2024
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2406

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the transfer of funds collected from the tax on managed care organizations (MCOs) to the General Fund (GF) to be used by the Department to fund related managed care capitation rate increases.

Authority:
AB 119 (Chapter 13, Statutes of 2023)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
2023 MCO Enrollment Tax Mgd. Care Plans-Incr. Cap. Rates
2023 MCO Enrollment Tax Managed Care Plans

Background:
Effective April 1, 2023, the Department enacted a multi-year renewal of the MCO provider tax that provides for a statewide tax on managed care plans based on reported enrollment into these plans during the 12-month calendar year (CY) 2022 period. The tax is tiered based on whether the enrollee is a Medi-Cal enrollee or other enrollee.

This policy change estimates the offset of GF costs for the capitated rate increases.

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. 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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

2023 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ

REGULAR POLICY CHANGE NUMBER: 89

- 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:
The change from the prior estimate, for FY 2023-24, is a decrease due to updated enrollment and FFCRA calculations. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to updated fund transfer dates.

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 Title XIX and Title XXI COVID-19 increased FMAP is assumed for expenditure through December 31, 2023, for this policy change.

4. The Managed Care Enrollment Fund transfers to the GF are expected to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	MCO Tax
FY 2023-24	**$0**	($3,464,400)	$3,464,400
FY 2024-25	**$0**	($3,960,627)	$3,960,627

Funding:
100% GF (4260-101-0001)
3428 Managed Care Enrollment Fund

2023 MCO ENROLLMENT TAX MANAGED CARE PLANS

REGULAR POLICY CHANGE NUMBER: 90
IMPLEMENTATION DATE: 3/2024
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2407

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the transfer of funds collected from the enrollment tax on managed care organizations (MCOs) to the General Fund (GF) to be retained by the Department beginning April 1, 2023 to support the Medi-Cal program.

Authority:
AB 119 (Chapter 13, Statutes of 2023)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
2023 MCO Enrollment Tax Mgd. Care Plans-Incr. Cap. Rates
2023 MCO Enrollment Tax Mgd. Care Plans-Funding Adj.

Background:
Effective April 1, 2023, the Department enacted a multi-year renewal of the MCO provider tax that provides for a statewide tax on managed care plans based on reported enrollment into these plans during the 12-month calendar year (CY) 2022 period. The tax is tiered based on whether the enrollee is a Medi-Cal enrollee or other enrollee.

This policy change estimates offset GF costs resulting from the imposition of the 2023 MCO Enrollment Tax.

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. 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).

The Consolidated Appropriations Act of 2023 was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on

2023 MCO ENROLLMENT TAX MANAGED CARE PLANS
REGULAR POLICY CHANGE NUMBER: 90

the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due to updated transfer amounts. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to updated transfer amounts.

Methodology:
1. The 2023 MCO Enrollment Tax is based on the cumulative enrollment of health plans during the 12-month CY 2022 period.

2. Different rates are assessed to Medi-Cal and non-Medi-Cal health plans.

3. The impact of the increase in capitation payments related to the tax is included in the 2023 MCO Enrollment Tax Mgd. Care Plans-Incr. Cap. Rates policy change.

4. The Title XIX and Title XXI COVID-19 increased FMAP is assumed for expenditure through December 31, 2023, for this policy change.

5. The Managed Care Enrollment Fund transfers to the GF are expected to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	MCO Tax
FY 2023-24	**$0**	($4,408,600)	$4,408,600
FY 2024-25	**$0**	($4,636,914)	$4,636,914

Funding:
100% GF (4260-101-0001)
3428 Managed Care Enrollment Fund

MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND

REGULAR POLICY CHANGE NUMBER: 91
IMPLEMENTATION DATE: 2/2019
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2063

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates reimbursements to the General Fund (GF) by Intergovernmental Transfer (IGT) from allowable public entities for Medi-Cal payment contributions and administration and processing fees.

Authority:
Welfare & Institution Code 14164 and 14301.4
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
Effective July 1, 2017, rating period, this policy change consolidates voluntary IGT reimbursements to the GF and administration and processing fees from allowable public entities servicing Medi-Cal managed care beneficiaries.

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. 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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;

MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND
REGULAR POLICY CHANGE NUMBER: 91

- No increased FMAP beginning January 2024.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due to the GF reimbursement collection in this policy change being updated to align with the most recent corresponding GF expenditure payments and expected GF reimbursement levels. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to growth in the size of programs that are supported by voluntary IGT reimbursements.

Methodology:
1. Data from CY 2021, CY 2022, and CY 2023 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 through December 31, 2023, for this policy change 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	$120,095
CY 2022	$1,752,775
CY 2023	$12,188
Total	$1,885,058
CY 2022 Support Cost to GF	($251)
GF	($1,884,807)
FY 2023-24 Net Impact	**$0**

(Dollars in Thousands)

Reimbursement	GF
CY 2022	$128,146
CY 2023	$1,863,578
CY 2024	$13,647
Total	$2,005,370
CY 2023 Support Cost to GF	($251)
GF	($2,005,119)
FY 2024-25 Net Impact	**$0**

Funding:
Reimbursement (4260-601-0995)
100% State GF (4260-101-0001)

COORDINATED CARE INITIATIVE RISK MITIGATION

REGULAR POLICY CHANGE NUMBER: 92
IMPLEMENTATION DATE: 6/2024
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2135

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	-$111,260,000	$0
- STATE FUNDS	-$55,630,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$111,260,000	$0
STATE FUNDS	-$55,630,000	$0
FEDERAL FUNDS	-$55,630,000	$0

Purpose:
This policy change estimates additional payments to and recoveries from managed care plans (MCPs) who participated in the Coordinated Care Initiative (CCI) related to the risk mitigation strategies applicable to Cal MediConnect (CMC) and non-CMC full-benefit dual-eligible beneficiaries, partial-benefit dual eligible beneficiaries, and non-dual-eligible beneficiaries.

Authority:
Welfare and Institutions (W&I) Code section 14182.18
CMC Three-Way Contract

Interdependent Policy Changes:
Not Applicable

Background:
Risk mitigation strategies were put in place for CMC and non-CMC full-benefit dual eligible beneficiaries. Risk mitigation strategies were also put in place for partial-benefit dual eligible beneficiaries and non-dual-eligible beneficiaries enrolled in managed care in the CCI counties.

There was a limited up-side risk corridor and a limited down-side risk corridor for CMC full-benefit dual eligible beneficiaries, as specified in the CMC Three-Way Contract, for all demonstration years (DYs) through December 31, 2017. This two-sided risk corridor allowed for additional recoveries from MCPs in the event of profit (up-side) above a specific threshold, and additional payments to MCPs in the event of loss (down-side) greater than a specified threshold.

There was also a one-sided (up-side) risk corridor in place for the period of January 1, 2020, through December 31, 2022, for CMC beneficiaries. The necessary data to perform the calculation for this risk corridor is not currently available, thus an estimated net recoupment is unable to be determined at this time. The Department expects any recoupments from MCPs to occur no sooner than FY 2024-25.

For non-CMC full-benefit dual eligible beneficiaries, partial-benefit dual eligible beneficiaries, and non-dual-eligible beneficiaries, there was a separate 24-month symmetrical down-side and

COORDINATED CARE INITIATIVE RISK MITIGATION
REGULAR POLICY CHANGE NUMBER: 92

up-side risk corridors, as specified in W&I Code, section 14182.18 and existing Medi-Cal MCP contracts.

Capitation payments for CMC and non-CMC full-benefit dual eligible beneficiaries were subject to an additional risk mitigation requirement. This requirement is applicable to periods for which capitation payments are based on a projected mix of members of varying acuity levels. If there is a difference between the projected member mix and the actual member mix that would result in a greater than 2.5 percent impact to the capitation rates, the Department and MCPs will equally share any increases or decreases beyond the 2.5 percent threshold (independent of the MCPs' actual gains or losses).

Reason for Change:
There is no change from the prior estimate for FY 2023-24. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease in recoupments due to FY 2024-25 recoupment data not being available at this time.

Methodology:
1. Assume all payments and recoupments attributable to full-benefit dual eligibles for the 2.5 percent member mix threshold for 2014 through 2017 will occur in FY 2023-24.

2. Assume all CMC payments and recoupments for DY one (1) through three (3) will occur in FY 2023-24.

3. Assume all payments and recoupments for the first 24-month period, for the non-CMC full-benefit dual eligibles, partial-benefit dual eligibles, and non-dual-eligibles will occur in FY 2023-24.

4. Total recoupments are estimated to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2023-24	($111,260)	($55,630)	($55,630)
FY 2024-25	$0	$0	$0

*Totals may differ due to rounding.

Funding:
50/50 FFP Title XIX (4260-101-0890)

PROP 56 - DIRECTED PAYMENT RISK MITIGATION

REGULAR POLICY CHANGE NUMBER: 93
IMPLEMENTATION DATE: 7/2023
ANALYST: Ryan Woolsey
FISCAL REFERENCE NUMBER: 2333

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	-$1,373,716,000	-$400,000,000
- STATE FUNDS	-$126,691,340	-$120,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,373,716,000	-$400,000,000
STATE FUNDS	-$126,691,340	-$120,000,000
FEDERAL FUNDS	-$1,247,024,660	-$280,000,000

Purpose:
This policy change budgets additional payments owed to managed care plans (MCPs), or recoupment of payments due from managed care plans, as determined by risk corridor calculations applicable to Proposition 56 payments.

Authority:
All Plan Letter (APL) 19-015
APL 19-016
APL 19-018
APL 20-013
APL 20-014
Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:
Proposition 56 Funding

Background:
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56, 2016) increased the excise tax rate on cigarettes and tobacco products and allocates a portion of the tobacco tax revenue to the Department for use as the nonfederal share of health care expenditures.

Proposition 56 funds are used to fund various payments to Medi-Cal providers, through both the fee-for-service and managed care delivery systems.

CMS instituted the Medicaid Managed Care Final Rule in May 2016, which modernized Medicaid managed care regulations. The result is changes in the usage of managed care delivery systems, 42 CFR section 438.6(c) provides states flexibility to implement delivery system and provider payment initiatives under Medicaid managed care plans (MCPs) contracts based on allowable directed payments.

PROP 56 - DIRECTED PAYMENT RISK MITIGATION

REGULAR POLICY CHANGE NUMBER: 93

Beginning with the July 1, 2017 rating period, the state has directed MCPs to make enhanced supplemental payments to eligible provider types for specified CPT codes upon approval from CMS and availability of federal funding. The enhanced supplemental payment is contingent upon the MCPs' receipt of providers' actual utilization for these codes reported through encounter data.

For the Bridge Period rating period (July 1, 2019 through December 31, 2020), there are a subset of Proposition 56 directed payment programs that were subject to one of three two-sided risk corridors. The first risk corridor applied to the Proposition 56 Physicians Services, Proposition 56 Developmental Screening Services, and Proposition 56 Adverse Childhood Experiences Screening Services programs. The second risk corridor applied to the Proposition 56 Family Planning Services program. The third risk corridor will apply to the Proposition 56 Value-Based Payment program. The same risk corridors were also in effect for the calendar year (CY) 2021 and CY 2022 rating periods.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to:

- An upward revision to estimated Bridge Period recoupments, as well as a portion of those recoupments shifting into FY 2023-24.
- The addition of repayment of the federal share of recoupments from the Bridge Period.
- Including estimated recoupments for the CY 2021 rating period.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is based on early projections of CY 2022 net collections.

Methodology:

1. The two-sided risk corridors for the Bridge Period are based on the aggregate MEPs achieved by each MCP and utilize MCP-submitted encounters and/or other utilization data. These recoupments are estimated to be $1.11 billion TF ($345.4 million state funds). A portion of these recoupments were collected in FY 2022-23, with the remaining $333.3 million TF ($96.8 million state funds) to be recouped in FY 2023-24.

2. The federal share for a portion of Bridge Period recoupments, estimated at $273.1 million, was collected from managed care plans in FY 2022-23 but will be returned to the federal government in FY 2023-24.

3. For the CY 2021 rating period, $1.04 billion TF ($303 million state funds) are estimated to be recouped in FY 2023-24.

4. For the CY 2022 rating period, $400 million TF ($120 million state funds) are estimated to be recouped in FY 2024-25.

5. This policy change identifies the use of the General Fund for these Proposition 56 adjustments. See the Proposition 56 Funding policy change for the Proposition 56 offset to the GF.

6. Total impacts related to this policy change are summarized below:

PROP 56 - DIRECTED PAYMENT RISK MITIGATION

REGULAR POLICY CHANGE NUMBER: 93

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
Bridge Period recoupments	($333,343)	($96,762)	($236,581)
Return of federal portion of Bridge Period rating period recoupments	$0	$273,119	($273,119)
CY 21 recoupments	($1,040,373)	($303,048)	($737,325)
Total	**($1,373,716)**	**($126,691)**	**($1,247,025)**

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
CY 2022 recoupments	($400,000)	($120,000)	($280,000)
Total	**($400,000)**	**($120,000)**	**($280,000)**

Funding:
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)
ACA 93% Title XIX FF / 7% GF (4260-101-0001 / 0890)
ACA 90% Title XIX FF / 10% GF (4260-101-0001 / 0890)
88% Title XXI FF / 12% GF (4260-101-0001 / 0890)
76.5% Title XXI FF / 23.5% GF (4260-101-0001 / 0890)
65% Title XXI FF / 35% GF (4260-101-0001 / 0890)
Family Planning 90% Title XIX FF / 10% GF (4260-101-0001 / 0890)
100% ACA FF (4260-101-0890)
100% Title XXI FF (4260-101-0890)
100% State GF (4260-101-0001)
COVID-19 Title XIX Increased FMAP
COVID-19 Title XXI Increased FMAP

RATE INCREASE FOR FQHCS/RHCS/CBRCS

REGULAR POLICY CHANGE NUMBER: 94
IMPLEMENTATION DATE: 10/2005
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 88

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$410,517,000	$477,890,000
- STATE FUNDS	$149,440,400	$173,966,500
PAYMENT LAG	0.9241	0.9299
% REFLECTED IN BASE	0.45 %	0.39 %
APPLIED TO BASE		
TOTAL FUNDS	$377,651,600	$442,656,800
STATE FUNDS	$137,476,430	$161,140,540
FEDERAL FUNDS	$240,175,210	$281,516,250

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:
COVID-19 Increased FMAP – DHCS

Background:
The Benefits Improvement and Protection Act of 2000 required the Department to reimburse FQHCs and RHCs based on the PPS reimbursement methodology. Clinics chose a PPS rate based on either 1) the average of the clinic's 1999 and 2000 cost-based rate or, 2) the clinic's 2000 cost-based rate. The clinic receives an annual rate adjustment based on the percentage increase in the Medicare Economic Index and is effective October 1st of each year.

The Department reimburses the CBRCs, owned or operated by Los Angeles County, at 100% of reasonable and allowable costs. The Department pays an interim rate to the clinics, which is adjusted once the audit reports are finalized. The interim rate is adjusted July 1 of each year.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due to an increase in rates and reported visits. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to the projected increase in rates and visits.

Methodology:
1. The projected visits are based on the average percent increase of the last three years of actual visit counts.

RATE INCREASE FOR FQHCS/RHCS/CBRCS

REGULAR POLICY CHANGE NUMBER: 94

2. The rate increase will be used as a trend factor to calculate the estimated cost per visit rate. The rate increase percent was 4.84% for calendar year (CY) 2022 and 4.77% for CY 2023 and CY 2024.

Rate Year	Projected Visits	Current Rate	Rate with Increase
2022	22,586,788	$188.74	$188.74 x (1+4.84%) = $197.88
2023	23,822,849	$197.88	$197.88 x (1+4.77%) = $207.31
2024	25,126,553	$207.31	$207.31 x (1+4.77%) = $217.20

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
2022	$4,263,030	$4,469,474	$206,443
2023	$4,714,065	$4,938,715	$224,649
2024	$5,208,986	$5,457,236	$248,250

4. The FY 2023-24 CBRC rate increase of $35,587,000 is based on the FY 2021-22 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 2020-21, FY 2021-22, and FY 2022-23.

5. The FY 2024-25 CBRC rate increase of $31,466,000 is based on the FY 2021-22 reported rates. FY 2021-22 reported rates utilized a three year average of payment data from the Paid Claims Summary Reports for FY 2021-22 and FY 2022-23 and the FY 2023-24 estimates. The estimated payment increase is determined by the difference between the calculated estimated payments and the total three year average of visits and payments.

6. The estimated expenditures in FY 2023-24 and FY 2024-25 are:

(Dollars in Thousands)

FY 2023-24	TF
CY 2023 Increase	$205,259
CY 2024 Increase	$205,259
FY 2023-24 Total	**$410,517**

FY 2024-25	TF
CY 2024 Increase	$238,945
CY 2025 Increase	$238,945
FY 2024-25 Total	**$477,890**

RATE INCREASE FOR FQHCS/RHCS/CBRCS

REGULAR POLICY CHANGE NUMBER: 94

Funding:

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF	$261,008,000	$130,504,000	$130,504,000
90% Title XIX ACA / 10% GF	$133,567,000	$13,357,000	$120,210,000
65% Title XXI / 35% GF	$15,942,000	$5,580,000	$10,362,000
FY 2023-24 Total	**$410,517,000**	**$149,441,000**	**$261,076,000**

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF	$303,845,000	$151,923,000	$151,922,000
90% Title XIX ACA / 10% GF	$155,487,000	$15,549,000	$139,938,000
65% Title XXI / 35% GF	$18,558,000	$6,495,000	$12,063,000
FY 2024-25 Total	**$477,890,000**	**$173,967,000**	**$303,923,000**

*Totals may differ due to rounding.

**COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

MEDI-CAL PROVIDER PAYMENT RESERVE FUND

REGULAR POLICY CHANGE NUMBER: 95
IMPLEMENTATION DATE: 7/2023
ANALYST: Erik Stacey
FISCAL REFERENCE NUMBER: 2421

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$200,000,000	$30,308,000
- STATE FUNDS	$200,000,000	$30,308,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$200,000,000	$30,308,000
STATE FUNDS	$200,000,000	$30,308,000
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates funding to be spent from the Medi-Cal Provider Payment Reserve Fund (Fund 3431).

Authority:
Welfare & Institutions (W&I) Code Section 14105.200
W&I Code Section 14199.82

Interdependent Policy Changes:
Medi-Cal Provider Rate Increase
Medi-Cal Provider Rate Increase 2025
Prop 56 – Funding Reduction

Background:
The Medi-Cal Provider Payment Reserve Fund receives revenues from the Managed Care Enrollment Fund (Fund 3428) to be used to support various provider payments, subject to appropriation by the Legislature.

Reason for Change:
The change from the prior estimate for FY-2023-24 is based on updated expenditure projections for the Medi-Cal Provider Rate Increase and the Graduate Medi-Cal Education item now being reflected in the University of California budget.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is based on updated expenditure projections for the Medi-Cal Provider Rate Increase, the introduction of the Medi-Cal Provider Rate Increase 2025, and the start of the annual Medi-Cal Workforce Pool – Labor Management Committee payments, in addition to the one-time payment to the Department of Health Care Access and Information (HCAI) not carrying over into FY 2024-25.

MEDI-CAL PROVIDER PAYMENT RESERVE FUND
REGULAR POLICY CHANGE NUMBER: 95

Methodology:

1. The Medi-Cal Provider Payment Reserve Fund will support the non-federal share of increasing provider rates for Primary Care, non-specialty mental health services, and Obstetric Care services, including mid-level practitioners and doula services, to at least 87.5% of Medicare rates effective for dates of services beginning January 1, 2024, as well as additional rate increases in various specified domains beginning on January 1, 2025 and July 1, 2025. These costs are budgeted in the Medi-Cal Provider Rate Increase and Medi-Cal Provider Rate Increase 2025 policy changes using General Fund as the non-federal share. This policy change replaces General Fund spending on these rate increases with spending from the Medi-Cal Provider Payment Reserve Fund.

2. In FY 2024-25, due to the condition of the state budget and declining availability of Proposition 56 funding, the Governor's Budget reduces $77 million in state costs from Proposition 56. Given the overlap between Proposition 56 supplemental payments and the proposed Medi-Cal provider rate increases, providers will still see an overall rate increase funded through the Medi-Cal Provider Payment Reserve Fund despite this reduction.

3. The Budget Act of 2023 provides $200 million from the Medi-Cal Provider Payment Reserve Fund for a one-time transfer to the Department of Health Care Access and Information (HCAI). Of this amount, $50 million will be used to support the Small and Rural Hospital Relief Program for seismic assessment and construction. The remaining $150 million is for the Distressed Hospital Loan Program.

4. An additional $75 million from the Medi-Cal Provider Payment Reserve Fund is provided annually for the Medi-Cal Workforce Pool – Labor Management Committee, starting in FY 2024-25. Of this amount, $30,308,000 has been identified as the cash basis amount for FY 2024-25.

5. Allocations from the Medi-Cal Provider Payment Reserve Fund in FY 2023-24 are summarized below:

(Dollars in Thousands)

FY 2023-24	TF	GF	SF
Medi-Cal Provider Rate Increase	$0	-$121,000	$121,000
Transfer to HCAI	$200,000	$0	$200,000
Total	**$200,000**	**-$121,000**	**$321,000**

MEDI-CAL PROVIDER PAYMENT RESERVE FUND
REGULAR POLICY CHANGE NUMBER: 95

6. Allocations from the Medi-Cal Provider Payment Reserve Fund in FY 2024-25 are summarized below:

(Dollars in Thousands)

FY 2024-25	TF	GF	SF
Medi-Cal Provider Rate Increase	$0	-$291,000	$291,000
Medi-Cal Provider Rate Increase 2025	$0	-$773,859	$773,859
Medi-Cal Workforce Pool – Labor Management Committee	$30,308	$0	$30,308
Total	**$30,308**	**-$1,064,859**	**$1,095,167**

Funding:
Medi-Cal Provider Payment Reserve Fund (4260-101-3431)
100% General Fund (4260-101-0001)

PP-GEMT IGT PROGRAM

REGULAR POLICY CHANGE NUMBER: 96
IMPLEMENTATION DATE: 1/2023
ANALYST: Donna Lee
FISCAL REFERENCE NUMBER: 2267

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$275,197,000	$248,646,000
- STATE FUNDS	$92,869,000	$88,468,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.98 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$272,500,100	$248,646,000
STATE FUNDS	$91,958,880	$88,468,000
FEDERAL FUNDS	$180,541,180	$160,178,000

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)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023
State Plan Amendment (SPA) 22-0015

Interdependent Policy Changes:
Ground Emergency Medical Transportation QAF

Background:
AB 1705 requires the Department to implement the Public Provider GEMT Intergovernmental Transfer (PP-GEMT IGT) Program no sooner than July 1, 2021. Currently, the Department administers the GEMT Quality Assurance Fee (QAF) program under Welfare and Institutions Code § 14129 et seq. for private and public providers, which is budgeted in the GEMT QAF policy change. Pursuant to AB 1705, the GEMT Supplemental Payment Program for public governmental entities had a sunset date on December 31, 2022. The reimbursements made to public providers previously enrolled in the GEMT QAF program have transitioned into the new PP-GEMT IGT Program. The Department has implemented the PP-GEMT IGT program effective January 1, 2023. As of January 1, 2023, public providers are no longer eligible to participate in the GEMT QAF program.

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 FFS fee-for-service (FFS) payment schedule for certain procedure codes. The Department developed the add-on increase based on specific

PP-GEMT IGT PROGRAM
REGULAR POLICY CHANGE NUMBER: 96

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.

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 increased FMAP is effective January 1, 2020, and extended its availability through the last day of the calendar quarter of the national public health emergency (PHE).

The Consolidated Appropriations Act of 2023 was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

The Department anticipates a major policy shift effective January 2024 to 99% Managed Care and Medi-Cal Coverage for all Californians under 138% FPL. With the CalAIM goal to standardize managed care enrollment and benefits statewide, the last transition will take place in 2023, thereby carving in long-term care services and dually eligible members. Current estimates show that by 2024, 99% of Medi-Cal beneficiaries will receive the bulk of their Medi-Cal services through a MCP (inclusive of Program of All-Inclusive Care for the Elderly or PACE).

Reason for Change:
The change in FY 2023-24, from the prior estimate, is a decrease due to revised FFS Calendar Year (CY) 2023 and 2024 cost projections.

The change in FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to updated utilization estimates for Managed Care and FFS in CY 2024 and 2025.

Methodology:
1. Assume the PP-GEMT IGT program was implemented on January 1, 2023.

2. The total payments in FY 2023-24 on a cash basis are expected to be $275,197,000 Total Fund (TF), of which $13,940,000 TF is FFS and $261,257,000 is for managed care.

3. Assume that the transfer to the GF for FY 2023-24, based on the 10% assessment of each IGT and costs to administer the program, is $8,579,000.

4. The total payments in FY 2024-25 on an accrual basis are expected to be $248,646,000 TF, of which -$10,665,000 is FFS and $259,311,000 is for managed care.

PP-GEMT IGT PROGRAM
REGULAR POLICY CHANGE NUMBER: 96

5. Assume that the transfer to the GF for FY 2024-25, based on the 10% assessment of each IGT and costs to administer the program, is $8,132,000.

6. The Title XIX and Title XXI FFCRA increased FMAP is assumed for expenditures through December 31, 2023 for this policy change.

7. FY 2023-24 and FY 2024-25 are summarized as follows:

FY 2023-24	TF	GF	IGT*	FF	COVID 19 FF
GF Offset	$0	($8,579,000)	$8,579,000	$0	$0
FFS Payments	$13,940,000	$0	$4,504,000	$9,288,000	$148,000
Managed Care Payments	$261,257,000	$0	$88,365,000	$171,239,000	$1,653,000
Total:	**$275,197,000**	**($8,579,000)**	**$101,448,000**	**$180,527,000**	**$1,801,000**

FY 2024-25	TF	GF	IGT*	FF
GF Offset	$0	($8,132,000)	$8,132,000	$0
FFS Payments	($10,665,000)	$0	($3,559,000)	($7,106,000)
Managed Care Payments	$259,311,000	$0	$92,027,000	$167,284,000
Total:	**$248,646,000**	**($8,132,000)**	**$96,600,000**	**$160,178,000**

PP-GEMT IGT PROGRAM
REGULAR POLICY CHANGE NUMBER: 96

Funding:

FY 2023-24	TF	GF	IGT*	FF
100% GF (4260-101-0001)	$0	($8,579,000)	$8,579,000	$0
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	$164,308,000	$0	$82,154,000	$82,154,000
90%Title XIX FF / 10% GF (4260-101-0001 / 0890)	$105,180,000	$0	$10,518,000	$94,662,000
65% Title XXI FF / 35% GF (4260-101-0890)	$5,709,000	$0	$1,998,000	$3,711,000
COVID-19 Title XIX GF (4260-101-0001)	($1,706,000)	$0	($1,706,000)	$0
COVID-19 Title XIX Increased FFP (4260-101-0890)	$1,706,000	$0	$0	$1,706,000
COVID-19 Title XXI GF (4260-101-0001)	($95,000)	$0	($95,000)	$0
COVID-19 Title XXI Increased FFP (4260-101-0890)	$95,000	$0	$0	$95,000
Total	**$275,197,000**	**($8,579,000)**	**$101,448,000**	**$182,328,000**

FY 2024-25	TF	GF	IGT*	FF
100% GF (4260-101-0001)	$0	($8,132,000)	$8,132,000	$0
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	$155,602,000	$0	$77,801,000	$77,801,000
90%Title XIX FF / 10% GF (4260-101-0001 / 0890)	$87,593,000	$0	$8,759,000	$78,834,000
65% Title XXI FF / 35% GF (4260-101-0001 / 0890)	$5,451,000	$0	$1,908,000	$3,543,000
Total	**$248,646,000**	**($8,132,000)**	**$96,600,000**	**$160,178,000**

*Reimbursement GF (4260-601-0995)

MEDI-CAL PROVIDER RATE INCREASE

REGULAR POLICY CHANGE NUMBER: 97
IMPLEMENTATION DATE: 1/2024
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2417

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$303,000,000	$727,000,000
- STATE FUNDS	$121,000,000	$291,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$303,000,000	$727,000,000
STATE FUNDS	$121,000,000	$291,000,000
FEDERAL FUNDS	$182,000,000	$436,000,000

Purpose:
This policy change estimates the costs associated with increasing provider rates, effective January 1, 2024, as required for the CalAIM Designated State Health Programs (DSHP) and for Primary Care, non-specialty mental health services, and Obstetric Care (including doulas) services to at least 87.5% of Medicare rates.

Authority:
California Advancing and Innovating Medi-Cal (CalAIM) Section 1115(a) Medicaid Demonstration
Title 42, Code of Federal Regulations (CFR), 438.6(c)
Budget Act of 2023 [AB 118 (Chapter 42, Statutes of 2023)]

Interdependent Policy Changes:
Not Applicable

Background:
CalAIM DSHP rate increases
As a requirement for the CalAIM DSHP, states must increase rates for certain services if the average Medicaid to Medicare provider payment rate ratio for these services is below 80 percent. If rates are below the 80 percent threshold, states must increase rates to close the gap by a certain percentage point by the first rating period of Demonstration Year 3 (January 1, 2024).

Provider rate increases to 87.5% of Medicare
Provider rates for Primary Care, non-specialty mental health services, and Obstetric Care services, including mid-level practitioners and doula services, will be increased to at least 87.5% of Medicare rates effective for dates of service beginning January 1, 2024. In the Fee-for-Service (FFS) delivery system, the rate increases will be implemented as increases to the applicable FFS base rates. In the Managed Care delivery system, the rate increases will be implemented via a directed payment arrangement requiring Medi-Cal managed care plans (MCPs) to pay eligible providers at no less than the increased FFS base rates for qualifying services.

MEDI-CAL PROVIDER RATE INCREASE
REGULAR POLICY CHANGE NUMBER: 97

Implementation of the January 1, 2024 rate increases will be implemented such that providers can bill for the services regardless of their specialty taxonomy codes.

The non-federal share of these provider rate increases will be borne by the Medi-Cal Provider Payment Reserve Fund, item 4260-101-3431. This policy change identifies the use of General Fund (GF) for the rate increases. See the Medi-Cal Provider Payment Reserve Fund policy change for the shift from the GF to item 4260-101-3431.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to:

- There is a change in the display of the rate increase policy changes. The CalAIM DSHP rate increases that are effective January 1, 2024 are now included in this policy change and were previously budgeted in the CalAIM Designated State Health Programs policy change in the May 2023 Estimate.
- To mitigate implementation delays, the Department will permit eligible providers to bill the primary carer services, effective January 1, 2024, regardless of their specialty.

The change from FY 2023-24 to FY 2024-25 is due to including 12 months of the rate increases in FY 2024-25 compared to a partial year in FY 2023-24.

Methodology:
1. The effective date for the rate increases in both the Fee-for-Service and Managed Care delivery systems is January 1, 2024.

2. Assume the annual impact is $727,000,000 TF ($291,000,000 GF).

3. On a cash basis, the estimated costs in FY 2023-24 and FY 2024-25 are:

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
Primary Care, OB, MH	$251,000	$100,000	$151,000
Specialty Care	$52,000	$21,000	$31,000
Total	**$303,000**	**$121,000**	**$182,000**

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
Primary Care, OB, MH	$602,000	$241,000	$361,000
Specialty Care	$125,000	$50,000	$75,000
Total	**$727,000**	**$291,000**	**$436,000**

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

NURSING FACILITY RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 98
IMPLEMENTATION DATE: 1/2023
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2181

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$695,703,000	$520,822,000
- STATE FUNDS	$329,763,100	$246,869,400
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	74.08 %	63.06 %
APPLIED TO BASE		
TOTAL FUNDS	$180,326,200	$192,391,600
STATE FUNDS	$85,474,600	$91,193,560
FEDERAL FUNDS	$94,851,620	$101,198,090

Purpose:
This policy change estimates the cost of extending the skilled nursing facility rate methodology and Quality Assurance Fee (QAF).

Authority:
AB 186 (Chapter 46, Statutes of 2022)

Interdependent Policy Changes:
COVID-19 Increased FMAP – DHCS

Background:
AB 1629 (Chapter 875, Statutes of 2004), most recently extended by AB 186 (Chapter 46, Statutes of 2022) through 2026, requires the Department to implement a facility-specific rate methodology on Freestanding Skilled Nursing Facilities, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facilities, Level-B (FSSA/NF-B). For calendar years (CYs) 2023 through 2026, annual rate increase for labor costs will be limited to 5 percent and annual rate increases for non-labor costs will be limited to 2 percent. Beginning in CY 2026, half of the annual increase for non-labor costs will be allocated to base rates and half to increasing Workforce & Quality Incentive Program (WQIP) directed payments.

Calendar 2023 Bridge Rate Equivalent to COVID-19 PHE rate add-on
For CY 2023 only, facilities will receive a bridge rate add-on equivalent to the current COVID-19 PHE rate add-on. This add-on will not be considered part of the base rate for future rate increases. The funds will continue to be restricted to allowable costs set forth in AB 81 and subject to audit. Additionally, at least 85% of the funds from the add-on must be used for labor costs (increased wages or benefits, shift incentive payments, staff retention bonuses, pay differential for workers employed by more than one facility, or overtime payments to nonmanagerial workers). Spent funds determined not to meet these requirements will be recouped and redistributed to the WQIP.

NURSING FACILITY RATE ADJUSTMENTS
REGULAR POLICY CHANGE NUMBER: 98

Workforce Standards and Base Rate Augmentation
For CY 2024 through CY 2026, AB 186 requires the Department to establish workforce standards such as a collective bargaining agreement or similar agreement, prevailing wage, average salary above minimum wage, participation in a Labor Management Committee of skilled nursing facility employers and workers, or other determined factors. These criteria could vary based on facility demographics or other factors, such as facility size or rural versus urban location. Facilities that meet the workforce standards will receive a facility-specific workforce rate adjustment. AB 186 requires the Department to calculate a workforce rate adjustment by "rebasing" audited costs within the labor cost category trended for inflation to CY 2024 without applying historic cost growth limits. A facility could receive the workforce rate adjustment for the first time in CY 2024, CY 2025, or CY 2026 depending on when the facility meets the workforce standards. Subsequent annual rate increases for a facility that has met and continues to meet the workforce standards would be calculated off the augmented base rate subject to the annual growth limits described above. Annual rate increases for a facility which has not yet met or fails to continue to meet the workforce standards would be calculated off the unaugmented base rate subject to the annual growth limits described above.

The methodology also imposes a Quality Assurance Fee (QAF) equivalent to 6% of all facility revenue, which is used to increase rates and offset a portion of the General Fund cost for the rate increases. Receipts from the extended QAF are budgeted in the Long-Term Care Quality Assurance Fund Expenditures policy change.

AB 186 also authorized WQIP directed payments in the managed care delivery system to replace the former fee-for-service Quality and Accountability Supplemental Payment (QASP). The WQIP directed payments are budgeted in the Workforce & Quality Incentive Program policy change.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to:
- Including the cost for retroactive CY 2023 FFS payments in FY 2023-24,
- The managed care impacts are fully captured in the managed care base capitation rates and are display only in this policy change.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to:
- Including the full impact of the CY 2023 and CY 2024 FFS rates om FY 2024-25.
- Including a partial year of the CY 2025 FFS rate impact in FY 2024-25.

Methodology:
1. Assume a 5% rate increase for Labor costs and 2% rate increase for Non-Labor costs. The rate increase is effective January 2023.

2. The fee-for-service (FFS) CY 2023 rates were implemented in November 2023. The retroactive correction for the period from January 2023 to October 2023 is expected to be implemented in January 2024.

3. Assume the CY 2024 FFS rates will be implemented in January 2024.

4. Assume the managed care rate impacts are budgeted in the managed care base capitation rates.

NURSING FACILITY RATE ADJUSTMENTS
REGULAR POLICY CHANGE NUMBER: 98

5. Assume that a rate add-on equivalent to the COVID-19 PHE rate add-on is continued for Calendar Year 2023.

6. Assume a workforce standard base rate increase for Labor costs starting in Calendar Year (CY) 2024 assuming all facilities meet specified workforce standards. Assume a 1% rate increase for non-Labor costs in CY 2024.

7. The cash basis FFS and managed care rate adjustment impact for FY 2023-24 and FY 2024-25 are estimated to be:

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
FFS (Lagged)	$180,310	$85,467	$94,843
Managed Care (In MC Base)	$515,393	$244,296	$271,097
Total	**$695,703**	**$329,763**	**$365,940**

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
FFS (Lagged)	$192,396	$91,196	$101,200
Managed Care (In MC Base)	$328,426	$155,674	$172,752
Total	**$520,822**	**$246,870**	**$273,952**

Funding:
50% Title XIX / 50% GF (4260-101-0001/ 0890)
90% Title XIX / 10% GF (4260-101-0001/ 0890)
COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

GROUND EMERGENCY MEDICAL TRANSPORTATION QAF

REGULAR POLICY CHANGE NUMBER: 99
IMPLEMENTATION DATE: 4/2019
ANALYST: Donna Lee
FISCAL REFERENCE NUMBER: 2081

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$149,554,000	$137,946,000
- STATE FUNDS	$45,006,000	$43,563,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	3.35 %	1.25 %
APPLIED TO BASE		
TOTAL FUNDS	$144,543,900	$136,221,700
STATE FUNDS	$43,498,300	$43,018,460
FEDERAL FUNDS	$101,045,640	$93,203,210

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

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).

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,

GROUND EMERGENCY MEDICAL TRANSPORTATION QAF
REGULAR POLICY CHANGE NUMBER: 99

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. The Department will submit SPA 23-0019 to continue the add-on payment in FY 2023-24.

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.

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change for FY 2023-24, from the prior estimate, is due to:

- Revised QAF collection estimates and payment data.
- Public providers transitioning into the AB 1705 PP-GEMT IGT program where funds associated with public providers will shift to this new program.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to the anticipated transition in January 2024 to 99% of Medi-Cal managed care coverage for all Californians under 138% of the Federal Poverty Level (FPL).

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

REGULAR POLICY CHANGE NUMBER: 99

2. Assume the GEMT QAF revenue will be $60,278,000 in FY 2023-24 and $61,323,000 in FY 2024-25.

3. For FY 2018-19, $1,003,000 will be transferred from the MEMTF to the GF for administration costs. Beginning FY 2019-20 and every year after, $374,000 will be transferred.

4. The transfer from the MEMTF to the GF for the 10% set aside for health care coverage is estimated to be $5,990,000 for FY 2023-24 and $6,095,000 for FY 2024-25. The FY 2018-19, FY 2019-20, and majority of FY 2020-21 offsets were transferred from the MEMTF to the GF in FY 2022-23. The remainder of FY 2020-21 offsets and FY 2021-22 and FY 2022-23 offsets are estimated to be transferred in FY 2023-24.

5. From the remaining GEMT QAF revenue available, total annual GEMT add-on payments for FY 2023-24 are estimated to be $149,554,000 TF, of which $5,008,000 TF is for FFS and $144,546,000 TF is for Managed Care GEMT transport services.

6. From the remaining GEMT QAF revenue available, total annual GEMT add-on payments for FY 2024-25 are estimated to be $137,946,000 TF, of which $1,727,000 TF is for FFS and $136,219,000 TF is for Managed Care GEMT transport services.

7. FFS Payments: Beginning January 1, 2023, a decrease in FY 2022-23 add-on payments is expected due to the impact of the AB 1705 PP-GEMT IGT Program.

8. Managed Care Payments:
   a. FY 2023-24 is expected to include 7 months of the CY 2023 rates and 5 months of the CY 2024 rates.
   b. FY 2024-25 is expected to include 7 months of the CY 2024 rates and 5 months of the CY 2025 rates.
   c. A decrease in the CY 2023 rates is expected due to the impact of AB 1705 PP-GEMT IGT Program.

9. The Title XIX and Title XXI COVID increased FMAP is assumed for expenditures through December 31, 2023 for this policy change.

10. The cash basis estimate is summarized as follows:

FY 2023-24	TF	GF	MEMTF	FF	COVID-19 FF
FFS Payments	$5,008,000	$0	$1,623,000	$3,337,000	$48,000
Managed Care Payments	$144,546,000	$0	$43,383,000	$100,404,000	$759,000
General Fund Offset 2023-24	$0	($5,990,000)	$5,990,000	$0	$0
Total	**$149,554,000**	**($5,990,000)**	**$50,996,000**	**$103,741,000**	**$807,000**

GROUND EMERGENCY MEDICAL TRANSPORTATION QAF

REGULAR POLICY CHANGE NUMBER: 99

FY 2024-25	TF	GF	MEMTF	FF
FFS Payments	$1,727,000	$0	$576,000	$1,151,000
Managed Care Payments	$136,219,000	$0	$42,987,000	$93,232,000
General Fund Offset 2024-25	$0	($6,095,000)	$6,095,000	$0
Total	**$137,946,000**	**($6,095,000)**	**$49,658,000**	**$94,383,000**

Funding:

FY 2023-24	TF	GF	MEMTF	FF	COVID-19 FF
100% General Fund (4260-101-0001)	($5,990,000)	($5,990,000)	$0	$0	$0
MEMTF (4260-601-3323)	$50,996,000	$0	$50,996,000	$0	$0
ACA Title XIX FF (4260-101-0890)	$63,642,000	$0	$0	$63,642,000	$0
Title XIX FF (4260-101-0890)	$37,159,000	$0	$0	$37,159,000	$0
Title XXI FF (4260-101-0890)	$2,940,000	$0	$0	$2,940,000	$0
Title XIX COVID-19 FF	$774,000	$0	$0	$0	$774,000
Title XXI COVID-19 FF	$33,000	$0	$0	$0	$33,000
Total	**$149,554,000**	**($5,990,000)**	**$50,996,000**	**$103,741,000**	**$807,000**

FY 2024-25	TF	GF	MEMTF	FF
100% General Fund (4260-101-0001)	($6,095,000)	($6,095,000)	$0	$0
MEMTF (4260-601-3323)	$49,658,000	$0	$49,658,000	$0
ACA Title XIX FF (4260-101-0890)	$55,709,000	$0	$0	$55,709,000
Title XIX FF (4260-101-0890)	$35,860,000	$0	$0	$35,860,000
Title XXI FF (4260-101-0890)	$2,814,000	$0	$0	$2,814,000
Total	**$137,946,000**	**($6,095,000)**	**$49,658,000**	**$94,383,000**

FQHC/RHC/CBRC RECONCILIATION PROCESS

REGULAR POLICY CHANGE NUMBER: 100
IMPLEMENTATION DATE: 7/2008
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 1329

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$152,809,000	$159,541,000
- STATE FUNDS	$55,627,200	$58,077,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	20.45 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$121,559,600	$159,541,000
STATE FUNDS	$44,251,440	$58,077,500
FEDERAL FUNDS	$77,308,120	$101,463,500

Purpose:
This policy change estimates the reimbursement of participating Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) according to the prospective payment system (PPS), Indian Health Services/Memorandum of Agreement (IHS/MOA), and the reimbursement to Cost-Based Reimbursement Clinics (CBRCs).

Authority:
Welfare & Institutions Code, sections 14132 and 14170
Social Security Act, 1902 (bb)(5)

Interdependent Policy Changes:
Not Applicable

Background:
Annually, each FQHC/RHC submits a reconciliation request for full reimbursement. The Department must provide payment to the clinics equal to the difference between each clinic's final PPS rate and the expenditures already reimbursed by an interim payment and third party payors (i.e. managed care entities, Medicare, etc.) in order to calculate the final settlement with the clinic.

The Department reimburses the CBRCs, owned or operated by Los Angeles County, at 100% of reasonable and allowable costs. The Department pays an interim rate to the clinics, which is adjusted once the audit reports are finalized. The adjusted interim rate is used for subsequent fiscal year claims.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due to updated Erroneous Payment Corrections (EPCs) and actual settlement recoveries. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an overall net increase due to FY 2024-25 being based on actual settlement recoveries and the FY 2023-24 estimated amounts.

FQHC/RHC/CBRC RECONCILIATION PROCESS

REGULAR POLICY CHANGE NUMBER: 100

Methodology:

1. FY 2023-24 FQHC and RHC reconciliations are based on a three-year average of actual settlements from July 2020 through June 2023. The FY 2024-25 reconciliations are based on a three-year average of actual settlements from July 2021 through December 2023 and the FY 2023-24 estimated amounts. The FQHC reconciliation amount includes settlements for IHS.

2. The estimated FQHC retroactive rate adjustment of $72,527,000 for FY 2023-24 and FY 2024-25 is based on an average of paid EPCs from July 2020 through June 2023. Currently, the fiscal intermediary processes EPCs quarterly.

3. The LA CBRC reconciliation for FY 2023-24 is based on a three-year average of actual settlements from July 2020 through June 2023. The FY 2024-25 reconciliation is based on a three-year average of actual settlements from July 2021 through June 2023 and the FY 2023-24 estimated amount.

Reconciliations and Adjustments	FY 2023-24	FY 2024-25
FQHCs Reconciliation	$15,208,000	$14,405,000
RHCs Reconciliation	$6,241,000	$5,735,000
FQHC Retroactive Rate Adjustment	$72,527,000	$72,527,000
LA CBRCs Reconciliation	$58,833,000	$66,874,000
Total	**$152,809,000**	**$159,541,000**

FY 2023-24	TF	GF	FF
90% Title XIX ACA / 10% GF	$49,718,000	$4,972,000	$44,746,000
65% Title XXI / 35% GF	$5,934,000	$2,077,000	$3,857,000
50% Title XIX / 50% GF	$97,157,000	$48,579,000	$48,578,000
Total	**$152,809,000**	**$55,628,000**	**$97,181,000**

*Totals may differ due to rounding.

FY 2024-25	TF	GF	FF
90% Title XIX ACA / 10% GF	$51,909,000	$5,191,000	$46,718,000
65% Title XXI / 35% GF	$6,196,000	$2,169,000	$4,027,000
50% Title XIX / 50% GF	$101,436,000	$50,718,000	$50,718,000
Total	**$159,541,000**	**$58,078,000**	**$101,463,000**

*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)

DPH INTERIM & FINAL RECONS

REGULAR POLICY CHANGE NUMBER: 101
IMPLEMENTATION DATE: 10/2007
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1152

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$47,457,000	$159,712,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$47,457,000	$159,712,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$47,457,000	$159,712,000

Purpose:
This policy change estimates the funds for the reconciliation of Designated Public Hospital (DPH) interim payments to their finalized hospital inpatient costs.

Authority:
SPA 05-21

Interdependent Policy Changes:
Not Applicable

Background:
As approved on April 25, 2006 through SPA 05-21, effective for dates of service on or after July 1, 2005, each DPH's fiscal year interim per diem rate, comprised of 100% federal funds, for inpatient hospital costs for Medi-Cal beneficiaries will be reconciled to its filed Medi-Cal cost report for the respective fiscal year. The reconciliations, interim and final, are based on the hospitals' Certified Public Expenditures (CPE).

This reconciliation process may result in an overpayment or underpayment to a DPH and will be handled as follows:

- For DPHs that have been determined to be overpaid, the Department will recoup any overpayments.
- For DPHs that have been determined to be underpaid, the Department will make a payment equal to the difference between the DPH's computed Medi-Cal cost, and a DPH's payments consisting of: share of cost, third party liability, other health coverage, Medicare, Medi-Cal administrative days, crossovers, and interim payments.

Final payment reconciliation will be completed when the Department has audited the hospitals' cost reports.

DPH INTERIM & FINAL RECONS
REGULAR POLICY CHANGE NUMBER: 101

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to:
- Shifting the FY 2015-16 final reconciliations for LA County DPHs from FY 2022-23 to FY 2023-24,
- Shifting the FY 2016-17 final reconciliations from FY 2022-23 to FY 2023-24, and
- Shifting the FY 2018-19 and FY 2019-20 final reconciliations to FY 2024-25.

The change from FY 2023-24 to FY 2024-25, 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 2023-24	TF	FF	ACA FF
2014-15 Final Reconciliation	($13,736)	($7,990)	($5,746)
2015-16 Final Reconciliation	$10,342	$8,538	$1,804
2016-17 Final Reconciliation	($7,061)	$16,831	($23,892)
2017-18 Final Reconciliation	$57,912	$30,518	$27,394
Total	**$47,457**	**$47,897**	**($440)**

(Dollars in Thousands)

FY 2024-25	TF	FF	ACA FF
2018-19 Final Reconciliation	$21,548	$24,849	($3,301)
2019-20 Final Reconciliation	$120,324	$97,809	$22,515
2020-21 Final Reconciliation	$17,840	$56,416	($38,576)
Total	**$159,712**	**$179,074**	**($19,362)**

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

DPH INTERIM RATE COVID-19 INCREASED FMAP ADJUST

REGULAR POLICY CHANGE NUMBER: 102
IMPLEMENTATION DATE: 7/2020
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 2238

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$45,246,000	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$45,246,000	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$45,246,000	$0

Purpose:
This policy change estimates the additional interim payments to the Designated Public Hospitals (DPHs) as a result of the 6.2% Title XIX increased Federal Medical Assistance Percentage (FMAP) related to the Coronavirus 2019 (COVID-19).

Authority:
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
DPHs receive interim per diem rates based on estimated costs using the hospitals' two years prior Medi-Cal costs trended forward. Interim payments based on these rates are 100% Federal Funds (FF) based on the hospitals' Certified Public Expenditures (CPEs), resulting in 50% FF and 50% CPE.

The FFCRA provides increased federal funding by increasing the 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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;

DPH INTERIM RATE COVID-19 INCREASED FMAP ADJUST
REGULAR POLICY CHANGE NUMBER: 102

- No increased FMAP beginning January 2024.

Adjustment payments will be issued to the DPHs to account for additional federal funding from COVID-19 increased FMAP for service periods from January 1, 2020 to December 31, 2023.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is an increase in expenditures due to:
- Shifting payments for February 2023 and March 2023 from FY 2022-23 to FY 2023-24,
- Updating the payments for April 2023 to June 2023 with actuals, and
- Revising the projected monthly payments based on an average of actual expenditures.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is no expenditures are estimated in FY 2024-25 due to the COVID-19 increased FMAP ending on December 31, 2023.

Methodology:
1. The COVID-19 Title XIX increased FMAP is assumed for expenditures through December 31, 2023 for this policy change.

2. Actual payments for February 2023 through June 2023 service months will be made in August 2023 and September 2023.

3. January 2021-June 2023 actual amounts were used to project the service months from July 2023 through December 2023.

4. The estimated adjustment payments on a cash basis are:

(Dollars in Thousands)

Fiscal Year	TF	COVID-19 FF
FY 2023-24	$45,246	$45,246

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

AB 97 ELIMINATIONS

REGULAR POLICY CHANGE NUMBER: 103
IMPLEMENTATION DATE: 5/2023
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2347

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$44,476,000	$28,423,000
- STATE FUNDS	$17,490,650	$11,028,400
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	9.96 %	13.84 %
APPLIED TO BASE		
TOTAL FUNDS	$40,046,200	$24,489,300
STATE FUNDS	$15,748,580	$9,502,070
FEDERAL FUNDS	$24,297,610	$14,987,190

Purpose:
This policy change estimates the costs of eliminating the AB 97 (Chapter 3, Statutes of 2011) provider payment reductions for certain services and providers.

Authority:
SB 184 (Chapter 47, Statutes of 2022)
Welfare & Institutions Code 14105.192
State Plan Amendment 22-0039
AB 97 (Chapter 3, Statutes of 2011)

Interdependent Policy Changes:
COVID-19 Increased FMAP – DHCS

Background:
The Budget Act of 2022 and SB 184 (Chapter 47, Statutes of 2022) authorized the exemption of specified services and providers from the AB 97 payment reductions, effective July 1, 2022 and January 1, 2023.

The following services and providers will be exempt from the AB 97 payment reductions for dates of service on or after July 1, 2022:

- Nurses, including certified nurse-midwives, nurse anesthetists, certified pediatric nurse practitioners, certified family nurse practitioners, and group certified pediatric nurse practitioners.
- Alternative Birthing Centers
- Audiologists/hearing aid dispensers
- Respiratory care providers
- Durable Medical Equipment (DME)
- Chronic dialysis clinics
- Emergency medical air transportation services

AB 97 ELIMINATIONS
REGULAR POLICY CHANGE NUMBER: 103

- Non-emergency medical transportation (NEMT) services (Transition of funding of NEMT providers from a Proposition 56 supplemental payment to an AB 97 exclusion)
- Doula services
- Community health worker services
- DME and related supplies or accessories, that is a continuous glucose monitoring system or continuous glucose monitoring system supplies and accessories
- Physician services and services by other licensed practitioners delivered via remote patient monitoring (RPM)
- Asthma prevention services
- Dyadic services
- Medication therapy management services
- Clinical laboratory services, that are 2019 novel coronavirus disease (COVID-19) diagnostic testing or specimen collection services
- Blood Banks
- Occupational Therapy
- Orthotists
- Psychologists
- Medical Social Work or Medical Social Services
- Speech pathologists
- Outpatient heroin detoxification services
- Dispensing opticians
- Optometrists, including optometry groups
- Acupuncturist
- Portable imaging services
- The following primary care or specialty clinics
    - Community clinics
    - Free clinics
    - Surgical clinics
    - Rehabilitation clinics
    - Clinics exempt from licensure under Section 1206 of the Health and Safety Code, including non-hospital county-operated community clinics.
- Services provided under the California Children's Services Program and under the Genetically Handicapped Persons Program

The following services and provider types will be exempt from the AB 97 payment reductions for dates of service on or after January 1, 2023:

- Podiatrists
- Prosthetists

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to:

- Delayed system implementation of the fee-for-service (FFS) rates by one month, and
- Delayed system implementation of the retroactive corrections from July 2023 to August 2023.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to:

- Retroactive FFS corrections are expected to be completed in FY 2023-24.

AB 97 ELIMINATIONS
REGULAR POLICY CHANGE NUMBER: 103

Methodology:

1. The FFS system implementation of the FFS rates occurred on May 30, 2023 and the retroactive corrections occurred on August 31, 2023.

2. The estimated FFS and managed care total funds costs are estimated for the following providers and services in this policy change:

Providers and Services	FFS TF	MC TF	Total FY 2023-24
Nurses, including certified nurse-midwives, nurse anesthetists, certified pediatric nurse practitioners, certified family nurse practitioners, and group certified pediatric nurse practitioners.	$456,000	$0	$456,000
Alternative Birthing Centers	$11,000	$0	$11,000
Audiologists/hearing aid dispensers	$1,239,000	$0	$1,239,000
Respiratory care providers	$0	$0	$0
Durable Medical Equipment (DME)	$17,256,000	$0	$17,256,000
Chronic dialysis clinics	$12,647,000	$0	$12,647,000
Emergency medical air transportation services	$1,584,000	$0	$1,584,000
Blood Banks	$26,000	$0	$26,000
Occupational Therapy	$1,000	$0	$1,000
Orthotists	$90,000	$0	$90,000
Psychologists	$88,000	$0	$88,000
Medical Social Work or Medical Social Services	$0	$0	$0
Speech pathologists	$93,000	$0	$93,000
Outpatient heroin detoxification services	$43,000	$0	$43,000
Dispensing opticians	$99,000	$0	$99,000
Optometrists, including optometry groups	$620,000	$0	$620,000
Acupuncturist	$10,000	$0	$10,000

AB 97 ELIMINATIONS
REGULAR POLICY CHANGE NUMBER: 103

Providers and Services	FFS TF	MC TF	Total FY 2023-24
Portable imaging services	$123,000	$0	$123,000
Community clinics	$741,000	$0	$741,000
Free clinics	$0	$0	$0
Surgical clinics	$269,000	$0	$269,000
Rehabilitation clinics	$129,000	$0	$129,000
Clinics exempt from licensure under Section 1206 of the Health and Safety Code, including non-hospital county-operated community clinics.	$204,000	$0	$204,000
Services provided under the California Children's Services Program and under the Genetically Handicapped Persons Program	$4,000	$0	$4,000
Podiatrists	$140,000	$516,000	$656,000
Prosthetists	$1,722,000	$6,365,000	$8,087,000
Total	**$37,595,000**	**$6,881,000**	**$44,476,000**

Providers and Services	FFS TF	MC TF	Total FY 2024-25
Nurses, including certified nurse-midwives, nurse anesthetists, certified pediatric nurse practitioners, certified family nurse practitioners, and group certified pediatric nurse practitioners.	$253,000	$0	$253,000
Alternative Birthing Centers	$6,000	$0	$6,000
Audiologists/hearing aid dispensers	$695,000	$0	$695,000
Respiratory care providers	$0	$0	$0
Durable Medical Equipment (DME)	$9,800,000	$0	$9,800,000
Chronic dialysis clinics	$7,011,000	$0	$7,011,000

AB 97 ELIMINATIONS

REGULAR POLICY CHANGE NUMBER: 103

Providers and Services	FFS TF	MC TF	Total FY 2024-25
Emergency medical air transportation services	$903,000	$0	$903,000
Blood Banks	$14,000	$0	$14,000
Occupational Therapy	$1,000	$0	$1,000
Orthotists	$51,000	$0	$51,000
Psychologists	$49,000	$0	$49,000
Medical Social Work or Medical Social Services	$0	$0	$0
Speech pathologists	$51,000	$0	$51,000
Outpatient heroin detoxification services	$24,000	$0	$24,000
Dispensing opticians	$56,000	$0	$56,000
Optometrists, including optometry groups	$343,000	$0	$343,000
Acupuncturist	$5,000	$0	$5,000
Portable imaging services	$70,000	$0	$70,000
Community clinics	$441,000	$0	$441,000
Free clinics	$0	$0	$0
Surgical clinics	$149,000	$0	$149,000
Rehabilitation clinics	$71,000	$0	$71,000
Clinics exempt from licensure under Section 1206 of the Health and Safety Code, including non-hospital county-operated community clinics.	$83,000	$0	$83,000
Services provided under the California Children's Services Program and under the Genetically Handicapped Persons Program	$3,000	$0	$3,000
Podiatrists	$110,000	$516,000	$626,000
Prosthetists	$1,353,000	$6,365,000	$7,718,000
Total	**$21,542,000**	**$6,881,000**	**$28,423,000**

AB 97 ELIMINATIONS
REGULAR POLICY CHANGE NUMBER: 103

3. The estimated FY 2023-24 and FY 2024-25 FFS and managed care costs are:

FY 2023-24	TF	GF	FF
FFS	$37,595,000	$15,119,000	$22,476,000
Managed Care	$6,881,000	$2,371,000	$4,510,000
Total	**$44,476,000**	**$17,490,000**	**$26,986,000**

FY 2024-25	TF	GF	FF
FFS	$21,542,000	$8,657,000	$12,885,000
Managed Care	$6,881,000	$2,371,000	$4,510,000
Total	**$28,423,000**	**$11,028,000**	**$17,395,000**

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)
COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

DPH INTERIM RATE GROWTH

REGULAR POLICY CHANGE NUMBER: 104
IMPLEMENTATION DATE: 7/2023
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1162

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$22,693,000	$79,885,000
- STATE FUNDS	$7,121,700	$24,932,100
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$22,693,000	$79,885,000
STATE FUNDS	$7,121,700	$24,932,100
FEDERAL FUNDS	$15,571,300	$54,952,900

Purpose:
This policy change estimates the cost of increases in payments to Designated Public Hospitals (DPHs) due to interim rate growth.

Authority:
SPA 05-21

Interdependent Policy Changes:
DPH Interim Rate

Background:
As approved on April 25, 2006 through SPA 05-21, effective July 1, 2005, DPHs receive interim per diem rates based on estimated costs using the hospitals' prior Medi-Cal costs trended forward. The DPHs' interim rate receives a growth percent increase to reflect an increase in the hospitals' costs. The interim per diem rate consists of 100% federal funding.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to:

- A decrease in estimated DPH expenditures and,
- A decrease in the DPH county and DPH community interim rate growth for FY 2023-24.

The change from FY 2023-24 to FY 2024-24, in the current estimate, is due to:

- An increase in estimated DPH expenditures in FY 2024-25 and,
- An increase in estimated DPH county and DPH community interim rate growth for FY 2024-25.

Methodology:
1. The FY 2023-24 interim rates were implemented July 2023.

2. For FY 2023-24:

DPH INTERIM RATE GROWTH
REGULAR POLICY CHANGE NUMBER: 104

- Assume a 3.18% interim rate increase for county and 1.19% for community-based DPHs.
- An additional cost of $22,693,000 TF is estimated for the FY 2023-24 interim rates.

3. For FY 2024-25:
   - Assume a 6.36% interim rate increase for county and 2.38% for community-based DPHs.
   - An additional cost of $79,885,000 TF is estimated for the FY 2024-25 interim rates.

4. The interim payments are 100% federal funds, after the Department's adjustment. The rate growth policy change estimates the increased DPH payments at 50% FFP/ 50% GF and 90% FFP/ 10% GF newly funding. The full adjustment to 100% FFP is shown in the DPH Interim Rate policy change.

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

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 105
IMPLEMENTATION DATE: 8/2007
ANALYST: Ryan Woolsey
FISCAL REFERENCE NUMBER: 1046

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$162,422,000	$88,655,000
- STATE FUNDS	$78,980,100	$43,109,850
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	87.64 %	78.73 %
APPLIED TO BASE		
TOTAL FUNDS	$20,075,400	$18,856,900
STATE FUNDS	$9,761,940	$9,169,460
FEDERAL FUNDS	$10,313,420	$9,687,450

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)

Interdependent Policy Changes:
COVID-19 Increased FMAP – DHCS

Background:
Prior to rate year 2009-10, Medi-Cal rates for LTC facilities were adjusted after completion of an annual rate study for specified provider types. ABX4 5 froze rates for rate year 2009-10 and every year thereafter at the 2008-09 levels. On February 24, 2010, in the case of *CHA v. David Maxwell-Jolly*, the court enjoined the Department from continuing to implement the freeze in

LTC RATE ADJUSTMENT
REGULAR POLICY CHANGE NUMBER: 105

reimbursement at the 2008-09 rate levels for DP/NF-Bs, Rural Swing Beds, DP Adult Subacute, and DP/PSA.

Effective June 1, 2011, AB 97 required the Department to freeze rates and reduce payments by up to 10% for the facilities enjoined from the original rate freeze, which was required by ABX4 5. In addition, AB 97 extends this requirement to the other LTC facility types. The Department received approval from the Centers for Medicare and Medicaid Services (CMS) to implement a rate freeze on NF-As and DP/NF-Bs and to reduce the payments by 10%.

Effective September 1, 2013, State Plan Amendment (SPA) 13-034 exempted Rural Swing Beds in DP/NF-B facilities located in designated rural and frontier areas from the AB 97 rate freeze and rate reduction. All other bed types in DP/NF-B facilities were exempted October 1, 2013.

The Department also received CMS approval to exempt DP Adult Subacute and DP/PSA from the rate freeze based on access and utilization analyses.

AB 119 extends the FS/PSA QAF sunset from July 31, 2015 to July 31, 2020. Pursuant to AB 81, FS/PSA are exempt from the QA fee, effective August 1, 2020.

Effective August 1, 2016, ABX2 1 requires the Department to forgo the AB 97 retroactive recoupment for the rate reduction and rate freeze that would have been applied to the reimbursement for services provided by DP/NF-Bs between June 1, 2011 and September 30, 2013. ABX2 1 also required the Department to restore the AB 97 payment reduction and reimburse ICF/DD facilities at the 2008-09 levels, increased by 3.7%.

The reimbursement rates for DP Adult Subacute and DP Pediatric Subacute types are described in the State Plan and are currently not subject to any rate reductions.

AB 133 removes reductions or limitations for FS/PSA or ICF/DD rate setting effective August 1, 2021, including the rate freeze imposed by AB 97 and related legislation. Beginning with RY 2021-22, ICF/DD facilities shall receive an unfrozen reimbursement rate inclusive of any Proposition 56 supplemental payments. However, for RY 2021-22, the reimbursement rate may not be less than the rate authorized by the California Medicaid State Plan, plus any Proposition 56 supplemental payment, in effect for that facility on July 31, 2021.

For FS/PSAs, as defined in Section 51215.8 of Title 22 of the California Code of Regulations, reimbursement rates shall be determined without applying the rate freeze and limitations imposed by AB 97 and related legislation. Beginning with RY 2021-22, the unfrozen reimbursement rates for these facilities shall be inclusive of any Proposition 56 supplemental payments.

The Budget Act of 2022 transitioned Proposition 56 supplemental payments for ICF/DDs and FS-PSAs to ongoing rate increase funded from the General Fund. SPA 22-0061 will incorporate amounts equivalent to the former Proposition 56 supplemental payment amounts into the facility's base rates. For RY 2022-23, Proposition 56 supplemental payment amounts are included in the annual base rate build up.

SB 184 established a hold harmless provision for ICF/DDs for dates of service after the declared end of the federal COVID-19 public health emergency (PHE). The hold harmless provision provides that after the last day of the PHE, facilities will receive the greater of the

LTC RATE ADJUSTMENT
REGULAR POLICY CHANGE NUMBER: 105

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.

In accordance with AB 118, pending federal approval and effective January 1, 2024, DHCS 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. DHCS will calculate new rates for the August 1, 2023 to December 31, 2023 period (referred to hereafter as the "bridge period" and for the January 1, 2024 to December 31, 2024 period utilizing the same underlying cost reports and by adjusting the months of inflation applied in the rate study.

Additionally, pending federal approval, for dates of service July 1, 2023, through December 31, 2023, FS/PSA reimbursement rates will be set at the total per diem rate in effect on August 1, 2022, inclusive of an amount equivalent to the COVID-19 PHE rate increase then in effect. For dates of service on or after January 1, 2024, FS/PSA rates shall be the greater of: (1) the reimbursement rate established by the applicable State Plan reimbursement methodology or (2) the reimbursement rate in effect for the facility on December 31, 2023, inclusive of the amount equivalent to the COVID-19 PHE rate increase.

Add-ons reflect costs associated with new mandates that have yet to be captured within the audited cost reports used to compute facility specific reimbursement rates. These new mandated costs are determined on an annual basis and take three years to be reflected in the regular facility specific reimbursement rates.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is a decrease due to more refined projections for the August through December 2023 bridge period and calendar year (CY) 2024 period.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is a net decrease due smaller projected rate increases in the bridge period, the CY 2024 period, and the CY 2025 period, compared to FY 2022-23, as well as fewer retroactive adjustments projected to be paid in FY 2024-25 compared to FY 2023-24.

Methodology:
1. The effective date for the rate adjustments through the August-December 2023 period is August 1st of each rate year. Beginning in CY 2024, the effect date for rate adjustments is January 1st of each calendar year. The assumed implementation dates are as follows:

Facility	23-24 (Bridge Period)	CY 2024	CY 2025
DP/NF-B	1/1/2024	1/1/2024	1/1/2025
Rural Swing Beds (non-exempt)	1/1/2024	1/1/2024	1/1/2025
Rural Swing Beds (exempt)	1/1/2024	1/1/2024	1/1/2025
DP Adult Subacute	1/1/2024	1/1/2024	1/1/2025
NF-A	1/1/2024	1/1/2024	1/1/2025
ICF/DDs	1/1/2024	1/1/2024	1/1/2025
DP Pediatric Subacute	1/1/2024	1/1/2024	1/1/2025
FS Pediatric Subacute	1/1/2024	1/1/2024	1/1/2025

LTC RATE ADJUSTMENT
REGULAR POLICY CHANGE NUMBER: 105

2. Assume add-ons remain in place for ongoing costs for providers' rates impacted by a rate freeze. The add-on descriptions are listed below:
    a. SB 3 (Chapter 4, Statues of 2016) Minimum Wage Increases: For employers who employ 26 or more employees.
        i. $15.50 per hour, effective January 2023.
        ii. $16.00 per hour, effective January 2024.
        iii. $16.40 per hour, effective January 2025 (estimated).
    b. Payroll-Based Journal: Effective July 1, 2016, CMS requires facilities to submit direct care staffing information based on payroll data.

3. The impact of setting FS/PSA reimbursement rates 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, and effective January 1, 2024, setting rates at the greater of the state plan reimbursement methodology or the December 31, 2023 rate, was previously budgeted in a separate Freestanding Pediatric Subacute Rates policy change. Beginning with this Estimate, these impacts are incorporated into this policy change. The impact of these FS/PSA reimbursement rate policies (compared to a scenario where rates are only set using the state plan reimbursement methodology) are estimated to be $1,322,000 TF in FY 2023-24 and $506,000 in FY 2024-25.

4. The costs below reflect the estimated impact, before accounting for payment lags, of incremental rate adjustments and add-ons for each facility type in the fee-for-service (FFS) delivery system:

LTC RATE ADJUSTMENT
REGULAR POLICY CHANGE NUMBER: 105

Unlagged Fee-for-Service	FY 2023-24	FY 2024-25
Rate Adjustment (22-23)		
DP/NF-B	$18,728,000	
Rural Swing Beds (non-exempt)	$0	
Rural Swing Beds (exempt)	$53,000	
DP Adult Subacute	$1,107,000	
NF-A	$219,000	
ICF/DDs	$38,069,000	
DP Pediatric Subacute	$640,000	
FS Pediatric Subacute	$711,000	
Rate Adjustment (23-24, Bridge Period)		
DP/NF-B	$1,111,000	$2,221,000
Rural Swing Beds (non-exempt)	$0	$0
Rural Swing Beds (exempt)	$10,000	$20,000
DP Adult Subacute	$107,000	$215,000
NF-A	$0	$0
ICF/DDs	$0	$0
DP Pediatric Subacute	$100,000	$199,000
FS Pediatric Subacute	$0	$0
Rate Adjustment (CY 2024)		
DP/NF-B	$1,555,000	$3,110,000
Rural Swing Beds (non-exempt)	$0	$0
Rural Swing Beds (exempt)	$14,000	$28,000
DP Adult Subacute	$151,000	$302,000
NF-A	$9,000	$17,000
ICF/DDs	$94,000	$189,000
DP Pediatric Subacute	$103,000	$205,000
FS Pediatric Subacute	$0	$0
Rate Adjustment (CY 2025)		
DP/NF-B		$2,650,000
Rural Swing Beds (non-exempt)		$0
Rural Swing Beds (exempt)		$20,000
DP Adult Subacute		$1,684,000
NF-A		$6,000
ICF/DDs		$11,020,000
DP Pediatric Subacute		$210,000
FS Pediatric Subacute		$182,000
Retro FFS Rate Adjustments		
DP/NF-B	$16,532,000	$0
Rural Swing Beds (non-exempt)	$0	$0
Rural Swing Beds (exempt)	$53,000	$0
DP Adult Subacute	$90,000	$0
NF-A	$0	$0
ICF/DDs	$0	$0
DP Pediatric Subacute	$510,000	$0
FS Pediatric Subacute	$593,000	$0
Total FFS	**$80,559,000**	**$22,278,000**

LTC RATE ADJUSTMENT
REGULAR POLICY CHANGE NUMBER: 105

5. The costs below reflect the estimated impact, before accounting for payment lags, of incremental rate adjustments and add-ons in the managed care delivery system. These impacts are fully reflected in managed care base policy changes.

Unlagged Managed Care	FY 2023-24	FY 2024-25
Rate Adjustment (22-23)	$58,436,000	
Rate Adjustment (23-24, Bridge Period)	$15,869,000	$17,311,000
Rate Adjustment (CY 2024)	$11,954,000	$23,909,000
Rate Adjustment (CY 2025)		$34,296,000
Total Managed Care	**$86,259,000**	**$75,516,000**

6. Payment lag factors of 0.9738 for FY 2023-24 and 0.9082 for FY 2024-25 are applied to the FFS and managed care costs to account for payment timing. Lagged amounts are displayed below.

Lagged Amounts	FY 2023-24	FY 2024-25
Fee-for-Service	$79,597,000	$18,855,000
Managed Care	$82,825,000	$69,800,000
Total Lagged Costs	**$162,422,000**	**$88,655,000**

Funding:

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	$153,141,000	$76,570,000	$76,571,000
90% Title XIX / 10% GF (4260-101-0001 / 0890)	$3,355,000	$336,000	$3,019,000
65% Title XXI / 35% GF (4260-101-0001 / 0890)	$5,926,000	$2,074,000	$3,852,000
Total	**$162,422,000**	**$78,980,000**	**$83,442,000**

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	$83,589,000	$41,795,000	$41,794,000
90% Title XIX / 10% GF (4260-101-0001 / 0890)	$1,831,000	$183,000	$1,648,000
65% Title XXI / 35% GF (4260-101-0001 / 0890)	$3,235,000	$1,132,000	$2,103,000
Total	**$88,655,000**	**$43,110,000**	**$45,545,000**

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

GDSP NEWBORN SCREENING PROGRAM FEE INCREASE

REGULAR POLICY CHANGE NUMBER: 106
IMPLEMENTATION DATE: 1/2023
ANALYST: Donna Lee
FISCAL REFERENCE NUMBER: 2184

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$4,461,000	$5,253,000
- STATE FUNDS	$1,756,300	$2,068,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	63.94 %	70.80 %
APPLIED TO BASE		
TOTAL FUNDS	$1,608,600	$1,533,900
STATE FUNDS	$633,320	$603,860
FEDERAL FUNDS	$975,320	$930,020

Purpose:
This policy change estimates the costs associated with a fee increase for newborn screening provided to Medi-Cal beneficiaries under the California Department of Public Health (CDPH) Genetic Disease Screening Program (GDSP).

Authority:
Health & Safety Code, 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

Interdependent Policy Changes:
COVID-19 Increased FMAP – DHCS

Background:
Pursuant to Health & Safety Code, Division 106, Part 5, Chapter 1, Article 1, Section 124977, the Newborn Screening (NBS) Program fee shall be periodically adjusted to fully support GDSP. Section 124977(d)(1) outlines the GDSP's ability to adopt emergency regulations surrounding newborn and prenatal screening.

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 RUSP adopted the Spinal Muscular Atrophy (SMA) condition on July 2, 2018. Pursuant to SB 1095, GDSP added SMA to the Newborn Screening panel in July 2020. A fee increase of $35.00 per specimen was effective July 1, 2020 for costs associated with adding SMA to the Newborn Screening panel, increased contracted screening rates, and increased referrals for case management, coordination, and diagnostic services.

Another fee increase of $33.75 (from $177.25 to $211.00) became effective July 1, 2022, and was needed to support the loss of revenue due to the decrease in projected caseload resulting

GDSP NEWBORN SCREENING PROGRAM FEE INCREASE
REGULAR POLICY CHANGE NUMBER: 106

from the projection of live births; increased expenditures related to higher contract rates for screening; higher costs associated with the computer system redesign and the Screening Information System (SIS) migration to the new Cloud platform; the ongoing cost of software license and maintenance to support the activities of the NBS Program.

The Department has obtained federal approval for SPA 22-0021 and 22-0054 for the fee increases.

On August 2, 2022, newborn screening for mucopolysaccharidosis type II (MPS II) was added to the federal RUSP. On January 4, 2023, guanidinoacetate methyltransferase (GAMT) deficiency was added to the federal RUSP. By August 2024, CDPH will incorporate screening for MPS II and GAMT deficiency into the Newborn Screening panel. A fee increase of $15 will be proposed for the NBS program starting July 1, 2024 to cover the costs of the adding the two conditions.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to a decrease in estimated GDSP caseloads in FY 2023-24.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to a decrease in projected GDSP caseloads in FY 2024-25, and a $15 fee increase, effective July 1, 2024.

Methodology:
1. The Department of Public Health implemented a $35.00 fee increase for the GDSP NBS program, effective July 1, 2020; a separate $33.75 fee increase for the GDSP NBS program, effective July 1, 2022; and another $15.00 fee increase for the GDSP NBS program, effective July 1, 2024. The Department implements corresponding Medi-Cal Fee-for-Service (FFS) GDSP NBS rate increases based on the CDPH fee increases.

2. The Medi-Cal FFS rate increase that covers the $35.00 increase implemented on December 27, 2022. The retroactive correction for the July 1, 2020 to December 26, 2022 period was implemented in March 2023.

3. The Medi-Cal FFS rate increase that covers the $33.75 increase implemented on February 20, 2023. The retroactive correction for the July 1, 2022 to February 19, 2023 period, was implemented in April 2023.

4. CDPH has proposed a $15 fee increase due to adding MPS II and GAMT to the NBS program, effective July 1, 2024.

5. Assume approximately 60% of newborns screened are from the Medi-Cal population. Of the percentage Medi-Cal newborn population, assume approximately 32% are in Medi-Cal FFS.

6. Assume approximately 99% of newborns will be screened by the NBS program each year.

7. 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.

8. Assume 99% of Medi-Cal FFS claims submitted are paid.

9. The estimated Medi-Cal FFS costs in FY 2023-24 and FY 2024-25 are:

GDSP NEWBORN SCREENING PROGRAM FEE INCREASE

REGULAR POLICY CHANGE NUMBER: 106

FY 2023-24	TF	GF	FF
FFS Prospective Rate Increases	$4,461,000	$1,756,000	$2,705,000
Total	**$4,461,000**	**$1,756,000**	**$2,705,000**

FY 2024-25	TF	GF	FF
FFS Prospective Rate Increases	$5,253,000	$2,068,000	$3,185,000
Total	**$5,253,000**	**$2,068,000**	**$3,185,000**

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)

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 107
IMPLEMENTATION DATE: 10/2006
ANALYST: Donna Lee
FISCAL REFERENCE NUMBER: 96

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$1,126,000	$1,877,000
- STATE FUNDS	$532,600	$887,950
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	42.16 %	33.25 %
APPLIED TO BASE		
TOTAL FUNDS	$651,300	$1,252,900
STATE FUNDS	$308,060	$592,710
FEDERAL FUNDS	$343,220	$660,190

Purpose:
This policy change estimates the annual rate increase for hospice services and hospice room and board rates.

Authority:
Sections 1902(a)(13) and 1814(i)(1)(C)(ii) of the Social Security Act
42 Code of Federal Regulations (CFR) Part 418 – Centers for Medicare & Medicaid Services (CMS) Final Rule

Interdependent Policy Changes:
COVID-19 Increased FMAP – DHCS

Background:
1. **Hospice Services**
   Medi-Cal hospice service rates are established in accordance with Section 1902(a)(13), (42 USC 1396 a(a)(13)) of the federal Social Security Act. This act requires annual rate increases for hospice care services based on corresponding Medicare rates effective October 1st of each year.

   Effective January 1, 2016, the CMS final hospice rule changed the payment methodology for Routine Home Care (RHC) rates to implement two rates that will result in a higher base payment for the first 60 days of hospice care and a reduced payment rate for days thereafter. Additionally, the CMS final hospice rule established a Service Intensity Add-On (SIA) payment for services provided by a registered nurse or social worker during the last seven days of a beneficiary'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

HOSPICE RATE INCREASES
REGULAR POLICY CHANGE NUMBER: 107

Developmentally Disabled – Nursing (ICF/DD-N), and Intermediate Care Facility for the Developmentally Disabled – Habilitative (ICF/DD-H).

On March 4, 2020, Governor Newsom declared a state of emergency in response to the developing pandemic of COVID-19. A statewide stay at home order was introduced on March 19, 2020. The federal government declared a national public health emergency (PHE) on January 31, 2020, and a national emergency on March 13, 2020. The public health emergency for the COVID-19 outbreak expired on May 11, 2023.

The Department received federal approval for State Plan Amendment (SPA) 20-0024, which authorizes a temporary additional 10 percent reimbursement for eligible Long-Term Care (LTC) facilities during the PHE. For Freestanding Skilled Nursing facilities – Level B (FS/NF-B) and Freestanding Adult Subacute (FSSA), the 2022 Budget Act extended the PHE rate increase through December 31, 2023 and established a new Workforce Augmentation effective January 1, 2024 which is intended to succeed the PHE rate increase for these facilities. For Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), the 2022 Budget Act provided that after the last day of the PHE, rates would be held harmless at the rate in effect on the last day of the PHE until the unfrozen rate calculated pursuant to the State Plan exceeds the hold harmless rate. For all other LTC facilities the COVID-19 increased reimbursement will cease 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 2023-24, from the prior estimate, is due to updated rate calculations that assumes the COVID-19 PHE rate increase end for certain LTC facilities resulting in decreased estimates for hospice room and board in FY 2023-24.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to assuming a full year's impact for RY 2023-24 rates and including RY 2024-25 impacts in FY 2024-25.

Methodology:
1. Hospice Services:
   a. The weighted increase for hospice service rates, excluding RHC and SIA, is 5.59% for RY 2023-24 and 5.61% for FY 2024-25.

   b. The RY 2022-23 hospice rates, excluding RHC rates were implemented December 2022. The retroactive payment for the period of October 2022 through November 2022 was implemented in March 2023. Hospice RHC rates were implemented in January 2023 and the retroactive payment for October 2022 to December 2022 was implemented in March 2023.

   c. The RY 2023-24 hospice rates, including RHC rates, are expected to implement in December 2023. The retroactive payment for the period from October 2023 through November 2023 is expected to be implemented in March 2024.

   d. The RY 2024-25 hospice rates, including RHC rates, are expected to implement in December 2024. The retroactive payment for the period from October 2024 through November 2024 is expected to be implemented in March 2025.

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 5.92%

HOSPICE RATE INCREASES
REGULAR POLICY CHANGE NUMBER: 107

for RY 2022-23. There are no overall net increases assumed for hospice room and board for RY 2023-24 and RY 2024-25.

3. Managed care costs for hospice rate adjustments are included in the base capitation rates, and currently budgeted in the following policy changes: County Organized Health Systems, Two Plan Model, Regional Model, and Geographic Managed Care.

4. The estimated Fee-for-Service (FFS) payments on a cash basis are:

Cash Basis	FY 2023-24	FY 2024-25
Hospice Services (22-23)	$91,000	$91,000
RHC & SIA Payments (22-23)	$637,000	$639,000
Hospice Services (23-24)	$40,000	$96,000
RHC & SIA Payments (23-24)	$269,000	$644,000
Hospice Services Retro (23-24) Retro	$12,000	$0
RHC & SIA Payments (23-24) Retro	$77,000	$0
Hospice Services (24-25)	$0	$43,000
RHC & SIA Payments (24-25)	$0	$274,000
Hospice Services Retro (24-25) Retro	$0	$12,000
RHC & SIA Payments (24-25) Retro	$0	$78,000
TOTAL	**$1,126,000**	**$1,877,000**

Funding:

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	$1,050,000	$525,000	$525,000
90% Title XIX / 10% GF (4260-101-0001 / 0890)	$76,000	$8,000	$68,000
65% Title XXI / 35% GF (4260-101-0001 / 0890)	$0	$0	$0
Total	**$1,126,000**	**$533,000**	**$593,000**

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 107

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	$1,750,000	$875,000	$875,000
90% Title XIX / 10% GF (4260-101-0001 / 0890)	$126,000	$13,000	$113,000
65% Title XXI / 35% GF (4260-101-0001 / 0890)	$1,000	$0	$1,000
Total	**$1,877,000**	**$888,000**	**$989,000**

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

ACUPUNCTURE RATE INCREASE

REGULAR POLICY CHANGE NUMBER: 108
IMPLEMENTATION DATE: 1/2023
ANALYST: Donna Lee
FISCAL REFERENCE NUMBER: 2370

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$26,735,000	$27,487,000
- STATE FUNDS	$8,094,300	$8,320,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	99.87 %	99.88 %
APPLIED TO BASE		
TOTAL FUNDS	$34,800	$33,000
STATE FUNDS	$10,520	$9,980
FEDERAL FUNDS	$24,230	$23,000

Purpose:
This policy change estimates the costs of increasing acupuncture rates.

Authority:
Budget Act of 2022 [AB 178 (Chapter 45, Statutes of 2022)]
State Plan Amendment (SPA) 22-0066

Interdependent Policy Changes:
COVID-19 Increased FMAP - DHCS

Background:
The Budget Act of 2022, Assembly Bill (AB) 178, Chapter 45, Statutes of 2022, authorizes the Department to increase fee-for-service (FFS) reimbursement rates for acupuncture services, effective January 1, 2023. The Centers for Medicare and Medicaid Services (CMS) approved SPA 22-0066, authorizing the reimbursement rate increase effective January 1, 2023.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to lower estimated FFS retroactive payments resulting from the implementation of the FFS increase occurring earlier than previously estimated, on April 25, 2023.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to:

- Retroactive FFS payments were completed in FY 2023-24.
- Costs for the Managed Care Calendar Year (CY) 2024 and ongoing are estimated to increase compared to CY 2023. The managed care costs are display only in this policy change.

Methodology:

1. This estimate captures the increase in rates from $17.37 maximum per visit, up to $60.00 per visit for applicable Current Procedural Terminology (CPT) codes.

ACUPUNCTURE RATE INCREASE
REGULAR POLICY CHANGE NUMBER: 108

2. The estimated costs of the acupuncture rate increase is $26.7 million total fund (TF) in FY 2023-24 and $27.4 million TF in FY 2024-25 for managed care. The managed care costs are captured in the managed care base capitation rates and are display only in this policy change.

3. The estimated costs of the acupuncture rate increase is $60,000 TF in FY 2023-24 and $50,000 TF in FY 2024-25 for FFS. Implementation of the FFS rate increase occurred on April 25, 2023. The retroactive adjustment from January to April 2023 was implemented in July 2023.

4. The estimated expenditures for the increase to acupuncture rates are:

FY 2023-24	TF	GF	FF
FFS (Lagged)	$60,000	$27,000	$33,000
Managed Care (In Managed Care Base)	$26,675,000	$8,067,000	$18,608,000
Total	**$26,735,000**	**$8,094,000**	**$18,641,000**

FY 2024-25	TF	GF	FF
FFS (Lagged)	$50,000	$23,000	$27,000
Managed Care (In Managed Care Base)	$27,437,000	$8,298,000	$19,139,000
Total	**$27,487,000**	**$8,321,000**	**$19,166,000**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX / 10% GF (4260-101-0001/0890)
COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

DPH INTERIM RATE

REGULAR POLICY CHANGE NUMBER: 109
IMPLEMENTATION DATE: 7/2005
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1161

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$431,425,800	-$448,531,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$431,425,800	-$448,531,800
FEDERAL FUNDS	$431,425,800	$448,531,800

Purpose:
This policy change estimates the technical adjustment in funding to reimburse Designated Public Hospitals (DPHs) at 100% federal financial participation (FFP).

Authority:
SPA 05-21

Interdependent Policy Changes:
DPH Interim Rate Growth

Background:
As approved on April 25, 2006 through SPA 05-21, effective July 1, 2005, DPHs receive interim per diem rates based on estimated costs using the hospitals' two years prior Medi-Cal costs trended forward. These interim payments are 100% federal funds based on the hospitals' certified public expenditures (CPEs), resulting in 50% FFP and 50% CPE.

The Medi-Cal Estimate FFS base expenditures are calculated at 50% FFP and 50% GF. Since the DPH interim rate receives a 100% FFP, an adjustment to shift from 50% GF to 100% FFP is made.

In addition, the Medi-Cal Estimate makes funding adjustments to inpatient services for the applicable Federal Medical Assistance Percentage (FMAP) for the Affordable Care Act (ACA) optional population. As a result, this policy change will also make adjustments for the ACA optional population to shift from 5% GF / 95% FFP to 100% FFP beginning January 2017 through December 2017, 6% GF / 94% FFP to 100% FFP beginning January 2018 through December 2018, 7% GF / 93% FFP to 100% FFP beginning January 2019, and 10% GF / 90% FFP to 100% FFP beginning January 2020.

DPH INTERIM RATE

REGULAR POLICY CHANGE NUMBER: 109

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to:

- Updated DPH actual data through July 2023, and
- Lower projected expenditures in FY 2023-24.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to higher projected expenditures in FY 2024-25.

Methodology:
1. The funding adjustment is estimated at:

(Dollars in Thousands)

	Expenditures	GF to FF Shift
FY 2023-24	**$1,332,670**	**$431,426**
FY 2024-25	**$1,394,450**	**$448,532**

Funding:
(Dollars in Thousands)

FY 2023-24	**TF**	**GF**	**FF**
50% Title XIX / 50% GF (4260-101-0890 / 0001)	($745,397)	($372,699)	($372,698)
100% Title XIX FF (4260-101-0890)	$1,332,670	$0	$1,332,670
90% Title XIX ACA / 10% GF (4260-101-0890 / 0001)	($587,273)	($58,727)	($528,546)
Total Funds	**$0**	**($431,426)**	**$431,426**

FY 2024-25	**TF**	**GF**	**FF**
50% Title XIX / 50% GF (4260-101-0890 / 0001)	($772,717)	($386,359)	($386,358)
100% Title XIX FF (4260-101-0890)	$1,394,450	$0	$1,394,450
90% Title XIX ACA / 10% GF (4260-101-0890 / 0001)	($621,733)	($62,173)	($559,560)
Total Funds	**$0**	**($448,532)**	**$448,532**

*Totals may differ due to rounding.

LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES

REGULAR POLICY CHANGE NUMBER: 110
IMPLEMENTATION DATE: 8/2013
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 1784

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change budgets the funding adjustment from the Long Term Care Quality Assurance Fund (LTCQAF) to the state General Fund (GF) to partially offset GF costs associated with providing Long Term Care Services.

Authority:
AB 1762 (Chapter 230, Statutes of 2003)
AB 1629 (Chapter 875, Statutes of 2004)
ABX1 19 (Chapter 4, Statutes of 2011)
AB 1467 (Chapter 23, Statutes of 2012)
AB 119 (Chapter 17, Statutes of 2015)
SB 833 (Chapter 30, Statutes of 2016)
AB 81 (Chapter 13, Statutes of 2020)
AB 186 (Chapter 46, Statutes of 2022)

Interdependent Policy Changes:
Not Applicable

Background:
AB 1762 (Chapter 230, Statutes of 2003) imposed a Quality Assurance (QA) fee for certain LTC provider types. AB 1629 (Chapter 875, Statutes of 2004) and ABX1 19 (Chapter 4, Statutes of 2011) imposed a QA fee, in conjunction with a facility specific reimbursement program, for additional LTC providers. The revenue generated from the fee is used to draw down a federal match to partially offset LTC rate reimbursement. The following LTC providers are subject to a QA fee:

- Freestanding Nursing Facilities Level-B (FS/NF-Bs)
- Freestanding Subacute Nursing Facilities level-B (FSSA/NF-Bs)
- Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs)

LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES

REGULAR POLICY CHANGE NUMBER: 110

AB 1467 established the LTCQAF. Effective August 1, 2013, the QA fees collected by LTC and ICF-DD facilities are deposited into the fund, rather than the state GF, which are used for LTC provider reimbursement rate expenditures.

AB 119 extended the AB 1629 facility-specific rate methodology, QAF, and Quality and Accountability Supplemental Payments (QASP) Program through July 31, 2020.
SB 833 established a continuous appropriation for the LTCQAF to allow moneys from the fund to be appropriated without further legislative action.

A withhold process was developed to collect past due AB 1629 QAF assessed on specified Skilled Nursing Facilities. The withheld portion is transferred to the LTCQAF, and subsequently to the GF. The withheld QAF payments are budgeted in the QAF Withhold Transfer policy change.

AB 81 (Chapter 13, Statutes of 2020) extends the QAF and AB 1629 methodology through December 31, 2022, and exempts Freestanding Pediatric Subacute Care Facilities (FS-PSAs) from the QAF, effective August 1, 2020.

AB 186 (Chapter 46, Statutes of 2022) extends the QAF and AB1629 methodology through December 31, 2026.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to updated actual QAF collections through June 2023, and higher monthly projections in FY 2023-24.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is an estimated net decrease in GF transfers, due to decreased withhold transfers estimated in FY 2024-25.

Methodology:
1. Based on collections data through June 2023 and transfer data through August 2023; assume $540.2 million will be transferred to the GF in FY 2023-24 and $539.5 million in FY 2024-25.

2. The estimated withhold transfers for the AB 1629 QAF and QAF assessed on ICF-DDs expected to occur are $48.5 million in FY 2023-24 and $36.8 million in FY 2024-25.

LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES
REGULAR POLICY CHANGE NUMBER: 110

3. The estimated fund adjustment from the LTCQAF to the GF is:

(Dollars in Thousands)

FY 2023-24	TF	GF	LTCQAF
FY 2022-23	$0	($114,647)	$114,647
FY 2023-24	$0	($377,060)	$377,060
Subtotal	$0	($491,707)	$491,707
Withhold Transfers	$0	($48,454)	$48,454
Total	**$0**	**($540,161)**	**$540,161**

(Dollars in Thousands)

FY 2024-25	TF	GF	LTCQAF
FY 2023-24	$0	($125,687)	$125,687
FY 2024-25	$0	($377,060)	$377,060
Subtotal	$0	($502,747)	$502,747
Withhold Transfers	$0	($36,799)	$36,799
Total	**$0**	**($539,546)**	**$539,546**

Funding:
Long Term Care Quality Assurance Fund (4260-601-3213)
100% GF (4260-101-0001)

REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER: 111
IMPLEMENTATION DATE: 8/2015
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1505

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	-$1,160,000	-$5,663,000
- STATE FUNDS	-$482,750	-$2,319,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	1.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,160,000	-$5,606,400
STATE FUNDS	-$482,750	-$2,296,400
FEDERAL FUNDS	-$677,250	-$3,309,970

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:
COVID-19 Increased FMAP – DHCS

Background:
SB 853 mandates that Medi-Cal rates for radiology services not exceed 80% of Medicare rates for dates of service on or after October 1, 2010. In light of the AB 97 (Chapter 3, Statutes of 2011) 10% payment reduction, and that a lengthy retroactive recoupment would likely create access to care issues for radiology services, the effective date for retroactive savings shifted from October 1, 2010 to October 1, 2012.

The Centers for Medicare and Medicaid Services (CMS) requires SPA approval for all rate reductions. SPA 22-0006 was approved on April 29, 2022 for rate adjustments effective January 1, 2022, and the Department submitted SPA 23-0004 on March 20, 2023 to adjust rates effective January 1, 2023.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to:

- The prospective rate adjustments for January 2019 to January 2022 are now fully reflected in the FFS base estimate, and
- Rate adjustments for January 2023 have been delayed by one year to start in May 2024.
- Including rate adjustments for January 2024 in FY 2023-24 to start in May 2024.

REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER: 111

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to:

- Including a full year impact of the January 2023 and January 2024 rate adjustments in FY 2024-25, and
- Including retroactive recoupments for the January 2023 and January 2024 rate adjustments starting August 2024 in FY 2024-25.

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 rate adjustments effective January 1, 2022, reflect an annual FFS savings of $2,545,000 TF. These rates were implemented on August 22, 2022

   The total recoupment of retroactive savings from January 1, 2022 through August 21, 2022, was implemented November 30, 2022, with recoupments occurring over 12 months.

4. The annual FFS savings for the rate adjustments effective January 1, 2023 is expected to be $1,612,000 TF. These adjustments are expected to be implemented in May 2024.

   The total recoupment of retroactive savings from January 1, 2023 through April 30, 2024 is expected to be implemented August 2024, with recoupments occurring over 12 months.

5. The annual FFS savings for the rate adjustments effective January 1, 2024 is expected to be $1,612,000 TF. These adjustments are expected to be implemented in May 2024.

   The total recoupment of retroactive savings from January 1, 2024 through April 30, 2024 is expected to be implemented August 2024, with recoupments occurring over 12 months.

6. The estimated savings for the reduction to radiology reimbursement rates are:

FY 2023-24	TF	GF	TITLE XIX FF	TITLE XXI FF	ACA FF
Prospective Savings	($452,000)	($193,000)	($169,000)	($33,000)	($1,203,000)
Recoupment of Retro Savings	($708,000)	($290,000)	($264,000)	($21,000)	($596,000)
Total	**($1,160,000)**	**($483,000)**	**($433,000)**	**($54,000)**	**($1,799,000)**

FY 2024-25	TF	GF	TITLE XIX FF	TITLE XXI FF	ACA FF
Prospective Savings	($3,206,000)	($1,313,000)	($1,195,000)	($95,000)	($603,000)
Recoupment of Retro Savings	($2,457,000)	($1,006,000)	($916,000)	($73,000)	($462,000)
Total	**($5,663,000)**	**($2,319,000)**	**($2,111,000)**	**($168,000)**	**($1,065,000)**

REDUCTION TO RADIOLOGY RATES
REGULAR POLICY CHANGE NUMBER: 111

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)
COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

GDSP PRENATAL SCREENING PROGRAM FEE INCREASE

REGULAR POLICY CHANGE NUMBER: 112
IMPLEMENTATION DATE: 10/2022
ANALYST: Donna Lee
FISCAL REFERENCE NUMBER: 2336

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$43,000	$4,182,000
- STATE FUNDS	$17,100	$1,640,150
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$43,000	$4,182,000
STATE FUNDS	$17,100	$1,640,150
FEDERAL FUNDS	$25,900	$2,541,850

Purpose:
This policy change estimates the costs associated with a fee increase for prenatal screening provided to Medi-Cal beneficiaries 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
State Plan Amendment (SPA) 22-0063
SPA 22-0064

Interdependent Policy Changes:
COVID-19 Increased FMAP – DHCS

Background:
Pursuant to Health & Safety Code, Division 106, Part 5, Chapter 1, Article 1, Section 124977, the prenatal screening (PNS) Program fee shall be periodically adjusted to fully support GDSP. Section 124977 (d)(1) outlines the GDSP's ability to adopt emergency regulations surrounding newborn and prenatal screening.

CDPH administers California's GDSP, which includes the Prenatal Screening (PNS) Program and the Newborn Screening (NBS) Program. These programs screen for genetic disorders that are, for the most part, preventable or remediable by early intervention and provide clinical oversight for the follow-up services, which include genetic counseling and confirmatory testing, including ultrasound and diagnostic procedures.

CDPH replaced GDSP's conventional biochemical screening for chromosome abnormalities with a Cell-free DNA (cfDNA) screening that screen for chromosomal abnormalities. GDSP's screening for Maternal Serum Alpha-Fetoprotein (MSAFP) screening remains as part of the overall screening process. A total fee increase of $95.40 was proposed beginning September 2022 and the components are as follows:

GDSP PRENATAL SCREENING PROGRAM FEE INCREASE

REGULAR POLICY CHANGE NUMBER: 112

1. CDPH charges a fee increase of $10.40 ($221.60 to $232.00) for the GDSP PNS cfDNA test, with Current Procedural Terminology (CPT) code 81420 and Proprietary Laboratory Analyses (PLA) Code 0327U.
2. Additionally, the MSAFP screening test in the second trimester, which is currently included in the GDSP PNS biochemical screening fees, requires a new separate fee of $85.00, with CPT code 82105.
3. These fee structure changes will generate sufficient ongoing revenue to offset CDPH's additional laboratory screening costs.

The Department has obtained federal approval for SPA 22-0063 and SPA 22-0064 to adjust the corresponding Medi-Cal rates for GDSP PNS. SPA 22-0063 for the rate increase of $85.00 was approved in November 2022, and SPA 22-0064 for the rate decrease for code 81420 was approved in February 2023.

Medi-Cal have published on April 2023 on their website the New Billable Codes for CDPH Genetic Disease Screening Program and Presumptive Eligibility for Pregnant Women (PE4PW).

Effective retroactively for dates of service on or after September 19, 2022, the following CPT® codes are billable under the CDPH GDSP:

Code	Description	Rates
0327U	Fetal aneuploidy (trisomy 13, 18, and 21), DNA sequence analysis of selected regions using maternal plasma, algorithm reported as a risk score for each trisomy, includes sex reporting, if performed	$232
81420	Fetal chromosomal aneuploidy (e.g., trisomy 21, monosomy X) genomic sequence analysis panel, circulating cell-free fetal DNA in maternal blood, must include analysis of chromosomes 13, 18, and 21	$232
82105	Alpha-fetoprotein (AFP); serum	$85

Effective July 1, 2024, CDPH proposes to implement fee increases totaling $112 for:

- A $38 fee increase due to updates to the caseload methodology, and
- A $74 fee increase for the addition of prenatal screenings for Sex Chromosome Aneuploidies (SCAs).

Reason for Change:

The change in FY 2023-24, from the prior estimate, is due to:

- A change that all providers can bill both CPT codes 81420 and 82105, not limited to only providers enrolled in the CDPH GDSP program;
- Updated estimates based on estimated decrease in GDSP PNS projected caseload;
- Updates to the retroactive implementation dates of the GDSP PNS rate adjustments.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to:

- Less retroactive savings are occurring in FY 2024-25.
- Full impact of the annual savings are estimated in FY 2024-25.
- Including the costs for the $112 rate increase that will be effective July 1, 2024.

GDSP PRENATAL SCREENING PROGRAM FEE INCREASE

REGULAR POLICY CHANGE NUMBER: 112

Methodology:

1. CDPH implemented a $95.40 fee increase for the GDSP PNS program, effective September 19, 2022. The Department implemented a corresponding Medi-Cal FFS GDSP PNS rate adjustment based on the CDPH fee increase and new fee structure.

2. The Department implemented a $375.24 fee adjustment for CPT 81420, reducing the current FFS rate from $607.24 to $232.00 to reflect CDPH's new participation fee of $232.00 for the cfDNA screening, effective October 1, 2022. This adjustment was implemented on May 22, 2023 and the Erroneous Payment Correction (EPC) for the October 1, 2022 through May 21, 2023 period was implemented on August 2, 2023, occurring over 12 months.

3. The Department implemented a $72.97 fee increase for CPT code 82105, increasing the current FFS rate from $12.03 to $85.00 to reflect CDPH's new participation fee for the MSAFP screening, effective September 19, 2022. This increase was implemented on February 20, 2023, and the EPC for the September 19, 2022 through February 19, 2023 period was implemented in March 2023 occurring over 12 months.

4. It is assumed that all providers can bill both CPT codes 81420 and 82105. It is not limited to only providers enrolled in the CDPH GDSP program. Therefore, cost estimation of Medi-Cal expenditures on MSAFP exams and cfDNA screening includes screening outside of the Prenatal Screening Program for FY 2022-23 onward. Fiscal estimates are derived from caseload forecasts received from CDPH in July 2023.

5. CDPH has proposed a fee increase for CPT 81420, increasing the rate from $232.00 to $344.00, effective July 1, 2024.

6. Of the percentage Medi-Cal newborn population, assume approximately 32% are in Medi-Cal FFS.

7. The Medi-Cal managed care impact is assumed in the managed care base capitation rates; therefore, there are no managed care impact included in this policy change.

8. The estimated Medi-Cal FFS savings for FY 2023-24 and FY 2024-25, on a cash basis are:

FY 2023-24	**TF**	**GF**	**FF**
FFS Prospective Rate Change	($3,218,000)	($1,262,000)	($1,956,000)
FFS Retroactive Rate Change	($2,193,000)	($860,000)	($1,333,000)
FY 2023-24 Decreased Savings	$5,454,000	$2,139,000	$3,315,000
Total	**$43,000**	**$17,000**	**$26,000**

FY 2024-25	**TF**	**GF**	**FF**
FFS Prospective Rate Change	($3,110,000)	($1,220,000)	($1,890,000)
FFS Retroactive Rate Change	($185,000)	($73,000)	($112,000)
FY 2023-24 Decreased Savings	$6,618,000	$2,595,000	$4,023,000
FY 2024-25 Rate Increase	$859,000	$337,000	$522,000
Total	**$4,182,000**	**$1,639,000**	**$2,543,000**

GDSP PRENATAL SCREENING PROGRAM FEE INCREASE

REGULAR POLICY CHANGE NUMBER: 112

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)
COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

LABORATORY RATE METHODOLOGY CHANGE

REGULAR POLICY CHANGE NUMBER: 113
IMPLEMENTATION DATE: 2/2016
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1703

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	-$4,113,000	-$13,516,000
- STATE FUNDS	-$1,751,900	-$5,756,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$4,113,000	-$13,516,000
STATE FUNDS	-$1,751,900	-$5,756,200
FEDERAL FUNDS	-$2,361,100	-$7,759,800

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 19-0011
SPA 20-0003
SPA 20-0010
SPA 21-0052
SPA 22-0053

Interdependent Policy Changes:
COVID-19 Increased FMAP – DHCS

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

LABORATORY RATE METHODOLOGY CHANGE
REGULAR POLICY CHANGE NUMBER: 113

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.

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. The Department will submit SPA-230019 to seek federal approval to adjust clinical laboratory or laboratory services reimbursement rates based on the Triennial reimbursement methodology, effective July 1, 2023.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to:
- Retroactive adjustments from the July 2022 rate adjustments previously were estimated to be completed in July 2023 but instead were completed in FY 2022-23,
- Savings for the triennial rate adjustment, effective July 2023.decreased, and
- Implementation of the July 2023 triennial rate adjustment was delayed from August 2023 to February 2024. The retroactive adjustments were also delayed to May 2024 and now estimated to occur over 12 months,

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to including a full year's impact of the July 2023 triennial rate adjustment and the remaining retroactive adjustments for the July 2023 triennial rate adjustments in FY 2024-25.

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 2023 annual rate adjustment is effective July 1, 2023. No rates require an adjustment, so no fiscal impact is assumed.
    b. The 2024 annual rate adjustment o is effective July 1, 2024. No rates require an adjustment, so no fiscal impact is assumed.

LABORATORY RATE METHODOLOGY CHANGE

REGULAR POLICY CHANGE NUMBER: 113

4. **Triennial rate adjustment:** The CMS approved the new laboratory rate methodology in July 2015.

    a. The savings resulting from the July 2023 rate adjustment is estimated to be $9.1 million TF and is expected to be implemented in February 2024. The retroactive recoupment for July 2023 through January 2024 is expected to implement in May 2024 over 12 months.

5. The expected adjustments are as follows:

FY 2023-24	TF	GF	FF
Prospective Savings			
2023 Triennial Rate Adjustment	($3,335,000)	($1,421,000)	($1,914,000)
Retroactive Adjustments			
2023 Triennial Rate Adjustment	($778,000)	($331,000)	($447,000)
Total	**($4,113,000)**	**($1,752,000)**	**($2,361,000)**

FY 2024-25	TF	GF	FF
Prospective Savings			
2023 Triennial Rate Adjustment	($9,095,000)	($3,873,000)	($5,222,000)
Retroactive Adjustments			
2023 Triennial Rate Adjustment	($4,421,000)	($1,883,000)	($2,538,000)
Total	**($13,516,000)**	**($5,756,000)**	**($7,760,000)**

Funding:

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	($3,319,000)	($1,660,000)	($1,659,000)
90% Title XIX / 10% GF (4260-101-0001 / 0890)	($742,000)	($74,000)	($668,000)
65% Title XXI / 35% GF (4260-101-0001 / 0890)	($52,000)	($18,000)	($34,000)
Total	**($4,113,000)**	**($1,752,000)**	**($2,361,000)**

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	($10,904,000)	($5,452,000)	($5,452,000)
90% Title XIX / 10% GF (4260-101-0001 / 0890)	($2,440,000)	($244,000)	($2,196,000)
65% Title XXI / 35% GF (4260-101-0001 / 0890)	($172,000)	($60,000)	($112,000)
Total	**($13,516,000)**	**($5,756,000)**	**($7,760,000)**

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS

REGULAR POLICY CHANGE NUMBER: 114
IMPLEMENTATION DATE: 9/2019
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 2055

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$3,617,930,000	$4,550,530,000
- STATE FUNDS	$1,161,240,000	$1,452,111,900
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,617,930,000	$4,550,530,000
STATE FUNDS	$1,161,240,000	$1,452,111,900
FEDERAL FUNDS	$2,456,690,000	$3,098,418,100

Purpose:
This policy change estimates the managed care Private Hospital Directed Payments (PHDP) to private hospitals through enhanced capitation payments to managed care plans (MCPs).

For more information about the Hospital QAF, see the Hospital QAF - FFS Payments, Hospital QAF - Managed Care Payments, and Hospital QAF – Children's Health Care policy changes.

Authority:
Proposition 52 (2016)
Title 42, Code of Federal Regulations (CFR) 438.6(c)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
The Centers for Medicare & Medicaid Services (CMS) instituted the final rule which modernized Medicaid managed care regulations. The result is changes in the usage of managed care delivery systems. 42 CFR 438.6(c) provides states flexibility to implement delivery system and provider payment initiatives under Medicaid MCPs contracts based on allowable directed payments that focus on delivery system reform.

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. The 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

MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS
REGULAR POLICY CHANGE NUMBER: 114

Department will adjust MCP's per-member-per-month rates to appropriately fund MCPs for the enhanced payment obligation.

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 annual basis. On December 17, 2018, the Department received CMS pre-print approval to continue the PHDP for the FY 2018-19 rating period. On June 12, 2020, the Department received approval from CMS for the July 1, 2019, through December 31, 2020, rating period. On October 8, 2021, the Department received approval from CMS for the Calendar Year (CY) 2021 rating period (January 1 through December 31, 2021). On May 10, 2022, the Department received approval from CMS for the CY 2022 rating period (January 1 through December 31, 2022). In FY 2023-24, the Department will request approval from CMS for the CY 2023 rating period (January 1 through December 31, 2023).

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
There is no change in the total fund in FY 2023-24 from the prior estimate. The funding splits have been updated based on actual utilization data from months July 2021 to December 2021 of the CY 2021 rating period and implementation of rates specific to members who have Unsatisfactory Immigration Status (UIS).

The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to growth of the total pool size.

Methodology:
1. The total value of the funding for the private hospital directed payment pool on an accrual basis is $3.53 billion total fund for CY 2021 rating period, $3.71 billion total fund for the CY 2022 rating period and $5.39 billion total fund for the CY 2023 rating period.

2. The non-federal share will be supported by the Hospital Quality Assurance Revenue Fund (HQARF).

MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS
REGULAR POLICY CHANGE NUMBER: 114

3. Enhanced payments will be issued to MCPs based on actual private hospital utilization for contracted services.

4. Within each managed care rating period, the payments are issued, separately, for each 6-month service period.

5. Payments are anticipated to occur in September and March of each fiscal year.

6. The final six months of the CY 2021 rating period (July 1, 2021, through December 31, 2021) payments occurred in September 2023. The first six months of the CY 2022 rating period (January 1, 2022, through June 30, 2022) payments are expected to occur in March 2024.

7. The final six months of the CY 2022 rating period (July 1, 2022, through December 31, 2022) payments are expected to occur in September 2024. The first six months of the CY 2023 rating period (January 1, 2023, through June 30, 2023) payments are expected to occur in March 2025.

8. The Title XIX and Title XXI COVID-19 increased FMAP is assumed for expenditures through June 30, 2023, for this policy change.

9. On a cash basis, the estimated payments are:

(Dollars in Thousands)

FY 2023-24	TF	SF (HQARF)	FF (Title 19)	FF (Title 21)	ACA FF	COVID-19 FF
CY 2021 P2 (July - Dec 2021) +CY 2022 P1 (Jan - June 2022)	$3,617,930	$1,161,240	$1,023,662	$141,743	$1,154,887	$136,398
Total FY 2023-24	**$3,617,930**	**$1,161,240**	**$1,023,662**	**$141,743**	**$1,154,887**	**$136,398**

(Dollars in Thousands)

FY 2024-25	TF	SF (HQARF)	FF (Title 19)	FF (Title 21)	ACA FF	COVID-19 FF
CY 2022 P2 (July - Dec 2022) +CY 2023 P1 (Jan - June 2023)	$4,550,530	$1,452,112	$1,313,369	$178,281	$1,452,584	$154,184
Total FY 2024-25	**$4,550,530**	**$1,452,112**	**$1,313,369**	**$178,281**	**$1,452,584**	**$154,184**

Funding:
Hospital Quality Assurance Revenue Fund (4260-611-3158)
SCHIP HQARF (4260-101-0890/4260-611-3158), 65/35
Title XIX FFP (4260-101-0890)
ACA Title XIX FFP (4260-101-0890)
Title XXI FFP (4260-101-0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)
COVID-19 Title XXI Increased FFP (4260-101-0890)
COVID-19 SCHIP 4.34% (4260-101-0890), 100% FFP

HOSPITAL QAF - MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 115
IMPLEMENTATION DATE: 7/2023
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 1761

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$3,594,800,000	$1,297,400,000
- STATE FUNDS	$1,098,044,350	$420,932,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,594,800,000	$1,297,400,000
STATE FUNDS	$1,098,044,350	$420,932,500
FEDERAL FUNDS	$2,496,755,650	$876,467,500

Purpose:
This policy change estimates the Managed Care payments hospitals will receive from the extension of the quality assurance fee (QAF) program.

For more information about the Hospital QAF, 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)
Families First Coronavirus Response Act (FFCRA)
Title 42, Code of Federal Regulations (CFR) 438.6(d)(3)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
Proposition 52, approved by California voters on November 8, 2016, permanently extended the Hospital QAF program. The program period from January 1, 2017, to June 30, 2019, is referred to as QAF V.

The Department received federal approval for the QAF VI program period (July 1, 2019, through December 31, 2021) in February 2020. This QAF program period is referred to as QAF VI.

The Department received federal approval for the QAF VII program period (January 1, 2022, through December 31, 2022) in September 2022. This QAF program period is referred to as QAF VII.

The Department is currently developing the subsequent program period (HQAF VIII) which will include payments for the period beginning January 1, 2023. The Department is proposing a two-year program period for dates of service January 1, 2023, through December 31, 2024, which

HOSPITAL QAF - MANAGED CARE PAYMENTS
REGULAR POLICY CHANGE NUMBER: 115

was submitted to the Centers for Medicare and Medicaid Services (CMS) in March 2023 via SPAs 23-0007 and 23-0008.

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
There is no change in total fund for FY 2023-24 from the prior estimate, however, the funding splits have been updated based on recent enrollment data from months in Calendar Year (CY) 2022 and implementation of rates specific to Unsatisfactory Immigration Status.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to FY 2023-24 capturing both CY 2022 and CY 2023 amounts, and FY 2024-25 capturing only CY 2024 which has been reduced in comparison to previous service periods in order to comply with the phase-down requirements established under the 2017 Medi-Cal Final Rule.

Methodology:
1. Both CY 2022 and CY 2023 HQAF are anticipated to pay in FY 2023-24 while the CY 2024 payments are anticipated to occur in FY 2024-25.

2. The Department will collect intergovernmental transfers (IGTs) from the Non-Designated Public Hospitals, and payments will be made from the Hospital Quality Assurance Revenue Fund.

3. The CY 2022 total amounts are within the approved HQAF VII fee model.

4. The CY 2023 and CY 2024 total amounts have been submitted to CMS as part of the HQAF VIII program prior to the start of the rating period.

5. The Title XIX and Title XXI COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

HOSPITAL QAF - MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 115

6. On a cash basis, the estimated QAF payments are:

(Dollars in Thousands)

FY 2023-24	TF	SF (HQARF)	FF (TITLE 19)	FF (TITLE 21)	ACA FF	COVID-19 FF
Managed Care						
Calendar Year 2022 & 2023	$3,400,000	$1,038,542	$892,406	$79,146	$1,301,917	$87,989
Total MC	$3,400,000	$1,038,542	$892,406	$79,146	$1,301,917	$87,989
DMPH IGT						
Calendar Year 2022 & 2023	$194,800	$59,502	$51,130	$4,535	$74,592	$5,041
Total DMPH IGT	$194,800	$59,502	$51,130	$4,535	$74,592	$5,041
Total FY 2023-24	**$3,594,800**	**$1,098,044**	**$943,536**	**$83,681**	**$1,376,509**	**$93,030**

(Dollars in Thousands)

FY 2024-25	TF	SF (HQARF)	FF (TITLE 19)	FF (TITLE 21)	ACA FF
Managed Care					
Calendar Year 2024	$1,200,000	$389,331	$323,234	$27,934	$459,501
Total MC	$1,200,000	$389,331	$323,234	$27,934	$459,501
DMPH IGT					
Calendar Year 2024	$97,400	$31,601	$26,236	$2,267	$37,296
Total DMPH IGT	$97,400	$31,601	$26,236	$2,267	$37,296
Total FY 2024-25	**$1,297,400**	**$420,932**	**$349,470**	**$30,201**	**$496,797**

Funding:
Hospital Quality Assurance Revenue Fund (4260-611-3158)
SCHIP HQARF (4260-101-0890/4260-611-3158), 65/35
Title XIX FFP (4260-101-0890)
Title XXI FFP (4260-101-0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)
COVID-19 Title XXI Increased FFP (4260-101-0890)
COVID-19 SCHIP 4.34% (4260-101-0890), 100% FFP

HOSPITAL QAF - FFS PAYMENTS

REGULAR POLICY CHANGE NUMBER: 116
IMPLEMENTATION DATE: 7/2017
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 1475

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$3,268,514,000	$2,565,503,000
- STATE FUNDS	$1,757,575,000	$1,080,478,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,268,514,000	$2,565,503,000
STATE FUNDS	$1,757,575,000	$1,080,478,000
FEDERAL FUNDS	$1,510,939,000	$1,485,025,000

Purpose:
This policy change estimates the fee-for-service (FFS) payments that hospitals will receive from the hospital quality assurance fee (QAF) program.

For more information about the Hospital QAF, 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)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
Proposition 52, approved by California voters on November 8, 2016, permanently extended the Hospital QAF program.

The Department received federal approval for the QAF VI program period (July 1, 2019, through December 31, 2021) in February 2020. This QAF program period is referred to as QAF VI.

The Department received federal approval for the QAF VII program period (January 1, 2022, through December 31, 2022) in September 2022. This QAF program period is referred to as QAF VII.

The Department is currently developing the subsequent program period (HQAF VIII) which will include payments for the period beginning January 1, 2023. The Department is proposing a two-year program period for dates of service January 1, 2023, through December 31, 2024, which was submitted to the Centers for Medicare and Medicaid Services (CMS) in March 2023 via SPAs 23-0007 and 23-0008.

HOSPITAL QAF - FFS PAYMENTS
REGULAR POLICY CHANGE NUMBER: 116

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to:

- An HQAF VI Cycle 4 payment was reissued using General Fund in FY 2023-24 Q1.
- Updated FY 2023-24 FFS estimated payment amounts based on the updated version of the HQAF VIII Fee & Payment model, which is under development and subject to change.
- HQAF VII Cycle 2 ACA adjustment now included in FY 2023-24. Previously HQAF Cycle 2 was to occur during FY 2022-23.
- Updated HQAF VIII cycles 1-2 ACA adjustments based on updated estimated payment amounts, which are under development and subject to change.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to:

- FY 2020-21 and FY 2021-22 UPL Overage backlog will be paid by FY 2023-24 and program will be current.
- HQAF VIII Calendar Year 2024 payments are lower than Calendar Year 2023 payments.

Methodology:
QAF VI-QAF VIII

1. The Hospital QAF VI program periods covers a 30-month period from July 1, 2019, through December 31, 2021.

2. The ACA claiming methodology for the FFS supplemental payments was approved in FY 2017-18. The Hospital Quality Assurance Revenue Fund will be reimbursed for the SF portion (non-federal share) and an adjustment will be made for the federal share processed at the applicable FMAP.

3. QAF VI payments are based on the QAF VI model that was approved by CMS in February 2020. Exact payment timings are subject to change.

4. The QAF VI inpatient (IP) UPL overages payback for FY 2020-21 and FY 2021-22 will take place in FY 2023-24. This was calculated in accordance with State Medicaid Director Letter

HOSPITAL QAF - FFS PAYMENTS
REGULAR POLICY CHANGE NUMBER: 116

(SMDL) #13-003 and assumes additional room from the QAF VI outpatient (OP) UPLs can be offset with the paybacks.

5. The QAF VII program period covers a 12-month period from January 1, 2022, through December 31, 2022.

6. QAF VII payments are based on the QAF VII model that was approved by CMS. Payment timings and amounts will change.

7. Assume the QAF VIII program period covers a 24-month period from January 1, 2023, through December 31, 2024. QAF VIII payments are currently being developed and assumed amounts are subject to change.

8. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

9. 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 Hospital Quality Assurance Revenue Fund to be expended at a later time.

10. An HQAF VI Cycle 4 (FY 2019-20 Q4) payment was issued to a provider in FY 2019-20. However, the payment was not cashed and was subsequently returned to the Department. The non-federal share of the payment was deposited in the General Fund. In July 2023, the payment was reissued from both the General Fund and Federal Fund.

HOSPITAL QAF - FFS PAYMENTS
REGULAR POLICY CHANGE NUMBER: 116

11. On a cash basis, the estimated QAF VI- QAF VIII payments are:

(Dollars in Thousands)

FY 2023-24	TF	GF	SF (HQARF)	FF	ACA FF	COVID-19 FF	*Return to Fund 3158
QAF VI							
FY 2020-21 UPL Overage	$0	$0	$306,526	($165,401)	($120,615)	($20,510)	$0
FY 2021-22 UPL Overage	$0	$0	$182,835	($100,173)	($70,241)	($12,421)	$0
FY 2019-20 Payment Reissuance	$4,959	$2,172	$0	$2,480	$0	$307	$0
QAF VIII							
CY 2023	$3,263,555	$0	$1,607,077	$1,539,478	$0	$117,000	$0
QAF VII & QAF VIII							
CY 2022 ACA FFCRA Adjustment	$0	$0	($198,669)	($293,890)	$529,001	($36,442)	$198,669
CY 2023 ACA FFCRA Adjustment	$0	$0	($142,366)	($206,927)	$372,469	($23,176)	$142,366
Total FY 2023-24	**$3,268,514**	**$2,172**	**$1,755,403**	**$775,567**	**$710,614**	**$24,758**	$341,035

(Dollars in Thousands)

FY 2024-25	TF	SF (HQARF)	FF	ACA FF	COVID-19 FF	*Return to Fund 3158
QAF VIII						
CY 2024	$2,565,503	$1,374,185	$1,191,318	$0	$0	$0
QAF VIII						
CY 2023 ACA FFCRA Adjustment	$0	($157,265)	($206,928)	$372,470	($8,277)	$157,265
CY 2024 ACA FFCRA Adjustment	$0	($136,442)	($170,553)	$306,995	$0	$136,442
Total FY 2024-25	**$2,565,503**	**$1,080,478**	**$813,837**	**$679,465**	**($8,277)**	$293,707

*The Return to Fund 3158 column is for display purposes only (see QAF VI-QAF VIII Methodology #2 and #9).

Funding:
100% GF (4260-101-0001)
Hospital Quality Assurance Revenue Fund (4260-611-3158)
ACA Title XIX FFP (4260-101-0890)
Title XIX FFP (4260-101-0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)

PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 117
IMPLEMENTATION DATE: 1/2018
ANALYST: Ryan Woolsey
FISCAL REFERENCE NUMBER: 2048

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$1,435,814,000	$1,360,367,000
- STATE FUNDS	$555,310,150	$542,348,900
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	4.32 %	4.56 %
APPLIED TO BASE		
TOTAL FUNDS	$1,373,786,800	$1,298,334,300
STATE FUNDS	$531,320,750	$517,617,790
FEDERAL FUNDS	$842,466,080	$780,716,480

Purpose:
This policy change estimates the expenditures related to providing supplemental payments for certain physician services.

Authority:
Title 42, Code of Federal Regulations (CFR) 447(f)
State Plan Amendment (SPA) 17-030
SPA 21-0004
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Proposition 56 Funding
Prop 56 – Funding Reduction

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 physician services. The Legislature has continued this funding in subsequent budget acts.

The Department will provide supplemental payments for certain physician services in both Medi-Cal Fee-for-Service (FFS) and Medi-Cal managed care delivery systems. Providers who are eligible to provide and bill for the specified physician services will receive the associated supplemental payment identified, in addition to any other payment they receive from the State in FFS or from the health plan as a network provider in managed care.

PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS
REGULAR POLICY CHANGE NUMBER: 117

Targeted Provider Rate Increases
The Budget Act of 2023 increased rates to at least 87.5 percent of Medicare for Primary Care (inclusive of Nurse Practitioners and Physician Assistants), Maternity Care (inclusive of OB/GYN and doulas), and non-specialty mental health services, effective January 1, 2024. The Governor's Budget proposes additional rate increases. These rate increases partially overlap with Proposition 56 physicians services supplemental payments. Upon implementation, rate increases that overlap with Proposition 56 supplemental payments will replace the supplemental payments, and Proposition 56 funding, subject to revenue availability, will continue to be used to support the non-federal share of cost for the portion of the rate increases that overlaps with the physicians services supplemental payments.

For budgeting purposes, the cost of the portion of targeted rate increases that overlap with Proposition 56 physicians services supplemental payments continue to be reflected in this policy change.

Managed Care Physician Directed Payments
The Centers for Medicare and Medicaid Services (CMS) instituted the Medicaid Managed Care Final Rule in May 2016, which modernized Medicaid managed care regulations. The result is changes in the usage of managed care delivery systems, 42 CFR section 438.6(c) provides states flexibility to implement delivery system and provider payment initiatives under Medicaid managed care plans (MCPs) contracts based on allowable directed payments.

Beginning with the July 1, 2017 rating period, the state has directed MCPs to make enhanced supplemental payments to eligible provider types for specified CPT codes upon approval from CMS and availability of federal funding. The enhanced supplemental payment is contingent upon the MCPs' receipt of providers' actual utilization for these codes reported through encounter data.

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 annual basis. On October 8, 2021, the Department received pre-print approval from CMS for the CY 2021 rating period (January 1 through December 31, 2021). The pre-print for the CY 2022 rating period (January 1 through December 31, 2022) has been submitted to CMS.

For FY 2018-19, the directed payments are subject to a minimum medical expenditure percentage (MEP). MCPs that do not achieve a minimum MEP of 95 percent must remit to the Department the difference between their MEP and the 95 percent threshold.

Beginning July 1, 2019, the directed payments are subject to a two-sided risk corridor. The two-sided risk corridor will be calculated retrospectively by the Department with activities beginning no sooner than January 1, 2022. The risk corridors will be based on the aggregate MEPs achieved by each MCP and will utilize MCP-submitted encounters and/or other utilization data.

Pandemic Increased Federal Medical Assistance Percentage (FMAP)
The FFCRA provides increased federal funding by increasing the 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).

PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS
REGULAR POLICY CHANGE NUMBER: 117

The Consolidated Appropriations Act of 2023 was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Proposition 56 Funding Policy Change
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.

Proposition 56 Funding Reduction
Due to declining Proposition 56 revenues and the General Fund condition, the Budget reduces funding for Proposition 56 supplemental payments for physician services by $193.4 million ($77.1 million Proposition 56) in FY 2024-25. This reduction is not shown in this policy change but is shown in the Prop 56 – Funding Reduction policy change.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to:

- Increased estimated managed care expenditures based on updated member months projections.

The change from FY 2023-24 to FY 2024-25, in the current estimate is due to:

- An expected decline in managed care expenditures in FY 2024-25, and
- FFCRA increased FMAP funding will no longer be available in FY 2024-25.

Methodology:
1. This policy is effective July 1, 2017.

FFS Physician Supplemental Payments
2. Payments will be made via supplemental payments.

3. Absent the reduction described below, assume the FFS supplemental payments are approximately $62 million TF for FY 2023-24 and FY 2024-25, consistent with levels observed over the most recent six months of actual payments.

Managed Care Physician Directed Payments
4. Risk-based capitation rates paid to MCPs will be enhanced, based on anticipated utilization of the specified services, to fund the required provider payments.

5. Assume that the annual estimated value of enhanced capitation rate increases for MCPs to fund the supplemental rate increase, on a cash basis, is $1,373,805,000 TF in FY 2023-24 and $1,298,357,000 TF in 2024-25.

PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS
REGULAR POLICY CHANGE NUMBER: 117

6. The Title XIX and Title XXI FFCRA increased FMAP is assumed for expenditures through December 31, 2023 for this policy change.

7. Funds allocated for the supplemental payments are as follows:

FY 2023-24	TF	GF	Title XXI FF	Title XIX FF	ACA FF	FFCRA
FFS Pmts	$62,009,000	$28,142,000	$7,059,000	$19,863,000	$6,472,000	$473,000
Mgd Care Pmts	$1,373,805,000	$527,168,000	$87,465,000	$357,028,000	$394,062,000	$8,082,000
Total	**$1,435,814,000**	**$555,310,000**	**$94,524,000**	**$376,891,000**	**$400,534,000**	**$8,555,000**

FY 2024-25	TF	GF	Title XXI FF	Title XIX FF	ACA FF	FFCRA
FFS Pmts	$62,010,000	$28,616,000	$7,059,000	$19,863,000	$6,472,000	$0
Mgd Care Pmts	$1,298,357,000	$513,733,000	$85,884,000	$346,657,000	$352,083,000	$0
Total	**$1,360,367,000**	**$542,349,000**	**$92,943,000**	**$366,520,000**	**$358,555,000**	**$0**

Funding:

FY 2023-24	TF	GF	FF	FFCRA
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	$753,782,000	$376,891,000	$376,891,000	$0
90%Title XIX FF / 10% GF (4260-101-0001 / 0890)	$445,037,000	$44,503,000	$400,534,000	$0
65% Title XXI FF / 35% GF (4260-101-0001 / 0890)	$145,422,000	$50,898,000	$94,524,000	$0
100% GF (4260-101-0001)	$91,573,000	$91,573,000	$0	$0
COVID-19 Title XXI Increased FMAP (4260-101-0001)	($1,018,000)	($1,018,000)	$0	$0
COVID-19 Title XXI Increased FMAP (4260-101-0890)	$1,018,000	$0	$0	$1,018,000
COVID-19 Title XIX Increased FMAP (4260-101-0001)	($7,537,000)	($7,537,000)	$0	$0
COVID-19 Title XIX Increased FMAP (4260-101-0890)	$7,537,000	$0	$0	$7,537,000
Total	**$1,435,814,000**	**$555,310,000**	**$871,949,000**	**$8,555,000**

PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 117

FY 2024-25	TF	GF	FF	FFCRA
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	$733,040,000	$366,520,000	$366,520,000	$0
90%Title XIX FF / 10% GF (4260-101-0001 / 0890)	$398,394,000	$39,839,000	$358,555,000	$0
65% Title XXI FF / 35% GF (4260-101-0001 / 0890)	$142,989,000	$50,046,000	$92,943,000	$0
100% GF (4260-101-0001)	$85,944,000	$85,944,000	$0	$0
Total	**$1,360,367,000**	**$542,349,000**	**$818,018,000**	**$0**

GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS

REGULAR POLICY CHANGE NUMBER: 118
IMPLEMENTATION DATE: 6/2020
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 2024

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$827,005,000	$617,054,000
- STATE FUNDS	$267,874,000	$268,335,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$827,005,000	$617,054,000
STATE FUNDS	$267,874,000	$268,335,000
FEDERAL FUNDS	$559,131,000	$348,719,000

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, CFR, Section 438.60
SB 97 (Chapter 52, Statutes of 2017)
SPA 17-0009
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

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, 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

GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS
REGULAR POLICY CHANGE NUMBER: 118

the Medicare program, the GME payments would recognize the Medi-Cal managed care share of the cost for a combination of the following:

- Direct GME payments for Medicaid's share of the cost of training new health care providers
- Indirect GME payments for the additional training time and resources

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.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) for certain expenditures in Medicaid and 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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to:

- FY 2019-20 ACA Adjustments, FY 2020-21 ACA Adjustments, and FY 2021-22 Final Settlement & Q1-Q2 ACA Adjustments shifted from date of payment FY 2022-23 to FY 2023-23.
- Revised FY 2021-22 Q3-Q4 ACA Adjustment based on updated data.
- Revised FY 2022-23 Final Settlement & Q1-Q2 ACA Adjustment based on updated data.
- Revised FY 2023-24 Interim Payments based on updated data.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to:

- Higher volume of ACA Adjustments and final settlements are expected to occur in FY 2023-24 compared to FY 2024-25.

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.

GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS
REGULAR POLICY CHANGE NUMBER: 118

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 2023-24 payments were calculated based on FY 2021-22 cost report data and are estimated at $501.8 million TF.
    - FY 2024-25 payments assumed an increase from FY 2023-24 estimated payments based on the CPI annual adjustment. FY 2024-25 payments are estimated to provide $514 million TF.

4. Payments will be made on a lump-sum quarterly basis throughout the fiscal year and will not be paid as individual increases to current reimbursement rates for specific services.

5. The IGTs referenced in this policy change are not the basis for the 5% administrative fee for GME supplemental payments. The administrative fees are reflected in the IGT Admin & Processing Fee policy change and will be 5% of the aggregate nonfederal share that is calculated at 50% FMAP of the Total Funds.

6. The ACA allows for 100% FMAP for calendar year 2016 for newly eligible Medi-Cal members. Beginning January 1, 2017, the ACA optional population FMAP reduces to 95%, 94% beginning January 1, 2018, 93% beginning January 1, 2019, and 90% beginning January 1, 2020. The ACA reimbursement methodology was approved in the fourth quarter of FY 2022-23.

7. ACA adjustments are anticipated to be processed after the respective FY has closed in order to determine the proportion of the hospital's GME payment attributable to ACA. Beginning with FY 2017-18, ACA adjustments for Q1 and Q2 will be processed concurrently with final settlements for the respective FY. ACA adjustments for Q3 and Q4 will be processed once complete encounter data is available. The nonfederal share of the adjustment amount will be reimbursed to the DPHs.

8. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023 for this policy change.

9. Assume FY 2021-22 and FY 2022-23 final settlements will be paid in FY 2023-24.

10. Assume all four quarters of FY 2023-24 will be paid in FY 2023-24.

11. Assume ACA adjustments for FY 2019-20 through FY 2022-23 Q2 will occur in FY 2023-24.

12. Assume FY 2023-24 final settlements will occur in FY 2024-25.

13. Assume all four quarters of FY 2024-25 will be paid in FY 2024-25.

GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS

REGULAR POLICY CHANGE NUMBER: 118

14. Assume ACA adjustments for FY 2022-23 Q3 through FY 2023-24 Q2 will be paid in FY 2024-25.

(Dollars in Thousands)

FY 2023-24	TF	IGT	FF	ACA FF	COVID-19 FF
FY 2019-20 ACA Adjustment	$62,160	$0	($80,948)	$148,132	($5,024)
FY 2020-21 ACA Adjustment	$66,763	$0	($98,763)	$177,773	($12,247)
FY 2021-22 Final Settlement & Q1-Q2 ACA Adjustment	$92,974	$10,974	($13,164)	$96,796	($1,632)
FY 2021-22 Q3-Q4 ACA Adjustment	$36,352	$0	($53,776)	$96,796	($6,668)
FY 2022-23 Final Settlement & Q1-Q2 ACA Adjustment	$66,958	$11,019	($38,666)	$99,168	($4,563)
FY 2023-24 Interim Payment	$501,798	$245,881	$250,899	$0	$5,018
Total	**$827,005**	**$267,874**	**($34,418)**	**$618,665**	**($25,116)**

(Dollars in Thousands)

FY 2024-25	TF	IGT	FF	ACA FF	COVID-19 FF
FY 2022-23 Q3-Q4 ACA Adjustment	$37,905	$0	($55,093)	$99,168	($6,170)
FY 2023-24 Final Settlement & Q1-Q2 ACA Adjustment	$65,057	$11,289	($46,891)	$101,597	($938)
FY 2024-25 Interim Payment	$514,092	$257,046	$257,046	$0	$0
Total	**$617,054**	**$268,335**	**$155,062**	**$200,765**	**($7,108)**

Funding:
Title XIX FFP (4260-101-0890)
DPH Graduate Medical Education Special Fund (4260-601-8113)
Title XIX ACA (4260-101-0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)

PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER: 119
IMPLEMENTATION DATE: 7/2005
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 1071

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$711,882,000	$712,818,000
- STATE FUNDS	$350,160,000	$356,409,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$711,882,000	$712,818,000
STATE FUNDS	$350,160,000	$356,409,000
FEDERAL FUNDS	$361,722,000	$356,409,000

Purpose:
This policy change estimates the funds for the private Disproportionate Share Hospital (DSH) replacement payments.

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.11
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)
SB 90 (Chapter 19, Statutes of 2011)
SB 335 (Chapter 286, Statutes of 2011)
HR 2 (2015)
SPA 05-022
SPA 16-010
HR 1892 (2018)
HR 4378 (2019)
HR 3055 (2019)
HR 1865 (2019)
HR 748 (2020)
Families First Coronavirus Response Act (FFCRA)
HR 133 (2020)
American Rescue Plan (ARP) Act (2021)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
ACA DSH Reduction

Background:
Beginning July 1, 2005, based on SB 1100, private hospitals receive Medi-Cal DSH replacement payments under the DSH Replacement Program. These payments are determined using the same formulas and methodology that were previously in effect under the prior DSH methodology for the 2004-05 fiscal year. These payments are distributed to private hospitals along with $160.00, with the federal share of the $160.00 funded via the annual DSH allotment,

PRIVATE HOSPITAL DSH REPLACEMENT
REGULAR POLICY CHANGE NUMBER: 119

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 transfers the authority for DSH replacement payments from the BTR waiver to the California State Plan effective January 1, 2016.

The federal share of the DSH replacement payments is regular Title XIX funding and is not claimed from the federal DSH allotment. The non-federal share of these payments is State General Fund.

The Affordable Care Act (ACA) requires a reduction to the DSH allotments and was previously scheduled to go into effect on October 1, 2013. Subsequent federal action has delayed the reduction. Most recently, on December 27, 2020, HR 133 (2020) was enacted which eliminated the DSH reductions for Federal Fiscal Year (FFY) 2021 through FFY 2023, lowered the overall aggregate national reduction to $32 billion, and postponed the implementation until FFY 2024.

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.

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

On March 11, 2021, HR 1319 (2021), ARP, was enacted. ARP requires that for the federal fiscal years in which the FFCRA increased FMAP is applicable, the states’ annual DSH allotments be recalculated such that the total computable DSH expenditures for a state is equal to the total computable DSH expenditures that would have resulted in the absence of the FFCRA increased FMAP. The result is an increase in the DSH allotments for the impacted fiscal years. This policy change reflects the preliminary ARP-adjusted FFY 2023 allotment released by CMS on September 26, 2022, and the Department-estimated FFY 2024 and 2025 non-ARP-adjusted allotments.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to updated FY 2022-23 June Phase I and II payment and recoupment amounts due to updated program year data.

PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER: 119

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to a larger DSH allotment estimate. The Department estimated FY 2024-25 DSH allotment will not be subject to ARP adjustments and is derived by trending forward the estimated non-ARP adjusted FY 2023-24 allotment by 2%.

Methodology:

1. CMS released a preliminary ARP-adjusted FFY 2023 DSH allotment on September 26, 2022.

2. The FY 2023-24 DSH allotment is subject to ARP adjustments for 3 months (October to December 2023), and therefore assumes a 2% annual increase from the preliminary non-ARP adjusted FFY 2023 allotment with 3 months of COVID-19 increased FMAP consistent with the Consolidated Appropriations Act of 2023.

3. The FY 2024-25 DSH allotment will not be subject to ARP adjustments, and thus assumes a 2% annual increase from the estimated non-ARP adjusted FY 2023-24 allotment.

4. The remaining 1/12 of the FY 2022-23 DSH replacement payment will be completed in FY 2023-24.

5. Assume 11/12 of the FY 2023-24 DSH replacement payment will occur in FY 2023-24 and the remaining 1/12 will occur in FY 2024-25.

6. Assume 11/12 of the FY 2024-25 DSH replacement payment will occur in FY 2024-25.

7. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31 2023, for this policy change.

It is assumed that the DSH replacement payments will be made as follows on a cash basis:

(Dollars in Thousands)

FY 2023-24	TF	GF	FF	COVID-19 FF
FY 2022-23	$66,602	$31,920	$33,301	$1,381
FY 2023-24	$645,280	$318,240	$322,640	$4,400
Total FY 2023-24	**$711,882**	**$350,160**	**$355,941**	**$5,781**

FY 2024-25	TF	GF	FF
FY 2023-24	$58,662	$29,331	$29,331
FY 2024-25	$654,156	$327,078	$327,078
Total FY 2024-25	**$712,818**	**$356,409**	**$356,409**

Funding:

50% Title XIX/ 50% GF (4260-101-0001/0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)
COVID-19 Title XIX GF (4260-101-0001)

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 120
IMPLEMENTATION DATE: 7/2005
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 1085

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$685,566,000	$459,199,000
- STATE FUNDS	$326,036,000	$191,784,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$685,566,000	$459,199,000
STATE FUNDS	$326,036,000	$191,784,000
FEDERAL FUNDS	$359,530,000	$267,415,000

Purpose:
This policy change estimates the supplemental payments made to private hospitals from the Private Hospital Supplemental Fund.

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code (W&I) 14166.12
AB 1467 (Chapter 23, Statutes of 2012), W&I Code 14166.14
SPA 23-0013
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
Effective July 1, 2005, based on the requirements of SB 1100, supplemental reimbursement will be available to private hospitals.

Private hospitals will receive payments from the Private Hospital Supplemental Fund (Item 4260-601-3097) using General Fund (GF), intergovernmental transfers (IGTs), and interest accrued in the Private Hospital Supplemental Fund as the non-federal share of payments. This funding, along with the federal reimbursement, will replace the amount of funding the private hospitals previously received under the Emergency Services and Supplemental Payments Program (SB 1255, Voluntary Governmental Transfers), the Graduate Medical Education Program (GME), and the Small and Rural Hospital Supplemental Payment Program (Fund 0688).

SB 1100 requires the transfer of $118,400,000 annually from the 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 (SPCP) for private hospitals on July 1, 2013, State Plan

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
REGULAR POLICY CHANGE NUMBER: 120

Amendments (SPAs) were required to continue the Private Hospital Supplemental Program and secure distributions from the Private Hospital Supplemental Fund.

The Department received SPA approvals from the Centers of Medicare and Medicaid Services (CMS) to continue the Private Hospital Supplemental Program for FY 2013-14 through FY 2022-23. The most recent SPA, 22-0027, was approved by CMS on August 16, 2022 and extended the Private Hospital Supplemental Fund Program through June 30, 2023. In the first quarter of FY 2023-24, a 1-year SPA to extend the Private Hospital Supplemental Program through FY 2023-24 is anticipated to be submitted to CMS. The SPA will also propose that carryover funds be matched with federal financial participation (FFP) and distributed to private hospitals. If approved by CMS, this methodology would be implemented beginning in FY 2023-24.

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to:

- Updated FY 2022-23 ACA Adjustments based on more recent data, and
- FY 2023-24 cash expenditures to providers was updated to reflect the shift of the distribution of prospective carryover funds from FY 2023-24 to FY 2024-25.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to higher expenditures anticipated to occur in FY 2023-24 compared to FY 2024-25 due to the distribution of retroactive carryover funds.

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 2023-24 $118,400,000 GF appropriation will be adjusted by the enhanced federal funds provided by the FFCRA and the FY 2023-24 and FY 2024-25 $118,400,000 GF appropriation will be adjusted by the enhanced federal funds provided by the ACA, resulting in carryover funds. The Department will be proposing a methodology to match carryover

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
REGULAR POLICY CHANGE NUMBER: 120

funds with FFP and distribute to private hospitals in the subsequent fiscal year, beginning in FY 2023-24.

3. IGT payments will be $54.1 million TF in FY 2023-24 and $63.2 million TF in FY 2024-25.

4. The ACA allows for 100% FMAP for calendar years 2014 through 2016. Beginning January 1, 2017, the ACA optional population FMAP is 95%, and reduces to 94% beginning January 1, 2018. Beginning January 1, 2019, the ACA optional population FMAP reduces to 93%, and further reduces to 90% beginning January 1, 2020. CMS approved the ACA claiming methodology in August 2017.

5. ACA payments will be processed nine months after the respective FY's supplemental payments have been issued in order to determine the proportion of the costs for newly eligible Medi-Cal members. FY 2022-23 ACA supplemental payments will be claimed in FY 2023-24, and FY 2023-24 ACA supplemental payments will be claimed in FY 2024-25.

   - The counties will be reimbursed for the IGTs (non-federal share) and an adjustment will be made for the federal share processed at the COVID-19 increased 56.2% FMAP for FY 2022-23 Q1 through Q3, at the COVID-19 increased 55% FMAP for FY 2022-23 Q4, at the COVID-19 increased 52.5% FMAP for FY 2023-24 Q1, at the COVID-19 increased 51.5% FMAP for FY 2023-24 Q2, and at the 50% FMAP for FY 2023-24 Q3 through Q4.

   - The SF will be reimbursed for the SF portion (non-federal share) and an adjustment will be made for the federal share processed at the COVID-19 increased 56.2% FMAP for FY 2022-23 Q1 through Q3 and at the COVID-19 increased 55% FMAP for FY 2022-23 Q4, at the COVID-19 increased 52.5% FMAP for FY 2023-24 Q1, at the COVID-19 increased 51.5% FMAP for FY 2023-24 Q2, and at the 50% FMAP for FY 2023-24 Q3 through Q4.

6. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023 for this policy change.

   - FY 2023-24 Q1 payments will be issued at 52.5% FF / 47.5% SF (GF appropriated); resulting in $3.82 million carryover funds. FY 2023-24 Q2 payments will be issued at 51.5% FF / 48.5% SF (GF appropriated); resulting in $2.29 million carryover funds.

7. The ending balance shown is on a cash basis and does not necessarily mean that the remaining funds are available. Funds in the ending balance may be committed and scheduled to be expended in the following year.

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 120

8. The estimated Private Hospital Supplemental payments and ending balance for FY 2023-24 are shown below:

(Dollars in Thousands)

FY 2023-24 Private Hospital Supplemental Fund Summary	**SF**
FY 2022-23 Ending Balance	$70,055
Appropriation (GF)	$118,400
Carryover Funds	$152,079
FY 2023-24 IGT	$26,516
FY 2022-23 Interest Earned	$1,649
Funds Available	$368,699
Less: FY 2023-24 Cash Expenditures to Hospitals	($326,036)
Est. FY 2023-24 Remaining Balance	$42,663

(Dollars in Thousands)

FY 2023-24	**TF**	**SF**	**FF**	**ACA FF**	**COVID-19 FF**	**Return to SF***	**Return to Counties***
FY 2023-24 Cash Expenditures to Providers**	$665,380	$326,036	$332,690	$0	$6,654	$0	$0
FY 2022-23 ACA FF Adjustment to Special Fund***	$17,551	$0	($25,735)	$46,323	($3,037)	$17,551	$0
FY 2022-23 ACA FF Adjustment to Counties***	$2,635	$0	($3,864)	$6,955	($456)	$0	$2,635
Total	**$685,566**	**$326,036**	**$303,091**	**$53,278**	**$3,161**	$17,551	$2,635

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
REGULAR POLICY CHANGE NUMBER: 120

9. The estimated Private Hospital Supplemental payments and ending balance for FY 2024-25 are shown below:

(Dollars in Thousands)

FY 2024-25 Private Hospital Supplemental Fund Summary	SF
FY 2023-24 Ending Balance	$42,663
Appropriation (GF)	$118,400
Carryover Funds	$71,814
FY 2024-25 IGT	$31,601
Est. FY 2023-24 Interest Earned	$1,649
Funds Available	$266,127
Less: FY 2024-25 Cash Expenditures to Hospitals	($191,784)
Est. FY 2024-25 Remaining Balance	$74,343

(Dollars in Thousands)

FY 2024-25	TF	SF	FF	ACA FF	COVID-19 FF	Return to SF*	Return to Counties*
FY 2024-25 Cash Expenditures to Providers**	$383,567	$191,784	$191,783	$0	$0	$0	$0
FY 2023-24 ACA FF Adjustment to Special Fund***	$71,814	$0	($92,069)	$165,724	($1,841)	$71,814	$0
FY 2023-24 ACA FF Adjustment to Counties***	$3,818	$0	($4,894)	$8,810	($98)	$0	$3,818
Total	**$459,199**	**$191,784**	**$94,820**	**$174,534**	**($1,939)**	$71,814	$3,818

*The Return to SF and Return to Counties columns are for display purposes only (see Methodology #5).

Funding:
100% Private Hospital Supplemental Fund (less funded by GF) (4260-698-3097)
100% Private Hospital Supplemental Fund (non-GF) (4260-601-3097)**
100% Title XIX ACA (4260-101-0890)***
100% Title XIX (4260-101-0890)**,***
100% GF (4260-105-0001)
100% GF (4260-101-0001)
COVID-19 Title XIX Increased FMAP (4260-101-0890)

PROP 56 - MEDI-CAL FAMILY PLANNING

REGULAR POLICY CHANGE NUMBER: 121
IMPLEMENTATION DATE: 1/2020
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 2130

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$505,912,000	$481,460,000
- STATE FUNDS	$101,315,200	$96,561,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	3.65 %	3.82 %
APPLIED TO BASE		
TOTAL FUNDS	$487,446,200	$463,068,200
STATE FUNDS	$97,617,200	$92,872,850
FEDERAL FUNDS	$389,829,020	$370,195,380

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 & Medicaid Services (CMS) approved SPA 19-0027. SPA 19-0027 allows the Department to implement time-limited supplemental payments for specific family planning services delivered in the Medi-Cal FFS delivery system from July 1, 2019, through December 31, 2021. The FFS supplemental payment implemented in January 2020. In FY 2019-20, an Erroneous Payment Correction deployed to retroactively apply supplemental payments to July 1, 2019. SPA 21-0034 was submitted to CMS to extend the supplemental reimbursements under FFS indefinitely.

In the Medi-Cal managed care delivery system, the Department has implemented these payments as directed payments to eligible providers. Prior to implementation of a directed payment program, CMS requires states to seek pre-approval of any requested directed payment program through the standard CMS “pre-print” form. This “pre-print” is typically submitted on an

PROP 56 - MEDI-CAL FAMILY PLANNING
REGULAR POLICY CHANGE NUMBER: 121

annual basis. On May 5, 2020, the Department received pre-print approval from CMS for the July 1, 2019, through December 31, 2020, rating period. On October 8, 2021, the Department received pre-print approval from CMS for the CY 2021 rating period January 1, 2021, through December 31, 2021. The pre-print for the CY 2022 rating period (January 1 through December 31, 2022) and for the CY 2023 rating period (January 1 through December 31, 2023) have been submitted to CMS.

Beginning July 1, 2019, the directed payments are subject to a two-sided risk corridor which is calculated retrospectively by the Department. Recoupments/payments are captured in the Prop 56 Risk Mitigation policy change.

These supplemental payments for Medi-Cal family planning services are intended to help support the larger Medi-Cal population in accessing and using family planning services as well as the providers delivering such services in the Medi-Cal program. This policy change identifies the use of the General Fund (GF) for these Proposition 56 funded payments. See the Proposition 56 Funding policy change for the Proposition 56 offset to the GF.

Reason for Change:
The change for FY 2023-24, from the prior estimate, is an increase in MC expenditures due to updated actual expenditures and revised CY 2024 enrollment projections.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease in projected MC expenditures due to revised enrollment projections.

Methodology:
1. Assume an effective date of July 1, 2019.

2. Assume the continuation of the Proposition 56 payments through FY 2024-25, on a cash basis.

3. The supplemental payments are paid in both FFS and MC for family planning office visits billed under specified procedure codes for service periods beginning July 1, 2019.

4. Expenditures are estimated to be:

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
Fee-For-Service	$18,475	$6,850	$11,625
Managed Care	$487,437	$94,465	$392,972
Total	**$505,912**	**$101,315**	**$404,597**

PROP 56 - MEDI-CAL FAMILY PLANNING

REGULAR POLICY CHANGE NUMBER: 121

FY 2024-25	TF	GF	FF
Fee-For-Service	$18,395	$6,820	$11,575
Managed Care	$463,065	$89,742	$373,323
Total	**$481,460**	**$96,562**	**$384,898**

Funding:

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
90% Title XIX / 10% GF (4260-101-0890/0001)	$449,551	$44,955	$404,596
100% GF (4260-101-0001)	$56,360	$56,360	$0
Total	**$505,911**	**$101,315**	**$404,596**

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
90% Title XIX / 10% GF (4260-101-0890/0001)	$427,663	$42,766	$384,897
100% GF (4260-101-0001)	$53,796	$53,796	$0
Total	**$481,459**	**$96,562**	**$384,897**

DSH PAYMENT

REGULAR POLICY CHANGE NUMBER: 122
IMPLEMENTATION DATE: 7/2005
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 1073

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$451,274,000	$461,140,000
- STATE FUNDS	$102,154,000	$113,180,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$451,274,000	$461,140,000
STATE FUNDS	$102,154,000	$113,180,000
FEDERAL FUNDS	$349,120,000	$347,960,000

Purpose:
This policy change estimates the payments to Disproportionate Share Hospitals (DSHs).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.6 and 14166.16
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)
AB 1066 (Chapter 86, Statutes of 2011)
HR 2 (2015)
SPA 05-022
California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)
SB 815 (Chapter 111, Statutes of 2016)
HR 1892 (2018)
HR 4378 (2019)
HR 3055 (2019)
HR 1865 (2019)
HR 748 (2020)
Families First Coronavirus Response Act (FFCRA)
HR 133 (2020)
American Rescue Plan (ARP) Act (2021)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
ACA DSH Reduction

Background:
Effective July 1, 2005, based on State Plan Amendment (SPA) 05-022 and as part of the MH/UCD and BTR, the federal DSH allotment is available to provide funding for uncompensated Medi-Cal and uninsured costs incurred by DSHs. Eligible hospitals are to receive funding through the DSH program in the following manner:

DSH PAYMENT
REGULAR POLICY CHANGE NUMBER: 122

- Designated Public Hospitals (DPHs) receive their allocation of federal DSH payments from the Demonstration DSH Fund based on the hospitals' certified public expenditures (CPEs), up to 100% of uncompensated Medi-Cal and uninsured costs. DPHs may also receive allocations of federal and non-federal DSH funds through intergovernmental transfer-funded payments for expenditures above 100% of costs, up to 175% of the hospitals' uncompensated Medi-Cal and uninsured costs.

  Effective July 1, 2015, DPHs, except State Government-operated University of California (UC) Hospitals, receive their allocation of the federal DSH payments through the Global Payment Program. See the Global Payment Program (GPP) policy change for more information and for the portion of DSH budgeted for the GPP. State Government-operated University of California Hospitals will continue to receive their allocation of federal DSH payments through CPE and intergovernmental transfer-funded payments for expenditures up to 175% of the hospitals' uncompensated Medi-Cal and uninsured costs in this policy change.

  Beginning January 1, 2023, pending CMS approval, University of California Los Angeles (UCLA) will be participating in the GPP rather than the DSH program. Accordingly, beginning with PY 9, the proposed percentage of the DPH DSH Allotment Federal Financial Participation (FFP) allocated to DSH DPH hospitals will be adjusted to 20.371% rather than 21.896%. Until CMS approves the transition, UCLA will continue to be paid through DSH based on the 21.896% DPH DSH allocation. Once the transition is approved, the DPH DSH allocation percentage will be adjusted, DSH funds will be recouped, and a payment will be issued through GPP.

- Non-Designated Public Hospitals (NDPHs) receive their allocation from the federal DSH allotment and State General Fund (GF) based on hospitals' uncompensated Medi-Cal and uninsured costs up to the Omnibus Budget Reconciliation Act of 1993 (OBRA) limits. The federal reimbursement that is claimed based on the GF is drawn from the Federal Trust Fund.

- Private DSH hospitals, under the Special Terms and Conditions and SPA 05-022, are allocated a total of $160.00 from the federal DSH allotment and GF each demonstration year. All DSH eligible Private hospitals receive a pro-rata share of the $160.00.

The MH/UCD was extended to October 31, 2010. The Centers for Medicare and Medicaid Services (CMS) approved the BTR effective November 1, 2010, continuing the same DSH payment methodology from the MH/UCD.

AB 1066 amended Welfare & Institutions Code 14166.1 and provides the authority for the Department to implement new payment methodologies under the successor demonstration project to determine the federal DSH allotment for DPHs.

The Affordable Care Act (ACA) requires a reduction in the DSH allotments and was previously scheduled to go into effect on October 1, 2013. Subsequent federal action has delayed the reduction. Most recently, on December 27, 2020, HR 133 (2020) was enacted which eliminated the DSH reductions for Federal Fiscal Year (FFY) 2021 through FFY 2023, lowered the overall aggregate national reduction to $32 billion, and postponed the implementation until FFY 2024.

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).

DSH PAYMENT
REGULAR POLICY CHANGE NUMBER: 122

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024

On March 11, 2021, HR 1319 (2021), ARP, was enacted. ARP requires that for the federal fiscal years in which the COVID-19 increased FMAP is applicable, the states' annual DSH allotments be recalculated such that the total computable DSH expenditures for a state is equal to the total computable DSH expenditures that would have resulted in the absence of the COVID-19 increased FMAP. The result is an increase in the DSH allotments for the impacted fiscal years. This policy change reflects the preliminary ARP-adjusted FFY 2023 allotment released by CMS on September 26, 2022, and the Department estimated FFY 2024 and 2025 non-ARP-adjusted allotments.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to:

- The assumption that until the transition is approved, UCLA will continue to be paid through DSH and not through GPP.
- The inclusion of FY 2019-20 NDPH Audit Reconciliation payments in the updated estimate for FY 2023-24.
- The utilization of updated P14 cost report data for calculating DPH DSH payments, which resulted in an updated FY 2022-23 Q4 payment, updated FY 2023-24 payment estimates, and an Interim Reconciliation of overpaid intergovernmental transfer (IGT)+FFP funds for FY 2022-23.
- Updated program year data, which resulted in an updated FY 2022-23 NDPH FFP allocation as well as updated FY 2022-23 June Phase I and Phase II payment and recoupment amounts.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to a larger DSH allotment estimate for FY 2024-25. The Department estimated FY 2024-25 DSH allotment will not be subject to ARP adjustments and is derived by trending forward the estimated non-ARP-adjusted FY 2023-24 allotment by 2%.

Methodology:

1. CMS released a preliminary ARP-adjusted FFY 2023 DSH allotment on September 26, 2022.

2. The FY 2023-24 DSH allotment estimate is subject to ARP adjustments for three months (October to December 2023) and therefore assumes a 2% annual increase from the

DSH PAYMENT
REGULAR POLICY CHANGE NUMBER: 122

preliminary non-ARP-adjusted FFY 2023 allotment and accounts for the COVID-19 increased FMAP phase-out consistent with the Consolidated Appropriations Act of 2023.

3. The FY 2024-25 DSH allotment will not be subject to ARP adjustments and therefore assumes a 2% annual increase from the Department estimated non-ARP-adjusted FY 2023-24 allotment.

4. Effective July 1, 2019, DPH UC DSH hospitals 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. Prior to July 1, 2019, 11/12 of the total annual allotment was paid in the same fiscal year and 1/12 was paid in the following fiscal year.

5. Until CMS approves the transition of UCLA to GPP, it is assumed that UCLA will continue to be paid through DSH.

6. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023 for this policy change.

7. 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 (TF), while keeping the FFP the same that would have been paid at 50% federal share / 50% non-federal share. The FFP does not change, while the non-federal share is reduced.

8. It is assumed that the DSH payments will be made as follows on a cash basis:

FY 2023-24	TF	GF**	IGT*	FF	COVID-19 FF
DSH 2019-20	$404,000	$187,000	$0	$202,000	$15,000
DSH 2022-23	$103,452,000	$10,015,000	$7,445,000	$86,025,000	($33,000)
DSH 2023-24	$347,418,000	$22,325,000	$62,182,000	$260,926,000	$1,985,000
Total FY 2023-24	**$451,274,000**	**$32,527,000**	**$69,627,000**	**$347,153,000**	**$1,967,000**

FY 2024-25	TF	GF**	IGT*	FF
DSH 2023-24	$105,950,000	$2,058,000	$21,845,000	$82,047,000
DSH 2024-25	$355,190,000	$22,916,000	$66,361,000	$265,913,000
Total FY 2024-25	**$461,140,000**	**$24,974,000**	**$88,206,000**	**$347,960,000**

DSH PAYMENT

REGULAR POLICY CHANGE NUMBER: 122

Funding:
100% Demonstration DSH Fund (4260-601-7502)
50% Title XIX / 50% GF (4260-101-0001/0890)**
100% GF (4260-101-0001)
100% Title XIX (4260-101-0890)
100% MIPA Fund (4260-606-0834)*
COVID-19 Title XIX Increased FFP (4260-101-0890)
COVID-19 Title XIX GF (4260-101-0001)

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 123
IMPLEMENTATION DATE: 4/2004
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 78

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$274,979,000	$249,637,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$274,979,000	$249,637,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$274,979,000	$249,637,000

Purpose:
This policy change estimates the outpatient supplemental payments based on certified public expenditures (CPEs) for providing outpatient hospital care to Medi-Cal members.

Authority:
AB 915 (Chapter 747, Statutes of 2002)
State Plan Amendment (SPA) 02-018
SPA 16-019
SPA 22-0060
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

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.

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

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS
REGULAR POLICY CHANGE NUMBER: 123

availability through the last day of the calendar quarter of the national public health emergency (PHE).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to:

- FY 2013-14 and FY 2018-19 LAC Final Reconciliations shifted to Date of Payment (DOP) FY 2024-25.
- FY 2018-19 Non-LAC Final Reconciliations shifted to DOP FY 2024-25.
- Revised FY 2021-22 Calendar Year Interim Payments based on updated data.
- Revised FY 2022-23 Interim Payments based on updated data.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to:

- Higher volume of final reconciliations are expected to occur in FY 2024-25 compared to FY 2023-24.

Methodology:

1. Payments of $274,979,000 and $249,637,000 are expected to be made in FY 2023-24 and FY 2024-25 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 2023-24.
   - Final reconciliations for LAC hospitals will be on a separate timeline from non-LAC hospitals.

3. The ACA allows for 100% FMAP for calendar years 2014 through 2016, for newly eligible Medi-Cal members. Beginning calendar year 2017, the ACA allows for the following FMAPs: 95% beginning on January 1, 2017, 94% beginning on January 1, 2018, 93% beginning on January 1, 2019, and 90% beginning on January 1, 2020.

4. Traditional and ACA claims are processed separately. Payments are based on CPE claims and ACA claims which are adjusted based on the FMAP methodology described above. FY 2022-23 and FY 2023-24 Traditional and ACA claims are estimated based on FY 2021-22 actuals that further adjusted the estimated percentage change in the Consumer Price Index for all Urban Consumers (CPI-U) for outpatient hospital services and an additional 5% increase.

5. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 123

FY 2023-24	TF	FF	ACA	COVID-19 FF
FY 2011-12 (LAC only Final Rec)	($2,991,000)	($2,991,000)	$0	$0
FY 2016-17 (Non LAC only Final Rec)	($3,329,000)	($1,822,000)	($1,507,000)	$0
FY 2017-18 (Non LAC only Final Rec)	($8,955,000)	($4,806,000)	($4,149,000)	$0
FY 2021-22 (Calendar Year) Interim Payments	$1,082,000	$618,000	$387,000	$77,000
FY 2022-23 Interim Payments	$289,172,000	$138,701,000	$134,103,000	$16,368,000
Total	**$274,979,000**	**$129,700,000**	**$128,834,000**	**$16,445,000**

FY 2024-25	TF	FF	ACA	COVID-19 FF
FY 2004-05 (Non LAC Final Rec)	($17,020,000)	($17,020,000)	$0	$0
FY 2005-06 (Non LAC Final Rec)	($26,885,000)	($26,885,000)	$0	$0
FY 2013-14 (LAC only Final Rec)	$1,880,000	$1,201,000	$679,000	$0
FY 2015-16 (Non LAC Final Rec)	($6,387,000)	($3,731,000)	($2,656,000)	$0
FY 2015-16 (LAC only Final Rec)	($1,304,000)	($568,000)	($736,000)	$0
FY 2018-19 (Non LAC only Final Rec)	($3,427,000)	($1,851,000)	($1,576,000)	$0
FY 2018-19 (LAC only Final Rec)	($696,000)	($254,000)	($442,000)	$0
FY 2022-23 (Calendar Year) Interim Payments	$1,188,000	$679,000	$425,000	$84,000
FY 2023-24 Interim Payments	$302,288,000	$152,432,000	$147,378,000	$2,478,000
Total	**$249,637,000**	**$104,003,000**	**$143,072,000**	**$2,562,000**

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

FFP FOR LOCAL TRAUMA CENTERS

REGULAR POLICY CHANGE NUMBER: 124
IMPLEMENTATION DATE: 2/2006
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 104

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$138,083,000	$182,729,000
- STATE FUNDS	$56,411,000	$81,670,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$138,083,000	$182,729,000
STATE FUNDS	$56,411,000	$81,670,000
FEDERAL FUNDS	$81,672,000	$101,059,000

Purpose:
This policy change estimates the supplemental reimbursement to specific hospitals that provide trauma care to Medi-Cal beneficiaries, through the use of Intergovernmental Transfers (IGTs).

Authority:
Welfare & Institutions Code, Sections 14164 and 14087.3
SPA 03-032
SPA 22-0026
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
This program allows Los Angeles and Alameda counties to submit IGTs used as the non-federal share of costs to draw down Title XIX federal funds. The Department uses the IGTs matched with the federal funds to make supplemental payments to specified hospitals for the costs of trauma care center services provided to Medi-Cal beneficiaries.

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

FFP FOR LOCAL TRAUMA CENTERS
REGULAR POLICY CHANGE NUMBER: 124

- 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:
The change in FY 2023-24, from the prior estimate, is due to:
- FY 2022-23 payments and ACA adjustments decreased due to updated estimates from counties.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to:
- Higher estimated payments and ACA adjustments to occur in FY 2024-25 as compared to FY 2023-24.

Methodology:
1. IGTs are deposited in the Special Deposit Fund (Local Trauma Centers).

2. ACA allows for 100% Federal Medical Assistance Percentage (FMAP) for calendar years 2014 through 2016, 95% FMAP for calendar year 2017, 94% FMAP for calendar year 2018 and 93% FMAP for calendar year 2019, and 90% for calendar year 2020 for newly eligible Medi-Cal beneficiaries. The ACA methodology has been approved by CMS.

3. ACA payments will be processed nine months after the respective FY's supplemental payments have been issued in order to determine the proportion of the hospital's trauma care costs for newly eligible Medi-Cal beneficiaries. ACA payments for FY 2022-23 will be claimed in FY 2023-24 and ACA payments for FY 2023-24 will be claimed in FY 2024-25. The County will be reimbursed for the nonfederal share, and an adjustment will be made for the federal share processed at the COVID-19 Increased FMAP 56.2% for FY 2022-23 Q1 through Q3; 55% FMAP for FY 2022-23 Q4; 52.5% FMAP for FY 2023-24 Q1; 51.5% FMAP for FY 2023-24 Q2; and 50% FMAP for FY 2023-24 Q3 through Q4.

4. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

FFP FOR LOCAL TRAUMA CENTERS

REGULAR POLICY CHANGE NUMBER: 124

(Dollars in Thousands)

FY 2023-24	TF	Special Deposit Fund	FF	ACA FF	COVID-19 FF	*Return to Counties
FY 2022-23 ACA Adjustment to Counties	$10,167	$0	($14,907)	$26,833	($1,759)	$10,167
FY 2022-23	$127,916	$56,411	$63,958	$0	$7,547	$0
Total FY 2023-24	**$138,083**	**$56,411**	**$49,051**	**$26,833**	**$5,788**	$10,167

(Dollars in Thousands)

FY 2024-25	TF	Special Deposit Fund	FF	ACA FF	COVID-19 FF	*Return to Counties
FY 2023-24 ACA Adjustment to Counties	$16,055	$0	($20,694)	$37,250	($501)	$16,055
FY 2023-24	$166,674	$81,670	$83,337	$0	$1,667	$0
Total FY 2024-25	**$182,729**	**$81,670**	**$62,643**	**$37,250**	**$1,166**	$16,055

*The Return to Counties column is for display purposes only (see Methodology #3).

Funding:
100% Local Trauma Centers Fund (4260-601-0942142)
50% Local Trauma Centers Fund / 50% Title XIX FF (4260-601-0942142) / (4260-101-0890)
100% Title XIX ACA (4260-101-0890)
100% Title XIX FF (4260-101-0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)

MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 125
IMPLEMENTATION DATE: 11/2015
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 1899

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$119,735,000	$119,017,000
- STATE FUNDS	$49,976,000	$50,229,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$119,735,000	$119,017,000
STATE FUNDS	$49,976,000	$50,229,000
FEDERAL FUNDS	$69,759,000	$68,788,000

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
SPA 18-0021
SPA 21-0012
SPA 23-0017 (Pending Center for Medicare & Medicaid Services (CMS) Approval)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

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 fiscal year MLK-LA opens through FY 2016-17, the non-federal share of a guaranteed level (minimum payment level) of 77% of the total Medi-Cal FFS inpatient projected cost. If current Medi-Cal private hospital reimbursement methods result in funding that is less than 77% of the Medi-Cal FFS inpatient projected costs, GF appropriations are required to fund the non-federal share of the additional payments up to the 77% of costs.

Beginning FY 2017-18, and subsequent fiscal years, this GF obligation is reduced to 72% of projected Medi-Cal FFS costs. If current Medi-Cal private hospital reimbursement methods

MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS
REGULAR POLICY CHANGE NUMBER: 125

result in funding that is less than 72% of the Medi-Cal FFS inpatient projected costs, the GF will be required to fund the non-federal share of the additional payments up to 72% of the costs.

In order to enable reimbursement for the MLK-LA to reach 100% of the FFS inpatient projected costs, the remaining non-federal share amounts may be transferred by the County of Los Angeles via voluntary intergovernmental transfers (IGTs). Any public funds transferred shall be expended solely for the non-federal share of the supplemental payment. Additionally, the Department shall seek further federal approval to enable MLK-LA to receive Medi-Cal supplemental payments to the extent necessary to meet minimum funding requirements. Further reimbursement exceeding the 100% minimum funding requirement may be sought through additional supplemental programs upon federal approval.

State Plan Amendment (SPA) 18-0021 capped payments at $115.2 million effective July 1, 2018. SPA 21-0012, which was approved by 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 is pending CMS approval, proposes to reduce 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.

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.

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 125

Reason for Change:

The change in FY 2023-24, from the prior estimate, is due to:

- Updated FY 2022-23 interim reconciliations based on updated data, and
- Updated FY 2020-21 final reconciliations based on updated data.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to:

- Updated interim and final reconciliations, and
- Updated ACA payment data based on updated data.

Methodology:

1. Medi-Cal certification approval is retroactive to the effective date of June 30, 2015.

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 2023-24 and FY 2024-25.

5. Expenditures for FY 2023-24 and FY 2024-25 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 2023-24 and FY 2024-25, the supplemental payments and DRG add-on payments are limited by the payment cap of $116.8 million (pending CMS approval). FY 2023-24 and FY 2024-25 supplemental payments are estimated to be $100 million.

8. The ACA supplemental payments will be processed nine months after the respective FY's supplemental payments have been issued in order to determine the proportion of the costs for newly eligible Medi-Cal beneficiaries. FY 2022-23 ACA supplemental payments will be claimed in FY 2023-24. For FY 2023-24, the ACA payment will be claimed in FY 2024-25. The County will be reimbursed for the IGT (non-federal share), and an adjustment will be made for the federal share processed at the regular 50% FMAP, including FFCRA increased FMAPs of 6.2%, 5%, 2.5%, and 1.5% when applicable. Beginning January 1, 2017, the ACA optional population FMAP is 95%, and reduces to 94% beginning January 1, 2018, and reduces again to 93% beginning January 1, 2019, and further reduces to 90% beginning January 1, 2020. CMS approved the ACA supplemental payment methodology in August 2017.

9. Managed care costs for MLK-LA are reflected in the Retro MC Rate Adjustment policy change.

10. The Title XIX COVID-19 increased FMAP is assumed for expenditures through

MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS
REGULAR POLICY CHANGE NUMBER: 125

December 31, 2023 for this policy change.

11. On a cash basis, costs in FY 2023-24 and FY 2024-25 are expected to be:

(Dollars in Thousands)

FY 2023-24	TF	GF	IGT*	FF	ACA FF	COVID-19 FF	Return to County**
Supplemental FY 2023-24	$100,000	$0	$49,000	$50,000	$0	$1,000	$0
Supplemental ACA FY 2022-23	$16,026	$0	$0	($23,500)	$42,300	($2,774)	$16,026
Interim Reconciliation FY 2022-23	$3,699	$1,026	$0	$962	$1,598	$113	$0
Final Reconciliation FY 2020-21	$10	$27	($77)	($76)	$145	($9)	$0
Total	**$119,735**	**$1,053**	**$48,923**	**$27,386**	**$44,043**	**($1,670)**	$16,026

(Dollars in Thousands)

FY 2024-25	TF	GF	IGT*	FF	ACA FF	COVID-19 FF	Return to County**
Supplemental FY 2024-25	$100,000	$0	$50,000	$50,000	$0	$0	$0
Supplemental ACA FY 2023-24	$18,498	$0	$0	($23,500)	$42,300	($302)	$18,498
Interim Reconciliation FY 2023-24	$261	$79	$0	$68	$113	$1	$0
Final Reconciliation FY 2021-22	$258	$150	$0	$183	($98)	$23	$0
Total	**$119,017**	**$229**	**$50,000**	**$26,751**	**$42,315**	**($278)**	$18,498

**The Return to County column is for display purposes only (see methodology #8)

MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 125

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)

DPH PHYSICIAN & NON-PHYS. COST

REGULAR POLICY CHANGE NUMBER: 126
IMPLEMENTATION DATE: 5/2008
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1078

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$113,695,000	$92,801,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$113,695,000	$92,801,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$113,695,000	$92,801,000

Purpose:
This policy change estimates the payments to Designated Public Hospitals (DPHs) for the uncompensated costs of their physician and non-physician practitioner professional services.

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.35
Welfare & Institutions Code 14166.4
State Plan Amendment (SPA) 05-023
SPA 16-020
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

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
REGULAR POLICY CHANGE NUMBER: 126

Medi-Cal beneficiaries who are patients of the hospital or its affiliated hospital and non-hospital settings. Each DPH's physician and non-physician costs will be reconciled 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.

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to:

- The FY 2012-13 through FY 2019-20 final reconciliations for a portion of non-LA County DPHs have been shifted from FY 2022-23 to FY 2023-24,
- The FY 2013-14 and FY 2018-9 final reconciliations for LA County DPHs have been shifted from FY 2023-24 to FY 2024-25, and
- Final reconciliations, interim reconciliations, and interim payment amounts for all DPHs estimated to occur in FY 2023-24 have been updated based on revised payment calculations.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to:

- Fluctuations in the number of reconciliations and amounts each year, and
- A decrease in COVID-19 increased FMAP due to no COVID-19 increased FMAP in FY 2024-25 interim payments.

Methodology:
1. One annual interim payment is expected to occur for all DPHs for in quarter 4 of each FY for the respective fiscal year.

DPH PHYSICIAN & NON-PHYS. COST
REGULAR POLICY CHANGE NUMBER: 126

2. Interim reconciliations of program years are anticipated to be completed upon receipt of the Physician/Non-Physician Practitioner time studies and the filed cost report information which are required components of the reconciliation process.

3. The ACA optional population supplemental payment methodology was approved by CMS on August 17, 2021 and first time ACA payments were issue in FY 2021-22 Quarter 2. ACA payments will be retroactive to January 1, 2014. The ACA allows for 100% FMAP for calendar years (CYs) 2014 through 2016, 95% FMAP for CY 2017, 94% FMAP for CY 2018, 93% FMAP for CY 2019, and 90% FMAP for CY 2020 and after for newly eligible Medi-Cal beneficiaries.

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 expenditures through December 31, 2023 for this policy change.

FY 2023-24	TF	FF	ACA FF	COVID-19 FF
FY 2005-06 Final Reconciliation	($2,070,000)	($2,070,000)	$0	$0
FY 2006-07 Final Reconciliation	($2,032,000)	($2,032,000)	$0	$0
FY 2007-08 Final Reconciliation	($12,750,000)	($12,750,000)	$0	$0
FY 2008-09 Final Reconciliation	$7,569,000	$7,569,000	$0	$0
FY 2011-12 Final Reconciliation	($1,446,000)	($1,446,000)	$0	$0
FY 2012-13 Final Reconciliation	($10,613,000)	($10,613,000)	$0	$0
FY 2013-14 Final Reconciliation	($3,616,000)	($3,611,000)	($5,000)	$0
FY 2014-15 Final Reconciliation	($2,011,000)	($2,013,000)	$2,000	$0
FY 2015-16 Final Reconciliation	($861,000)	($860,000)	($1,000)	$0
FY 2016-17 Final Reconciliation	$5,302,000	$5,302,000	$0	$0
FY 2017-18 Final Reconciliation	$779,000	$920,000	($141,000)	$0
FY 2018-19 Final Reconciliation	$712,000	$864,000	($152,000)	$0
FY 2019-20 Final Reconciliation	$8,215,000	$7,623,000	$119,000	$473,000
FY 2021-22 Interim Reconciliation	$57,336,000	($11,561,000)	$70,331,000	($1,434,000)
FY 2023-24 Interim Payment	$69,181,000	$68,306,000	$0	$875,000
Total	**$113,695,000**	**$43,628,000**	**$70,153,000**	**($86,000)**

DPH PHYSICIAN & NON-PHYS. COST

REGULAR POLICY CHANGE NUMBER: 126

FY 2024-25	TF	FF	ACA FF	COVID-19 FF
FY 2009-10 Final Reconciliation	($1,386,000)	($1,386,000)	$0	$0
FY 2010-11 Final Reconciliation	($6,507,000)	($6,507,000)	$0	$0
FY 2011-12 Final Reconciliation	($1,585,000)	($1,585,000)	$0	$0
FY 2012-13 Final Reconciliation	($3,079,000)	($3,079,000)	$0	$0
FY 2013-14 Final Reconciliation	($5,178,000)	($4,890,000)	($288,000)	$0
FY 2014-15 Final Reconciliation	($15,583,000)	($8,459,000)	($7,124,000)	$0
FY 2018-19 Final Reconciliation	($3,177,000)	($1,355,000)	($1,822,000)	$0
FY 2022-23 Interim Reconciliation	$60,990,000	($8,355,000)	$70,331,000	($986,000)
FY 2024-25 Interim Payment	$68,306,000	$68,306,000	$0	$0
Total	**$92,801,000**	**$32,690,000**	**$61,097,000**	**($986,000)**

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)

NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 127
IMPLEMENTATION DATE: 10/2013
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 1600

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$108,900,000	$78,610,000
- STATE FUNDS	$43,198,000	$34,905,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$108,900,000	$78,610,000
STATE FUNDS	$43,198,000	$34,905,000
FEDERAL FUNDS	$65,702,000	$43,705,000

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
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
AB 113 established a NDPH supplemental payment program funded by intergovernmental transfers (IGTs). AB 113 authorizes the State to retain 9% of each IGT to reimburse the administrative costs of operating the program and for the benefit of Medi-Cal children's health programs. This policy change also reflects the portion of the 9% that is used to offset General Fund (GF) costs of Medi-Cal children's health services.

SPA 16-015 was approved by the Centers for Medicare & Medicaid Services (CMS) on July 20, 2016, to allow for an interim IGT payment in the event that an Upper Payment Limit (UPL) has not been finalized by CMS by April 1st of each State fiscal year.

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).

NDPH IGT SUPPLEMENTAL PAYMENTS
REGULAR POLICY CHANGE NUMBER: 127

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to:

- FY 2022-23 Affordable Care Act (ACA) adjustment shifted to a payment finalization, as the FY 2022-23 UPL was not approved when interim payments were issued; therefore, FY 2022-23 interim payments will be reconciled to the approved FY 2022-23 UPL;
- FY 2022-23 General Fund transfer for the benefit of Children's Services updated based on approved SFY 2022-23 UPL room.
- FY 2023-24 interim payments updated based on approved SFY 2022-23 UPL room.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to:

- Higher payment finalization and interim payment expenditures expected to occur in FY 2023-24 as compared to FY 2024-25.

Methodology:

1. The NDPH IGT supplemental payments program is a formula-based program which depends on the UPL's available room. The available room is then applied to the formula to determine the supplemental payments, the administrative costs of operating the program, and the benefit of Medi-Cal's children's health programs.

2. The FY 2022-23 UPL was approved by CMS on July 13, 2023, and the FY 2023-24 UPL will be subsequently submitted.

3. ACA allows for 100% FMAP for calendar years 2014 through 2016, for newly eligible Medi-Cal members. The ACA methodology has been approved. Beginning on January 1, 2017, FMAP for the ACA population decreases to 95%, 94% beginning on January 1, 2018, 93% beginning on January 1, 2019, and then 90% beginning on January 1, 2020, for all subsequent years.

4. FY 2022-23 interim supplemental payments were processed using 80% of the approved UPL room from FY 2021-22 which was the last approved UPL at the date of payment. Payment finalizations for FY 2022-23 will occur in FY 2023-24, FY 2023-24 and FY 2024-25 interim payment estimates assume that the respective FY's UPLs will be approved prior to interim supplemental payments being processed. For the purpose of this estimate, FY 2022-23 payment finalizations and FY 2023-24 and FY 2024-25 interim payments were estimated, utilizing the approved UPL room for FY 2022-23.

5. ACA payments will be processed nine months after the respective FY's supplemental payments have been issued in order to determine the proportion of the costs for newly eligible Medi-Cal members. FY 2022-23 ACA supplemental payments will be claimed in FY

NDPH IGT SUPPLEMENTAL PAYMENTS
REGULAR POLICY CHANGE NUMBER: 127

2023-24, and FY 2023-24 ACA supplemental payments will be claimed in FY 2024-25. An adjustment will be made for the federal share processed at the COVID-19 Increased 56.2% FMAP for FY 2022-23 Q1 through Q3, 55% FMAP for FY 2022-23 Q4, 52.5% FMAP for FY 2023-24 Q1, 51.5% FMAP for FY 2023-24 Q2, and 50% FMAP for FY 2023-24 Q3 and Q4.

6. FY 2022-23 2021-22 Children's Services amounts that were collected based on the interim payments for the respective FY will be reconciled to the respective FY's approved UPL room and processed in FY 2023-24. FY 2023-24 Children's Services payments will be processed based on the FY 2023-24 UPL in FY 2024-25.

7. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

8. The estimated NDPH IGT supplemental payments are:

(Dollars in Thousands)

FY 2023-24	TF	GF	IGT	FF	ACA	COVID-19 FF	***Return to NDPHs
FY 2022-23 Payment Finalization	$40,078	$0	$9,979	$8,755	$20,311	$1,033	$0
FY 2022-23 Children's Services (Est.)	($987)	($2,218)	$1,231	$0	$0	$0	$0
FY 2023-24 Interim Payments	$69,809	$0	$34,206	$34,905	$0	$698	$0
Total FY 2023-24	**$108,900**	**($2,218)**	**$45,416**	**$43,660**	**$20,311**	**$1,731**	$0

(Dollars in Thousands)

FY 2024-25	TF	GF	IGT	FF	ACA	COVID-19 FF	***Return to NDPHs
FY 2023-24 ACA Adjustments	$8,801	$0	$0	($11,284)	$20,311	($226)	$8,801
FY 2023-24 Children's Services (Est.)	$0	($2,447)	$2,447	$0	$0	$0	$0
FY 2024-25 Interim Payments	$69,809	$0	$34,905	$34,904	$0	$0	$0
Total FY 2024-25	**$78,610**	**($2,447)**	**$37,352**	**$23,620**	**$20,311**	**($226)**	$8,801

***The Return to NDPHs column is for display purposes only.

Funding:
100% GF (4260-101-0001)
100% Title XIX ACA (4260-101-0890)
100% MIPA (4260-606-0834)
COVID-19 Title XIX Increased FFP (4260-101-0890)

NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 128
IMPLEMENTATION DATE: 2/2023
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 2185

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$105,000,000	$105,000,000
- STATE FUNDS	$51,450,000	$52,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$105,000,000	$105,000,000
STATE FUNDS	$51,450,000	$52,500,000
FEDERAL FUNDS	$53,550,000	$52,500,000

Purpose:
This policy change (PC) estimates the cost of the Non-Hospital 340B Clinics Supplemental Payment Pool.

Authority:
Welfare & Institutions Code Section 14105.467
SPA 21-0015
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Change:
Not Applicable

Background:
On January 7, 2019, the Governor issued Executive Order N-01-19, which required the Department to transition Medi-Cal pharmacy from Managed Care (MC) to Fee-for-Service (FFS) through Medi-Cal Rx. The Medi-Cal Rx Assumption of Operations (AOO) began January 1, 2022.

Non-hospital 340B clinics that previously received reimbursement from MC plans for pharmacy services now bill Medi-Cal at their acquisition cost, which has resulted in cost savings to the State. To mitigate the revenue impact to these 340B clinics, the Department has created a supplemental payment pool.

Supplemental payments are provided to non-hospital 340B clinics. These payments support their overall safety net services that might otherwise be limited or eliminated due to the change in billing to a FFS delivery system.

Per Welfare and Institution Code Section 14105.467, the Department convened a stakeholder workgroup to develop the methodology for the distribution of supplemental pool payments to qualifying non-hospital 340B community clinics. The workgroup topics include the eligibility criteria for receipt of supplemental payments, the aggregate amount of pool funding available in

NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS
REGULAR POLICY CHANGE NUMBER: 128

a respective fiscal year, and the criteria for apportioning the pool funding among qualifying non-hospital 340B community clinics including the timing, frequency, and amount of the resultant supplemental payments.

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

This PC is part of the carve-out effort transitioning MC pharmacy services to FFS delivery system. The PCs related to Medi-Cal Rx are:

<u>Regular</u>

- Medical Supply Rebates
- Non-Hospital 340B Clinic Supplemental Payments

<u>Other Admin</u>

- Medi-Cal Rx – Administrative Costs

Reason for Change:
There is no change in FY 2023-24, from the prior estimate.

There is no change from FY 2023-24 to FY 2024-25, in the current estimate, for the total funds (TF). The change in the General Fund (GF) share is due to COVID-19 increased FMAP is not assumed in FY 2024-25.

Methodology:

1. The estimated Non-hospital 340B Clinic Supplemental Payment Pool annual cost is $105,000,000 TF.

2. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS
REGULAR POLICY CHANGE NUMBER: 128

(Dollars in Thousands)

Annual	TF	GF	FF
Non-hospital 340B Clinic Supplemental Payments	$105,000	$52,500	$52,500
Total	**$105,000**	**$52,500**	**$52,500**

3. The estimated cost in both FY 2023-24 and FY 2024-25 is $105,000,000 TF.

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
Non-hospital 340B Clinic Supplemental Payments	$105,000	$51,450	$53,550
Total	**$105,000**	**$51,450**	**$53,550**

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
Non-hospital 340B Clinic Supplemental Payments	$105,000	$52,000	$52,000
Total	**$105,000**	**$52,000**	**$52,000**

Funding:
(Dollars in Thousands)

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF	$105,000	$52,500	$52,500
COVID-19 Title XIX Increased FMAP	$0	($1,050)	$1,050
Total	**$105,000**	**$51,450**	**$53,550**

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF	$105,000	$52,500	$52,500
Total	**$105,000**	**$52,000**	**$52,000**

CAPITAL PROJECT DEBT REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 129
IMPLEMENTATION DATE: 7/1991
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 82

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$94,594,000	$84,513,000
- STATE FUNDS	$23,568,000	$23,344,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$94,594,000	$84,513,000
STATE FUNDS	$23,568,000	$23,344,500
FEDERAL FUNDS	$71,026,000	$61,168,500

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
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

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.

CAPITAL PROJECT DEBT REIMBURSEMENT
REGULAR POLICY CHANGE NUMBER: 129

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is a net decrease, due to:
For hospitals (SB 1732):

- Updated interim payment amounts for FY 2022-23 and FY 2023-24 based on more recent data;
- Updated FY 2021-22 ACA adjustment amounts based on actuals;
- Updated FY 2020-21 interim reconciliation amounts based on more recent data;
- FY 1989-90 through FY 2019-20 final reconciliation shifted from FY 2022-23 to FY 2023-24.

For DP-NFs (SB 1128):

- Updated FY 2021-22 and FY 2022-23 interim payment amounts based on more recent data.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is a net decrease, due to:
For hospitals (SB 1732):

- Increased interim payment and interim reconciliation expenditures occurring in FY 2023-24 compared to FY 2024-25.

For DP-NFs (SB 1128):

- Increased interim payment expenditures are estimated in FY 2023-24 compared to FY 2024-25.

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.

CAPITAL PROJECT DEBT REIMBURSEMENT
REGULAR POLICY CHANGE NUMBER: 129

2. The ACA allows for 100% FMAP for calendar years (CY) 2014 through 2016, 95% FMAP for CY 2017, 94% FMAP for CY 2018, 93% for CY 2019, and 90% for CY 2020 and after, for newly eligible Medi-Cal members.

3. For SB 1732, ACA payments will be processed one year after the respective FY has closed in order to determine the proportion of the hospital's costs for newly eligible Medi-Cal members. FY 2021-22 and FY 2022-23 ACA supplemental payments will be claimed in FY 2023-24 and FY 2024-25, respectively. The General Fund (GF) will be reimbursed for the non-federal share, and an adjustment will be made for the federal share processed at the FFCRA 56.2% FMAP FY 2021-22 through FY 2022-23 Q3 and at the FFCRA 55% FMAP for FY 2022-23 Q4.

4. For SB 1732, capital projects funded by new debt for which final plans were submitted to the Office of the Statewide Architect and the Office of Statewide Health Planning and Development after September 1, 1988, and prior to June 30, 1994, are eligible for this program.

   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 Medicaid Utilization Ratio (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.

5. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

CAPITAL PROJECT DEBT REIMBURSEMENT
REGULAR POLICY CHANGE NUMBER: 129

6. The estimated payments on a cash basis are:

FY 2023-24	TF	GF	FF	COVID-19 FF	ARRA	ACA
Hospitals (SB 1732)						
Interim Payment						
FY 2022-23	$49,260,000	$21,932,000	$24,630,000	$2,698,000	$0	$0
FY 2023-24	$33,480,000	$16,090,000	$16,740,000	$650,000	$0	$0
ACA Adjustment						
FY 2021-22	$0	($12,430,000)	($18,388,000)	($2,280,000)	$0	$33,098,000
Interim Reconciliation						
FY 2020-21	$2,265,000	$618,000	$579,000	$72,000	$0	$996,000
Final Reconciliation Adjustment						
FY 1989-90 to FY 2019-20	($5,633,000)	($2,642,000)	($2,836,000)	($3,000)	($148,000)	($4,000)
DP-NF (SB 1128)						
Interim Payment						
FY 2021-22	$190,000	$0	$169,000	$21,000	$0	$0
FY 2022-23	$15,032,000	$0	$13,443,000	$1,589,000	$0	$0
Total FY 2023-24	**$94,594,000**	**$23,568,000**	**$34,337,000**	**$2,747,000**	**($148,000)**	**$34,090,000**

CAPITAL PROJECT DEBT REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 129

FY 2024-25	TF	GF	FF	COVID-19 FF	ARRA	ACA
Hospitals (SB 1732)						
Interim Payment						
FY 2023-24	$44,755,000	$22,335,000	$22,378,000	$42,000	$0	$0
FY 2024-25	$29,580,000	$14,790,000	$14,790,000	$0	$0	$0
ACA Adjustment						
FY 2022-23	$0	($12,780,000)	($18,633,000)	($2,127,000)	$0	$33,540,000
Interim Reconciliation						
FY 2021-22	($3,748,000)	($932,000)	($824,000)	($102,000)	$0	($1,890,000)
Final Reconciliation						
FY 2003-04 to FY 2021-22	($212,000)	($69,000)	($103,000)	$0	($40,000)	$0
DP-NF (SB 1128)						
Interim Payment						
FY 2022-23	$231,000	$0	$210,000	$21,000	$0	$0
FY 2023-24	$13,907,000	$0	$13,630,000	$277,000	$0	$0
Total FY 2024-25	**$84,513,000**	**$23,344,000**	**$31,448,000**	**($1,889,000)**	**($40,000)**	**$31,650,000**

Funding:
100% Title XIX (4260-101-0890)
50% Title XIX Capital Debt FFP / 50% GF (4260-102-0001/0890)
100% GF Capital Debt (4260-102-0001)
100% Title XIX Capital Debt FFP (4260-102-0890)
100% Title XIX ACA (4260-101-0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)

PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 130
IMPLEMENTATION DATE: 1/2018
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2049

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$712,573,000	$788,662,000
- STATE FUNDS	$279,992,250	$315,198,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	88.51 %	89.21 %
APPLIED TO BASE		
TOTAL FUNDS	$81,874,600	$85,096,600
STATE FUNDS	$32,171,110	$34,009,860
FEDERAL FUNDS	$49,703,530	$51,086,770

Purpose:
This policy change estimates the expenditures related to providing supplemental payments for specific dental services.

Authority:
Families First Coronavirus Response Act (FFCRA)
Budget Act of 2021
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Proposition 56 Funding

Background:
The California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56, 2016), increased the excise tax rate on cigarettes and tobacco products and allocates a portion of the tobacco tax revenue to the Department for use as the non-federal share of health care expenditures, subject to appropriation by the Legislature.

The Budget Act of 2017 allocated Proposition 56 funds for supplemental payments for dental services. The Legislature has continued this funding in subsequent budget acts.

These supplemental payments for specific dental categories include restorative, endodontic, prosthodontic, oral and maxillofacial, adjunctive, orthodontic, periodontal, preventative and visits and diagnostic services. For FY 2018-19 and FY 2019-20, the supplemental payment rates for the existing categories remain at a rate equal to 40 percent of the Schedule of Maximum Allowances (SMA). Effective July 1, 2018, SB 840 appropriated additional funds to allow for an increase in supplemental payments ranging from 20-60% and specified dollar amounts for specific procedures, and the addition of other dental procedures.

This policy change identifies the use of the General Fund for these Proposition 56 payments. See the Proposition 56 Funding policy change for the Proposition 56 offset to the GF.

PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 130

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due to higher check write and managed care cost projections. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to updated managed care rates and check write projections.

Methodology:

1. Payments are made via supplemental payments.

2. This policy was effective on July 1, 2017. Beginning July 1, 2018, the Department made changes to add additional procedures and changed the supplemental amount for specific procedures.

3. Supplemental payments are either a percentage of the Dental SMA or a flat rate.

4. The 2.5% Title XIX and 1.75% Title XXI FFCRA increased FMAP is assumed for expenditures through September 30, 2023. The 1.5% Title XIX and 1.05% Title XXI FFCRA increased FMAP is assumed for expenditures through December 31, 2023, in this policy change.

5. Funds allocated for the supplemental payments are as follows:

PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 130

FY 2023-24	TF	SF	FF
Fee-for-Service			
50% Title XIX / 50% GF	$398,045,000	$199,022,000	$199,022,000
ACA 90% FFP/10% GF	$175,591,000	$17,559,000	$158,032,000
Title 21 65% FFP/35% GF	$70,086,000	$24,530,000	$45,556,000
UIS 100% State GF	$27,027,000	$27,027,000	$0
COVID-19 Tile XIX Increased FMAP	$0	($3,758,000)	$3,758,000
COVID-19 Tile XXI Increased FMAP	$0	($484,000)	$484,000
Total Fee-for-Service	**$670,749,000**	**$263,896,000**	**$406,852,000**
FY 2023-24	**TF**	**SF**	**FF**
Dental Managed Care			
50% Title XIX / 50% GF	$23,262,000	$11,631,000	$11,631,000
ACA 90% FFP/10% GF	$13,490,000	$1,349,000	$12,141,000
Title 21 65% FFP/35% GF	$2,623,000	$918,000	$1,705,000
UIS 100% State GF	$2,448,000	$2,448,000	$0
COVID-19 Tile XIX Increased FMAP	$0	($233,000)	$233,000
COVID-19 Tile XXI Increased FMAP	$0	($18,000)	$18,000
Total Dental Managed Care	**$41,823,000**	**$16,095,000**	**$25,728,000**
Combined FY 2023-24			
50% Title XIX / 50% GF	$421,308,000	$210,654,000	$210,654,000
ACA 90% FFP/10% GF	$189,081,000	$18,908,000	$170,173,000
Title 21 65% FFP/35% GF	$72,709,000	$25,448,000	$47,261,000
UIS 100% State GF	$29,475,000	$29,475,000	$0
COVID-19 Tile XIX Increased FMAP	$0	($3,991,000)	$3,991,000
COVID-19 Tile XXI Increased FMAP	$0	($502,000)	$502,000
Grand Total	**$712,573,000**	**$279,992,000**	**$432,581,000**

PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 130

FY 2024-25	TF	SF	FF
Fee-for-Service			
50% Title XIX / 50% GF	$441,446,000	$220,723,000	$220,723,000
ACA 90% FFP/10% GF	$193,927,000	$19,393,000	$174,535,000
Title 21 65% FFP/35% GF	$78,079,000	$27,328,000	$50,752,000
UIS 100% State GF	$30,141,000	$30,141,000	$0
Total Fee-for-Service	**$743,593,000**	**$297,585,000**	**$446,010,000**
FY 2024-25	**TF**	**SF**	**FF**
Dental Managed Care			
50% Title XIX / 50% GF	$25,068,000	$12,534,000	$12,534,000
ACA 90% FFP/10% GF	$14,538,000	$1,454,000	$13,084,000
Title 21 65% FFP/35% GF	$2,826,000	$989,000	$1,837,000
UIS 100% State GF	$2,636,000	$2,636,000	$0
Total Dental Managed Care	**$45,068,000**	**$17,613,000**	**$27,455,000**
Combined FY 2024-25			
50% Title XIX / 50% GF	$466,515,000	$233,257,000	$233,258,000
ACA 90% FFP/10% GF	$208,464,000	$20,846,000	$187,618,000
Title 21 65% FFP/35% GF	$80,906,000	$28,317,000	$52,589,000
UIS 100% State GF	$32,777,000	$32,777,000	$0
Grand Total	**$788,662,000**	**$315,197,000**	**$473,465,000**

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)
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)

CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS

REGULAR POLICY CHANGE NUMBER: 131
IMPLEMENTATION DATE: 6/2002
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 86

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$57,687,000	$53,799,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$57,687,000	$53,799,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$57,687,000	$53,799,000

Purpose:
This policy change estimates federal financial participation (FFP) payments based on Certified Public Expenditures (CPE) to nursing facilities (NF) that are distinct parts (DP) of acute care hospitals that are owned or operated by a public entity.

Authority:
AB 430 (Chapter 171, Statutes of 2001)
State Plan Amendment (SPA) 01-022
SPA 12-021
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

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 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).

CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS

REGULAR POLICY CHANGE NUMBER: 131

ABX2 1 (Chapter 3, Statutes of 2016) prohibits the Department from seeking to retroactively implement certain Medi-Cal provider base payment reductions and limitations with regards to reimbursements for services provided by skilled nursing facilities that are distinct parts of general acute care hospitals for dates of service on or after June 1, 2011, and on or before September 30, 2013, and from seeking to recoup overpayments of the base rate. This prohibition does not apply to supplemental payments for skilled nursing services nor the recoupment of such supplemental funds.

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:

The change in FY 2023-24, from the prior estimate, is a net decrease, due to:

- Addition of RY 2015-16 final reconciliation recoupments, RY 2020-21 interim payments, and RY 2021-22 interim payments.
- RY 2018-19 final reconciliations revised based on updated data.
- RY 2021-22 interim reconciliation revised based on updated data.
- RY 2022-23 and 2023-24 interim payments revised based on updated data.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is a net decrease, due to:

- Delayed final reconciliations and interim payments for prior FYs anticipated to occur in FY 2023-24 compared to FY 2024-25.

Methodology:

1. Expenditures may receive the applicable FMAP based on date of service, such as DP-NF payments when Medi-Cal draws the federal funds in a subsequent fiscal year.

2. The reconciliation, against audited cost reports, started in FY 2010-11. This process is mandated by the Office of Inspector General (OIG) Audit (A-09-05-00050) for fiscal years subsequent to the audit year 2003-04. Scheduled interim payments and reconciliation payments are represented below.

3. ACA allows for 100% FMAP for calendar years 2014 through 2016, for newly eligible Medi-Cal members. Beginning calendar year 2017, FMAP for ACA population allows for the following: 95% beginning on January 1, 2017, 94% beginning on January 1, 2018, and 93%

CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS
REGULAR POLICY CHANGE NUMBER: 131

beginning January 1, 2019, and 90% beginning on January 1, 2020, and thereafter. The ACA methodology has been approved by CMS.

Assume a portion of the interim ACA payments for the three most recent RYs will occur in each fiscal year.

4. Assume a portion of the interim payments for the three most recent RYs will occur each fiscal year.

5. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

FY 2023-24	TF	Regular FFP	ACA FF	COVID-19 FF
RY 2015/16 Final Reconciliation	($631,000)	($631,000)	$0	$0
RY 2018/19 Final Reconciliation	($3,403,000)	($3,269,000)	($134,000)	$0
RY 2021/22 Interim Reconciliation	$18,800,000	$14,480,000	$2,510,000	$1,810,000
RY 2020/21 Interim Payments	$55,000	$43,000	$7,000	$5,000
RY 2021/22 Interim Payments	$435,000	$342,000	$57,000	$36,000
RY 2022/23 Interim Payments	$22,057,000	$16,836,000	$4,382,000	$839,000
RY 2023/24 Interim Payments	$20,374,000	$16,124,000	$3,995,000	$255,000
Total	**$57,687,000**	**$43,925,000**	**$10,817,000**	**$2,945,000**

FY 2024-25	TF	Regular FFP	ACA FF	COVID-19 FF
RY 2019/20 Final Reconciliation	($3,659,000)	($3,417,000)	($136,000)	($106,000)
RY 2022/23 Interim Reconciliation	$17,221,000	$13,854,000	$2,550,000	$817,000
RY 2023/24 Interim Payments	$20,118,000	$16,124,000	$3,994,000	$0
RY 2024/25 Interim Payments	$20,119,000	$16,124,000	$3,995,000	$0
Total	**$53,799,000**	**$42,685,000**	**$10,403,000**	**$711,000**

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)

STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 132
IMPLEMENTATION DATE: 12/2010
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 1616

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$20,715,000	$21,618,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$20,715,000	$21,618,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$20,715,000	$21,618,000

Purpose:
This policy change estimates the supplemental payments to state veterans' homes.

Authority:
AB 959 (Chapter 162, Statutes of 2006)
State Plan Amendment 06-017
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

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.

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).

STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 132

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to:

- Updated FY 2023-24 interim payments estimates based on updated data.
- Updated FY 2022-23 initial reconciliation estimates based on updated data.
- Updated FY 2020-21 final reconciliations estimates based on updated data.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is a net increase due to:

- Increased interim payments occurring in FY 2024-25.
- Lower initial reconciliations and final reconciliations estimated to occur in FY 2024-25.

Methodology:
Supplemental payments for state veterans' homes began in FY 2010-11 and payments are estimated based on actual historical reported certified expenditures.

The estimate is based on:

1. Interim payments,
2. Initial reconciliation payments,
    a. First time (interim) ACA payments occur during initial reconciliations using as filed cost report data to calculate payments, and;
3. A final reconciliation payment, if necessary.
4. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 132

Program payment amounts are estimated to be:

FY 2023-24	TF	Regular FF	ACA FF	COVID-19 FF
Interim Payments				
FY 2023-24	$15,264,000	$14,979,000	$0	$285,000
Initial Reconciliation				
FY 2022-23	$5,760,000	$3,990,000	$1,299,000	$471,000
Final Reconciliation				
FY 2019-20	($309,000)	($293,000)	$2,000	($18,000)
FY 2023-24 Total	**$20,715,000**	**$18,676,000**	**$1,301,000**	**$738,000**

FY 2024-25	TF	Regular FF	ACA FF	COVID-19 FF
Interim Payments				
FY 2024-25	$16,592,000	$16,592,000	$0	$0
Initial Reconciliation				
FY 2023-24	$5,369,000	$3,990,000	$1,299,000	$80,000
Final Reconciliation				
FY 2020-21	($343,000)	($306,000)	$1,000	($38,000)
FY 2024-25 Total	**$21,618,000**	**$20,276,000**	**$1,300,000**	**$42,000**

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)

GEMT SUPPLEMENTAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 133
IMPLEMENTATION DATE: 4/2014
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 1661

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	-$15,797,000	-$8,733,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$15,797,000	-$8,733,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$15,797,000	-$8,733,000

Purpose:
This policy change estimates the supplemental payments to publicly owned or operated ground emergency medical transportation (GEMT) service providers.

Authority:
AB 678 (Chapter 397, Statutes of 2011)
SB 523 (Chapter 773, Statutes of 2017)
State Plan Amendment (SPA) 09-024
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
A provider that delivers GEMT services to Medi-Cal members will be eligible for supplemental payment under the GEMT Supplemental Payment Program for services if the following requirements are met:

1. The provider must be enrolled as a Medi-Cal provider for the period being claimed, and
2. The provider must be owned or operated by the state, a city, county, city and county, federally recognized Indian tribe, health care district, special district, community services district, or fire protection district.

Supplemental payments combined with other reimbursements cannot exceed 100% of actual costs.

Specified governmental entities will pay the non-federal share of the supplemental reimbursement through certified public expenditures (CPEs). The supplemental reimbursement program is retroactive to January 30, 2010. The Centers for Medicare and Medicaid Services (CMS) approved SPA 09-024 on September 4, 2013. Annual payments are scheduled to be submitted on a lump-sum basis following the State fiscal year.

GEMT SUPPLEMENTAL PAYMENT PROGRAM
REGULAR POLICY CHANGE NUMBER: 133

SPA 18-0007, was submitted to CMS in FY 2018-19, proposes to update the definition of allowable costs to include shared direct costs and to revise the timeline for final settlements. However, as the Department continues to work on SPA 18-0007 approvals, supplemental reimbursements have resumed based on the payment methodologies set forth in the current approved SPA 09-024, which excludes shared direct costs.

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

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.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to:

- FY 2010-11 through FY 2015-16 final reconciliations updated based on actuals.
- FY 2018-19 through FY 2020-21 final reconciliations revised based on updated data.
- FY 2022-23 interim payments revised based on updated data.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to:

- Higher volume of final reconciliations expected to occur in FY 2023-24 compared to FY 2024-25.
- No interim payments expected to occur in FY 2024-25.

GEMT SUPPLEMENTAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 133

Methodology:

1. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's FMAP increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

2. The ACA allows for 100% FMAP for calendar years (CY) 2014 through 2016, 95% FMAP for CY 2017, 94% FMAP for CY 2018, 93% for CY 2019, and 90% for CY 2020 and after for newly eligible Medi-Cal members. The ACA methodology has been approved by CMS.

3. 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.

4. The GEMT CPE reimbursements sunset on December 31, 2022.

5. Interim reconciliations are performed within two years of receipt of the as-filed cost report. Final reconciliations are based on audited cost reports, and the audit and settlement process is completed within three years of the postmark date of the approved cost report. Due to delays in receipt of cost reports, retroactive years are being reconciled in FY 2023-24.

6. SPA 18-0007, when approved, will be retroactive to dates of service beginning July 1, 2018. SPA 18-0007 proposes to expand claimable costs that can be allocated to two or more departmental functions on the basis of shared benefits, for increased GEMT supplemental reimbursement. However, as the Department continues to work on approvals for SPA 18-0007, payments will resume under the current approved SPA 09-024.

7. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

GEMT SUPPLEMENTAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 133

The estimated payments on a cash basis are:

FY 2023-24	Total FFP	Regular FFP	ARRA	ACA	COVID-19 FF
FY 2010-11 Final Recon.	($195,000)	($164,000)	($31,000)	$0	$0
FY 2011-12 Final Recon.	($171,000)	($171,000)	$0	$0	$0
FY 2012-13 Final Recon.	($96,000)	($96,000)	$0	$0	$0
FY 2015-16 Final Recon.	($55,000)	($25,000)	$0	($30,000)	$0
FY 2018-19 Final Recon.	($7,374,000)	($2,475,000)	$0	($4,899,000)	$0
FY 2019-20 Final Recon.	($9,291,000)	($3,261,000)	$0	($5,838,000)	($192,000)
FY 2020-21 Final Recon.	($10,425,000)	($3,729,000)	$0	($6,234,000)	($462,000)
FY 2022-23 Interim Payment	$11,810,000	$4,407,000	$0	$6,857,000	$546,000
Total FY 2023-24	**($15,797,000)**	**($5,514,000)**	**($31,000)**	**($10,144,000)**	**($108,000)**

FY 2024-25	Total FFP	Regular FFP	ACA	COVID-19 FF
FY 2021-22 Final Recon.	($8,733,000)	($3,129,000)	($5,217,000)	($387,000)
Total FY 2024-25	**($8,733,000)**	**($3,129,000)**	**($5,217,000)**	**($387,000)**

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

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH

REGULAR POLICY CHANGE NUMBER: 134
IMPLEMENTATION DATE: 1/2005
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 1038

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$10,000,000	$10,000,000
- STATE FUNDS	$4,900,000	$5,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$10,000,000	$10,000,000
STATE FUNDS	$4,900,000	$5,000,000
FEDERAL FUNDS	$5,100,000	$5,000,000

Purpose:
This policy change estimates the supplemental reimbursement to hospitals providing a disproportionate share of outpatient services.

Authority:
SB 2563 (Chapter 976, Statutes of 1988)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
SB 2563 established a supplemental program for hospitals providing a disproportionate share of outpatient services. The Department calculates payments on a calendar year (CY) basis and reimburses eligible providers on a quarterly basis through a payment action notice (PAN). Each payment represents one quarter of the total annual amount due to each eligible hospital. Due to the payment being made at the end of a quarter, the last quarter of each calendar year will be paid the following calendar year.

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH
REGULAR POLICY CHANGE NUMBER: 134

- 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:
There is no change in FY 2023-24 from the prior estimate.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to a change in FMAP assumptions. The first two payments of FY 2023-24, namely the CY 2023 Q2 and CY 2023 Q3 payments, will be subject to the COVID-19 increased FMAPs. None of the FY 2024-25 payments will be subject to the COVID-19 increased FMAP.

Methodology:
1. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

2. Assume annual reimbursements for disproportionate share of outpatient services are $10,000,000 Total Fund (TF).

FY 2023-24	TF	GF	FF	COVID-19 FF
CY 2023	$7,500,000	$3,650,000	$3,750,000	$100,000
CY 2024	$2,500,000	$1,250,000	$1,250,000	$0
Total	**$10,000,000**	**$4,900,000**	**$5,000,000**	**$100,000**

FY 2024-25	TF	GF	FF
CY 2024	$7,500,000	$3,750,000	$3,750,000
CY 2025	$2,500,000	$1,250,000	$1,250,000
Total	**$10,000,000**	**$5,000,000**	**$5,000,000**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
COVID-19 Title XIX Increased FMAP (4260-101-0001/0890)

EMERGENCY MEDICAL AIR TRANSPORTATION ACT

REGULAR POLICY CHANGE NUMBER: 135
IMPLEMENTATION DATE: 11/2012
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 1612

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$9,272,000	$0
- STATE FUNDS	$3,687,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$9,272,000	$0
STATE FUNDS	$3,687,000	$0
FEDERAL FUNDS	$5,585,000	$0

Purpose:
This policy change estimates the Fee-for-Service (FFS) augmentation payments and the offset of General Fund (GF) expenditures for Medi-Cal emergency medical air transportation service reimbursements.

Authority:
AB 2173 (Chapter 547, Statutes of 2010)
AB 215 (Chapter 392, Statutes of 2011)
AB 1410 (Chapter 718, Statutes of 2017)
AB 651 (Chapter 537, Statutes of 2019)
AB 2450 (Chapter 52, Statutes of 2020)
State Plan Amendment (SPA) 21-0046
AB 1104 (Chapter 476, Statutes of 2021)
AB 2648 (Chapter 440, Statutes of 2022)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023
State Plan Amendment (SPA) 22-0052

Interdependent Policy Changes:
Not Applicable

Background:
AB 2173 (Chapter 547, Statutes of 2010), established a requirement effective January 1, 2011 that a penalty of $4 be assessed by a court for any conviction involving a vehicle violation except certain parking offenses until January 1, 2016 in addition to other existing state penalties. The legislation further required the moneys collected be deposited in a dedicated county fund and then transferred quarterly by the county treasurer to the State Controller. Funds transferred to the Controller were to be deposited in the Emergency Medical Air Transportation Act Transportation Act (EMATA) Fund administered by the Department that remained after any withholding by the county treasurer for an amount sufficient to offset county costs administering the program.

EMERGENCY MEDICAL AIR TRANSPORTATION ACT
REGULAR POLICY CHANGE NUMBER: 135

AB 2173 also established that moneys available in the EMATA Fund were subject to appropriation by the Legislature, including to pay for the Department's administrative costs. 20% of the funds remaining were to be set aside to offset the State's portion of the Medi-Cal reimbursement rate for emergency medical air transportation services. The other 80% of the funds remaining was required to augment reimbursement payments for emergency medical air transportation services made through the Medi-Cal program and submit any SPA or Medicaid waiver to obtain federal matching funds for this purpose.

AB 215 (Chapter 392, Statutes of 2011) repealed the authority for a county to withhold its administrative costs and allowing all monies collected to be remitted to the State under an existing process established by current law at the time. Adopting the existing remittance procedures required an increase in the frequency from quarterly to monthly moneys were be remitted to the EMATA Fund in the State Treasury.

AB 1410 (Chapter 718, Statutes of 2017) subsequently renamed the EMATA Fund to the Emergency Medical Air Transportation and Children's Coverage (EMATCC) Fund, effective January 1, 2018. The bill also made the Fund available for the purpose of providing children's health care coverage and Medi-Cal reimbursements for emergency medical air transportation services not to exceed normal and customary charges charged by the providers AB 1410 also extended the assessment of the $4 penalty for vehicle code violations until January 1, 2020, the deadline to issue supplemental payments to June 30, 2021, and the program's sunset date to January 1, 2022.

AB 651 (Chapter 537, Statutes of 2019) subsequently extended the assessment of the $4 penalty for vehicle code violations until July 1, 2020 the deadline to issue supplemental payments until December 31, 2021, and revised the program's sunset date to July 1, 2022.

AB 2450 (Chapter 52, Statutes of 2020) extended the assessment of the $4 penalty for vehicle code violations until July 1, 2021, the deadline to issue supplemental payments until December 31, 2022, and revised the program's sunset date to July 1, 2024.

On December 8, 2021, the Centers for Medicare & Medicaid Services (CMS) approved SPA 21-0046 to continue augmentation payments for FY 2021-22. The augmentation payment amount is per transport and calculated annually; therefore, a SPA is required annually. SPA 22-0052 has been approved and will continue augmentation payments in FY 2022-23.

AB 1104 (Chapter 476, Statutes of 2021) 1104 extends the $4 penalty assessment for vehicle code violations through December 31, 2022, the deadline to issue supplemental payments to providers through December 31, 2023, and revised the program's sunset date to January 1, 2025.

AB 2648 (Chapter 440, Statutes of 2022) modifies the date in which any remaining unexpended and unencumbered EMATACC funds are to be transferred to the General Fund to June 30, 2024, and revises the sunset date the EMATA program to January 1, 2026.

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).

EMERGENCY MEDICAL AIR TRANSPORTATION ACT

REGULAR POLICY CHANGE NUMBER: 135

The Consolidated Appropriations Act of 2023 was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

The Title XIX and Title XXI COVID-19 increased FMAP is assumed for expenditures through December 31, 2023 for this policy change.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to:

- Revised augment payments in FY 2023-24 based on updated data.
- Delayed payment for FY 2022-23.
- FY 2021-22 and first half of FY 2022-23 ACA recoupment.

There is no change from FY 2023-24 to FY 2024-25 in the current estimate. The completion of closeout activities for the program is in FY 2023-24.

Methodology:

1. Implementation date began November 2012.

2. Assessed penalty to continue to be collected until December 31, 2022.

3. For FY 2023-24 estimated payments include the:
   - FFS augmentation payment for the second half of FY 2022-23
   - FFS augmentation payment for first half of FY 2023-24
   - Delayed payment for FY 2022-23, and
   - ACA Recoupment*.

EMERGENCY MEDICAL AIR TRANSPORTATION ACT
REGULAR POLICY CHANGE NUMBER: 135

4. Based on estimated fee collections, the estimated payments on a cash basis are:

FY 2023-24	TF	GF	EMATCC	FFP	ACA FF**	COVID-19 FF	Return to Special Fund*
FY 2022-23 EMATA Payment	$3,722,000	$1,576,000	$0	$1,947,000	$0	$199,000	$0
Augment Payments	$4,730,000	$0	$2,111,000	$2,365,000	$0	$254,000	$0
EMATA ACA Adjustment to Special Fund	$820,000	$0	$0	($1,697,000)	$2,703,000	($186,000)	$820,000
Total	**$9,272,000**	**$1,576,000**	**$2,111,000**	**$2,615,000**	**$2,703,000**	**$267,000**	**$820,000**

*The Return to Special Fund column is for display purposes only.

Funding:
100% GF (4260-101-0001)
EMATA / EMATCC Fund (4260-101-3168)
Title XIX FFP (4260-101-0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)
COVID-19 Title XIX GF (4260-101-0001)
100% Title XIX ACA (4260-101-0890)**

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH

REGULAR POLICY CHANGE NUMBER: 136
IMPLEMENTATION DATE: 1/2005
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 1039

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$8,000,000	$8,000,000
- STATE FUNDS	$3,920,000	$4,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$8,000,000	$8,000,000
STATE FUNDS	$3,920,000	$4,000,000
FEDERAL FUNDS	$4,080,000	$4,000,000

Purpose:
This policy change estimates the supplemental reimbursement to Small and Rural Hospitals (SRHs) that provide outpatient services.

Authority:
AB 2617 (Chapter 158, Statutes of 2000)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

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 (PAN). Each payment represents one quarter of the total annual amount due to each eligible hospital. Due to the payment being made at the end of a quarter, the last quarter of each calendar year will be paid the following calendar year.

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH
REGULAR POLICY CHANGE NUMBER: 136

- 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:
There is no change in FY 2023-24 from the prior estimate.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to a change in FMAP assumptions. The first two payments of FY 2023-24, namely the CY 2023 Q2 and CY 2023 Q3 payments, will be subject to the COVID-19 increased FMAPs. None of the FY 2024-25 payments will be subject to the COVID-19increased FMAP.

Methodology:
1. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

2. Assume annual reimbursements to SRHs providing outpatient services are $8,000,000 Total Fund (TF).

FY 2023-24	TF	GF	FF	COVID-19 FF
CY 2023	$6,000,000	$2,920,000	$3,000,000	$80,000
CY 2024	$2,000,000	$1,000,000	$1,000,000	$0
Total	**$8,000,000**	**$3,920,000**	**$4,000,000**	**$80,000**

FY 2024-25	TF	GF	FF
CY 2024	$6,000,000	$3,000,000	$3,000,000
CY 2025	$2,000,000	$1,000,000	$1,000,000
Total	**$8,000,000**	**$4,000,000**	**$4,000,000**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
COVID-19 Title XIX Increased FMAP (4260-101-0001/0890)

PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 137
IMPLEMENTATION DATE: 12/2017
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 2044

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$62,132,000	$76,365,000
- STATE FUNDS	$25,585,000	$30,445,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	91.15 %	93.16 %
APPLIED TO BASE		
TOTAL FUNDS	$5,498,700	$5,223,400
STATE FUNDS	$2,264,270	$2,082,440
FEDERAL FUNDS	$3,234,410	$3,140,930

Purpose:
This policy change estimates the expenditures related to supplemental reimbursements under the Family Planning, Access, Care, Treatment (Family PACT) program for the Evaluation and Management (E&M) portion of office visits and medical pregnancy termination services.

Authority:
Proposition 56 (2016)

Interdependent Policy Changes:
Proposition 56 Funding
SPA 17-029
SPA 18-0031
SPA 19-0040
SPA 21-0033

Background:
The California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56, 2016), increased the excise tax rate on cigarettes and tobacco products and allocates a portion of the tobacco tax revenue to the Department for use as the non-federal share of health care expenditures, subject to appropriation by the Legislature.

The Budget Act of 2017 allocated Proposition 56 funds for supplemental payments for supplemental reimbursements under the Family PACT program. The Legislature has continued this funding in subsequent budget acts.

The Centers for Medicare & 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 approved SPA

PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS
REGULAR POLICY CHANGE NUMBER: 137

19-0040, which extended the supplemental reimbursements under Family PACT for the period of July 1, 2019, through December 31, 2021. SPA 21-0033 was submitted to CMS to extend the supplemental reimbursements under Family PACT indefinitely.

This policy change identifies the use of the General Fund (GF) for these Proposition 56 payments. See the Proposition 56 Funding policy change for the Proposition 56 offset to the GF.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is decrease due to updated actual expenditure data coming in lower than initially projected and a reduction in projected users. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to higher projected users of Family PACT services in FY 2024-25.

Methodology:
1. Payments will be made via fee-for-service supplemental payments and increased managed capitation payments.

2. This policy is effective July 1, 2017; however payments began for pregnancy termination supplemental payments in December 2017, and for E&M office visit supplemental payments in January 2018.

3. Estimated expenditures on a cash basis are as follows:

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
Managed Care			
E&M Office Visits	$0	$0	$0
Medical Pregnancy Termination	$5,498	$5,498	$0
Fee-For-Service			
E&M Office Visits	$55,157	$18,610	$36,546
Medical Pregnancy Termination	$1,477	$1,477	$0
Total	**$62,132**	**$25,585**	**$36,546**

PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 137

FY 2024-25	TF	GF	FF
Managed Care			
E&M Office Visits	$0	$0	$0
Medical Pregnancy Termination	$5,223	$5,223	$0
Fee-For-Service			
E&M Office Visits	$69,303	$23,384	$45,920
Medical Pregnancy Termination	$1,838	$1,838	$0
Total	**$76,365**	**$30,445**	**$45,920**

*Totals may differ due to rounding.

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

NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 138
IMPLEMENTATION DATE: 7/2005
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 1076

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$4,179,000	$14,900,000
- STATE FUNDS	$1,862,000	$7,233,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$4,179,000	$14,900,000
STATE FUNDS	$1,862,000	$7,233,000
FEDERAL FUNDS	$2,317,000	$7,667,000

Purpose:
This policy change estimates the supplemental payments made to Non-Designated Public Hospitals (NDPHs).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.17
State Plan Amendment (SPA) 14-009
SPA 15-004
SPA 16-031
SPA 18-017
SPA 19-0024
SPA 20-0013
SPA 21-0013
SPA 22-0025
SPA 23-0016
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
Effective July 1, 2005, based on the requirements of SB 1100, supplemental reimbursements will be available to NDPHs.

Payments to the NDPHs will be from the NDPH Supplemental Fund, Item 4260-601-3096, using State General Fund (GF) and interest accrued in the NDPH Supplemental Fund as the non-federal share of costs. It is assumed that interest accrued in a fiscal year will be paid in the subsequent fiscal year. This funding along with the federal reimbursement will replace the amount of funding the NDPHs previously received under the Emergency Services and Supplemental Payments Program (SB 1255, Voluntary Governmental Transfers). Due to the inactivation of the Selective Provider Contracting Program (SPCP) for NDPHs on

NDPH SUPPLEMENTAL PAYMENT
REGULAR POLICY CHANGE NUMBER: 138

January 1, 2014, State Plan Amendments (SPAs) were required to continue the NDPH Supplemental Program and secure distributions from the NDPH Supplemental Fund. In September 2016, the Department received SPA approval for a two-year transitional SPA 16-031 from the Centers for Medicare and Medicaid Services (CMS) to continue the NDPH Supplemental Program for FY 2016-17 and FY 2017-18. In October 2018, CMS approved SPA 18-017 to continue the NDPH Supplemental program through June 30, 2019. In June 2019, CMS approved SPA 19-0024 to continue the NDPH Supplemental Program through June 30, 2020. In June 2020, CMS approved SPA 20-0013 to continue the NDPH Supplemental Program through June 30, 2021. In June 2021, CMS approved SPA 21-0013 to continue the NDPH Supplemental Program through June 30, 2022. In July 2021, CMS approved SPA 22-0025 to continue the NDPH Supplemental Program through June 30, 2023. SPA 23-0016 was submitted to CMS in June 2023 for approval to continue the NDPH Supplemental Program for FY 2023-24.

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to:

- FY 2023-24 supplemental payments updated based on more recent FFCRA increased FMAP data, and
- FY 2022-23 ACA adjustments updated based on more recent ACA data.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to:

- Higher expenditures occurring in FY 2024-25 compared to FY 2023-24 due to the distribution of retroactive carryover funds.

Methodology:
1. The State Funds (SF) item includes the annual GF appropriation, any unspent appropriations from prior years, and interest that has been accrued/estimated. Beginning in FY 2017-18, the SF item will also include ACA adjustments.

2. SB 1100 requires that $1,900,000 annually be transferred from the GF to the NDPH Supplemental Fund to be used for the non-federal share of payments.

NDPH SUPPLEMENTAL PAYMENT
REGULAR POLICY CHANGE NUMBER: 138

3. The ACA allows for 100% FMAP for calendar years 2014 through 2016 for newly eligible Medi-Cal beneficiaries. Beginning January 1, 2017, the ACA optional population FMAP is 95%, and reduces to 94% beginning January 1, 2018. Beginning January 1, 2019, the ACA optional population FMAP reduces to 93%, and further reduces to 90% beginning January 1, 2020. CMS approved the ACA claiming methodology in August 2017.

4. ACA adjustments will be processed nine months after the respective fiscal year's supplemental payments have been issued in order to determine the proportion of the costs for newly eligible Medi-Cal beneficiaries. The FY 2022-23 ACA adjustment will be claimed in FY 2023-24, and the FY 2023-24 ACA adjustment will be claimed in FY 2024-25.

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 Title XIX COVID-19 increase FMAP is assumed for expenditures through December 31, 2023 for this policy change.

7. The estimated NDPH Supplemental payments and ending balance for FY 2023-24 are shown below:

FY 2023-24 NDPH Supplemental Fund Summary	SF
FY 2022-23 Ending Balance	$5,577,000
Appropriation (GF)	$1,900,000
Carryover Funds	$379,000
FY 2022-23 Interest Earned	$138,000
Funds Available	$7,994,000
Less: FY 2023-24 Cash Expenditures to Hospitals	($1,862,000)
Est. FY 2023-24 Remaining Balance	$6,132,000

FY 2023-24	TF	SF**	FF	ACA FF***	COVID-19 FF****	Return to SF*
FY 2023-24 Cash Expenditures to Hospitals**	$3,800,000	$1,862,000	$1,900,000	$0	$38,000	$0
FY 2022-23 ACA FF Adjustment to Special Fund	$379,000	$0	($557,000)	$1,002,000	($66,000)	$379,000
Total	**$4,179,000**	**$1,862,000**	**$1,343,000**	**$1,002,000**	**($28,000)**	$379,000

NDPH SUPPLEMENTAL PAYMENT
REGULAR POLICY CHANGE NUMBER: 138

8. The estimated NDPH Supplemental payments and ending balance for FY 2024-25 are shown below:

FY 2024-25 NDPH Supplemental Fund Summary	SF
FY 2023-24 Ending Balance	$6,132,000
Appropriation (GF)	$1,900,000
Carryover Funds	$434,000
Est. FY 2023-24 Interest Earned	$138,000
Funds Available	$8,604,000
Less: FY 2024-25 Cash Expenditures to Hospitals	($7,233,000)
Est. FY 2024-25 Remaining Balance	$1,371,000

FY 2024-25	TF	SF**	FF	ACA FF***	COVID-19 FF****	Return to SF*
FY 2024-25 Cash Expenditures to Hospitals**	$14,466,000	$7,233,000	$7,233,000	$0	$0	$0
FY 2023-24 ACA FF Adjustment to Special Fund	$434,000	$0	($557,000)	$1,002,000	($11,000)	$434,000
Total	**$14,900,000**	**$7,233,000**	**$6,676,000**	**$1,002,000**	**($11,000)**	$434,000

*The Return to Providers column is for display purposes only (see Methodology #4).

Funding:
100% GF (4260-104-0001)
100% NDPH Supplemental Fund (less funded by GF) (4260-698-3096)
100% NDPH Supplemental Fund (non-GF) (4260-601-3096)**
100% Title XIX ACA (4260-101-0890)***
100% Title XIX (4260-101-0890)**,***
COVID-19 Title XIX Increased FFP (4260-101-0890)****

QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 139
IMPLEMENTATION DATE: 4/2014
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 1563

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$2,352,000	$0
- STATE FUNDS	$1,176,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,352,000	$0
STATE FUNDS	$1,176,000	$0
FEDERAL FUNDS	$1,176,000	$0

Purpose:
This policy change estimates supplemental payments to Freestanding Skilled Nursing Facility Level-Bs (FS/NF-Bs) and Freestanding Subacute Nursing Facility Level-B (FSSA/NF-B) facilities through the Skilled Nursing Facility Quality and Accountability Special Fund (Special Fund).

Authority:
SB 853 (Chapter 717, Statutes of 2010)
AB 1489 (Chapter 631, Statutes of 2012)
AB 119 (Chapter 17, Statutes of 2015)
SB 97 (Chapter 52, Statutes of 2017)
SPA 17-024
SPA 18-0034
SPA 19-0043
AB 81 (Chapter 13, Statutes of 2020)
SPA 20-0021
SPA 22-0011
AB 186 (Chapter 46, Statutes of 2022)

Interdependent Policy Changes:
Not Applicable

Background:
SB 853 implemented a quality and accountability supplemental payments (QASP) program for FS/NF-Bs and FSSA/NF-B facilities. The supplemental payments are tied to demonstrated quality of care improvements. Supplemental payments began April 2014 and are paid through the Special Fund. The Special Fund is comprised of penalties collected from skilled nursing facilities that do not meet minimum staffing requirements, one-third of the AB 1629 facilities reimbursement rate increase for rate year (RY) 2014-15 (up to a maximum of 1% of the overall rate), and the savings achieved from setting the professional liability insurance (PLI) cost category at the 75th percentile.

QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS
REGULAR POLICY CHANGE NUMBER: 139

AB 1489 implemented a 3% increase to the AB 1629 facilities weighted average Medi-Cal reimbursement rate for RY 2013-14 and RY 2014-15, and also extended the quality assurance fee (QAF) and the QASP at 1% of the overall rate level until July 31, 2015.

AB 119 extended the AB 1629 facility-specific rate methodology, QAF, and QASP program through July 31, 2020. Further, beginning in RY 2015-16, the annual weighted average rate increase was set at 3.62%, and the General Fund (GF) appropriation for the QASP program will continue at RY 2014-15 levels, rather than setting aside a portion of the annual rate increase. Additionally, beginning RY 2015-16, the Department is required to incorporate direct care staff retention as a performance measure into the QASP program.

SB 97 increases the minimum staffing hours requirement from 3.2 to 3.5, with a minimum of 2.4 certified nursing assistant hours, as an eligibility requirement for the QASP program, beginning in RY 2019-20. This requirement will have no fiscal impact on the QASP program.

The California Department of Aging (CDA) has direct appropriation authority of $1.9 million from the Special Fund to pay for the Ombudsman costs that are not matched with Federal Financial Participation (FFP).

The Department reimburses the California Department of Public Health (CDPH) administrative costs from the Special Fund. See the FFP for Department of Public Health Support Cost other administration policy change.

AB 81 (Chapter 13, Statutes of 2020) extends the QASP program through December 31, 2022, and authorizes the Department to conduct necessary closeout activities after January 1, 2023, to finalize the April 2022 and prior year payments.

The 2022 QASP awards payments will be separated by the three service periods:

- January 1, 2022 through June 30, 2022,
- July 1, 2022 through September 30, 2022, and
- October 1, 2022 through December 31, 2022.

The total pool of funds available for the awards will be prorated according to the number of days in each of the service periods.

AB 186 (Chapter 46, Statutes of 2022) sunsets the QASP program as of December 31, 2022, and authorizes closeout activities after that date. Additionally, after December 31, 2022, funds collected as a result of staffing standard penalty violations will not be transferred to the Special Fund.

Reason for Change:
There is no change in FY 2023-24 from the prior estimate.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to the completion of closeout activities in FY 2023-24.

QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 139

Methodology:

1. Administrative costs as well as supplemental payments are eligible for an FFP match. CDA Ombudsman costs are not eligible for FFP.

2. See the FFP for Department of Public Health Support Costs policy change for the estimated CDPH administrative costs.

3. Supplemental payments are estimated to be:

(Dollars in Thousands)

FY 2023-24	TF	SF	FF
Supplemental Payments***	$2,352	$1,176	$1,176
Total	**$2,352**	**$1,176**	**$1,176**

Funding:

SNF Quality & Accountability (4260-605-3167)***
Title XIX FFP (4260-101-0890)***

FREE CLINICS AUGMENTATION

REGULAR POLICY CHANGE NUMBER: 140
IMPLEMENTATION DATE: 10/2021
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 2303

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$2,000,000	$2,000,000
- STATE FUNDS	$2,000,000	$2,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,000,000	$2,000,000
STATE FUNDS	$2,000,000	$2,000,000
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the cost of providing funding to support to the California Association of Free and Charitable Clinics (CAFCC).

Authority:
Budget Act of 2021 [- AB 128 (Chapter 21, Statutes of 2021)]

Interdependent Policy Changes:
Not Applicable

Background:
AB 128 (Chapter 21, Statutes of 2021), the Budget Act of 2021, provides funding to support free and charitable clinics that are 501(c)(3) tax-exempt organizations, or operate as a program component or affiliate of a 501(c)(3) organization and do not qualify as Medi-Cal providers. The funds shall be distributed to the CAFCC and the amount allocated to each Free Clinic shall be determined through an allocation methodology developed by the CAFCC.

Reason for Change:
There is no change in FY 2023-24, from the prior estimate, as this is an annual amount determined when the budget was appropriated.

There is no change from FY 2023-24 to FY 2024-25 in the current estimate.

FREE CLINICS AUGMENTATION

REGULAR POLICY CHANGE NUMBER: 140

Methodology:

1. Assume an ongoing payment of $2 million GF annually to the CAFCC beginning in FY 2021-22.

(Dollars in Thousands)

Fiscal Year	TF	GF
FY 2023-24	$2,000	$2,000
FY 2024-25	$2,000	$2,000

Funding:

100% GF (4260-101-0001)

IGT ADMIN. & PROCESSING FEE

REGULAR POLICY CHANGE NUMBER: 141
IMPLEMENTATION DATE: 6/2020
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 1601

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the savings to the General Fund 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 (CMS) 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 General Fund (GF).

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to:
- FY 2021-22 final settlement shifted from FY 2022-23 to FY 2023-24.
- Revised FY 2022-23 support costs based on updated data.
- Revised FY 2022-23 final settlements based on updated data.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to:
- FY 2023-24 includes FY 2021-22 and FY 2022-23 final settlements, whereas a single fiscal year's final settlement will be processed in FY 2024-25.

IGT ADMIN. & PROCESSING FEE

REGULAR POLICY CHANGE NUMBER: 141

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 2023-24	IGT Subject to the Fee	5% Admin Fee	Support Costs	Reimbursement to GF
FY 2021-22 Final Settlement	$40,612,000	$2,031,000	$0	$2,031,000
FY 2022-23 Interim Payment	$237,795,000	$11,890,000	$124,000	$11,766,000
FY 2022-23 Final Settlement	$16,428,000	$821,000	$0	$821,000
Total	**$294,835,000**	**$14,742,000**	**$124,000**	**$14,618,000**

FY 2024-25	IGT Subject to the Fee	5% Admin Fee	Support Costs	Reimbursement to GF
FY 2023-24 Interim Payment	$250,899,000	$12,545,000	$136,000	$12,409,000
FY 2023-24 Final Settlement	$9,552,000	$478,000	$0	$478,000
Total	**$260,451,000**	**$13,023,000**	**$136,000**	**$12,887,000**

Fiscal Year	TF	GF	GME Special Fund Transfer
FY 2023-24	**$0**	**($14,618,000)**	**$14,618,000**
FY 2024-25	**$0**	**($12,887,000)**	**$12,887,000**

Funding:

100% State GF (4260-101-0001)
DPH Graduate Medical Education Special Fund (4260-601-8113)

PROPOSITION 56 FUNDING

REGULAR POLICY CHANGE NUMBER: 142
IMPLEMENTATION DATE: 7/2018
ANALYST: Erik Stacey
FISCAL REFERENCE NUMBER: 2102

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change replaces General Fund expenditures for specified supplemental payments and rate increases with Proposition 56 funds, and budgets additional General Fund necessary to continue Proposition 56 payments as program expenditures exceed available revenues.

Authority:
California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56)

Interdependent Policy Changes:
See Funding Chart Below

Background:
Effective April 2017, Proposition 56 (Prop 56) increased taxes imposed on distributors of cigarettes and tobacco products and allocates a specified percentage of those revenues to increase funding for existing health care programs under the Medi-Cal program.

Reason for Change:
The change from the prior estimate for FY 2023-24 is based on updated expenditure projections for Proposition 56 payments and updated projections of available Proposition 56 revenues.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is based on updated expenditure projections for Proposition 56 payments and updated projections of available Proposition 56 revenues.

Methodology:
1. The nonfederal share of Proposition 56 payment items is initially budgeted as General Fund costs in the respective policy changes for these payments. Subsequently, this policy change replaces the General Fund with Healthcare Treatment Fund for those payments budgeted to be supported by Proposition 56. General Fund amounts for Proposition 56 payments, rounded to the nearest thousand dollars, along with the projected amount of available Proposition 56 funding available, are displayed below.

PROPOSITION 56 FUNDING

REGULAR POLICY CHANGE NUMBER: 142

FY 2023-24	Total GF to Proposition 56
PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS	$279,992,000
PROP 56 - MEDI-CAL FAMILY PLANNING	$101,315,000
PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	$555,310,000
PROP 56 - PROVIDER ACES TRAININGS	$904,000
PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	$25,585,000
PROP 56 - BEHAVIORAL HEALTH INCENTIVE PROGRAM	$171,000
PROP 56 - DIRECTED PAYMENT RISK MITIGATION	-$126,691,000
Total of GF Dollars in Prop 56 PCs	**$836,586,000**
Available Proposition 56 Funding	**$767,112,000**
Additional GF Support for Proposition 56 Payments	**$69,474,000**

*Totals may differ due to rounding

FY 2024-25	Total GF to Proposition 56
PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS	$315,198,000
PROP 56 - MEDI-CAL FAMILY PLANNING	$96,561,000
PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	$542,349,000
PROP 56 – FUNDING REDUCTION	-$77,107,000
PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	$30,445,000
PROP 56 - DIRECTED PAYMENT RISK MITIGATION	-$120,000,000
Total of GF Dollars in Prop 56 PCs	**$787,446,000**
Available Proposition 56 Funding	**$594,892,000**
Additional GF Support for Proposition 56 Payments	**$192,554,000**

*Totals may differ due to rounding

2. Based on the projected amount of Proposition 56 revenues available, an estimated $69,474,000 from the General Fund will support Proposition 56 payments in FY 2023-24.

3. Based on the projected amount of Proposition 56 revenues available, an estimated $192,554,000 from the General Fund will support Proposition 56 payments in FY 2024-25.

PROPOSITION 56 FUNDING
REGULAR POLICY CHANGE NUMBER: 142

Funding:
Healthcare Treatment Fund (4260-101-3305)
100% Title XIX GF (4260-101-0001)
100% Title XXI GF (4260-101-0001)
Healthcare Treatment Fund (Less Funded by GF) (4260-695-3305)
GF Support for Prop 56 Payments (4260-112-0001)

COVID-19 VACCINES

REGULAR POLICY CHANGE NUMBER: 143
IMPLEMENTATION DATE: 7/2023
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 2456

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$300,395,000	$358,139,000
- STATE FUNDS	$107,949,150	$128,699,650
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	21.49 %	18.03 %
APPLIED TO BASE		
TOTAL FUNDS	$235,840,100	$293,566,500
STATE FUNDS	$84,750,880	$105,495,100
FEDERAL FUNDS	$151,089,240	$188,071,440

Purpose:
This policy change estimates the costs for changes to the COVID-19 vaccines.

Authority:
American Rescue Plan Act (ARPA)
SPA CA-22-0004 (Approved February 24, 2023; effective January 1, 2022)
SPA 22-0067A

Interdependent Policy Changes:
COVID-19 Increased FMAP - DHCS

Background:
Under the ARPA, Medi-Cal's COVID-19 vaccine reimbursement was the CMS required $40 per dose COVID-19 vaccine administration cost and allows a vaccine reimbursement of $67 per dose for Federally Qualified Health Centers/Rural Health Clinics (FQHC/RHCs). The COVID-19 vaccine ingredient costs were paid directly by the federal government. The ARPA also provides 100% federal funding for most Medi-Cal reimbursed COVID-19 vaccine claims through September 30, 2024. Starting in September 2023 with the updated COVID-19 vaccine, the federal government will no longer 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. Starting in October 2024, the 100% federal funding will end and the applicable Federal Medicaid Assistance Percentages (FMAPs) will apply. A new vaccine administrative fee will also occur starting in October 2024 as the $40 per dose for COVID-19 vaccine will end.

Reason for Change:
This is a new policy change.

COVID-19 VACCINES
REGULAR POLICY CHANGE NUMBER: 143

Methodology:

1. Assume approximately 3,384,000 Medi-Cal members will continue to receive COVID-19 vaccines (the same percentage of Medi-Cal members who received a COVID-19 booster).

2. Assume 25% of members have other healthcare coverage that pays for the COVID-19 vaccine, such as Medicare Part B. Resulting in Medi-Cal reimbursing for approximately 2,538,000 COVID-19 vaccines.

3. Assume the Vaccine for Children program will cover the ingredient cost for COVID-19 vaccinations to Medi-Cal children. Medi-Cal will cover the ingredient costs for adults ages 19 and over.

4. Assume the average COVID-19 vaccine ingredient reimbursement is $124.50 per dose.

5. Assume the COVID-19 vaccine administration fee is:

Vaccine Administered by:	7/1/2023 – 9/30/2024	10/1/2024 onward
Pharmacies	$40	$7.65
FQHC/RHCs	$67	$67
All Other Provider Types	$40	$9

   Through September 2024, the required $40 administrative fee will apply for all providers except for FQHC/RHCs who receive $67. Starting October 1, 2024, the Department proposes adjusting the COVID-19 vaccination administrative fee to $9. Pharmacies receive 85% of the physician rate of $7.65 and FQHC/RHCs will continue to receive $67 under SPA 22-0067A.

6. Assume pharmacies receives an average dispensing fee of $11.63.

7. This policy change uses General Fund for the non-federal share of COVID-19 vaccine costs. For information on the quarterly adjustment to shift the non-federal share of COVID-19 vaccine costs to 100% FMAP through September 2024, see the COVID-19 Vaccine Funding Adjustment policy change.

COVID-19 VACCINES
REGULAR POLICY CHANGE NUMBER: 143

8. Total costs are estimated to be:

(Dollars in Thousands)	FY 2023-24	FY 2024-25
Administrative Fee	$111,218	$64,619
Dispensing Fee	$10,020	$14,365
Ingredient Fee	$179,157	$279,155
Total Cost	$300,395	$358,139

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
COVID-19 Vaccines	**$300,395**	**$107,949**	**$192,446**

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
COVID-19 Vaccines	**$358,139**	**$128,700**	**$229,439**

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)

COVID-19 BEHAVIORAL HEALTH

REGULAR POLICY CHANGE NUMBER: 144
IMPLEMENTATION DATE: 7/2020
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2215

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$113,809,000	$814,000
- STATE FUNDS	$8,270,750	$58,400
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$113,809,000	$814,000
STATE FUNDS	$8,270,750	$58,400
FEDERAL FUNDS	$105,538,250	$755,600

Purpose:
This policy change estimates the cost of establishing interim rates for certain Behavioral Health Medi-Cal programs due to impacts resulting from the Coronavirus Disease 2019 (COVID-19) pandemic.

Authority:
Families First Coronavirus Response Act (FFCRA)
Coronavirus Aid, Relief, and Economic Security (CARES) Act

Interdependent Policy Changes:
COVID-19 Increased FMAP – DHCS

Background:
On March 4, 2020, Governor Newsom declared a state of emergency in response to the developing pandemic of COVID-19. A statewide stay at home order was introduced on March 19, 2020. The federal government declared a national public health emergency (PHE) on January 31, 2020, and a national emergency on March 13, 2020. These actions triggered the availability of Medicaid and Children's Health Insurance Program flexibilities, including under Section 1135 of the Social Security Act. Additionally, the President signed major federal legislation, including the FFCRA and the CARES Act, which provided increased federal funding in Medicaid and created new options for states to address the COVID-19 pandemic.

Due to COVID-19, there was a significant decrease in utilization with certain Specialty Mental Health Services (SMHS) and Drug Medi-Cal (DMC) (non-Narcotic Treatment Program (non-NTP)) outpatient services, while costs per unit of service increased. In order to account for the higher cost per unit of service and help counties to continue to provide necessary behavioral health services during the pandemic and to maintain their existing provider networks so that they are prepared to provide behavioral health treatment to all Medi-Cal members who need services when the PHE ends, the Department implemented the following changes to the reimbursement rates.

COVID-19 BEHAVIORAL HEALTH
REGULAR POLICY CHANGE NUMBER: 144

Specialty Mental Health Services:
For specialty mental health outpatient services delivered by county-owned providers, the current interim reimbursement methodology is the lower of the county's Certified Public Expenditure (CPE) or the county interim rate developed using the most recently filed cost report and an appropriate cost of living adjustment. Effective March 1, 2020 until the end of the COVID-19 PHE, each county may elect to receive interim reimbursement equal to the lower of the county's CPE or the county interim rate increased by 100%.

Drug Medi-Cal:
For non-NTP outpatient services in DMC State Plan counties, the current interim reimbursement methodology is the lower of the county's CPE or the Statewide Maximum Allowance (SMA) rate for the service rendered. Effective March 1, 2020, each county may elect to receive interim reimbursement equal to the lower of the county's CPE or the SMA rate increased by 100%. In the interim and final reconciliations, these costs would be settled to allowable cost, suspending the limitations of usual and customary charges and the SMA rate.

For non-NTP outpatient services in DMC Organized Delivery System (ODS) counties, counties are required to develop, and the Department reviews and approves, county interim rates on an annual basis. Counties are required to reimburse contract providers at these county interim rates and the Department reimburses counties the non-county share of these county interim rates. Effective March 1, 2020, each county may elect to receive interim reimbursement equal to the lower of the county's CPE or the county interim rates increased by 100%. In the interim and final reconciliations, these costs would be settled to allowable cost, suspending the limitation of usual and customary charges.

The COVID-19 PHE expired on May 11, 2023.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is an increase due to higher utilization of the increased interim rates for SMHS-Children and SMHS-Adult.

The change in the current estimate, from FY 2023-24 to FY 2024-25, is due to FY 2024-25 including only third year payment lag costs for SMHS-Adult and SMHS-Children.

Methodology:
1. Interim rate increases for SMHS and DMC State Plan were implemented in July 2020.

2. Interim rate increase for DMC-ODS Waiver counties were implemented in August 2020.

3. For SMHS, assume 63.4% of claims will be paid in the first year, 36.3% in the second year, and 0.2% in the third year. For DMC-ODS Waiver and DMC State plan, assume 76% of claims will be paid in the first year, and 24% in the second year.

COVID-19 BEHAVIORAL HEALTH
REGULAR POLICY CHANGE NUMBER: 144

4. Total cost for SMHS, DMC State Plan, and DMC ODS are as follows:

FY 2023-24	TF	GF	FF	CF
SMHS Interim Rate – Adult	$104,395,000	$5,959,000	$76,034,000	$22,402,000
SMHS Interim Rate – Children	$48,979,000	$1,725,000	$26,354,000	$20,900,000
Non-NTP DMC State Plan Interim Rate	$153,000	$16,000	$110,000	$27,000
Non-NTP DMC-ODS Interim Rate	$3,986,000	$571,000	$3,040,000	$375,000
Total	$157,513,000	**$8,271,000**	**$105,538,000**	$43,704,000

FY 2024-25	TF	GF	FF	CF
SMHS Interim Rate – Adult	$855,000	$49,000	$623,000	$183,000
SMHS Interim Rate – Children	$247,000	$9,000	$133,000	$105,000
Total	$1,102,000	**$58,000**	**$756,000**	$288,000

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)
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)
COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

PHARMACY-BASED COVID-19 TESTS

REGULAR POLICY CHANGE NUMBER: 145
IMPLEMENTATION DATE: 2/2022
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 2359

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$10,363,000	$14,665,000
- STATE FUNDS	$3,365,200	$4,762,150
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$10,363,000	$14,665,000
STATE FUNDS	$3,365,200	$4,762,150
FEDERAL FUNDS	$6,997,800	$9,902,850

Purpose:
This policy change estimates the costs for expanding COVID-19 specimen collections to pharmacies.

Authority:
American Rescue Plan Act (ARPA)
SPA CA-22-0004

Interdependent Policy Changes:
COVID-19 Increased FMAP - DHCS

Background:
According to the Centers for Medicare and Medicaid Services (CMS), the ARPA requires state Medicaid and Children Health Insurance Program (CHIP) to cover a broad array of COVID-19 testing, including all types of U.S. Food & Drug Administration (FDA) - authorized COVID-19 tests, without cost-sharing obligations that begins March 11, 2021, and ends on the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period described in section 1135(g)(1)(B) of the ARPA. The federal Coronavirus 2019 (COVID-19) Public Health Emergency (PHE) ended on May 11, 2023.

All types of FDA-authorized COVID-19 tests must be covered under CMS' interpretation of the ARPA COVID-19 testing coverage requirements, including laboratory tests where the specimen is collected via the pharmacy. Self-administered over-the-counter COVID-19 tests, pursuant to a covered List and quantity/frequency limits have been available as a Medi-Cal benefit since January 1, 2022.

PHARMACY-BASED COVID-19 TESTS

REGULAR POLICY CHANGE NUMBER: 145

Reason for Change:
The change in FY 2023-24, from the prior estimate, is a decrease due to the self-administered OTC COVID-19 tests that have been fully incorporated in the Fee-for-Service base and is no longer reflected in this policy change.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to FY 2024-25 is expected to have a full year of expenditures for the Pharmacy Specimen Collection.

Methodology:
Pharmacy Specimen Collection:

1. Assume the COVID-19 pharmacy specimen collection was implemented October 1, 2023 and is retroactive to February 1, 2022. However, minimal claims are expected during the retroactive period.

2. Assume this expansion of services will increase COVID-19 tests 50,000 per month and not offset any existing testing levels.

3. The pharmacy specimen collection cost is $23.46 and assuming the specimen collection is sent to a laboratory for processing at an average cost of $63.16. The total cost is $86.62 per test.

4. An estimated 98% of the members receive non-pharmacy services through the managed care delivery system and the laboratory test costs are part of the managed care capitation rate.

5. Total costs are estimated to be:

FY 2023-24	TF	GF	FF
Pharmacy Specimen Collection	$10,363,000	$3,365,000	$6,998,000
Total	**$10,363,000**	**$3,365,000**	**$6,998,000**

FY 2024-25	TF	GF	FF
Pharmacy Specimen Collection	$14,665,000	$4,762,000	$9,903,000
Total	**$14,665,000**	**$4,762,000**	**$9,903,000**

PHARMACY-BASED COVID-19 TESTS

REGULAR POLICY CHANGE NUMBER: 145

Funding:

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$5,541,000	$2,770,000	$2,771,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	$4,372,000	$437,000	$3,935,000
65% Title XXI FF / 35% GF (4260-101-0001/0890)	$450,000	$158,000	$292,000
Total	**$10,363,000**	**$3,365,000**	**$6,998,000**

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$7,841,000	$3,920,000	$3,921,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	$6,187,000	$619,000	$5,568,000
65% Title XXI FF / 35% GF (4260-101-0001/0890)	$637,000	$223,000	$414,000
Total	**$14,665,000**	**$4,762,000**	**$9,903,000**

COVID-19 VACCINE FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 146
IMPLEMENTATION DATE: 7/2021
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 2363

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$86,975,000	-$65,541,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$86,975,000	-$65,541,000
FEDERAL FUNDS	$86,975,000	$65,541,000

Purpose:
This policy change estimates the funding adjustment for the Fee-for-Service (FFS) COVID-19 vaccine payments to shift payments made at various Federal Medicaid Assistance Percentages (FMAPs) to 100% FMAP.

Authority:
American Rescue Plan Act (ARPA)

Interdependent Policy Changes:
COVID-19 Vaccines

Background:
On March 11, 2021, the President signed ARPA into law. The ARPA makes coverage of COVID-19 vaccines and their administration mandatory benefits under Medicaid for the period beginning on the date of the enactment through the last day of the first calendar quarter that begins at least one year after the last day of the emergency period declared by the Secretary of Health and Human Services (HHS). As of April 1, 2021, the FMAP for COVID-19 vaccines and administration of vaccines is increased to 100% for most Medi-Cal claims through September 30, 2024.

Prior to September 2023, the COVID-19 vaccine ingredient costs were paid directly by the federal government. Starting in September 2023 with the updated COVID-19 vaccine, the federal government will no longer be purchasing the vaccine and Medi-Cal will be responsible for the reimbursement of the COVID-19 vaccine ingredient cost, administration fee, and, as applicable, dispensing fee. Medi-Cal payments for all applicable COVID-19 vaccine costs are expected to start in October 2023.

Starting in October 2024, the 100% federal funding will end and the applicable FMAPs will apply.

COVID-19 VACCINE FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 146

Reason for Change:
The is a new policy change. Previously, these funding adjustments were shifted in the FFS base estimate.

Methodology:
1. The funding adjustment is needed to budget the COVID-19 vaccine payments at 100% federal financial participation through September 2024.

2. Quarters through September 2023 adjusts only for COVID-19 vaccine administration costs to 100% FMAP.

3. Quarters starting October 2023 to September 2024 adjusts for COVID-19 ingredient costs, vaccine administration costs, and dispensing fees to 100% FMAP.

4. Funding adjustments for the January 2022 through December 2023 quarters will be made in FY 2023-24.

5. Funding adjustments for January 2024 to September 2024 quarter will be made in FY 2024-25.

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
Jan - Mar 2022	$0	($9,304)	$9,304
Apr - Jun 2022	$0	($9,304)	$9,304
Jul - Sept 2022	$0	($9,304)	$9,304
Oct - Dec 2022	$0	($9,304)	$9,304
Jan - Mar 2023	$0	($9,304)	$9,304
Apr - Jun 2023	$0	($9,304)	$9,304
Jul - Sept 2023	$0	($9,304)	$9,304
Oct - Dec 2023	$0	($21,847)	$21,847
Total	**$0**	**($86,975)**	**$86,975**

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
Jan - Mar 2024	$0	($21,847)	$21,847
Apr - Jun 2024	$0	($21,847)	$21,847
Jul - Sept 2024	$0	($21,847)	$21,847
Total	**$0**	**($65,541)**	**$65,541**

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

CONTINUOUS CHIP COVERAGE DURING THE COVID-19 PHE

REGULAR POLICY CHANGE NUMBER: 147
IMPLEMENTATION DATE: 7/2023
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2301

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$52,670,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$52,670,000	$0
FEDERAL FUNDS	-$52,670,000	$0

Purpose:
The purpose of this policy change is to estimate the State General Fund impact to provide continuous coverage to individuals enrolled in the state's Title XXI children's health insurance programs during the full duration of the Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE).

Authority:
SPA 21-032
SB 129 (Chapter 69, Statutes of 2021)
SB 154 (Chapter 43, Statutes of 2022)
CalAIM Section 1115(a) Medicaid Demonstration

Interdependent Policy Changes:
Not Applicable

Background:
The Centers for Medicare and Medicaid Services (CMS) issued guidance which allowed individuals enrolled in Medicaid to remain in coverage for the duration of the COVID-19 PHE, excluding CHIP populations. To prevent coverage disparities from federal policies as it relates to Medicaid and CHIP populations, the Department issued guidance to maintain continuous coverage for individuals enrolled in the Medi-Cal Access Program (MCAP), Medi-Cal Access for Infants Program (MCAIP), and the County Children Health Initiative Program (CCHIP) during the COVID-19 PHE.

On March 17, 2023, the Department received CMS approval to maintain continuous coverage for individuals enrolled in MCAP and CCHIP during the COVID-19 PHE. Currently, this policy change only includes costs for the MCAIP population.

CONTINUOUS CHIP COVERAGE DURING THE COVID-19 PHE

REGULAR POLICY CHANGE NUMBER: 147

Reason for Change:
The change from the prior estimate, for FY 2023-24, is a General Fund (GF) decrease due to a projected decrease in benefit costs. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a GF decrease as all payments are expected to be completed in FY 2023-24.

Methodology:
1. Assume continuous coverage through the PHE for the MCAIP population.

2. Assume a retroactive payment (covering March 2020 through June 2022) will occur in FY 2023-24.

3. Assume the PHE ended May 11, 2023.

4. The estimated costs for FY 2023-24 and FY 2024-25 are:

(Dollars in Thousands)

Fiscal Years	TF	GF	FF
FY 2023-24	$0	$52,670	($52,670)
FY 2024-25	$0	$0	$0

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

COVID-19 ELIGIBILITY

REGULAR POLICY CHANGE NUMBER: 148
IMPLEMENTATION DATE: 7/2021
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 2211

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$1,715,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$1,715,000	$0
FEDERAL FUNDS	-$1,715,000	$0

Purpose:
This policy change estimates the cost of certain changes in program eligibility related to the coronavirus disease 2019 (COVID-19), including testing and treatment services to various populations and changes in hospital presumptive eligibility.

Authority:
Families First Coronavirus Response Act (FFCRA)
Coronavirus Aid, Relief, and Economic Security (CARES) Act
American Rescue Plan (ARP) Act (2021)
SB 154 (Chapter 43, Statutes of 2022)
State Plan Amendment (SPA) 22-004

Interdependent Policy Changes:
Not Applicable

Background:
On March 4, 2020, Governor Newsom declared a state of emergency in response to the developing pandemic of COVID-19. A statewide stay at home order was introduced on March 19, 2020. The federal government declared a national public health emergency (PHE) on January 31, 2020, and a national emergency on March 13, 2020. These actions triggered the availability of Medicaid and Children's Health Insurance Program flexibilities, including under Section 1135 of the Social Security Act. Additionally, the President signed major federal legislation—including the FFCRA and the CARES Act—that provides increased federal funding in Medicaid and creates new options for states to address the COVID-19 pandemic.

The effects of the COVID-19 pandemic are unprecedented in modern times from a PHE and economic perspective. This has a fiscal impact across policy areas and beneficiary populations within the Medi-Cal program.

The Department requested federal approvals for the various program modifications through the House Resolution (H.R.) 6201 FFCRA, Section 6004, SPA 20-0024, and waivers. The following program updates will allow individuals to access necessary COVID-19 diagnostic testing, testing

COVID-19 ELIGIBILITY
REGULAR POLICY CHANGE NUMBER: 148

related services, and treatment services, including all medically necessary care such as the associated office, clinic, or emergency room visits related to COVID-19 at no cost to the individuals:

- H.R. 6201 (FFCRA) – COVID-19 Uninsured Eligibility Group: Provides COVID-19 diagnostic testing, testing related services, and treatment services to individuals who have no insurance or currently have private insurance that does not cover diagnostic testing, testing related services, and treatment service, including all medically necessary care as a result of COVID-19 and are a California resident. Testing and testing-related services are funded at 100% federal funds (FF), and all other services are funded with General Fund (GF). However, California has requested federal approval through the 1115 waiver to provide COVID-19 treatment services at no cost to the individual and at 100% FF. The American Rescue Plan Act of 2021 enacted March 11, 2021, required COVID-19 vaccine and COVID-19 related treatments to be an included benefit under the COVID-19 Uninsured Eligibility Group. Claiming for the administration of the COVID-19 vaccine and COVID-19 related treatments are now available for the COVID-19 Uninsured Group at 100% FF. SPA 22-004 was approved on February 28, 2023, and allows the required COVID-19 vaccine and COVID-19 related treatments to be an included benefit under the COVID-19 Uninsured Eligibility Group and to be funded at 100% FF effective March 11, 2021. The federal Public Health Emergency ended on May 11, 2023. The COVID-19 Uninsured Eligibility Group ended on May 31, 2023. All services provided between May 12, 2023, and May 31, 2023, were paid for with 100% FF. These claims were tracked and reimbursed with the GF.

- SPA 20-0024 - Hospital Presumptive Eligibility (HPE) Expansion Group: Expands HPE to include the aged (65 years of age and older), disabled, and blind population. HPE COVID-19 is available to individuals with no insurance or currently have private insurance that does not cover diagnostic testing, testing related services, and treatment service, including all medically necessary care as a result of COVID-19 and are a California resident. This program also expands the current PE period limitations across all PE coverage groups to two periods within a 12-month timeframe.

Reason for Change:
The change for FY 2023-24, from the prior estimate, is a decrease due the COVID-19 Uninsured Eligibility Group ending with the PHE and due to costs for the HPE Expansion Group shifting into the base estimates. Also, this policy change includes a one-time claiming adjustment for the COVID-19 Uninsured Eligibility Group.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to the one-time claiming adjustment for the COVID-19 Uninsured Eligibility Group being completed in FY 2023-24.

Methodology:
1. Assume the PHE continued through May 11, 2023.

2. Assume coverage for the HPE expansion group will be continued after May 11, 2023. Beginning in the November 2023 Estimate, costs for this population shifted into the base estimates are shown as display only in this policy change.

3. The Department estimates the following funding for Treatment Services and Testing and Testing-Related Services as a result of the COVID-19:

COVID-19 ELIGIBILITY
REGULAR POLICY CHANGE NUMBER: 148

(Dollar in Thousands)

FY 2023-24	TF	GF	FF
Treatment Services	$61,144	$32,087	$29,057
Testing and Testing-Related Services	$8,077	$4,239	$3,838
Total	**$69,221**	**$36,325**	**$32,895**

*Totals may differ due to rounding.

4. The Department estimates the following Medi-Cal program costs as a result of the COVID-19:

(Dollar in Thousands)

FY 2023-24	TF	GF	FF
COVID-19 Uninsured Eligibility One-Time Claiming Adjustment	$0	$1,715	($1,715)
COVID-19 HPE Expansion (Display Only)	$69,221	$34,610	$34,610
Total	**$69,221**	**$36,325**	**$32,895**

*Totals may differ due to rounding.

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

COVID-19 INCREASED FMAP - DHCS

REGULAR POLICY CHANGE NUMBER: 149
IMPLEMENTATION DATE: 7/2021
ANALYST: Kalanie Coleman
FISCAL REFERENCE NUMBER: 2217

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	-$50,018,000	$0
- STATE FUNDS	-$663,604,000	$820,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$50,018,000	$0
STATE FUNDS	-$663,604,000	$820,000
FEDERAL FUNDS	$613,586,000	-$820,000

Purpose:
This policy change estimates the impact on benefits expenditures of assuming the availability of increased federal medical assistance percentage (FMAP) from January 2020 through December 2023. For the estimated impact of assuming increased FMAP from January 2020 through December 2023 on administrative expenditures, see the COVID-19 Increased FMAP – Other Admin policy change.

Authority:
Families First Coronavirus Response Act (FFCRA)
Coronavirus Aid, Relief, and Economic Security (CARES) Act
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
On March 4, 2020, Governor Newsom declared a state of emergency in response to the developing pandemic of COVID-19. A statewide stay at home order was introduced on March 19, 2020. The federal government declared a national public health emergency on January 31, 2020, and a national emergency on March 13, 2020. These actions triggered the availability of Medicaid and Children's Health Insurance Program flexibilities, including under Section 1135 of the Social Security Act. Additionally, the President signed major federal legislation—including the FFCRA and the CARES Act—that provides increased federal funding in Medicaid and creates new options for states to address the COVID-19 pandemic.

Medicare Part D is the prescription drug benefit provided to all dual eligible beneficiaries and other Medicare eligible beneficiaries that enroll in Part D. The federal government requires the states to contribute part of their savings for no longer providing the drug benefit to dual eligible beneficiaries. This is referred to as the Medicare Part D phased-down contribution and is funded 100% by State General Funds.

COVID-19 INCREASED FMAP - DHCS

REGULAR POLICY CHANGE NUMBER: 149

The effects of the COVID-19 pandemic are unprecedented in modern times from a public health emergency and economic perspective. This will have fiscal impacts across policy areas and beneficiary populations within the Medi-Cal program.

The increased FMAP is effective January 1, 2020, and extends through the last day of the calendar quarter of the Health and Human Services COVID-19 national public health emergency.

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
For dollars budgeted in this policy change, there is a decrease in general fund savings from the prior estimate for FY 2023-24 due to policy change updates. There is an increase in general fund expenditure from FY 2023-24 to FY 2024-25 due to the phase-out schedule for increased FMAP.

Methodology:

1. The increased FMAP of 6.2% is applicable on regular Medicaid 50% FMAP expenditures through March 2023, with a phase-out schedule to apply thereafter through December 2023.

2. A CHIP FMAP increase of 4.34% is applicable on CHIP expenditures through March 2023, with a phase-out schedule to apply thereafter through December 2023.

3. A Breast and Cervical Cancer Treatment Program (BCCTP) FMAP increase of 4.34% is applicable on BCCTP expenditures through March 2023, with a phase-out schedule to apply thereafter through December 2023.

4. The Medicare Part D increase in FMAP from the FFCRA affected the calculation of the phased-down State contribution per capita rates retroactive to January 1, 2020, producing a General Fund saving for the State. The Consolidated Appropriations Act of 2023 established a fixed phase-out schedule through December 2023 for the increased FMAP that is no longer dependent on the PHE timeline. A full year of General Fund savings are assumed for CY and eight months in BY because phased-down payments have a two-month lag. The first nine months of CY savings are reflected in actual expenditures as reported in the Medicare Payments – Part D Phased-Down policy change.

5. The FFCRA is assumed to continue through December 2023 with a phase-out schedule to apply from April 2023 through December 2023.

6. The following estimates reflect a cash basis:

COVID-19 INCREASED FMAP - DHCS

REGULAR POLICY CHANGE NUMBER: 149

(Dollars in Thousands)

FY 2023-24	TF	GF	SF	FF
COVID-19 Increased FMAP - DHCS:				
FFCRA T19 Increased FFP	$840	($580,463)	$0	$581,303
FFCRA T21 Increased FFP	$64	($32,219)	$0	$32,283
Medicare Part D FFCRA T19 Incr. FFP	($50,922)	($50,922)	$0	$0
Total COVID-19 Incr. FMAP - DHCS:	**($50,018)**	**($663,604)**	**$0**	**$613,587**
COVID-19 Increased FMAP - Other Admin:				
FFCRA T21 Increased FFP	$0	($223)	$0	$223
Total COVID-19 Incr. FMAP - Other Admin:	$0	($223)	$0	$223
COVID-19 Increased FMAP In other PCs:				
FFCRA T19 Increased FFP	$672,110	($115,673)	($277,369)	$1,065,151
FFCRA T21 Increased FFP	$1,394	($13,873)	($15,351)	$30,617
BCCTP T19 Increased FFP	$0	$26	$0	($26)
Medicare Part D FFCRA T19 Incr. FFP	($66,536)	($66,536)	$0	$0
Total COVID-19 Incr. FMAP In other PCs:	$606,967	($196,056)	($292,719)	$1,095,743
Total of PCs including COVID-19 Increased FMAP	$556,950	($859,883)	($292,719)	$1,709,552

*Totals may differ due to rounding.

COVID-19 INCREASED FMAP - DHCS

REGULAR POLICY CHANGE NUMBER: 149

(Dollars in Thousands)

FY 2024-25	TF	GF	SF	FF
COVID-19 Increased FMAP - DHCS:				
FFCRA T19 Increased FFP	$0	$820	$0	($820)
FFCRA T21 Increased FFP	$0	$0	$0	$0
Medicare Part D FFCRA T19 Increased FFP	$0	$0	$0	$0
Total COVID-19 Incr. FMAP - DHCS:	**$0**	**$820**	**$0**	**($820)**
COVID-19 Increased FMAP - Other Admin:				
FFCRA T21 Increased FFP	$0	$0	$0	$0
Total COVID-19 Incr. FMAP - Other Admin:	$0	$0	$0	$0
COVID-19 Increased FMAP In other PCs:				
FFCRA T19 Increased FFP	($1,701)	($103,728)	($132,650)	$234,676
FFCRA T21 Increased FFP	$0	($6,872)	($10,651)	$17,523
BCCTP 4.34% Increased FFP	$0	$0	$0	$0
Medicare Part D FFCRA T19 Incr. FFP	$0	$0	$0	$0
Total COVID-19 Incr. FMAP In other PCs:	($1,701)	($110,600)	($143,301)	$252,199
Total of PCs including COVID-19 Increased FMAP	($1,701)	($109,780)	($143,301)	$251,379

*Totals may differ due to rounding.

Funding:
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)
COVID-19 BCCTP Title XIX Increase FFP (4260-101-0890)
COVID-19 BCCTP Title XIX GF (4260-101-0001)

COVID-19 REDETERMINATIONS IMPACT

REGULAR POLICY CHANGE NUMBER: 150
IMPLEMENTATION DATE: 7/2023
ANALYST: Ryan Woolsey
FISCAL REFERENCE NUMBER: 2218

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	-$3,148,753,000	-$9,638,417,000
- STATE FUNDS	-$1,171,273,800	-$3,502,282,400
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$3,148,753,000	-$9,638,417,000
STATE FUNDS	-$1,171,273,800	-$3,502,282,400
FEDERAL FUNDS	-$1,977,479,200	-$6,136,134,600

Purpose:
This policy change estimates expenditure changes due to the resumption of eligibility redeterminations following the end of the federal COVID-19 public health emergency (PHE).

Authority:
Families First Coronavirus Response Act (FFCRA)
Coronavirus Aid, Relief, and Economic Security (CARES) Act
Consolidated Appropriations Act, 2023

Interdependent Policy Changes:
COVID-19 Increased FMAP – DHCS

Background:

COVID-19 Pandemic
On March 4, 2020, Governor Newsom declared a state of emergency in response to the developing pandemic of COVID-19. A statewide stay at home order was introduced on March 19, 2020. The federal government declared a national public health emergency on January 31, 2020, and a national emergency on March 13, 2020. These actions triggered the availability of Medicaid and Children's Health Insurance Program flexibilities, including under Section 1135 of the Social Security Act. Additionally, the President signed major federal legislation—including the FFCRA and the CARES Act—that provided increased federal funding in Medicaid and created new options for states to address the COVID-19 pandemic.

Continuous Coverage Requirement
The FFCRA included a "continuous coverage requirement." Under the continuous coverage requirement, states must 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 has increased due to reduced disenrollment under the continuous coverage requirement. The COVID-19 Caseload Impact policy change previously estimated the impact of increased

COVID-19 REDETERMINATIONS IMPACT
REGULAR POLICY CHANGE NUMBER: 150

caseload due to this requirement. This impact is now fully reflected in base policy projections and the COVID-19 Caseload Impact policy change has been deactivated.

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, ends the continuous coverage requirement on March 31, 2023 and requires 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 are disenrolled beginning July 2023. Eligibility redeterminations related to this population are expected to be completed over the course of approximately twelve months. This policy change estimates the impact of redeterminations on Medi-Cal spending.

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.

There is considerable uncertainty surrounding the fiscal impacts of resuming redeterminations in Medi-Cal.

Reason for Change:
This is a new policy change.

Methodology:

1. Based on redetermination and enrollment data through early November, Medi-Cal enrollment is projected to decline by approximately 1.9 million individuals by the end of July 2024, after which enrollment is assumed to level off.

2. Among those projected to shift out of Medi-Cal enrollment, 41 percent are in the Affordable Care Act (ACA) expansion category, 52 percent are in families and children categories, and 7 percent are in seniors or persons with disabilities categories. Based on this projected mix of cases, the average monthly value of services (other than Medicare) for these individuals is estimated to be $395 in FY 2023-24 and $411 in FY 2024-25.

3. The number of Medi-Cal members for whom the state pays Medicare Part B premiums (see the Medicare Pmnts.-Buy-In Part A & B Premiums policy change) is projected to decline by 105,000 individuals by July 2024, after which enrollment is assumed to level off.

4. The number of Medi-Cal member for whom the state makes payment under the Medicare Part D clawback (see the Medicare Payments – Part D Phased-Down policy change) is projected to decline by about 94,000 individuals by July 2024, after which enrollment is assumed to level off.

5. After accounting for payment timing, total estimated redetermination impacts on the Medi-Cal expenditures on a cash basis are:

COVID-19 REDETERMINATIONS IMPACT

REGULAR POLICY CHANGE NUMBER: 150

(Dollars in Thousands)

Fiscal Year	TF	GF	Title XIX FF	Title XXI FF	ACA FF
FY 2023-24	-$3,148,753	-$1,171,274	-$745,772	$23,092	-$1,254,799
FY 2024-25	-$9,638,417	-$3,502,282	-$2,173,395	$61,061	-$4,023,801

Funding:

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	-$1,582,767	-$791,383	-$791,383
90% Title XIX / 10% GF (4260-101-0001 / 0890)	-$1,530,243	-$153,024	-$1,377,218
65% Title XXI / 35% GF (4260-101-0001 / 0890)	$37,470	$13,115	$24,356
100% State General Fund	-$239,981	-$239,981	$0
100% FFP	$166,767	$0	$166,767
Total	**-$3,148,753**	**-$1,171,274**	**-$1,977,479**

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	-$4,614,335	-$2,307,168	-$2,307,168
90% Title XIX / 10% GF (4260-101-0001 / 0890)	-$4,907,074	-$490,707	-$4,416,367
65% Title XXI / 35% GF (4260-101-0001 / 0890)	$98,930	$34,625	$64,304
100% State General Fund	-$739,033	-$739,033	$0
100% FFP	$523,095	$0	$523,095
Total	**-$9,638,417**	**-$3,502,282**	**-$6,136,135**

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

STATE-ONLY CLAIMING ADJUSTMENTS - RETRO ADJ.

REGULAR POLICY CHANGE NUMBER: 151
IMPLEMENTATION DATE: 1/2021
ANALYST: Ryan Woolsey
FISCAL REFERENCE NUMBER: 2415

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	-$3,844,000	$0
- STATE FUNDS	$3,573,646,000	$944,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$3,844,000	$0
STATE FUNDS	$3,573,646,000	$944,000
FEDERAL FUNDS	-$3,577,490,000	-$944,000

Purpose:
This policy change estimates (1) the return of Federal Financial Participation (FFP) to the federal government for claiming for non-emergency or non-pregnancy related services provided to individuals without satisfactory immigrant status in full scope Medi-Cal coverage and (2) the claiming of FFP for certain immigrant populations for which the state has previously underclaimed.

Changes in claiming processes as a result of the updates described in this policy change will also affect the amount of federal funding the state will claim compared to the amount that was claimed in the past, on an ongoing basis. These prospective, ongoing impacts are reflected in various policy changes that correspond to the various services these claiming processes support.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
California provides state-only full scope Medi-Cal services to certain immigrant populations who meet all Medi-Cal eligibility requirements except for their citizenship status. For these covered populations, FFP is only available for emergency and pregnancy-related services, and nonemergency and non-pregnancy related services are paid using state only funds. Affected populations include qualified non-citizens subject to the five-year bar, individuals who are Permanent Residents or Permanently Residing Under Color of Law, and individuals under 26 years of age who otherwise meet all Medi-Cal eligibility criteria (such as income and state residency) but for their citizenship status.

The Department has identified claiming for ineligible covered benefits and is required to return the federal funding to the Centers for Medicare and Medicaid Services (CMS). The Department

STATE-ONLY CLAIMING ADJUSTMENTS - RETRO ADJ.
REGULAR POLICY CHANGE NUMBER: 151

has estimated the FFP amounts subject to repayment that must be retroactively returned and updates to associated claiming methodologies for prospective use.

The Department has also identified underclaiming for individuals who have a change in immigration status such that they now meet the five-year bar and become eligible for non-emergency and non-pregnancy related FFP claiming, but for which state systems lack business rules to appropriately identify and claim FFP.

Office of the Inspector General (OIG) Audit
On January 9, 2023, the OIG notified the Department of a preliminary finding related to an audit of the Department's managed care claiming methodology as it relates to state-only populations. The finding identified improper claiming for the period January 1, 2019, through March 31, 2019.

CMS Deferral
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 retroactive adjustments for FY 2023-24, from the prior estimate, is an increase due to:

- Higher managed care retroactive repayments than previously estimated.
- The shift of retroactive claiming for individuals that now meet the five-year bar and are eligible for non-emergency and non-pregnancy related FFP claiming from FY 2022-23 to FY 2023-24.
- The estimated timing of repayments for dental services for the October 2022 through June 2023 period shifted from FY 2022-23 to FY 2023-24.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to:

- Only relatively small repayments related to pharmacy rebates are expected to continue in FY 2024-25.

Methodology:

1. Estimated FFP repayments for Specialty Mental Health Services (SMHS) / Drug Medi-Cal (DMC) repayment cover prior claims related to a missing immigration status indicator.

2. The managed care retroactive repayment reflects claims from July 2019 through June 2023. Most of the identified funds were returned to the federal government early in FY 2023-24. Repayment amounts increased due to updated data on population sizes and actual rates.

3. This policy change includes $39,192,000 in repayments to the federal government in FY 2023-24 related to the preliminary OIG audit finding.

4. Estimated FFP repayments for Pharmacy Rebates in FY 2023-24 cover claims from July 2020 through June 2023 and repayments in FY 2024-25 cover claims from July 2023 through June 2024.

STATE-ONLY CLAIMING ADJUSTMENTS - RETRO ADJ.

REGULAR POLICY CHANGE NUMBER: 151

5. Estimated FFP repayments for Dental FFS and Dental Managed Care cover claims from January 2010 through June 2023.

6. Reclaiming for the immigration status change population took place in July 2023, reflecting a shift from FY 2022-23 on a cash basis.

7. Estimated repayments for Medicaid Administrative Activities (MAA) relate to the FY 2021-22 Quarter 4 period.

8. Estimated repayments for Local Education Agency (LEA) claiming are $2,770,000 and relate to the FY 2021-22 Quarter 4 through FY 2022-23 Quarter 4 period. The state cost of these repayments will be recovered within FY 2023-24. A correction to Local Education Agency (LEA) claiming will return an additional estimated $1,074,000 to the General Fund in FY 2023-24.

9. Estimated repayments for Targeted Case Management (TCM) claiming relate to the FY 2021-22 Quarter 4 period.

10. The estimated net retroactive adjustments are:

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
SMHS/DMC	$0	$3,100	($3,100)
Managed Care	$0	$3,958,974	($3,958,974)
OIG Audit	$0	$39,192	($39,192)
Pharmacy Rebates	$0	$73,416	($73,416)
Dental FFS and Managed Care	$0	$67,079	($67,079)
Immigration Status Change	$0	($567,253)	$567,253
MAA	$0	$187	($187)
LEA	($3,844)	($1,074)	($2,770)
TCM	$0	$25	($25)
Total	**($3,844)**	**$3,573,646**	**($3,577,490)**

STATE-ONLY CLAIMING ADJUSTMENTS - RETRO ADJ.

REGULAR POLICY CHANGE NUMBER: 151

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
Managed Care	$0	$0	$0
OIG Audit	$0	$0	$0
Pharmacy Rebates	$0	$944	($944)
Dental FFS and Managed Care	$0	$0	$0
Immigration Status Change	$0	$0	$0
MAA	$0	$0	$0
LEA	$0	$0	$0
TCM	$0	$0	$0
Total	**$0**	**$944**	**($944)**

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

ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS

REGULAR POLICY CHANGE NUMBER: 152
IMPLEMENTATION DATE: 5/2013
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1476

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$719,320,000	$751,126,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$719,320,000	$751,126,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$719,320,000	$751,126,000

Purpose:
This policy change estimates the federal match to the California Department of Developmental Services (CDDS) for participant-directed Home and Community Based Services (HCBS) for persons with developmental disabilities under a 1915(i) state plan option.

Authority:
Section 6086 of the Deficit Reduction Act (DRA) of 2005, Public Law 109-171
Interagency Agreement (IA) 09-86388
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

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 will expire on September 30, 2021. The Department submitted SPA 21-0002 to CMS on March 23, 2021, to renew the 1915(i) state plan option for a new five year term effective October 1, 2021, through September 30, 2026.

ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS
REGULAR POLICY CHANGE NUMBER: 152

ABX3 5 “AB 5” (Chapter 20, Statutes of 2009), eliminated non-emergency medical transportation and various optional services for adults in September 2009. SPA 11-041 authorizes CDDS to claim reimbursement, effective October 1, 2011 for the eliminated services rendered in FY 2011-12 and forward, enabling persons with developmental disabilities access to these benefits.

On October 9, 2015, SPA 11-040 was approved, retroactive to October 1, 2011, which extends Medi-Cal coverage for existing infant development programs provided to Medi-Cal eligible infants and toddlers with a developmental delay. The Department and CDDS have a separate IA to draw down FFP for infant development services.

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to an increase in prior year expenditures as a result of some invoices previously scheduled to be paid in FY 2022-23, were not paid until FY 2023-24.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is a net increase due to a growth in population and utilization of services, as well as planned rate increases occurring at the beginning of FY 2024-25, and less prior expenditures to be paid in FY 2024-25 than in FY 2023-24.

Methodology:
1. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023 for this policy change.

ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS

REGULAR POLICY CHANGE NUMBER: 152

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

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	FF	COVID-19 FF
FY 2023-24	$1,381,678	$662,358	**$690,836**	**$28,484**
FY 2024-25	$1,502,252	$751,126	**$751,126**	**$0**

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

HCBS SP CDDS

REGULAR POLICY CHANGE NUMBER: 158
IMPLEMENTATION DATE: 6/2022
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 2348

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$601,116,000	$105,028,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$601,116,000	$105,028,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$601,116,000	$105,028,000

Purpose:
This policy change estimates the federal reimbursements for the California Department of Developmental Services (CDDS) home and community-based services (HCBS) spending plan items.

Authority:
American Rescue Plan (ARP) Act (2021)
Section 11.95, 2021 Budget Act
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
The American Rescue Plan Act of 2021 (ARP) provides additional Coronavirus Disease 2019 (COVID-19) relief to states. Section 9817 of the ARP provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS). Increased FMAP is available from April 1, 2021 through March 31, 2022. States must use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021, and states must use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. State funds equivalent to the amount of federal funds attributable to the increased FMAP are deposited in the Home and Community-Based Services American Rescue Plan Fund pursuant to Section 11.95 of the 2021 Budget Act. Section 11.95 appropriates this funding to eligible HCBS activities identified in the HCBS Spending Plan.

HCBS SP CDDS
REGULAR POLICY CHANGE NUMBER: 158

The FFCRA provides increased federal funding by increasing the 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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to the update of the spending plan and billing timing.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to the update of the spending plan and billing timing.

Methodology:
1. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023 for this policy change.

2. The cash basis estimate for the HCBS spending plan items for CDDS are:

(Dollars in Thousands)

FY 2023-24	TF	HCBS ARP Fund - CDDS	FF	COVID-19 FF
Developmental Services Rate Model Implementation	$1,361,111	$767,877	$544,761	$47,473
Social Recreation and Camp Services for Individuals with Developmental Disabilities	$12,027	$7,517	$4,034	$476
Language Access and Cultural Competency Orientations and Translations	$14,663	$11,291	$3,372	$0
Total	$1,387,801	$786,685	**$552,167**	**$48,949**

HCBS SP CDDS

REGULAR POLICY CHANGE NUMBER: 158

(Dollars in Thousands)

FY 2024-25	TF	HCBS ARP Fund - CDDS	FF	COVID-19 FF
Developmental Services Rate Model Implementation	$275,769	$170,741	$105,028	$0
Total	$275,769	$170,741	**$105,028**	**$0**

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

BEHAVIORAL HEALTH BRIDGE HOUSING

REGULAR POLICY CHANGE NUMBER: 159
IMPLEMENTATION DATE: 5/2023
ANALYST: Elena Susbilla
FISCAL REFERENCE NUMBER: 2354

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$483,968,000	$456,587,000
- STATE FUNDS	$483,968,000	$456,587,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$483,968,000	$456,587,000
STATE FUNDS	$483,968,000	$456,587,000
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the costs for behavioral health bridge housing.

Authority:
Budget Act of 2022 [AB 179 (Chapter 249, Statutes of 2022)]
Budget Act of 2023 [AB 102 (Chapter 38, Statutes of 2023)]

Interdependent Policy Changes:
Not Applicable

Background:
Funding for behavioral health bridge housing is proposed to address the immediate housing and treatment needs of people experiencing unsheltered homelessness with serious behavioral health conditions by providing time-limited operational supports in various bridge housing settings, including existing assisted living settings.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to less payments anticipated to be paid in FY 2023-24 and no longer budgeting Mental Health Services Funds.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to the addition of General Fund (GF) funding projected to be spent in FY 2024-25.

Methodology:
1. Of the $957,936,000 GF appropriated for behavioral health bridge housing, assume $90,794,000 GF is estimated in FY 2022-23, available for expenditure through June 30, 2027. Assume $265,000,000 GF is appropriated to the Department for behavioral health bridge housing in FY 2024-25. Assume $235,000,000 GF is appropriated to the Department for behavioral health bridge housing in FY 2025-26

2. A total of $483,968,000 ($453,968,000 and $30,000,000 from the 5% tribal set-aside from the FY 2022-23 appropriation) is estimated to be spent in FY 2023-24.

BEHAVIORAL HEALTH BRIDGE HOUSING
REGULAR POLICY CHANGE NUMBER: 159

3. The table below displays the estimated spending and remaining funds by Appropriation Years:

(Dollars In Thousands)

	TF	GF
Appropriation Year 2022-23	$957,936	$957,936
Prior Years	$90,794	$90,794
Estimated in FY 2023-24	$483,968	$483,968
Estimated in FY 2024-25	$191,587	$191,587
Total Estimated Remaining	$191,587	$191,587
Appropriation Year 2024-25	$265,000	$265,000
Estimated in FY 2024-25	$265,000	$265,000
Total Estimated Remaining	$0	$0

4. The estimated costs in FY 2023-24 and FY 2024-25 are as follows:

(Dollars In Thousands)

FY 2023-24	**TF**	**GF**
Appropriation Year 2022-23	$483,968	$483,968
Total FY 2023-24	**$483,968**	**$483,968**

(Dollars In Thousands)

FY 2024-25	**TF**	**GF**
Appropriation Year 2022-23	$191,587	$191,587
Appropriation Year 2024-25	$265,000	$265,000
Total FY 2024-25	**$456,587**	**$456,587**

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

CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY

REGULAR POLICY CHANGE NUMBER: 161
IMPLEMENTATION DATE: 11/2022
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 2292

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$351,500,000	$198,500,000
- STATE FUNDS	$351,500,000	$198,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$351,500,000	$198,500,000
STATE FUNDS	$351,500,000	$198,500,000
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates funding for direct grants to local education agencies (LEAs) and institutions of higher education to build infrastructure, partnerships, and capacity statewide to increase the number of children and youth 25 years of age and younger receiving preventive and early intervention behavioral health services from schools, providers in schools, school affiliated community-based organizations (CBOs), or school-based health centers.

Authority:
Budget Act of 2021 [SB 129 (Chapter 69, Statutes of 2021)]
Budget Act of 2022 [AB 179 (Chapter 249, Statutes of 2022)]
Welfare & Institutions Code 5961.2

Interdependent Policy Changes:
Not Applicable

Background:
Young people spend many hours in school settings and behavioral health (BH) services should be easily accessible and provided on or near school campuses, through partnerships between schools, commercial health insurance, counties, behavioral health providers and CBOs. This policy change estimates cost to provide direct grants available to various entities to build infrastructure, partnerships, and capacity statewide to increase access to preventive and early intervention BH services for students.

As part of Children and Youth Behavioral Health Initiative (CYBHI), the School-Linked Partnership and Capacity grant programs aims to increase capacity, infrastructure, and partnerships in various public schools and institutions of higher education for children and youth to receive appropriate BH supports and services. This grant program will provide $550 million to LEAs and institutions of higher education to support individuals 25 years of age and younger from schools, in school providers, school affiliated CBOs, or school-based health centers. Of the $550,000,000, $400,000,000 is allocated to pre-school through 12th grade and $150,000,000 for higher education (with $100,000,000 earmarked for community colleges).

CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY

REGULAR POLICY CHANGE NUMBER: 161

The CYBHI is a multiyear package of investments. The CYBHI is intended to transform California's BH system for children and youth aged 0-25 into a world-class, innovative, up-stream focused, ecosystem where all children and young adults are routinely screened, supported, and served for emerging BH needs.

Reason for Change:
The change for FY 2023-24, from the prior estimate, is due to shift in timing of contract execution with third-party administrator to administer grants and disseminate funds to county offices of education.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to decrease of grant payments made in FY 2024-25.

Methodology:
1. The Budget Act of 2021, SB 129 Provision 16(b) authorized $100,000,000 General Fund (GF) in FY 2021-22 with multi-year authority. This funding is available for expenditure through June 30, 2024. The Budget Act of 2022, AB 179 Provision 16 authorized $450,000,000 GF in FY 2022-23, with multi-year authority. This funding is available for encumbrance or expenditure until June 30, 2025.

2. Of the $550,000,000 GF, $400,000,000 is targeted to pre-school through 12th grade and $150,000,000 is targeted to higher education. Grant dollars will be distributed to LEAs from county offices of education, school districts, school sites, charter schools, CA Schools for the Deaf, CA Schools for the Blind, and institutions of higher education.

3. The table below displays the estimated spending and remaining funds by Appropriation Years:

(Dollars in Thousands)

Appropriations	TF	GF
Appropriation Year 2021-22	$100,000	$100,000
Prior Years	$0	$0
Estimated in FY 2023-24	$100,000	$100,000
Total Estimated Remaining	$0	$0
Appropriation Year 2022-23	$450,000	$450,000
Prior Years	$0	$0
Estimated in FY 2023-24	$251,500	$251,500
Estimated in FY 2024-25	$198,500	$198,500
Total Estimated Remaining	$0	$0

CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY

REGULAR POLICY CHANGE NUMBER: 161

4. The estimated costs in FY 2023-24 and FY 2024-25 are as follows:

(Dollars in Thousands)

FY 2023-24	TF	GF
Appropriation Year 2021-22	$100,000	$100,000
Appropriation Year 2022-23	$251,500	$251,500
Total FY 2023-24	**$351,500**	**$351,500**

(Dollars in Thousands)

FY 2024-25	TF	GF
Appropriation Year 2022-23	$198,500	$198,500
Total FY 2024-25	**$198,500**	**$198,500**

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

CALAIM - BH PAYMENT REFORM

REGULAR POLICY CHANGE NUMBER: 162
IMPLEMENTATION DATE: 9/2023
ANALYST: Elena Susbilla
FISCAL REFERENCE NUMBER: 2386

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$250,000,000	$0
- STATE FUNDS	$250,000,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$250,000,000	$0
STATE FUNDS	$250,000,000	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change provides one-time General Funds (GF) to initially fund the non-federal share of behavioral health-related services at the start of the CalAIM Behavioral Health (BH) Payment Reform implementation.

Authority:
Budget Act of 2023 [AB 102 (Chapter 38, Statutes of 2023)]
AB 118 (Chapter 42, Statutes of 2023)

Interdependent Policy Changes:
Not Applicable

Background:
The Short-Doyle Medi-Cal (SD/MC) claims payment system processes the fee-for-service claims, that include Drug Medi-Cal (DMC) State Plan, Drug Medi-Cal Organized Delivery System (DMC ODS), and Specialty Mental Health Services (SMHS). Currently, counties are reimbursed for these programs through the interim rate payment process according to Medicaid Certified Public Expenditure (CPE) methodologies. The county reimbursements are later reconciled through cost settlements.

As the Department implements the CalAIM BH payment reform and the new Intergovernmental Transfer (IGT) process in FY 2023-24, counties will need to transfer the county portion of the submitted claims before Federal Financial Participation can be used for payment. Counties have raised concerns that the IGT process will create a significant cash flow issue for counties.

CALAIM - BH PAYMENT REFORM
REGULAR POLICY CHANGE NUMBER: 162

To address the counties' cash flow concerns, initial one-time GF will be transferred to the Medi-Cal County Behavioral Health Fund to provide counties support for the non-federal share of behavioral health-related services at the start of the CalAIM BH payment reform implementation, effective July 1, 2023. The GF will be used as the non-federal share for direct services payments in lieu of IGTs during the first sixty (60) days of the BH payment reform implementation. After the first sixty days or when the $250,000,000 is exhausted, counties will begin reimbursing the state using IGTs on an ongoing basis.

Reason for Change:
There is no change in FY 2023-24 from the prior estimate.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to payments completed in FY 2023-24.

Methodology:
1. Assume a one-time $250,000,000 GF appropriation to the Medi-Cal County Behavioral Health Fund in FY 2023-24.

2. Funds will be allocated to SMHS Mental Health Plans (MHP) and DMC county providers.

3. The estimated payments in FY 2023-24 are:

(Dollars in Thousands)

FY 2023-24	TF	SF*
CalAIM BH Payment Reform	$250,000	$250,000
Total	**$250,000**	**$250,000**

Funding:
100% General Fund* (4260-119-0001)
Medi-Cal County Behavioral Health Payment Reform (less funded by GF) (4260-695-3420)
Medi-Cal County Behavioral Health Payment Reform* (4260-601-3420)

CYBHI - EVIDENCE-BASED BH PRACTICES

REGULAR POLICY CHANGE NUMBER: 163
IMPLEMENTATION DATE: 4/2023
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 2323

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$242,450,000	$151,610,000
- STATE FUNDS	$242,450,000	$151,610,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$242,450,000	$151,610,000
STATE FUNDS	$242,450,000	$151,610,000
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the cost of grants to scale Evidence-Based Practices (EBP) and Community-Defined Evidence Practices (CDEP) statewide, to improve youth Behavioral Health (BH) based on robust evidence for effectiveness, impact on racial equity, and sustainability.

Authority:
Budget Act of 2022 [AB 179 (Chapter 249, Statutes of 2022)]
Welfare & Institutions Code 5961.5
Interagency Agreement (22-20616)

Interdependent Policy Changes:
Not Applicable

Background:
As part of the Children and Youth Behavioral Health Initiative (CYBHI), the Department, will distribute $429 million in grants to organizations seeking to scale EBPs and/or CDEPs. By scaling EBPs and CDEPs throughout the state, the Department aims to improve access to critical BH interventions, including those focused on prevention, early intervention, and resiliency/recovery for children and youth, with a specific focus on children and youth who are from either or both of the following groups: Black, Indigenous, and People of Color (BIPOC) and the LGBTQIA+ community.

Through an extensive community engagement process, the Department selected a limited number of EBPs and CDEPs to consider for scaling throughout the state, subject to further refinement based on an assessment of sustainable financing mechanisms, including Medi-Cal and commercial coverage and/or other funding streams. Funding will be issued through competitive grants to counties, tribal entities, health plans (Medi-Cal and commercial), community-based organizations, and BH providers to support implementation of these EBPs and programs for children and youth. Grants would be administered through a third-party grant administrator. Grantees would be required to share standardized data in a statewide BH dashboard.

CYBHI - EVIDENCE-BASED BH PRACTICES

REGULAR POLICY CHANGE NUMBER: 163

The CYBHI is a multiyear package of investments. The CYBHI is intended to transform California's BH system for children and youth aged 0-25 into a world-class, innovative, up-stream focused, ecosystem where all children and young adults are routinely screened, supported, and served for emerging BH needs.

Reason for Change:
The change for Fiscal Year (FY) 2023-24, from the prior estimate, is due to shift in timing of grant payments to grantees based on timing of deliverables required to fulfill grant obligations.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to shift in timing of grant payments to grantees based on timing of deliverables required to fulfill grant obligations.

Methodology:
1. The Department will convene a stakeholder workgroup to identify a small number of evidence-based practices that would then be deployed across the state, through grant-making. The $429 million Total Fund (TF) is available for encumbrance or expenditure until June 30, 2025.

2. The Department is partnering, via an Interagency Agreement (IA), with the Mental Health Oversight & Accountability Commission (MHSOAC) to co-lead two of the six workstreams. Through this IA, the Department will transfer a portion of the dollars. These funds will support the MHSOAC's grant management activities and provision of technical assistance to grantees in these rounds of funding. Of the $42.9 million carved out for MHSOAC, $15 million TF will support grant management and the provision of technical assistance and $27.9 million will support direct awards for grantees in these two rounds of funding.

3. The Department will utilize up to $42.9 million to fund a third-party administrator to assist with grant management, technical assistance and data collection.

4. The estimates for FY 2023-24 and FY 2024-25 on a cash basis are:

(Dollars in Thousands)

FY 2023-24	TF	GF
Evidence-Based BH Practice Grants	$242,450	$242,450
Total FY 2023-24	**$242,450**	**$242,450**

(Dollars in Thousands)

FY 2024-25	TF	GF
Evidence-Based BH Practice Grants	$151,610	$151,610
Total FY 2024-25	**$151,610**	**$151,610**

CYBHI - EVIDENCE-BASED BH PRACTICES
REGULAR POLICY CHANGE NUMBER: 163

5. The table below displays the estimated spending and remaining funds by Appropriation Years:

(Dollars in Thousands)

	TF	GF
Appropriation Year 2022-23	$429,000	$429,000
Prior Year	$34,940	$34,940
Estimated in FY 2023-24	$242,450	$242,450
Estimated in FY 2024-25	$151,610	$151,610
Total Estimated Remaining	$0	$0

6. The estimated costs in FY 2023-24 and FY 2024-25 are as follows:

(Dollars in Thousands)

FY 2023-24	**TF**	**GF**
Appropriation Year 2022-23	$242,450	$242,450
Total FY 2023-24	**$242,450**	**$242,450**

(Dollars in Thousands)

FY 2024-25	**TF**	**GF**
Appropriation Year 2022-23	$151,610	$151,610
Total FY 2024-25	**$151,610**	**$151,610**

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

QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES

REGULAR POLICY CHANGE NUMBER: 164
IMPLEMENTATION DATE: 9/2023
ANALYST: Elena Susbilla
FISCAL REFERENCE NUMBER: 2329

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$168,021,000	$299,723,000
- STATE FUNDS	$25,203,000	$44,958,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$168,021,000	$299,723,000
STATE FUNDS	$25,203,000	$44,958,000
FEDERAL FUNDS	$142,818,000	$254,765,000

Purpose:
This proposal estimates the cost for counties to provide qualifying community-based mobile crisis intervention services to Medi-Cal members in need of Medi-Cal behavioral health services.

Authority:
Welfare & Institutions Code 14680-14685.1
California Constitution Article XIII Section 36
Specialty Mental Health Services (SMHS) Program 1915(b) Waiver
Drug Medi-Cal Organized Delivery System (DMC-ODS) 1115 Waiver
22 CCR § 51341.1
American Rescue Plan (ARP) Act of 2021

Interdependent Policy Changes:
Not Applicable

Background:
Under existing law, the Department is responsible for administering the Medi-Cal Specialty Mental Health Services (SMHS) Waiver Program that provides SMHS to Medi-Cal members through county Mental Health Plans (MHPs). The Department is also responsible for administering substance use disorder (SUD) treatment services through the Drug Medi-Cal Organized Delivery System (DMC-ODS), and the Drug Medi-Cal (DMC) program, for counties not participating in the DMC-ODS.

Crisis intervention services is a current benefit in SMHS, DMC-ODS, and DMC, and counties are required to provide or arrange the services anywhere in the community. However, these services are not currently required to be provided or arranged as “mobile” services, nor are they required to be available in the community 24 hours a day, 7 days a week, with on-call, multidisciplinary teams. Additionally, as currently defined, crisis intervention services does not meet the new federal definition for qualifying community-based mobile crisis intervention services.

QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES
REGULAR POLICY CHANGE NUMBER: 164

The Department added qualifying community-based mobile crisis intervention services, as of January 1, 2023, for a five-year period, as a mandatory Medi-Cal benefit in SMHS, DMC, and DMC-ODS, available to eligible Medi-Cal members, statewide, 24 hours a day, 7 days a week, implemented through the Medi-Cal behavioral health delivery systems by multidisciplinary mobile crisis teams in the community. The Department will develop statewide standards for the new service, including requirements for the multidisciplinary team. The benefit would be provided outside a hospital or other facility setting and include rapid response, assessment, community-based stabilization and de-escalation, warm handoffs, and coordination with and referrals to health, social, and other services and supports, as appropriate.

Section 9813 of the ARP provides states with the option of providing qualifying community-based mobile crisis intervention services during a five-year period, starting April 1, 2022, with an opportunity for three years of 85 percent federal medical assistance percentage for qualifying services. The ARP requires the additional federal medical assistance percentage to supplement, not supplant, the level of state spending for these services in the fiscal year before the first quarter the state elects to implement this service. No current Medi-Cal behavioral health services meet the federal definition of a qualifying community-based mobile crisis intervention services.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to updating the small counties to include Sierra and Amador which increased the Small County estimate and decreased the SMHS estimate.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to the county roll-out completion in the fourth quarter of FY 2023-24. FY 2024-25 reflects all the counties providing services.

Methodology:
1. To estimate the cost of qualifying community-based mobile crisis intervention services related to SMHS, use the total of FY 2018-19 approved claims for Crisis Stabilization (CS) as the basis. Assume the annual cost for qualifying community-based mobile crisis intervention services will be three times the total of FY 2018-19 CS approved claims.

2. For qualifying community-based mobile crisis intervention related to SUD, assume the annual cost is one-third of the total of FY 2018-19 CS approved claims, as we expect these calls to be less frequent. (Most SUD-related calls will be due to an overdose, where a paramedic is the appropriate response.) Assume the split between DMC-ODS and DMC State Plan counties is 80% and 20%, respectively.

3. Beginning July 1, 2023, under the ARP Act, initial funding splits for qualifying community-based mobile crisis intervention services will be covered with 85% federal funds and 15% State General fund through 2025.

QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES
REGULAR POLICY CHANGE NUMBER: 164

4. Assume the delivery of services for medium and large counties will increase by 16.6667% per month, for July 2023 through December 2023, due to roll-out. The twelve counties with the lowest expected number of encounters will begin roll-out January 2024 and complete roll-out by June 2024. The accrual estimates for FY 2023-24 and FY 2024-25 are:

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
Mobile Crisis Response – SMHS	$224,211	$33,632	$190,580
Mobile Crisis Response – DMC-ODS	$18,645	$2,797	$15,848
Mobile Crisis Response – DMC State Plan	$4,661	$699	$3,962
Small County	$3,260	$489	$2,771
Total	$250,778	$37,617	$213,161

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
Mobile Crisis Response – SMHS	$283,214	$42,482	$240,732
Mobile Crisis Response – DMC-ODS	$23,551	$3,533	$20,018
Mobile Crisis Response – DMC State Plan	$5,888	$883	$5,005
Small County	$11,178	$1,677	$9,501
Total	$323,831	$48,575	$275,256

5. Assume 67% of claims for mobile crisis intervention will be paid in the year services are provided and 33% paid in the subsequent year. The cash estimates for FY 2023-24 and FY 2024-25 are:

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
Mobile Crisis Response – SMHS	$150,222	$22,533	$127,688
Mobile Crisis Response – DMC-ODS	$12,492	$1,874	$10,618
Mobile Crisis Response – DMC State Plan	$3,123	$468	$2,655
Small County	$2,184	$328	$1,857
Total	**$168,021**	**$25,203**	**$142,818**

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
Mobile Crisis Response – SMHS	$263,743	$39,561	$224,182
Mobile Crisis Response – DMC-ODS	$21,932	$3,290	$18,642
Mobile Crisis Response – DMC State Plan	$5,483	$822	$4,661
Small County	$8,565	$1,285	$7,280
Total	**$299,723**	**$44,958**	**$254,765**

Funding:
85% Title XIX FF / 15% GF (4260-101-0001/0890)

SELF-DETERMINATION PROGRAM - CDDS

REGULAR POLICY CHANGE NUMBER: 165
IMPLEMENTATION DATE: 7/2020
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 2208

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$120,933,000	$186,473,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$120,933,000	$186,473,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$120,933,000	$186,473,000

Purpose:
This policy change estimates the federal match for the Self Determination Program (SDP) Waiver of the California Department of Developmental Services (CDDS).

Authority:
Welfare & Institutions (W&I) Code Section 4585.8
Interagency Agreement (IA) 19-96260

Interdependent Policy Changes:
Not Applicable

Background:
CDDS, under a federal Home and Community Based Services (HCBS) 1915 (c) waiver, offers and arranges for non-State Plan Medicaid services via the Regional Center system. The SDP waiver allows the State to offer these services to individuals who would otherwise require the level of care provided in a hospital, nursing facility (NF), or in an intermediate care facility for the developmentally disabled (ICF/DD). Services covered under this waiver include but are not limited to: home health aide services, community living and integration supports, non-medical transportation, communication support, family and consumer training, homemaker, nutritional consultation, specialized medical equipment/supplies, respite services, personal emergency response system, crisis intervention and support, employment and prevocational supports, vehicle and environmental accessibility adaptations, skilled nursing, financial management services, independent facilitator services, and transition/set-up expenses.

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

SELF-DETERMINATION PROGRAM - CDDS

REGULAR POLICY CHANGE NUMBER: 165

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to assuming a decrease in the number of individuals likely to enroll in this waiver during the fiscal year.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to projecting more individuals accessing services and utilizing the program in FY 2024-25.

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

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	DHCS FFP
FY 2023-24	$241,865	$120,932	**$120,933**
FY 2024-25	$372,945	$186,472	**$186,473**

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

HOME & COMMUNITY-BASED ALTERNATIVES WAIVER

REGULAR POLICY CHANGE NUMBER: 166
IMPLEMENTATION DATE: 10/2017
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2010

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$393,887,000	$363,800,000
- STATE FUNDS	$196,943,500	$181,900,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	67.95 %	68.75 %
APPLIED TO BASE		
TOTAL FUNDS	$126,240,800	$113,687,500
STATE FUNDS	$63,120,390	$56,843,750
FEDERAL FUNDS	$63,120,390	$56,843,750

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
COVID-19 Increased FMAP – DHCS

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 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 Centers for Medicare & Medicaid Services (CMS) approved a fifth 90-day extension, to March 26, 2023. CMS issued a formal approval for the new waiver on February 2, 2023, and the new HCBA Waiver term became effective on January 1, 2023. The Department's new HCBA waiver does not add slots until the beginning on of January 1, 2025, based on past projected enrollment and attrition trends. However, based on current enrollment and attrition trends, it has been determined that the waiver will reach capacity before the end of 2023. As a result, the Department will be submitting a waiver amendment to add slots earlier, beginning on January 1, 2024.

HOME & COMMUNITY-BASED ALTERNATIVES WAIVER
REGULAR POLICY CHANGE NUMBER: 166

The rate for Personal Care Agencies was increased on January 1, 2022, to align with the state minimum wage increase. Prospective minimum wage increases are budgeted in the Minimum Wage Increase for HCBS Waivers policy change.

Under the new waiver term, the waiver will:

- Add new waiver services,
- Increase waiver slots beginning January 1, 2024, based on projected enrollment and attrition trends, and
- Increase the rates for Intermediate Care Facilities/Developmentally Disabled – Continuous Nursing Care, retroactive to August 1, 2021.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due to increasing projected monthly enrollment based on more recent actuals. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a net decrease due to additional savings being realized from members transitioning from a skilled nursing facility (SNF) to the waiver.

Methodology:
1. Assume there are 8,368 members in the HCBA Waiver in FY 2022-23.

2. Assume the annual cost per member is $47,966.

3. Assume 1,176 new members will transition in FY 2023-24 and FY 2024-25.

4. Assume the PCA rate increase began on January 1, 2022.

5. Assume Assistive Technology Services were implemented, retroactive to January 1, 2023.

6. Assume 60% will be from long-term SNFs and 40% members will be from the community.

7. Assume the average monthly cost in a SNF is $10,349.

8. Assume the waiver costs include Waiver Agency reconciliation payments.

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
Waiver Costs	$441,347	$220,674	$220,673
Savings from SNF	($47,461)	($23,730)	($23,730)
Net Cost	**$393,887**	**$196,944**	**$196,943**
FY 2024-25	**TF**	**GF**	**FF**
Waiver Costs	$498,896	$249,448	$249,448
Savings from SNF	($135,096)	($67,548)	($67,548)
Net Cost	**$363,800**	**$181,900**	**$181,900**

*Totals may differ due to rounding.

HOME & COMMUNITY-BASED ALTERNATIVES WAIVER
REGULAR POLICY CHANGE NUMBER: 166

Funding:
50% Title XIX / 50% GF (4260-101-0890/0001)
COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

CYBHI - URGENT NEEDS AND EMERGENT ISSUES

REGULAR POLICY CHANGE NUMBER: 167
IMPLEMENTATION DATE: 7/2021
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2375

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$106,000,000	$29,000,000
- STATE FUNDS	$106,000,000	$29,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$106,000,000	$29,000,000
STATE FUNDS	$106,000,000	$29,000,000
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the program costs to address new programs categorized as Urgent Needs and Emergent Issues in Children and Youth Behavioral Health Initiative (CYBHI).

Authority:
AB 179 (Chapter 249, Statutes of 2022)
DHCS Agreement #22-20444

Interdependent Policy Change:
Not Applicable

Background:
The CYBHI is a multiyear package of investments as part of the FY 2021-22 budget agreement. The CYBHI is intended to transform California's behavioral health system for children and youth aged 0-25 into a world-class, innovative, up-stream focused, ecosystem where all children and young adults are routinely screened, supported, and served for emerging behavioral health needs.

The COVID-19 pandemic has intensified already swelling children's behavioral health issues. Addressing these needs is vital to California's recovery and consistent with the state's priorities to improve behavioral health for all Californians.

The most glaring behavioral health challenges are borne inequitably by communities of color, low-income communities, LGBTQ+ communities, and in places where adverse childhood experiences are widespread and prominent. These investments align with the state's commitment and ongoing efforts to improve health equity.

The significant investment of one-time funds through the CYBHI will have a meaningful impact on outcomes for children and youth in the long-term. However, as the components of the CYBHI continue to be developed and implemented, there is an urgent and immediate need to continue 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

CYBHI - URGENT NEEDS AND EMERGENT ISSUES
REGULAR POLICY CHANGE NUMBER: 167

issues in children and youth behavioral health. These proposals are consistent with and complementary of the investments in the Children and Youth Behavioral Health Initiative.

The Budget Act of 2022 provided $120,500,000 in FY 2022-23, $25,500,000 in FY 2023-24, and $29,000,000 in FY 2024-25 from the General Fund as part of a multiyear plan to provide $175 million from the General Fund for the following:

- Wellness and Resilience Building Supports for Children, Youth, and Parents (Wellbeing and Mindfulness Program)
- A Video Series to Provide Parents with Resources and Skills to Support their Children's Mental Health
- Leveraging of Emerging Technologies to Develop Next Generation Digital Supports for Remote Mental Health Assessment and Intervention
- School-Based Peer Mental Health Demonstration Project (High School Peer-to-Peer Program)

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due to updated payment timings to vendors. The change in the current estimate, from FY 2023-24 to FY 2024-25, is a decrease due to updated payment timings to vendors.

Methodology:
1. The Budget Act for FY 2022-23 provided $120,500,000 in FY 2022-23, available through June 30, 2025. The Department requested an additional $25,500,000 in FY 2023-24 and an additional $29,000,000 for the FY 2024-25. The table below displays the estimated spending and remaining funds by Appropriation Year:

	TF	GF	FF
Appropriation Year 2022-23			
Prior Years	$0	$0	$0
Estimated in FY 2022-23	$40,000,000	$40,000,000	$0
Estimated in FY 2023-24	$80,500,000	$80,500,000	$0
Total Estimated Remaining	$0	$0	$0
Appropriation Year 2023-24			
Prior Years	$0	$0	$0
Estimated in FY 2023-24	$25,500,000	$25,500,000	$0
Total Estimated Remaining	$0	$0	$0
Appropriation Year 2024-25			
Prior Years	$0	$0	$0
Estimated in FY 2024-25	$29,000,000	$29,000,000	$0
Total Estimated Remaining	$0	$0	$0

CYBHI - URGENT NEEDS AND EMERGENT ISSUES

REGULAR POLICY CHANGE NUMBER: 167

Fiscal Year	TF	GF	FF
FY 2023-24	$106,000,000	$106,000,000	$0
FY 2024-25	$29,000,000	$29,000,000	$0

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

EVIDENCE-BASED DENTAL PRACTICES

REGULAR POLICY CHANGE NUMBER: 168
IMPLEMENTATION DATE: 7/2022
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2322

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$103,921,000	$102,642,000
- STATE FUNDS	$34,176,050	$33,774,550
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$103,921,000	$102,642,000
STATE FUNDS	$34,176,050	$33,774,550
FEDERAL FUNDS	$69,744,950	$68,867,450

Purpose:
This policy change estimates the cost of implementing evidence-based dental practices. Updates include laboratory-processed crowns on posterior teeth for adult Medi-Cal beneficiaries.

Authority:
Welfare & Institutions (W&I) Code Section 14132.88(c)
SB 184 (Chapter 47, Statutes of 2022)

Interdependent Policy Changes:
COVID-19 Increased FMAP – DHCS

Background:
Senate Bill 184 (Chapter 47, Statutes of 2022) amended W&I Code Section 14132.88(c) to reflect coverage of evidence-based dental practices consistent with the American Academy of Pediatric Dentistry (AAPD) and American Dental Association (ADA) guidelines for Medi-Cal dental benefits located in the Medi-Cal Dental Manual of Criteria (MOC), including the restoration of a posterior tooth back to normal function. According to the AAPD and ADA guidelines, a laboratory-processed crown is recommended for custom fit and long lasting treatment to restore a tooth back to normal function if it is badly broken down regardless if it is an abutment for a partial denture. By limiting laboratory-processed crowns only as an abutment for a cast metal partial denture, Medi-Cal beneficiaries are denied the most current dental standard of care. If the tooth does not meet the criteria of an abutment for a cast partial denture, the only other treatment available to Medi-Cal beneficiaries is a pre-fabricated stainless steel crown. The use of stainless steel crowns can lead to decay and possible damage to gum tissue around the tooth because the margins of the stainless steel crowns are not custom fitted to the tooth the way laboratory-processed crowns are. In standard practice, the stainless steel crown is a temporary solution until a laboratory-processed crown can be produced.

Reason for Change:
The change from the previous estimate, for FY 2023-24, is an increase due to updated claims

EVIDENCE-BASED DENTAL PRACTICES
REGULAR POLICY CHANGE NUMBER: 168

data. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to lower estimated Dental Managed Care costs for FY 2024-25.

Methodology:

1. Fee-for-service (FFS) cost estimates for this benefit were developed using 6 months of actual claims data from October 2022 to March 2023.

2. All FFS claims were assessed at the Schedule of Maximum Allowances (SMA) of $340 and averaged for a monthly estimated expenditure.

3. Any portion of the costs attributable to Proposition 56 Supplemental Payments is captured in its respective policy change.

FY 2023-24	TF	GF	FF
Fee-for-Service	$100,097,000	$32,976,000	$67,120,000
Dental Managed Care	$3,824,000	$1,199,000	$2,625,000
Total	**$103,921,000**	**$34,175,000**	**$69,745,000**

FY 2024-25	TF	GF	FF
Fee-for-Service	$100,097,000	$32,976,000	$67,120,000
Dental Managed Care	$2,545,000	$798,000	$1,747,000
Total	**$102,642,000**	**$33,774,000**	**$68,867,000**

*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)
COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

CALAIM - PATH WPC

REGULAR POLICY CHANGE NUMBER: 169
IMPLEMENTATION DATE: 10/2023
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2439

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$101,000,000	$0
- STATE FUNDS	$50,500,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$101,000,000	$0
STATE FUNDS	$50,500,000	$0
FEDERAL FUNDS	$50,500,000	$0

Purpose:
This policy change estimates the funding available for the 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

Interdependent Policy Changes:
COVID-19 Increased FMAP – DHCS

Background:
On December 29, 2021, the Centers for Medicare & Medicaid Services (CMS) approved the CalAIM Section 1115 Wavier Demonstration, which provided funding for the CalAIM PATH Initiative through December 31, 2026. The state is authorized up to $1.85 billion (total computable) in expenditure authority for PATH. The PATH Initiative is to build up the capacity and infrastructure of on-the-ground partners and providers to successfully participate in CalAIM Enhanced Care Management (ECM) and Community Supports, and Justice Involved (JI) Services. PATH is comprised of the following efforts.

ECM and Community Supports Capacity and Infrastructure Building
PATH will provide funding to transition, build, expand, and maintain infrastructure/capacity to support the implementation of ECM and Community Supports. This goal will be achieved through four initiatives. Cost for the WPC Services and Transition to Managed Care Mitigation Initiative 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 Justice-Involved Capacity Building Program are budgeted in the CalAIM – PATH policy change. PATH initiatives consider

CALAIM - PATH WPC
REGULAR POLICY CHANGE NUMBER: 169

other efforts such as the Incentive Payment Program and the Housing and Homeless Incentive Program to ensure alignment and nonduplication of funding.

Under the WPC Services and Transition to Managed Care Mitigation Initiative, services provided by former Whole Person Care Pilots will be funded until the services transition to managed care coverage under CalAIM. This funding will end by 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 percent regular administrative expenditure matching rate. Funding for Sustaining Services Through the Transition to Managed Care will be matched at the federal medical assistance payment (FMAP) matching rate as Medicaid services and benefits.

Reason for Change:
This is a new policy change. Funding for WPC mitigation activities were previously budgeted in the CalAIM – PATH policy change, however, these dollars were shifted out as WPC Mitigation services are direct beneficiary services that align with approved Community Supports. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease as all payments will be completed in FY 2023-24.

Methodology:
1. The Department has awarded eight former WPC Lead Entities to receive PATH WPC Services and Transition to Managed Care Mitigation Initiative funding. Invoices will be processed in September and May for expenditures through April 2024 to cover JI Services that are delayed to transition under a Managed Care Plan.
    a. Assume midyear Invoices that capture expenditures from January 1 – June 30 are due in August 2023. The Department reviews and provides approval for payment process to begin in September.
    b. Assume annual invoices that capture expenditures from July 1 – December 31 are due in April 2024. The Department reviews and provides approval for payment process to begin in May.

2. The Department payment will be made through an Intergovernmental Transfer process. The Department will inform the WPC Lead Entity that their invoice has been approved. The former WPC Lead Entity has seven days to wire 50% of their approved invoice amount to the Department. The Department will provide the remaining 50% federal match amount. The total 100% approved invoice amount will be paid back to the former WPC Lead Entity.

3. Assume that due to the amendment of the 1115 waiver, Funding for Sustaining Services Through the Transition to Managed Care will be billed as direct beneficiary services and qualify for increased FMAP through December 31, 2023, as a result of Coronavirus Disease 2019 (COVID-19).

4. On a cash basis, PATH WPC Program costs are estimated to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2023-24	$101,000	$50,500	$50,500

CALAIM - PATH WPC
REGULAR POLICY CHANGE NUMBER: 169

Funding:
(Dollars in Thousands)

FY 2023-24	TF	GF	FF
100% Title XIX FF (4260-101-0890)	$50,500	$0	$50,500
Reimbursement GF (4260-601-0995)	$50,500	$50,500	$0
Total	**$101,000**	**$50,500**	**$50,500**

* COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

LA COUNTY JUSTICE-INVOLVED POP. SVCS & SUPPORTS

REGULAR POLICY CHANGE NUMBER: 170
IMPLEMENTATION DATE: 9/2023
ANALYST: Elena Susbilla
FISCAL REFERENCE NUMBER: 2365

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$99,220,000	$0
- STATE FUNDS	$99,220,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$99,220,000	$0
STATE FUNDS	$99,220,000	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates grant funding to support and expand access to treatment for individuals with behavioral health disorders that are involved in the justice system, including the misdemeanor incompetent to stand trial (MIST) population in Los Angeles County.

Authority:
Budget Act of 2022 [AB 179 (Chapter 249, Statutes of 2022)]

Interdependent Policy Changes:
Not Applicable

Background:
The Department seeks to address the needs of individuals with behavioral health disorders that are involved in the justice system, including the MIST population in Los Angeles County to access community-based treatment and housing. Of the $100 million one-time grant funding, $50 million is to support individuals charged with a misdemeanor and found incompetent to stand trial. The funding would be allocated as follows:

- At least 75% of the funding will be used for capital costs to construct, acquire or rehabilitate treatment and housing facilities which could include, but not limited to, any non-corrections settings including residential treatment settings, clinically enhanced interim housing settings, licensed adult and senior care settings, and permanent supportive housing.
    - Funding may be used for a capitalized operating subsidy reserve.
    - Facilities must commit to providing health care treatment or housing, or both, for the target population in the financed facility or facilities for a minimum of thirty years.
- Up to 25% of the funding will be used for rental subsidies to support placement of justice-involved individuals in residential settings.
- The Department plans to utilize a Department of Finance transfer of $780,000 from this appropriation for state operation costs.

LA COUNTY JUSTICE-INVOLVED POP. SVCS & SUPPORTS

REGULAR POLICY CHANGE NUMBER: 170

Los Angeles County would be required to provide a 10% match and the match may include an in-kind match such as the land value where a facility is sited.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to the shift in payments from FY 2022-23 to FY 2023-24.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to the completion of grant payments in FY 2023-24.

Methodology:
1. Assume $99,220,000 General Fund (GF) will be provided in FY 2023-24.

(Dollars in Thousands)

FY 2023-24	TF	GF
LA County Treatment and Housing	$99,220	$99,220
Total	**$99,220**	**$99,220**

2. Funding provided in the Budget Act for FY 2022-23 is available for expenditure through June 30, 2027. The table below displays the estimated spending and remaining funds by Appropriation Years:

(Dollars In Thousands)

Appropriation Year 2022-23	TF	GF
Prior Years	$0	$0
Estimated in FY 2023-24	$99,220	$99,220
Estimated in FY 2024-25	$0	$0
Total Estimated Remaining	$0	$0

3. The estimated costs in FY 2023-24 are as follows:

(Dollars In Thousands)

FY 2023-24	TF	GF
Appropriation Year 2022-23	$99,220	$99,220
Total FY 2023-24	**$99,220**	**$99,220**

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

ASSISTED LIVING WAIVER EXPANSION

REGULAR POLICY CHANGE NUMBER: 171
IMPLEMENTATION DATE: 10/2021
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2054

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$171,099,000	$146,900,000
- STATE FUNDS	$85,549,500	$73,450,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	43.41 %	37.00 %
APPLIED TO BASE		
TOTAL FUNDS	$96,824,900	$92,547,000
STATE FUNDS	$48,412,460	$46,273,500
FEDERAL FUNDS	$48,412,460	$46,273,500

Purpose:
This policy change estimates the cost to increase the capacity of the Assisted Living Waiver (ALW).

Authority:
SB 840 (Chapter 29, Statutes of 2018)
American Rescue Plan (ARP) Act (2021)
Families First Coronavirus Response Act (FFCRA), (P.L. 116-127), Section 6008
Coronavirus Aid Relief and Economic Security (CARES) Act, Public Law 116-136 (2020)

Interdependent Policy Changes:
American Rescue Plan Increased FMAP for HCBS

Background:
The ALW offers services in an assisted living or public subsidized housing setting to Medi-Cal members who would likely otherwise receive care in a skilled nursing facility. Eligibility into the ALW is based on a qualifying skilled nursing level of care which is captured through the assessment tool used by the Care Coordination Agencies to assess potential members.

The ARP provides additional Coronavirus Disease 2019 (COVID-19) relief to states. Section 9817 of the ARP provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS). States must use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021, and states must use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. State funds equivalent to the amount of federal funds attributable to the increased FMAP are deposited in the Home and Community-Based Services American Rescue Plan Fund. States must expend the federal funds attributable to the increased FMAP by March 31, 2024.

ASSISTED LIVING WAIVER EXPANSION
REGULAR POLICY CHANGE NUMBER: 171

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. 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 July 2023, approximately 4,100 slots have been released for transitioning members for placement into the ALW.

The FFCRA provides increased federal funding by increasing the 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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is a net increase in costs due to revised ALW enrollment data and clearing the enrollment backlog, which increased the average monthly enrollment. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease in net costs due to additional members transitioning from a skilled nursing facility (SNF) into the ALW, where waiver costs are lower than SNF costs.

Methodology:
1. Assume 7,000 new members will transition by FY 2023-24.

2. Of the new 7,000 members, assume 5,000 will be from the community only and 2,000 will be from the community and SNF.

3. Of the 2,000 members, assume 60% will be from long-term SNFs and 40% will be from the community; 1,200 members are from SNFs and 800 members are from the community.

4. Once all 7,000 slots are filled, assume members who leave the waiver will be back-filled with 60% of members coming from long-term SNFs and 40% of members coming from the community.

5. Assume a total of 3,319 members will transition in FY 2023-24 and 1,800 members in FY 2024-25.

6. Beginning January 1, 2023, assume ALW costs increased due to the minimum wage increase from $15.00 to $15.50 an hour. Beginning January 1, 2024, assume ALW costs increased due to the minimum wage increase from $15.50 to $16.00 per hour. Beginning

ASSISTED LIVING WAIVER EXPANSION
REGULAR POLICY CHANGE NUMBER: 171

January 1, 2025, assume an increase in ALW costs due to the minimum wage increase from $16.00 to $16.40 an hour. Prospective minimum wage increases are budgeted in the Minimum Wage Increase for HCBS Waivers policy change.

7. Assume an average of 282 members will enroll per month.

8. Assume the average annual cost for waiver services is $52,762.

9. Assume the average annual cost in an SNF is $124,189.

10. Assume a 10% enhanced FMAP through March 31, 2024.

11. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, and is captured in the HCBS SP - ALW Funding Shift policy change.

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
Total Cost from Waiver Services	$286,978	$143,489	$143,489
Total Savings from SNF Transitions	($115,879)	($57,939)	($57,940)
Net Impact	**$171,099**	**$85,550**	**$85,549**

FY 2024-25	TF	GF	FF
Total Cost from Waiver Services	$423,262	$211,631	$211,631
Total Savings from SNF Transitions	($276,362)	($138,181)	($138,181)
Net Impact	**$146,900**	**$73,450**	**$73,450**

*Totals may differ due to rounding.

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

EQUITY & PRACTICE TRANSFORMATION PAYMENTS

REGULAR POLICY CHANGE NUMBER: 172
IMPLEMENTATION DATE: 7/2023
ANALYST: Erik Stacey
FISCAL REFERENCE NUMBER: 2346

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$92,500,000	$135,000,000
- STATE FUNDS	$46,250,000	$67,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$92,500,000	$135,000,000
STATE FUNDS	$46,250,000	$67,500,000
FEDERAL FUNDS	$46,250,000	$67,500,000

Purpose:
This policy change estimates the costs of the Equity & Practice Transformation Payments.

Authority:
Budget Act of 2022 – AB 179 (Chapter 249, Statutes of 2022)

Interdependent Policy Changes:
COVID-19 Increased FMAP - DHCS

Background:
The Department will administer the Equity and Practice Transformation (EPT) Payments Program, which will support qualifying providers, in improving quality, health equity and primary care infrastructure. The program will include payments and a learning collaborative to do the following: advance equity; address gaps in preventive, maternity, and behavioral health care measures; reduce COVID-19 driven care disparities; support upstream interventions to address social drivers of health and improve early childhood outcomes; 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.

The multiyear plan for these payments includes $700 million TF over several years to:

- Support a statewide learning collaborative to ensure successful implementation ($25 million) beginning in 2024.
- Support practice-level activities in 2023. A portion of the funding ($25 million) will be used for MCP incentives to encourage MCPs to support small and medium independent practices in assessing ability to transform their practices.
- Support larger scale EPT payments ($650 million) beginning in 2024.

EQUITY & PRACTICE TRANSFORMATION PAYMENTS

REGULAR POLICY CHANGE NUMBER: 172

Equity and Practice Transformation Payments will support delivery system transformation, specifically targeting primary care practices (that provide primary care pediatrics, family medicine, internal medicine, primary care obstetrician/gynecologists, or behavioral health providers providing integrated behavioral health services in a primary care setting to Medi-Cal members). Recognizing the wide variation in primary care infrastructure, capacity, and ability to pursue value-based payment, DHCS envisions a 5-year primary care transformation process that begins with foundational infrastructure investments and, over the course of five years, scales evidence-based models of team-based care and prepares practices to assume risk-bearing contracts or join existing state alternative payment model demonstrations.

Practices are to work on one or more of the following pathways (although they must meet foundational pathway requirements in order to participate in other pathways):

- **Foundational Pathway:** Infrastructure building through investments in people, process and technology (technology infrastructure to support population health and high-quality care and foundational primary care processes and team-based care improvements)

- **Scaling Evidence-Based models Pathway:** Advanced primary care and other models focused on Bold Goal Focus Areas

- **Value-Based Payment Pathway:** Readiness activities to enter into VBP arrangements (e.g., FQHC APM, VBP contracts with MCP, other demonstrations)

Moreover, $200 million of the $650 million will be dedicated towards preparing practices for value-based care. The goal of this funding is to support the development of primary care practices that are delivering the kind of care that will support practices to move away from models of care centered on fee-for-service reimbursement that often prioritize utilization, to those that achieve high-value care. This care should include: integrated whole person care, including physical, behavioral, oral health, and long-term services and supports, designed to achieve high quality and equitable outcomes; data informed innovation that encourages routine health information exchange between managed care plans and providers; care model flexibility for practices to deliver care in the manner that is best for each member and to address member needs, including social determinants of health, and reduced administrative burden with alignment of measures across departmental programs to ensure greatest impact on quality targets.
Funding will be provided over several fiscal years as follows:

- $92.5 million TF ($46.25 million GF) in FY 2023-24
- $135 million TF ($67.5 million GF) in FY 2024-25
- $135 million TF ($67.5 million GF) in FY 2025-26
- $337.5 million TF ($168.75 million GF) in FY 2026-27 and later.

Reason for Change:
There is no change from the prior estimate for FY 2023-24.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to the anticipated payment timing of the Directed Payment portion of the program.

EQUITY & PRACTICE TRANSFORMATION PAYMENTS

REGULAR POLICY CHANGE NUMBER: 172

Methodology:

1. The Budget Act for FY 2022-23 provides $140 million TF ($70 million GF), available for expenditure through June 30, 2027. Funding appropriated in FY 2022-23 is sufficient to cover projected expenditures in FY 2023-24, with an additional $47.5 million TF ($23.75 million GF) available for FY 2024-25. An additional $87.5 million TF ($43.75 million GF)in spending authority will be required to meet projected expenditures for FY 2024-25.. The table below displays the estimated spending and remaining funds by Appropriation Year:

	TF	GF	FF*
Appropriation Year 2022-23			
Estimated in FY 2023-24	$92,500,000	$46,250,000	$46,250,000
Estimated in FY 2024-25	$47,500,000	$23,750,000	$23,750,000
Appropriation Year 2024-25			
Estimated in FY 2024-25	$87,500,0000	$43,750,0000	$43,750,0000

2. The estimated costs in FY 2023-24 are as follows:

FY 2023-24	TF	GF	FF*
Appropriation Year 2022-23	$92,500,000	$46,250,000	$46,250,000
Total FY 2023-24	**$92,500,000**	**$46,250,000**	**$46,250,000**

3. The estimated costs in FY 2024-25 are as follows:

FY 2024-25	TF	GF	FF*
Appropriation Year 2022-23	$47,500,000	$23,750,000	$23,750,000
Appropriation Year 2024-25	$87,500,000	$43,750,000	$43,750,000
Total FY 2024-25	**$135,000,000**	**$67,500,000**	**$67,500,000**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS

REGULAR POLICY CHANGE NUMBER: 173
IMPLEMENTATION DATE: 6/2011
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1232

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$69,501,000	$69,462,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$69,501,000	$69,462,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$69,501,000	$69,462,000

Purpose:
This policy change estimates the federal financial participation (FFP) for transportation and day care costs of Intermediate Care Facility - Developmentally Disabled (ICF-DD) members for the California Department of Developmental Services (CDDS).

Authority:
Interagency Agreement (IA) 07-65896
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

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 is currently arranged for and paid by the local Regional Centers, which in turn bills the CDDS for reimbursement with 100% General Fund (GF) dollars.

On April 15, 2011, the Centers for Medicare and Medicaid Services (CMS) approved a State Plan Amendment (SPA) to obtain FFP for the transportation and day care costs of ICF-DD members. CMS approved reimbursement for these costs retroactive to July 1, 2007.

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

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 extends its availability through the last day of the calendar quarter of the national public health emergency (PHE).

ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS

REGULAR POLICY CHANGE NUMBER: 173

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is an increase due to slight increases in current year expenditures from increased utilization and additional prior year expenditures in FY 2023-24.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to the assumption that the current year expenditures will be the same as in FY 2023-24 and less prior year expenditures in FY 2024-25.

Methodology:
1. FY 2023-24 includes a portion of payments for FY 2021-22 and FY 2022-23 expenditures. FY 2024-25 includes a portion of payments for FY 2023-24 expenditures.

2. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

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

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	FFP Regular	COVID-19 FF	Total FFP
FY 2023-24	$134,503	$65,002	**$67,251**	**$2,250**	**$69,501**
FY 2024-25	$138,924	$69,462	**$69,462**	**$0**	**$69,462**

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

MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG

REGULAR POLICY CHANGE NUMBER: 174
IMPLEMENTATION DATE: 7/2019
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 2097

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$55,581,000	$65,742,000
- STATE FUNDS	$55,581,000	$65,742,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$55,581,000	$65,742,000
STATE FUNDS	$55,581,000	$65,742,000
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the cost of the Medi-Cal Physicians and Dentists Loan Repayment Program.

Authority:
SB 170 (Chapter 240, Statutes of 2021)
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 beneficiaries of Medi-Cal and other specified health care programs.

Each cohort will receive the payments over five years.

SB 89 (Chapter 2, Statutes of 2020) appropriated an additional $120 million in Proposition 56 funding and made the combined $340 million available until June 30, 2029. SB 170 (Chapter 240, Statutes of 2021) transferred the balance of these appropriations to the Loan Repayment Program Account, Healthcare Treatment Fund.

MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG

REGULAR POLICY CHANGE NUMBER: 174

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.

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:
The change for FY 2023-24, from the prior estimate, is an increase due to updated loan repayment data and estimated payment timings. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due updated loan repayment data and projected invoice payments.

Methodology:
1. Cohort 1 is expected to receive $13.2 million each year for 5 years, with payments beginning in FY 2020-21. Cohort 2 is expected to receive $13.3 million each year for 5 years, with payment beginning in FY 2021-22. Cohort 3 is expected to receive $13.1 million each year for 5 years, with payment beginning in FY 2022-23. Cohort 4 is expected to receive $12.9 million each year for 5 years, with payment beginning in FY 2023-24.

2. Awardee payments are issued retrospectively and annually for five years for each Cohort and once the awardees annual review is complete and indicates they are within compliance per the program administrator. Due to some CalHealthCares awardees also receiving retroactive Public Student Loan Forgiveness (PSLF), some CalHealthCares awardees will be returning all or a portion of their CalHealthCares award amounts back to the Department.

3. The contract for the administrative costs is approximately $1.3 million in FY 2023-24 and $1.7 million FY 2024-25, with the payments being retrospective and invoices processed the month after services have been provided.

4. The estimated program expenditures for FY 2023-24 and FY 2024-25 are:

Fiscal Years	TF	SF
FY 2023-24	$55,581,000	$55,581,000
FY 2024-25	$65,742,000	$65,742,000

Funding:
100% Prop 56 Loan Repayment Program (4260-601-3375)

CALHOPE

REGULAR POLICY CHANGE NUMBER: 175
IMPLEMENTATION DATE: 5/2022
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 2355

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$51,813,000	$25,880,000
- STATE FUNDS	$51,813,000	$25,880,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$51,813,000	$25,880,000
STATE FUNDS	$51,813,000	$25,880,000
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the costs to temporarily extend support for the CalHOPE program.

Authority:
Budget Act of 2022 [AB 179 (Chapter 249, Statutes of 2022)]

Interdependent Policy Changes:
Not Applicable

Background:
The CalHOPE program, available to all populations including adults, is a component of the crisis continuum of support and care and its elements include:

- Media messaging to destigmatize stress and anxiety and promote help-seeking, including using trusted messengers to reach diverse populations,
- CalHOPE web services,
- CalHOPE Warm Line, and
- CalHOPE Connect partnership with up to 30 community-based organizations, with over 400 peer crisis counselors.

The CalHOPE program was initially funded through grants provided by the Federal Emergency Management Agency (FEMA), and the Substance Abuse and Mental Health Services Administration, with the federal grants expiring August 2022.

Because CalHOPE provides crisis services to a large California population, without additional funding to support the program after federal funding expires, services would abruptly stop, ending employment for 500 peer workers and ceasing the availability of crisis counseling by chat and phone for thousands of Californians currently using the services.

The Department, as part of the Children and Youth Behavioral Health Initiative (CYBHI) will procure a business services vendor to deliver and monitor BH wellness services and treatments through a direct service, virtual platform by January 2024. The behavioral health virtual services

CALHOPE
REGULAR POLICY CHANGE NUMBER: 175

platform will provide services, including peer support services, similar to those funded by the CalHOPE program.

In addition, the California Health and Human Services Agency is launching a stakeholder planning process to create a long term plan for the crisis continuum of care.

Until the CYBHI virtual platform launches in January 2024 and further work is done to enhance the behavioral health crisis continuum of care, temporary state funds would fund key services in CalHOPE through January 2024, at which point CalHOPE will continue by integrating into the CYBHI behavioral health virtual services platform.

Reason for Change:
The change for FY 2023-24, from the prior estimate, is due to the shift in timing of payments to vendors and delay payments of some funds until FY 2024-25.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to contracts ending in FY 2023-24 and remaining funds being spent in FY 2024-25.

Methodology:
1. A combined total of $120 million is available for expenditure over two years, FY 2022-23 and FY 2023-24. In FY 2022-23, actual expenditures totaled $68.2 million out of the $69.5 million General Fund (GF) allocation, with a remaining balance of $1.3 million. It is estimated that the remaining balance of $1.3 million from the prior year, and $50.5 million in Mental Health Special Fund (MHSF) will be spent in FY 2023-24.

2. Additionally, the Budget Act of 2022 [AB 179 (Chapter 249, Statutes of 2022)] appropriated $16.423 million one-time GF and $13.577 million one-time MHSF, available for expenditure until June 30, 2025, to support the peer-run warm line, administered by the Mental Health Association of San Francisco.

   The table below displays the estimated spending and remaining funds by Appropriation Year:

(Dollars in Thousands)

	TF	GF	MHSF
CalHOPE	$120,000	$69,500	$50,500
Prior Year	$68,187	$68,187	$0
Estimated in FY 2023-24	$51,813	$1,313	$50,500
Total Estimated Remaining	$0	$0	$0
Appropriation Year 2022-23	$30,000	$16,423	$13,577
Prior Year	$4,120	$0	$4,120
Estimated in FY 2024-25	$25,880	$16,423	$9,457
Total Estimated Remaining	$0	$0	$0

3. This funding is for services that are separate and distinct from those covered in the CYBHI - CalHOPE Student Support Services policy change.

CALHOPE
REGULAR POLICY CHANGE NUMBER: 175

4. The estimated payments for FY 2023-24 and FY 2024-25 are:

(Dollars in Thousands)

FY 2023-24	TF	GF	MHSF
CalHOPE	$51,813	$1,313	$50,500
Total FY 2023-24	**$51,813**	**$1,313**	**$50,500**

(Dollars in Thousands)

FY 2024-25	TF	GF	MHSF
Appropriation Year 2022-23	$25,880	$16,423	$9,457
Total FY 2024-25	**$25,880**	**$16,423**	**$9,457**

Funding:
100% State GF (4260-101-0001)
100% Mental Health Services Fund (4260-101-3085)

SECTION 19.56 LEGISLATIVE PRIORITIES

REGULAR POLICY CHANGE NUMBER: 176
IMPLEMENTATION DATE: 11/2021
ANALYST: Ryan Woolsey
FISCAL REFERENCE NUMBER: 2316

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$49,224,000	$0
- STATE FUNDS	$49,224,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$49,224,000	$0
STATE FUNDS	$49,224,000	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change allocates funding approved through Control Sections 19.56 of the Budget Act of 2022 and Sections 19.563 and 19.565 of the Budget Act of 2023 to the Department of Health Care Services as the designated state entity for the distribution of funds to the identified recipients.

Authority:
Budget Act of 2022 – SB 104 (Chapter 189, Statutes of 2023)
Budget Act of 2023 – SB 104 (Chapter 189, Statutes of 2023)

Interdependent Policy Changes:
Not Applicable

Background:
Sections 19.56 of the Budget Act of 2022 and Sections 19.563 and 19.565 of the Budget Act of 2023 appropriate from the state General Fund (GF) for a variety of legislative priorities. The Department of Health Care services is the distributing entity for some of these funds.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to carrying over unallocated funds from the Budget Act of 2022 and the addition of legislative priorities in the Budget Act of 2023.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is because payments are assumed to be completed in FY 2023-24.

SECTION 19.56 LEGISLATIVE PRIORITIES
REGULAR POLICY CHANGE NUMBER: 176

Methodology:

1. The following items from the Budget Act of 2022—totaling $7,000,000—are to be distributed by the Department of Health Care Services and are available through June 30, 2024:
   - $5,000,000 for Madera Community Hospital.
   - $2,000,000 to the County of Los Angeles for the Westside Infant and Family Network.

2. The following items from the Budget Act of 2023—totaling $42,224,023—are to be distributed by the Department of Health Care Services and are available through June 30, 2025:
   - $1,212,000 for City of Hayward for support of the Hayward Evaluation and Response Teams (HEART).
   - $1,250,000 for South Bay Center for counseling.
   - $2,500,000 for Kedren Community Health Center Inc. for the Kedren South – Psychiatric Acute Care Hospital and Children's Village
   - $357,023 for County of Stanislaus Mobile Mental Health Access Point for the Rural Californians Project.
   - $750,000 for City of Costa Mesa for the Behavioral Health Services Expansion & Mobile Mental Health Response Program.
   - $5,000,000 for Chinese Hospital of San Francisco.
   - $1,000,000 for City of Palm Springs for DAP Health.
   - $2,500,000 for Alcoholics Rehabilitation Association, Inc. (ARA).
   - $1,500,000 for Lestonnac Free Clinic Orange County for building improvements and program support.
   - $2,000,000 for San Ysidro Health for the Camp Locket Renovation Project.
   - $1,500,000 for County of San Bernardino For purchasing two mobile health clinics.
   - $500,000 for Friendship House for a drug recovery residential unit to serve Native American women and their children.
   - $1,500,000 for Lestonnac Free Clinic For building upgrades and purchase of a mobile RV unit.
   - $2,500,000 for Riverside University Health System for planning and design costs of Children and Youth Services facilities.
   - $2,000,000 for San Bernardino County for refurbishment of the county's Crisis Residential Treatment Facility in Victorville.
   - $1,000,000 for Center for Elder's Independence (CEI) for Program of All-Inclusive Care for the Elderly (PACE).
   - $1,500,000 for County of Monterey Health Department for the County of Monterey Clinic at Marina.
   - $2,000,000 for Children's Hospital of Los Angeles (CHLA) or the County of Los Angeles to expand the Division of Adolescent and Young Adult Medicine.
   - $2,000,000 for City of Hayward for the St. Rose Hospital Sub-Acute Facility.
   - $2,000,000 for County of San Bernardino for Fontana Crisis Residential Treatment Facility refurbishment.
   - $1,000,000 for County of Los Angeles, Department of Mental Health, for The Friendship Center— El Centro de Amistad.
   - $3,000,000 for Emanate Health Foundation for Emanate Health – Queen of the Valley.
   - $405,000 for Northeast Valley Health Corporation.

SECTION 19.56 LEGISLATIVE PRIORITIES
REGULAR POLICY CHANGE NUMBER: 176

- $1,250,000 for Beacon House Association of San Pedro for Beacon House Association of San Pedro's Bartlett Center.
- $1,000,000 for El Centro Del Pueblo for support of the Community Healing Through Culture and Connections project.
- $1,000,000 for Initiating Change in Our Neighborhoods Community Development Corporation (ICON CDC) for acquisition of a commissary.

3. The table below displays the estimated spending and remaining funds by Appropriation Years:

(Dollars in Thousands)

	TF	GF
Appropriation Year 2022-23	$94,575	$94,575
Prior Years	$87,575	$87,575
Estimated in FY 2023-24	$7,000	$7,000
Estimated in FY 2024-25	$0	$0
Total Estimated Remaining	$0	$0
Appropriation Year 2023-24	$42,224	$42,224
Estimated in FY 2023-24	$42,224	$42,224
Estimated in FY 2024-25	$0	$0

4. The estimated costs in FY 2023-24 are as follows:

(Dollars in Thousands)

FY 2023-24	**TF**	**GF**
Appropriation Year 2022-23	$7,000	$7,000
Appropriation Year 2023-24	$42,224	$42,224
Total FY 2023-24	**$49,224**	**$49,224**

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

INDIAN HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER: 178
IMPLEMENTATION DATE: 4/1998
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 111

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$41,731,000	$20,691,000
- STATE FUNDS	$13,910,500	$6,897,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.72 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$41,430,500	$20,691,000
STATE FUNDS	$13,810,340	$6,897,000
FEDERAL FUNDS	$27,620,190	$13,794,000

Purpose:
This policy change estimates the annual rate change posted in the Federal Register for services in Indian Health facilities.

Authority:
Public Law 93-638
Public Law 102-573 (Title 25, U.S.C. 1665c)

Interdependent Policy Changes:
COVID-19 Increased FMAP – DHCS

Background:
The Department implemented the Indian Health Services/Memorandum of Agreement 638 Clinics (IHS/MOA) between the federal IHS and the Centers for Medicare & Medicaid Services (CMS) on April 21, 1998. The agreement permits the Department to be reimbursed at 100% FFP for payments made by the State for services rendered to American Indians (AIs) through IHS tribal facilities.

Federal policy permits retroactive claiming of 100% federal financial participation (FFP) to the date of the MOA, July 11, 1996, or at whatever later date a facility qualifies and elects to participate as an IHS facility under the MOA.

The Department implemented the enrollment and reimbursement of Youth Regional Treatment Centers (YRTCs) for services rendered to AI youths. Indian health clinics refer these youths to YRTCs for culturally appropriate in-patient substance use disorder treatment. The Department receives 100% FFP for YRTC services provided to eligible AI Medi-Cal members under the age of 21.

The per visit rate payable to the Indian health facilities is adjusted annually through changes posted in the Federal Register. These rates are set by IHS with the concurrence of the Federal Office of Management and Budget and are based on cost reports compiled by IHS.

INDIAN HEALTH SERVICES
REGULAR POLICY CHANGE NUMBER: 178

Reason for Change:
There is no change from the prior estimate for FY 2023-24. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to the CY 2022 rate increase captured in FY 2023-24 being significantly higher than the rate increases captured in FY 2024-25.

Methodology:
1. Effective CY 2023, the updated per visit rate payable to the Indian health clinics increased by $14, from $640 to $654. The annual rate increase for the additional $14 is estimated at $4,288,000 TF.

2. It is estimated, effective CY 2024, the updated per visit rate payable to the Indian health clinics will increase by $34, from $654 to $688. The annual rate increase for the additional $34 is estimated at $10,935,000 TF.

3. It is estimated, effective CY 2025, the updated per visit rate payable to the Indian health clinics will increase by $36, from $688 to $724. The annual rate increase for the additional $36 is estimated at $12,157,000 TF.

4. On a cash basis, the FY 2023-24 and FY 2024-25 estimates are:

Rate Increase	FY 2023-24	FY 2024-25
CY 2022 Rate Increase	$35,298,000	$0
CY 2023 Rate Increase	$4,288,000	$4,288,000
CY 2024 Rate Increase	$0	$10,935,000
Retro Jan-June 2023 Incr.	$2,144,000	$0
Retro Jan-June 2024 Incr.	$0	$5,468,000
Total Rate Increase	**$41,731,000**	**$20,691,000**

Fiscal Year	TF	GF	FF
FY 2023-24	**$41,731,000**	**$13,910,000**	**$27,821,000**
FY 2024-25	**$20,691,000**	**$6,897,000**	**$13,794,000**

*Totals may differ due to rounding.

Funding:
Title XIX 100% FFP (4260-101-0890)
50% Title XIX / 50% GF (4260-101-0890/0001)
COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

CALAIM - PATH FOR CLINICS

REGULAR POLICY CHANGE NUMBER: 179
IMPLEMENTATION DATE: 4/2024
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2423

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$40,000,000	$0
- STATE FUNDS	$40,000,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$40,000,000	$0
STATE FUNDS	$40,000,000	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates cost for the California Advancing & Innovating Medi-Cal (CalAIM) Providing Access and Transforming Health (PATH) Initiative to support the implementation of Enhanced Care Management (ECM) and Community Supports at clinics, including Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs).

Authority:
AB 102 (Chapter 38, Statutes of 2023)
CalAIM Section 1115(a) Medicaid Demonstration

Interdependent Policy Changes:
Not Applicable

Background:
On December 29, 2021, the Centers for Medicare & Medicaid Services (CMS) approved the CalAIM Section 1115 Waiver Demonstration, which provided funding for the CalAIM PATH Initiative through December 31, 2026. The PATH Initiative is to build up the capacity and infrastructure of on-the-ground partners and providers to successfully participate in CalAIM ECM and Community Supports, and Justice Involved Services. This $40,000,000 additional PATH funding supports activities to provide grants to build and expand infrastructure and capacity, to implement ECM and Community Supports at clinics including FQHCs and RHCs.

Reason for Change:
There is no change from the prior estimate for FY 2023-24. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease as all funding is expected to be expended in FY 2023-24.

Methodology:
1. Implementation will begin on April 1, 2024, for this effort.

CALAIM - PATH FOR CLINICS
REGULAR POLICY CHANGE NUMBER: 179

2. It is assumed that PATH funding to support the implementation of ECM and Community Supports at clinics is budgeted at 100% GF.

3. The Budget Act for FY 2023-24 provided $40 million GF. The table below displays the estimated spending and remaining funds by Appropriation Year:

(Dollars in Thousands)

Appropriation Year 2023-24	TF	GF	FF
Estimated in FY 2023-24	$40,000	$40,000	$0
Total Estimated Remaining	$0	$0	$0

4. Total estimated costs for FY 2023-24 are:

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
Appropriation Year 2023-24	$40,000	$40,000	$0
Total FY 2023-24	**$40,000**	**$40,000**	**$0**

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

CARE ACT

REGULAR POLICY CHANGE NUMBER: 180
IMPLEMENTATION DATE: 1/2024
ANALYST: Elena Susbilla
FISCAL REFERENCE NUMBER: 2396

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$39,656,000	$104,928,000
- STATE FUNDS	$39,656,000	$104,928,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$39,656,000	$104,928,000
STATE FUNDS	$39,656,000	$104,928,000
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates county behavioral health department costs to provide services for the Community Assistance, Recovery, and Empowerment Act (CARE).

Authority:
SB 1338 (Chapter 319, Statutes of 2022)
SB 35 (Chapter 283, Statues of 2023)

Interdependent Policy Changes:
Not Applicable

Background:
The CARE Act framework delivers mental health and substance use disorder services for individuals who lack decision-making capacity due to serious mental illness. The framework provides individuals with an individualized, appropriate range of services and supports consisting of behavioral health (BH) care, stabilization medications, housing, and enumerated services.

The CARE Act connects a person in crisis with a court-ordered CARE plan for up to 12 months, with the possibility to extend for an additional 12 months. If a participant cannot successfully complete a CARE plan, the individual may be referred by the court for a conservatorship, consistent with current law. For individuals whose prior conservatorship proceedings were diverted, those proceedings will resume under the presumption that no suitable alternatives to conservatorship are available. For individuals whose criminal cases were diverted, those proceedings will resume.

The counties of Glenn, Orange, Riverside, San Diego, Stanislaus, and Tuolumne and the City and County of San Francisco will implement the program by October 1, 2023, Los Angeles County will implement by December 1, 2023, and the remaining counties no later than December 1, 2024.

CARE ACT
REGULAR POLICY CHANGE NUMBER: 180

SB 35 includes new notification requirements for county behavioral health agencies effective with the implementation of the CARE Act.

Reason for Change:
The change in FY 2023-24, from the prior estimate is due to applying a cash lag to the estimated amount and additional funding estimated due to SB 35 notification requirements.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to the continued implementation of the CARE Act by additional counties and a full year of claiming by the initial cohort.

Methodology:
1. The estimated costs are $6,380,000 GF for notice, $28,918,000 GF for clinical report assessments, $7,795,000 GF for court time, and $9,781,000 for outreach and engagement in FY 2023-24. The estimated costs are $14,755,000 GF for notice, $66,877,000 GF for clinical report assessments, $18,028,000 GF for court time, and $22,620,000 for outreach and engagement in FY 2024-25.

(Dollars in Thousands)

FY 2023-24	TF	GF
Court Time	$7,795	$7,795
Court Report	$28,918	$28,918
Outreach & Engagement	$9,781	$9,781
Notice	$6,380	$6,380
Total	$52,874	$52,874

(Dollars in Thousands)

FY 2024-25	TF	GF
Court Time	$18,028	$18,028
Court Report	$66,877	$66,877
Outreach & Engagement	$22,620	$22,620
Notice	$14,755	$14,755
Total	$122,280	$122,280

CARE ACT
REGULAR POLICY CHANGE NUMBER: 180

2. Assume on a cash basis for FY 2023-24, the Department will pay 75% of FY 2023-24 claims. On a cash basis for FY 2024-25, the Department will pay 25% of FY 2023-24 clams and 75% of FY 2024-25 claims. The estimated costs for FY 2023-24 and FY 2024-25 are:

(Dollars in Thousands)

FY 2023-24	TF	GF
Court Time	$5,847	$5,847
Court Report	$21,688	$21,688
Outreach & Engagement	$7,336	$7,336
Notice	$4,785	$4,785
Total	**$39,656**	**$39,656**

(Dollars in Thousands)

FY 2024-25	TF	GF
Court Time	$15,470	$15,470
Court Report	$57,387	$57,387
Outreach & Engagement	$19,410	$19,410
Notice	$12,661	$12,661
Total	**$104,928**	**$104,928**

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

CYBHI - CALHOPE STUDENT SUPPORT

REGULAR POLICY CHANGE NUMBER: 181
IMPLEMENTATION DATE: 12/2021
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 2291

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$32,000,000	$0
- STATE FUNDS	$32,000,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$32,000,000	$0
STATE FUNDS	$32,000,000	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the funding available to provide training, technical assistance, technology and tools to build and enhance positive social-emotional learning environments in California schools through administration of the CalHOPE Student Support Program.

Authority:
Budget Act of 2021 [SB 129 (Chapter 69, Statutes of 2021)]

Interdependent Policy Changes:
Not Applicable

Background:
The CalHOPE Student Support program launched as part of the Federal Emergency Management Agency (FEMA)/Substance Abuse and Mental Health Services Administration (SAMHSA) Crisis Counseling Program (CCP), in recognition of the challenges and stressors children, youth and families are experiencing: social isolation, lack of school structure, and need to adapt to distance learning. The Department previously partnered with the California Mental Health Services Authority to subcontract with the Sacramento County of Education (SCOE) and provided $12.6 million to SCOE to establish the CalHOPE Student Support program, available between November 2020 and February 9, 2022. There are $45 million included in the Children and Youth Behavioral Health Initiative (CYBHI) to extend this program and expand this effort over a three year period. In addition, a student engagement element will be added.

The CYBHI is a multiyear package of investments. The CYBHI is intended to transform California's behavioral health system for children and youth aged 0-25 into a world-class, innovative, up-stream focused ecosystem where all children and young adults are routinely screened, supported, and served for emerging behavioral health needs.

The CalHOPE Student Support Program was designed to give teachers and staff the skills to prepare a healthy learning environment for children, to be able to easily identify signs of stress and poor functioning, provide support for children and youth, and refer to more intensive services where needed. The training and technical assistance aims to create positive social-

CYBHI - CALHOPE STUDENT SUPPORT
REGULAR POLICY CHANGE NUMBER: 181

emotional learning environments in schools to support children, young people, parents, and school staff, addressing the behavioral health challenges created by social isolation and the stress of the public health emergency.

Reason for Change:
The change from the prior estimate, for FY 2023-24 is due to shift in timing of payments to subcontractors from primary contractor.

The change from FY 2023-24 to FY 2024-25 is due to estimating to fully expend the funding in FY 2023-24.

Methodology:
1. Assume a total of $45,000,000 General Fund (GF) will be provided to a training and technical assistance provider and learning communities. The 2021 Budget Act, Item 4260-101-0001, Provision 16(c) authorizes the funds for encumbrance or expenditure until June 30, 2024.

2. The table below displays the estimated spending and remaining funds by Appropriation Year:

(Dollars in Thousands)

	TF	GF
Appropriation Year 2021-22		
Prior Years	$13,000	$13,000
Estimated in FY 2023-24	$32,000	$32,000
Total Estimated Remaining	$0	$0

3. On a cash basis the Department will be paying $32,000,000 GF in FY 2023-24 for the CalHOPE Student Support program.

(Dollars in Thousands)

FY 2023-24	**TF**	**GF**
Appropriation Year 2021-22	$32,000	$32,000
Total FY 2023-24	**$32,000**	**$32,000**

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

PEER SUPPORT SPECIALIST SERVICES

REGULAR POLICY CHANGE NUMBER: 183
IMPLEMENTATION DATE: 7/2022
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2337

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$24,820,000	$27,255,000
- STATE FUNDS	$5,441,000	$6,685,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$24,820,000	$27,255,000
STATE FUNDS	$5,441,000	$6,685,000
FEDERAL FUNDS	$19,379,000	$20,570,000

Purpose:
This policy change estimates the costs for adding peer support specialist services as a covered benefit in the Specialty Mental Health Services (SMHS) Delivery System, the State Plan, and the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver programs.

Authority:
SB 802 (Chapter 150, Statutes of 2020)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
The SMHS program is currently authorized under California's SMHS Section 1915(b) waiver through December 31, 2021. Through the renewal of the Section 1915(b) waiver, California is seeking to renew that authority and consolidate other Medi-Cal managed care authorities with SMHS.

California Counties have the option to provide DMC services either under the Medi-Cal State Plan or the DMC-ODS Waiver program under the Medi-Cal 2020 Section 1115 demonstration to provide Medi-Cal members who reside in their county with a range of evidence-based substance use disorder (SUD) treatment services.

The DMC-ODS program was originally authorized under California's Medi-Cal 2020 Section 1115 demonstration, and extended through December 31, 2021. Under CalAIM, the Department is continuing and strengthening the SUD treatment system, building on the existing DMC-ODS program. The Department has submitted the renewal requests under the CalAIM Section 1115 Demonstration and a CalAIM 1915(b) waiver proposals requesting changes to the DMC-ODS authority and including additional services and benefits, effective January 2022.

PEER SUPPORT SPECIALIST SERVICES
REGULAR POLICY CHANGE NUMBER: 183

Prior to SB 803, counties could bill for specified peer support services under the Medi-Cal program, as "other mental health services." SB 803 allows counties to develop peer support specialist certification programs through the SMHS, DMC State Plan, and DMC ODS delivery systems, to establish a new peer support services provider type, and to add peer support services as a Medi-Cal benefit. The bill also allows counties to establish certification fee schedules to support ongoing program administration activities upon approval from the Department. Additionally, SB 803 requires the Department, subject to federal approval, to establish statewide requirements for counties that opt to certify peer support specialists by July 1, 2022.

The ongoing provision of peer support services is supported by federal funds (FF) and by county funds (CF) given that SB 803 requires a county that opts to establish a peer specialist certification program for the provision of peer support services to agree to fund the non-federal share of any applicable expenditures and prohibits General Fund moneys for such expenditures.

Peer support specialist services are culturally competent services, provided by certified peer support specialists that promote recovery, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths. Peer support specialists will support California's effort to promote health equity by providing culturally competent services to promote recovery and enhanced access to care across a diverse population, including race/ethnicity, gender identity, sexual orientation, generation, and geographic regions. Certified Peer Support Specialists are unique providers that will be certified by a county or an entity representing a county.

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to a decrease in estimated annual cost assumptions based on a lower ramp up of benefits.

The change in the current estimate, from FY 2023-24 to FY 2024-25, is an increase due to FY 2024-25 including a full year's expenditure and all county portion of the submitted claims being paid through the Intergovernmental Transfer (IGT) process.

PEER SUPPORT SPECIALIST SERVICES

REGULAR POLICY CHANGE NUMBER: 183

Methodology:

1. Peer support specialist services was implemented in July 2022.

2. The Title XIX and Title XXI COVID-19 increased FMAP is assumed for expenditures through December 31, 2023 for this policy change.

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

4. Effective July 1, 2023, non-federal share of costs that was initially funded with CF, is funded through an IGT.

5. Total cost for both SMHS and DMC are as follows:

FY 2023-24	TF	IGT*	FF	COVID-19 FF	CF
SMHS Interim Rate – Adult	$7,039,000	$1,122,000	$5,187,000	$40,000	$690,000
SMHS Interim Rate – Children	$6,341,000	$1,807,000	$3,530,000	$74,000	$930,000
Non-NTP DMC State Plan Interim Rate	$2,474,000	$503,000	$1,802,000	$13,000	$156,000
Non-NTP DMC-ODS Interim Rate	$11,367,000	$2,009,000	$8,685,000	$48,000	$625,000
Total	$27,221,000	**$5,441,000**	**$19,204,000**	**$175,000**	$2,401,000

FY 2024-25	TF	IGT*	FF
SMHS Interim Rate – Adult	$7,061,000	$1,141,000	$5,920,000
SMHS Interim Rate Children	$6,352,000	$2,189,000	$4,163,000
Non-NTP DMC State Plan Interim Rate	$2,475,000	$673,000	$1,802,000
Non-NTP DMC-ODS Interim Rate	$11,367,000	$2,682,000	$8,685,000
Total	$27,255,000	**$6,685,000**	**$20,570,000**

Funding:

100% Title XIX FF (4260-101-0890)
100% Title XXI FF (4260-101-0890)
100% ACA Title XIX FF (4260-101-0890)
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)
COVID-19 Title XIX Increased FFP (4260-101-0890)
COVID-19 Title XXI Increased FFP (4260-101-0890)
Medi-Cal County Behavioral Health Fund (4260-601-3420)*

INFANT DEVELOPMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 184
IMPLEMENTATION DATE: 7/2016
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 2009

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$18,120,000	$14,530,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$18,120,000	$14,530,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$18,120,000	$14,530,000

Purpose:
This policy change estimates the federal match provided to the California Department of Developmental Services (CDDS) for Infant Development Program (IDP) services for infants and toddlers ages 0 to 3 with or at risk of developmental disabilities.

Authority:
Interagency Agreement 11-88601
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

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.

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).

INFANT DEVELOPMENT PROGRAM
REGULAR POLICY CHANGE NUMBER: 184

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is a decrease due to actuals reflecting a decrease in usage of services and projecting a decline.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to assuming a decline in usage of services and no COVID-19 increased FMAP is assumed in FY 2024-25.

Methodology:
1. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

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

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	FF	COVID-19 FF	Total FFP
FY 2023-24	$35,153	$17,033	**$17,576**	**$544**	**$18,120**
FY 2024-25	$29,060	$14,530	**$14,530**	**$0**	**$14,530**

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

ABORTION SUPPLEMENTAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 185
IMPLEMENTATION DATE: 7/2023
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 2373

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$18,564,000	$11,144,000
- STATE FUNDS	$18,564,000	$11,144,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$18,564,000	$11,144,000
STATE FUNDS	$18,564,000	$11,144,000
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the abortion supplemental payment program for nonhospital community clinics that incur significant costs associated with providing abortion services to Medi-Cal beneficiaries.

Authority:
AB 179 (Chapter 249, Statutes of 2022)

Interdependent Policy Changes:
Not Applicable

Background:
The Budget Acts of 2022 and 2023, appropriated funding for the Department to establish a limited-term supplemental payment program for non-hospital community clinics that incur significant costs associated with providing abortion services and that serve Medi-Cal beneficiaries. On a quarterly basis the Department will provide qualifying non-hospital community clinics a supplemental payment for eligible abortion services billed in the Fee-for-Service delivery system.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is a decrease due to a shift in the implementation date for these supplemental payments.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to more supplemental payments occurring in FY 2023-24.

Methodology:
1. This policy implemented on January 1, 2023, and all funding must be expended by June 30, 2025.

2. The Budget Act for FY 2022-23 includes $14,849,000 GF for this item, available for expenditure through June 30, 2024.

ABORTION SUPPLEMENTAL PAYMENT PROGRAM
REGULAR POLICY CHANGE NUMBER: 185

3. For FY 2023-24, additional funding is available in the amount of $14,858,000 GF for expenditure through June 30, 2025, for this item.

4. The table below displays the estimated spending and remaining funds by Appropriations Years:

(Dollars in Thousands)

Appropriation Year 2022-23	**TF**	**GF**	**FF***
Estimated in FY 2023-24	$14,849	$14,849	$0
Total Estimated Remaining	$0	$0	$0
Appropriation Year 2023-24	**TF**	**GF**	**FF***
Estimated in FY 2023-24	$3,715	$3,715	$0
Estimated in FY 2024-25	$11,144	$11,144	$0
Total Estimated Remaining	$0	$0	$0

* Federal funds authority is newly requested for the fiscal year in which funds are anticipated to be expended.

5. The estimated costs in FY 2023-24 and FY 2024-25 are as follows:

(Dollars in Thousands)

FY 2023-24	**TF**	**GF**	**FF***
Appropriation Year 2022-23	$14,849	$14,849	$0
Appropriation Year 2023-24	$3,715	$3,715	$0
Total FY 2022-23	**$18,564**	**$18,564**	**$0**

FY 2024-25	**TF**	**GF**	**FF***
Appropriation Year 2023-24	$11,144	$11,144	$0
Total FY 2023-24	**$11,144**	**$11,144**	**$0**

*Federal funds authority is newly requested for the fiscal year in which funds are anticipated to be expended.

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

MINIMUM WAGE INCREASE FOR HCBS WAIVERS

REGULAR POLICY CHANGE NUMBER: 186
IMPLEMENTATION DATE: 1/2017
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 1975

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$94,716,000	$77,456,000
- STATE FUNDS	$47,358,000	$38,728,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	81.47 %	43.14 %
APPLIED TO BASE		
TOTAL FUNDS	$17,550,900	$44,041,500
STATE FUNDS	$8,775,440	$22,020,740
FEDERAL FUNDS	$8,775,440	$22,020,740

Purpose:
This policy change estimates the costs of increasing the minimum wage for the Home and Community-Based Services (HCBS) providers.

Authority:
SB 3 (Chapter 4, Statutes of 2016)

Interdependent Policy Changes:
COVID-19 Increased FMAP – DHCS
Assisted Living Waiver Expansion

Background:
The passage of AB 10 in 2013 set the minimum wage in California to $10 an hour after January 1, 2016. SB 3 requires a schedule for a phased increase in the minimum wage from $10.50 per hour to $15 per hour by January 1, 2022, or January 1, 2023, depending on the size of the employer and general economic conditions, and link the minimum wage to the U.S. Consumer Price Index once the minimum wage reaches $15 per hour.

Beginning January 1, 2023, an additional set of minimum wage increases will phase in over a 5-year period from $15 per hour to $17 per hour by January 1, 2027.

The minimum wage increase will result in increased costs for multiple long term care programs. HCBS are predominantly provided by individuals working for minimum wage, and this increase will raise the overall cost of HCBS for the Assisted Living Waiver (ALW), Waiver Personal Care Services (WPCS), and Personal Care Agencies (PCA).

The ALW offers Medi-Cal eligible members the choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility. The goal of the ALW is to facilitate nursing facility transition back into homelike and community settings or prevent skilled nursing admissions for members with an imminent need for nursing facility placement.

MINIMUM WAGE INCREASE FOR HCBS WAIVERS

REGULAR POLICY CHANGE NUMBER: 186

The Home and Community-Based Alternatives (HCBA) Waiver provides care management services to persons at risk for nursing home or institutional placement. WPCS is a benefit under the HCBA Waiver and was designed to assist waiver members with remaining safely in their residence and continuing to be part of the community. A PCA is a provider that employs individuals who provide services and is enrolled as an HCBA provider in the HCBA Waiver.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due to additional months of actual caseload data trending higher than previously estimated. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to a lower rate increase versus prior year rate increases.

Methodology:
1. Beginning January 1, 2023, the minimum wage increased from $15.00 to $15.50 per hour. Beginning January 1, 2024, the minimum wage increased from $15.50 to $16.00 per hour. Beginning January 1, 2025, the minimum wage will increase from $16.00 to $16.40 per hour.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2023-24	$94,716	$47,358	$47,358
FY 2024-25	$77,456	$38,728	$38,728

Funding:
50% Title XIX FFP / 50% GF (4260-101-0890/0001)
COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

CLINIC WORKFORCE STABILIZATION RETENTION PAYMENTS

REGULAR POLICY CHANGE NUMBER: 188
IMPLEMENTATION DATE: 7/2022
ANALYST: Erik Stacey
FISCAL REFERENCE NUMBER: 2383

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change budgets funding for the Clinic Workforce Stabilization Retention Program.

Authority:
Budget Act of 2022 – AB 179 (Chapter 249, Statutes of 2022)
Welfare & Institutions Code (W&IC) 14199.70, et seq.
Proposed Legislation

Interdependent Policy Changes:
Not Applicable

Background:
The Budget Act of 2022 provides $70,000,000 from the General Fund for a Clinic Workforce Stabilization Retention Program beginning in FY 2022-23. Funding is available for expenditure through June 30, 2024. Upon the order of the Director of Finance, any remaining funds were to be transferred to the California Department of Health Care Access and Information (HCAI) to fund workforce development programs.

Reason for Change:

There is no dollar change from the prior estimate in FY 2023-24.

There is no dollar change from FY 2023-24 to FY 2024-25 in the current estimate.

Methodology:

1. From the FY 2022-23 appropriation amount, $55,070,000 from the General Fund was provided in FY 2022-23. The remaining $14,930,000 in funds was originally to be transferred to HCAI. However, the Governor's Budget now proposes remaining funds revert to the General Fund to help address the budget shortfall. The table below displays the spending and remaining funds by Appropriation Year:

CLINIC WORKFORCE STABILIZATION RETENTION PAYMENTS

REGULAR POLICY CHANGE NUMBER: 188

	TF	GF
Appropriation Year 2022-23		
Funds Spent in Prior Years	$55,070,000	$55,070,000
Estimated in FY 2023-24	$0	$0
Total Estimated Remaining	$14,930,000	$14,930,000

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

HOSPITAL & SNF COVID-19 WORKER RETENTION PAYMENTS

REGULAR POLICY CHANGE NUMBER: 189
IMPLEMENTATION DATE: 7/2022
ANALYST: Erik Stacey
FISCAL REFERENCE NUMBER: 2367

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$5,984,000	$0
- STATE FUNDS	$5,984,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$5,984,000	$0
STATE FUNDS	$5,984,000	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the costs for Hospital and Skilled Nursing Facility COVID-19 Worker Retention Payments.

Authority:
Budget Act of 2021 – AB 180 (Chapter 44, Statutes of 2022)
SB 184 (Chapter 47, Statutes of 2022)

Interdependent Policy Changes:
Not Applicable

Background:
Pursuant to SB 184 (Chapter 47, Statutes of 2022), one-time payments will be provided to workers in qualifying hospitals and skilled nursing facilities as specified, to support their efforts throughout the COVID-19 pandemic to provide 24-hour patient care, despite the exceedingly high workload and difficult conditions. The payments will be funded from the California Emergency Relief Fund starting in FY 2021-22, available for expenditure through June 30, 2024.

The Budget Act of 2021 provides $1,077,600,000 for the one-time payments, available for expenditure through June 30, 2024.

Reason for Change:
The change in 2023-24 from the prior estimate is an increase due to final payments issued in 2023-24.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is because all remaining payments are assumed to be released in FY 2023-24.

HOSPITAL & SNF COVID-19 WORKER RETENTION PAYMENTS

REGULAR POLICY CHANGE NUMBER: 189

Methodology:

1. From the FY 2021-22 appropriation amount, $1,014,316,000 from the California Emergency Relief Fund was provided to health care workers in FY 2022-23. An additional $5,984,000 will be distributed in FY 2023-24. Remaining funds are not anticipated to be allocated. The table below shows the estimated spending and remaining funds by Appropriation Year:

(Dollars in Thousands)

	TF	California Emergency Relief Fund
Appropriation Year 2021-22		
Funds Spent in Prior Years	$1,014,316	$1,014,316
Estimated in FY 2023-24	$5,984	$5,984
Total Estimated Remaining	$57,300	$57,300

Funding:

California Emergency Relief Fund (4260-101-3398)

ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS

REGULAR POLICY CHANGE NUMBER: 190
IMPLEMENTATION DATE: 7/2010
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1526

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$11,771,000	$10,724,000
- STATE FUNDS	$5,397,000	$4,926,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$11,771,000	$10,724,000
STATE FUNDS	$5,397,000	$4,926,000
FEDERAL FUNDS	$6,374,000	$5,798,000

Purpose:
This policy change estimates the costs for the increased administrative expenses related to the active treatment and transportation services provided to members residing in Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) and the costs of the increased rates due to the Quality Assurance Fee (QAF).

Authority:
Interagency Agreement (IA) 07-65896

Interdependent Policy Changes:
Not Applicable

Background:
The California Department of Developmental Services (CDDS) makes supplemental payments to Medi-Cal providers that are licensed as ICF-DDs, ICF-DD Habilitative, or ICF-DD Nursing, for transportation and day treatment services provided to Regional Center (RC) consumers. The services and transportation are arranged for and paid by the local RCs, which will bill CDDS on behalf of the ICF-DDs. On April 15, 2011, the Centers for Medicare and Medicaid Services approved a State Plan Amendment (SPA) for CDDS to provide payment, retroactive to July 1, 2007, to the ICF-DDs so that they can reimburse the RCs for arranging the services.

On April 8, 2011, the Department entered into an interagency agreement with CDDS for the reimbursement of administrative expenses due to the addition of active treatment and transportation services to members residing in ICF-DDs.

ICF-DDs are subject to a QAF based upon their Medi-Cal revenues, with the revenue used to increase rates for the ICF-DDs.

ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS

REGULAR POLICY CHANGE NUMBER: 190

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to increases in utilization and additional prior year expenditures.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to assuming the same FY 2024-25 current year expenditures as in FY 2023-24 with lower prior expenditures.

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 2023-24	$977	$5,397	$12,748	$977	**$5,397**	**$6,374**
FY 2024-25	$872	$4,926	$11,596	$872	**$4,926**	**$5,798**

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

CYBHI - FEE SCHEDULE THIRD PARTY ADMINISTRATOR

REGULAR POLICY CHANGE NUMBER: 191
IMPLEMENTATION DATE: 1/2024
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2424

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$10,000,000	$0
- STATE FUNDS	$10,000,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$10,000,000	$0
STATE FUNDS	$10,000,000	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates costs related to the launch of a statewide infrastructure for provider management and to manage billing and claiming for the behavioral health (BH) services furnished to students by school-based/school-linked providers, under the Children and Youth Behavioral Health Initiative (CYBHI) fee schedule.

Authority:
W&I Code, Section 5961 and 5961.3

Interdependent Policy Change:
Not Applicable

Background:
As part of CYBHI, the Department is mandated to establish a statewide all-payer fee schedule to reimburse school-linked BH providers who provide services to students at or near a school-site. Specifically, the Department is required to:

- Develop and maintain a school-linked statewide fee schedule for medically necessary outpatient mental health or substance use disorder services provided to a student 25 years of age or younger at or near a school site, who is an enrollee of the plan or delivery system.
- Develop and maintain a school-linked statewide provider network of school site BH counselors.

Commercial & self-insured health plans and Medi-Cal delivery system must reimburse these school-linked providers at or above the fee schedule rate, regardless of network provider status. Local education agencies (LEAS) and institutions of higher education (California Community Colleges, California State University, and University of California) may adopt the fee schedule as well.

There are significant operational complexities around provider management and claims submission for the school-based/school-linked providers. Although many LEA districts participate in the LEA Billing Option Program (BOP), LEAs, colleges, and universities do not

CYBHI - FEE SCHEDULE THIRD PARTY ADMINISTRATOR
REGULAR POLICY CHANGE NUMBER: 191

currently have billing infrastructure necessary to submit claims to multiple Medi-Cal managed care plans, county behavioral health departments, commercial health plans, and self-insured plans in each county. Almost none of the school-based providers have any experience with billing commercial or self-insured plans for services provided to students.

In addition, although the statute states that the health plans are required to reimburse school-linked providers regardless of network status, there are also operational complexities around provider management, including critical functions such as credentialing and provider oversight.

The CYBHI is a multiyear package of investments. The CYBHI is intended to transform California's behavioral health system for children and youth aged 0-25 into a world-class, innovative, up-stream focused, ecosystem where all children and young adults are routinely screened, supported, and served for emerging behavioral health needs.

FY 2023-24 includes $10 million one-time to begin the development and implementation of the infrastructure for provider, billing, and claiming management for behavioral health services provided to students by school-linked providers as part of the Children and Youth Behavioral Health Initiative.

Reason for Change:
There is no change from the previous estimate for FY 2023-24. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due use of all available funds in FY 2023-24 and no additional funding available thereafter.

Methodology:

Estimated dollars for FY 2023-24 are as follows:

Fiscal Year	TF	SF	FF
FY 2023-24	$10,000,000	$10,000,000	$0

Funding:
100% Mental Health Services Fund (4260-101-3085)

FOSTER YOUTH SUBSTANCE USE DISORDER GRANT PROGRAM

REGULAR POLICY CHANGE NUMBER: 192
IMPLEMENTATION DATE: 10/2023
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2371

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$5,000,000	$0
- STATE FUNDS	$5,000,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$5,000,000	$0
STATE FUNDS	$5,000,000	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the cost of the Foster Youth Substance Use Disorder (SUD) Evidence-Based and Promising Practices grant program.

Authority:
Budget Act of 2022 [AB 179 (Chapter 249, Statutes of 2022)]

Interdependent Policy Changes:
Not Applicable

Background:
AB 179 provides $5 million General Fund (GF) for the Department to implement the Foster Youth SUD Evidence-Based and Promising Practices Program to serve foster youth with substance use disorders, including those who are residing in family-based settings.

In establishing the grant program, the Department will:

- Develop an application process for eligible applicants, which includes county child welfare agencies, county probation agencies, county behavioral health agencies, foster family agencies, short term residential therapeutic programs, and wraparound service providers;
- Develop criteria for awarding funding which includes establishing requirements for models and practices that have at the minimum:
    - Trauma-informed approaches to serving foster youth,
    - Harm-reduction approaches in service delivery,
    - Post treatment support planning, and
    - Training for clinical service providers to support foster youth with co-occurring substance use and mental health needs.
- Require grantees to collect data relating to the models and practices; and
- Require grantees to submit reports, including reports that address the grantee's implementation activities, the number and characteristics of youth served, and completion rates, and an outcome report.

FOSTER YOUTH SUBSTANCE USE DISORDER GRANT PROGRAM

REGULAR POLICY CHANGE NUMBER: 192

Reason for Change:
There is no change, in FY 2023-24 from the prior estimate.

The change in the current estimate, from FY 2023-24 to FY 2024-25, is due to all payments are expected to be completed in FY 2023-24.

Methodology:
1. The Department will enter into a contract to administer the grant program in September 2023 with payments starting in October 2023.

2. AB 179 provides $5 million GF for this item, available for expenditure through June 30, 2025. The table below displays the estimated spending and remaining funds by Appropriation Year:

(Dollars in Thousands)

	TF	GF
Appropriation Year 2022-23		
Prior Years	$0	$0
Estimated in FY 2023-24	$5,000	$5,000
Total Estimated Remaining	$0	$0

3. The estimated costs, on a cash basis, is as follows:

(Dollars in Thousands)

FY 2023-24	TF	GF
Appropriation Year 2022-23	$5,000	$5,000
Total FY 2023-24	**$5,000**	**$5,000**

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

HCBS SP - NON-IHSS CARE ECONOMY PMTS

REGULAR POLICY CHANGE NUMBER: 193
IMPLEMENTATION DATE: 11/2023
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2314

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$3,080,000	$0
- STATE FUNDS	$1,494,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,080,000	$0
STATE FUNDS	$1,494,000	$0
FEDERAL FUNDS	$1,586,000	$0

Purpose:
This policy change estimates the cost to provide a one-time incentive payment to each current direct care, non-In-Home Supportive Services (IHSS) provider of Medi-Cal home and community-based services (HCBS).

Authority:
American Rescue Plan (ARP) Act of 2021
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
American Rescue Plan Increased FMAP for HCBS

Background:
The ARP provides additional Coronavirus Disease 2019 (COVID-19) relief to states. Section 9817 of the ARP provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for HCBS. Increased FMAP was available from April 1, 2021, through March 31, 2022. States must use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021, and states must use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. State funds equivalent to the amount of federal funds attributable to the increased FMAP are deposited in the Home and Community-Based Services American Rescue Plan Fund. States must expend the federal funds attributable to the increased FMAP by March 31, 2024.

On July 12, 2021, the Department submitted the Medicaid HCBS Spending Plan to the Centers for Medicare & Medicaid Services (CMS) for approval. The multi-departmental HCBS spending plan includes HCBS initiatives and services that will be led by the Department and/or various other State Departments. On September 3, 2021, CMS responded to the Department's plan, which included a request for more information. The Department submitted a further updated

HCBS SP - NON-IHSS CARE ECONOMY PMTS
REGULAR POLICY CHANGE NUMBER: 193

plan on September 17, 2021. On January 4, 2022, CMS approved California's HCBS Spending Plan, including the Non-IHSS Care Economy Payments initiative.

This policy change provides additional support for direct care non-IHSS HCBS providers servicing members during the COVID-19 emergency, to provide a one-time incentive payment of $500 to each current direct care, non-IHSS provider of Medi-Cal home and community-based services. This funding focuses on payment for retention, recognition, and workforce development.

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change from the prior estimate in FY 2023-24, as well as the change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to delayed implementation of disbursing funds to eligible providers. Funding allocated for this initiative was completed in November 2023.

Methodology:
1. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

2. Assume payments were made in November 2023.

Fiscal Year	TF	HCBS ARP Fund	FF
FY 2023-24	$3,080,000	$1,540,000	$1,540,000
COVID-19 Tile XIX Increased FMAP	$0	($46,000)	$46,000
FY 2023-24 Total	**$3,080,000**	**$1,494,000**	**$1,586,000**

Funding:
100% Title XIX FFP (4260-101-0890)
Home and Community-Based Services American Rescue Plan Fund (4260-101-8507)
COVID-19 Title XIX Increased FFP (4260-101-0890)

PROP 56 - PROVIDER ACES TRAININGS

REGULAR POLICY CHANGE NUMBER: 194
IMPLEMENTATION DATE: 12/2019
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 2138

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$1,807,000	$0
- STATE FUNDS	$903,500	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,807,000	$0
STATE FUNDS	$903,500	$0
FEDERAL FUNDS	$903,500	$0

Purpose:
This policy change estimates the cost to train providers on delivering Adverse Childhood Experiences (ACEs) screenings.

Authority:
Budget Act of 2021 [AB 128 (Chapter 21, Statutes of 2021)]

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 provided $120 million total funds ($60 million Proposition 56 funds, $60 million Federal Funds), available until FY 2021-22 to provide training to Medi-Cal providers on administering ACEs screenings. Future funding will be through the Mental Health Services Fund (MHSF). See the MHSF Provider ACES Training policy change for training costs funded with the MHSF.

This policy change identifies the use of the General Fund (GF) for these Proposition 56 payments. See the Proposition 56 Funding policy change for the Proposition 56 offset to the GF.

Reason for Change:
There is no change in FY 2023-24, from the prior estimate.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to Proposition 56 Funding ending and no more payments in FY 2024-25.

PROP 56 - PROVIDER ACES TRAININGS

REGULAR POLICY CHANGE NUMBER: 194

Methodology:

1. Payments for ACEs provider trainings began in December 2019.

2. The table below displays the estimated spending and remaining funds by Appropriation Years:

	TF	GF	FF
Appropriation Year 2019-20			
Prior Years	$118,193,000	$59,097,000	$59,096,000
Estimated in FY 2023-24	$1,807,000	$903,000	$904,000
Total Estimated Remaining	$0	$0	$0

3. The provider trainings costs are estimated to be $1,807,000 TF ($904,000 GF) in FY 2023-24.

FY 2023-24	TF	GF	FF
Appropriation Year 2019-20	$1,807,000	$903,000	$904,000
Total FY 2023-24	**$1,807,000**	**$903,000**	**$904,000**

*Federal funds authority is newly requested for the fiscal year in which funds are anticipated to be expended.

Funding:

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

QAF WITHHOLD TRANSFER

REGULAR POLICY CHANGE NUMBER: 195
IMPLEMENTATION DATE: 7/2017
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 2092

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$1,178,000	$384,000
- STATE FUNDS	$236,000	$192,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,178,000	$384,000
STATE FUNDS	$236,000	$192,000
FEDERAL FUNDS	$942,000	$192,000

Purpose:
This policy change budgets for withheld Fee-for-Service payments (FFS) associated with the Hospital Quality Assurance Fee (HQAF), AB 1629 Skilled Nursing Facilities (SNF) QAF, Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs) QAF, and Ground Emergency Medical Transportation (GEMT) QAF.

Authority:
Welfare & Institutions (W&I) Code, Section 14169.52(h)
W&I Code, Section 14129.2(d)(2)
Health and Safety Code, Section 1324.22(e)(2)
Provider Bulletin LTC June 2009, #388, Code Section 103
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

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.

QAF WITHHOLD TRANSFER
REGULAR POLICY CHANGE NUMBER: 195

For GEMT QAF, the withheld portion is transferred to the Medi-Cal Emergency Medical Transport Fund.

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.

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is a net decrease due to:

- For HQAF, the new withholds pending transfer increased due to FY 2022-23 withholds coming in higher than previously expected.
- For LTC QAF, the prior year withhold transfers and new withholds pending transfer increased due to FY 2022-23 withholds coming in higher than previously expected. Previously, there was an expectation that there will be a more significant decrease in withheld payments following the shift from FFS to managed care under California Advancing and Innovating Medi-Cal (CalAIM).
- For GEMT QAF, the prior year withhold transfers increased due to FY 2022-23 withholds coming in higher than previously expected.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is a net decrease due to:

- For HQAF, the prior year withhold transfers increased in FY 2024-25 as the withhold transfer in FY 2023-24 is scheduled to occur later in the FY than the withhold transfer in FY 2024-25, resulting in an additional week of withholds in FY 2024-25.
- For LTC QAF, the estimate decreased due to an expectation that there will continue to be a decrease in withheld payments following the shift from FFS to managed care under CalAIM.
- For GEMT, the new withholds pending transfer increase in FY 2024-25 as there is an additional week of withholds in FY 2024-25 as a result of the checkwrite calendar.

QAF WITHHOLD TRANSFER
REGULAR POLICY CHANGE NUMBER: 195

Methodology:

HQAF

1. Prior year FY 2022-23 HQAF withheld payments totaling $1.49 million TF will be transferred in FY 2023-24.

2. An estimated $2.30 million TF in HQAF withholds will occur in FY 2023-24. These withholds are pending transfer in the next FY and offsets a portion of the $1.49 million HQAF withhold transfer.

3. An estimated $2.30 million TF of FY 2023-24 HQAF withheld payments will be paid in FY 2024-25. This prior year withhold transfer is offset by $2.30 million in withholds that are estimated to occur in FY 2024-25 but are pending transfer in FY 2025-26.

LTC QAF

4. Prior year FY 2022-23 LTC QAF withheld payments totaling $5.43 million TF will be transferred in FY 2023-24.

5. An estimated $3.49 million TF in LTC QAF withholds will occur in FY 2023-24. These withholds are pending transfer in the next FY and offsets a portion of the $5.43 million LTC QAF withhold transfer.

6. An estimated $3.49 million of FY 2023-24 LTC QAF withheld payments will be paid in FY 2024-25. This prior year withhold transfer is offset by $3.08 million in withholds that are estimated to occur in FY 2024-25 but are pending transfer in FY 2025-26.

GEMT QAF

7. Prior year FY 2022-23 GEMT withheld payments totaling $0.14 million TF will be transferred in FY 2023-24.

8. An estimated $0.100 million in GEMT QAF withholds will occur in FY 2023-24. These withholds are pending transfer in the next FY and offsets a portion of the $0.14 million GEMT QAF withhold transfer.

9. An estimated $0.100 million of FY 2023-24 GEMT QAF withheld payments will be paid in FY 2024-25. This prior year withhold transfer is offset by $0.126 million in withholds that are estimated to occur in FY 2024-25 but are pending transfer in FY 2025-26.

COVID-19 Increased FMAP

10. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

QAF WITHHOLD TRANSFER
REGULAR POLICY CHANGE NUMBER: 195

(Dollars in Thousands)

FY 2023-24	TF	GF	FF	COVID-19 FF
HQAF				
HQAF Prior Year Withhold Transfers	$1,487	$669	$744	$74
HQAF FY 2023-24 New Withholds Pending Transfer	($2,296)	($1,148)	($1,148)	$0
Subtotal HQAF for FY 2023-24	($809)	($479)	($404)	$74
LTC QAF				
LTC QAF Prior Year Withhold Transfers	$5,431	$2,444	$2,715	$272
LTC QAF FY 2023-24 New Withholds Pending Transfer	($3,486)	($1,743)	($1,743)	$0
Subtotal LTC QAF for FY 2023-24	$1,945	$701	$972	$272
GEMT QAF				
GEMT QAF Prior Year Withhold Transfers	$142	$64	$71	$7
GEMT QAF FY 2023-24 New Withholds Pending Transfer	($100)	($50)	($50)	$0
Subtotal GEMT QAF for FY 2023-24	$42	$14	$21	$7
Total FY 2023-24	**$1,178**	**$236**	**$589**	**$353**

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
HQAF			
HQAF Prior Year Withhold Transfers	$2,296	$1,148	$1,148
HQAF FY 2024-25 New Withholds Pending Transfer	($2,296)	($1,148)	($1,148)
Subtotal HQAF for FY 2024-25	$0	$0	$0
LTC QAF			
LTC QAF Prior Year Withhold Transfers	$3,486	$1,743	$1,743
LTC QAF FY 2024-25 New Withholds Pending Transfer	($3,076)	($1,538)	($1,538)
Subtotal LTC QAF for FY 2024-25	$410	$205	$205
GEMT QAF			
GEMT QAF Prior Year Withhold Transfers	$100	$50	$50
GEMT QAF FY 2024-25 New Withholds Pending Transfer	($126)	($63)	($63)
Subtotal GEMT QAF for FY 2024-25	($26)	($13)	($13)
Total FY 2024-25	**$384**	**$192**	**$192**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
COVID-19 Title XIX GF (4260-101-0001)
COVID-19 Title XIX Increased FFP (4260-101-0890)

HCBS SP - CALBRIDGE BH NAVIGATOR PROGRAM

REGULAR POLICY CHANGE NUMBER: 196
IMPLEMENTATION DATE: 4/2022
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2318

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$1,056,000	$89,000
- STATE FUNDS	$1,056,000	$89,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,056,000	$89,000
STATE FUNDS	$1,056,000	$89,000
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the costs for the CalBridge Behavioral Health Navigator Program using enhanced federal funding from the American Rescue Plan Act of 2021 (ARP).

Authority:
American Recue Plan (ARP) Act (2021)
Budget Act of 2021 [SB 129 (Chapter 69, Statutes of 2021)]

Interdependent Policy Changes:
American Rescue Plan Increased FMAP for HCBS

Background:
The American Rescue Plan Act of 2021 (ARP) provides additional Coronavirus Disease 2019 (COVID-19) relief to states. Section 9817 of the ARP provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS). Increased FMAP is available from April 1, 2021, through March 31, 2022. States must use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021, and states must use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. State funds equivalent to the amount of federal funds attributable to the increased FMAP are deposited in the Home and Community-Based Services American Rescue Plan Fund pursuant to Section 11.95 of the 2021 Budget Act. Section 11.95 appropriates this funding to eligible HCBS activities identified in the HCBS Spending Plan.

The CalBridge Behavioral Health Navigator Program provides grants to acute care hospitals to support hiring trained behavioral health navigators in emergency departments to screen patients and, if appropriate, offer intervention and referral to mental health or substance use disorder programs. Applicants will include general acute care hospitals or health systems, hospital foundations, or physician groups. The one-time funding would also support technical assistance

HCBS SP - CALBRIDGE BH NAVIGATOR PROGRAM
REGULAR POLICY CHANGE NUMBER: 196

and training for participating emergency departments and support for the Department to administer the funding.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is a decrease due to some monthly deliverables shifting to FY 2024-25 because of a contract extension through December 31, 2024.

The change in the current estimate, from FY 2023-24 to FY 2024-25, is due to a decrease in payments incurring in FY 2023-24 and final payments occurring in FY 2024-25 because of the $40 million allocation cap.

Methodology:
1. The Department entered into a contract with Public Health Institute (PHI), current administrator of the California Bridge Program, in FY 2021-22; PHI serves as an administrative and technical assistance (TA) entity for the CalBridge Behavioral Health Navigator Program.

2. The total contract amount is $40,000,000, with PHI receiving up to 10 percent ($4,000,000) to provide administrative and TA services to grantees, consistent with the current administrative percentage for the current contract with PHI. The remaining $36,000,000 was distributed to grantees for direct services beginning FY 2021-22.

3. Total estimated costs for the CalBridge Behavioral Health Navigator Program, on a cash basis, is as follows:

FY 2023-24	TF	HCBS ARP Fund
PHI Contractor	$1,056,000	$1,056,000
Direct Services	$0	$0
Total	**$1,056,000**	**$1,056,000**

FY 2024-25	TF	HCBS ARP Fund
PHI Contractor	$89,000	$89,000
Direct Services	$0	$0
Total	**$89,000**	**$89,000**

Funding:
100% Home and Community-Based Services American Rescue Plan Fund (4260-101-8507)

CLPP FUND

REGULAR POLICY CHANGE NUMBER: 197
IMPLEMENTATION DATE: 7/2005
ANALYST: Celine Donaldson
FISCAL REFERENCE NUMBER: 1633

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$902,000	$0
- STATE FUNDS	$902,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$902,000	$0
STATE FUNDS	$902,000	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the Childhood Lead Poisoning Prevention (CLPP) Fund allocation to counties for monitoring and oversight of blood lead testing activities.

Authority:
Health & Safety Code, Sections 105285,105286,105295,105305 and 105310
Interagency Agreement (IA) # 19-10498 A2

Interdependent Policy Changes:
Not Applicable

Background:
Medi-Cal provides blood lead tests to children at ages 12 and 24 months of age, or at any age at which the child is identified as at risk for lead poisoning and consistently offered to families for children age 24 to 72 months who were not tested earlier, or if there is no record of a previous test, and who are:

- Full-scope beneficiaries under the Medi-Cal for Kids & Teens, formerly known as Early and Periodic Screening, Diagnostic, and Treatment benefit of the Medi-Cal Program, or
- Pre-enrolled in Medi-Cal through the Child Health and Disability Prevention (CHDP) Gateway program.

The lead testing expenditures are in Medi-Cal's Fee-for-Service (FFS) base trends and the Managed Care capitation rate.

The CLPP Fund receives revenues from a fee assessed on entities formerly or presently engaged in commerce involving lead products and collected by the Board of Equalization.

Pursuant to AB 1316, (Chapter 507, statutes of 2017), the use of the CLPP Fund for blood lead testing is prohibited. The fund is now to be utilized for monitoring and oversight of blood lead testing, to include enhanced lead prevention activities.

CLPP FUND
REGULAR POLICY CHANGE NUMBER: 197

The IA establishes the Childhood Lead Poisoning Prevention (CLPP) program activities to be completed by the county staff of the Child Health and Disability Prevention (CHDP) program.

This IA will be discontinued as of July 1, 2024, when CHDP sunsets.

Reason for Change:
There is no change from the prior estimate for FY 2023-24.

The change between fiscal years in the current estimate is due to the discontinuance of the IA when the CHDP program sunsets July 1, 2024.

Methodology:

The CLPP Funding for FY 2023-24 is assumed to be $902,000.

Funding:

100% CLPP Fund (4260-101-0080)

WPCS WORKERS' COMPENSATION

REGULAR POLICY CHANGE NUMBER: 198
IMPLEMENTATION DATE: 11/2016
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 1866

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$620,000	$620,000
- STATE FUNDS	$310,000	$310,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$620,000	$620,000
STATE FUNDS	$310,000	$310,000
FEDERAL FUNDS	$310,000	$310,000

Purpose:
This policy change estimates the cost of workers' compensation coverage for Waiver Personal Care Services (WPCS) providers.

Authority:
In-Home Supportive Services v. Workers' Comp. Appeals Bd. (1984) 152 Cal.App.3d 720, 727 [199 Cal.Rptr. 697]
Interagency Agreement (IA) 22-20032

Interdependent Policy Changes:
COVID-19 Increased FMAP – DHCS

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 will be 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 2023-24. There is no change from FY 2023-24 to FY 2024-25 in the current estimate.

Methodology:
1. The Department will reimburse CDSS monthly for the costs of any WPCS program worker's compensation claims filed by eligible WPCS providers.

WPCS WORKERS' COMPENSATION
REGULAR POLICY CHANGE NUMBER: 198

2. The reimbursement of CDSS will cover costs associated with monthly administrative fees for Third Party Administrator / Sub-contractor services, monthly fees required by the State Controller's Office to perform Checkwrite functions and standard activities associated with issuing worker's compensation payments, and monthly administrative costs accrued by CDSS and the Office of Risk and Insurance Management.

3. WPCS recipients represent approximately 1% of the population receiving In-Home Supportive Services so the Department will only be 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 2023-24 and FY 2024-25.

Fiscal Year	TF	GF	FF
FY 2023-24	$620,000	$310,000	$310,000
FY 2024-25	$620,000	$310,000	$310,000

Funding:
50% Title XIX FFP / 50% GF (4260-101-0890/0001)
COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

HCBS SP - ETSB FOR LAGUNA HONDA HOSPITAL RESIDENTS

REGULAR POLICY CHANGE NUMBER: 199
IMPLEMENTATION DATE: 7/2023
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2393

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$550,000	$0
- STATE FUNDS	$550,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$550,000	$0
STATE FUNDS	$550,000	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the cost to provide Enhanced Transition Service Bundles (ETSB) to Laguna Honda Hospital (LHH) residents who need “bridge services” to support safe and sustainable transfers to alternate settings.

Authority:
American Rescue Plan (ARP) Act of 2021
Contract # 22-20595

Interdependent Policy Changes:
American Rescue Plan Increased FMAP for HCBS

Background:
The ARP provides additional COVID-19 relief to states. Section 9817 of the ARP provided qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS). Increased FMAP was available from April 1, 2021, through March 31, 2022. States must use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021, and states must use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. State funds equivalent to the amount of federal funds attributable to the increased FMAP are deposited in the HCBS American Rescue Plan Fund.

On July 12, 2021, the Department submitted the Medicaid HCBS Spending Plan to the Centers for Medicare & Medicaid Services (CMS) for approval. The multi-departmental HCBS spending plan includes HCBS initiatives and services that will be led by the Department and/or various other State Departments. On September 3, 2021, CMS responded to the Department’s plan, which included a request for more information. The Department submitted a further updated plan on September 17, 2021. On January 4, 2022, CMS approved California’s HCBS Spending Plan.

HCBS SP - ETSB FOR LAGUNA HONDA HOSPITAL RESIDENTS

REGULAR POLICY CHANGE NUMBER: 199

On July 22, 2022, the Department received approval from CMS to amend California's HCBS Spending Plan and utilize section 9817 funding to provide ETSBs to LHH residents who need "bridge services" to transition from LHH to community-based placements and enrollment into a Medi-Cal Managed Care Plan, HCBS Waiver, Program of All-Inclusive Care for the Elderly (PACE), In-Home Supportive Services (IHSS), etc. The intent of the service bundles is to combine intensive care management and housing navigation services to facilitate safe and sustainable transitions and continued access to care, for an extremely vulnerable population with complex care needs. If these services are not provided, some of the State's most vulnerable residents could experience limited access to essential services, homelessness, reduced quality of life, and other adverse events, including death.

On November 10, 2022, the City of San Francisco signed a settlement with CMS and the California Department of Public Health to extend the pause on involuntary discharges and transfers of residents until February 2, 2023. The San Francisco Department of Public Health (SFDPH) is working towards recertification and CMS will have the option to further extend the pause based on Laguna Honda's progress in complying with the settlement agreement. On June 27, 2023, the Department and SFDPH executed a contract that to provide ARPA Section 9817 funding as included in California's approved HCBS Spending Plan to support community transitions through the provision of ETSBs. The bundled services are to bridge the gap between LHH and enrollment into a Medi-Cal Managed Care Plan / HCBS Waiver / PACE / IHSS, etc., and to help facilitate the transition of residents that remain in Fee-For-Service. While the Settlement Agreement continues the pause on the involuntary discharge/transfer of nursing facility level of care residents, CMS clarified that LHH is still responsible for actively discharging residents that are determined to no longer meet nursing facility level of care.

On January 13, 2023, San Francisco's City Attorney's office sent CMS a request to extend the moratorium, until at least May 30, 2023, with the possibility of continuing the pause after that date, based on LHH's progress towards certification. On February 1, 2023, CMS approved the extended pause on involuntary discharges and transfers until at least May 19, 2023. On May 18, 2023, CMS agreed to continue the pause of involuntary transfers of LHH residents until September 19, 2023.

Reason for Change:
There is no change from the prior estimate for FY 2023-24. The change from FY 2023-24 to FY 2024-25 in the current estimate, is a decrease, due to funding ending on December 31, 2023.

Methodology:
1. Assume the pause on involuntary discharges and transfers of community discharge residents from LHH was lifted on September 19, 2023, and funds were used to provide ETSBs.

2. Assume that LHHs are still responsible for actively discharging residents that are determined to no longer meet nursing facility level of care.

3. The estimated costs for FY 2023-24 are:

HCBS SP - ETSB FOR LAGUNA HONDA HOSPITAL RESIDENTS

REGULAR POLICY CHANGE NUMBER: 199

Fiscal Year	TF	HCBS ARP Fund	FF
FY 2023-24	$550,000	$550,000	$0

Funding:
Home and Community-Based Services American Rescue Plan Fund (4260-101-8507)

URBAN INDIAN ORGANIZATIONS FUNDING SHIFT

REGULAR POLICY CHANGE NUMBER: 202
IMPLEMENTATION DATE: 7/2023
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2351

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$9,121,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$9,121,000	$0
FEDERAL FUNDS	$9,121,000	$0

Purpose:
This policy change estimates the technical adjustment in funding from Title XIX 50% federal financial participation (FFP) and Title XXI 65% FFP to 100% FFP temporarily for fee-for-service and managed care expenditures provided in Urban Indian Organizations (UIOs).

Authority:
American Rescue Plan (ARP) Act of 2021
25 U.S.C. 1603(29)

Interdependent Policy Changes:
Not applicable

Background:
The ARP provided 100% Federal Medical Assistance Percentage (FMAP) to states for their medical assistance expenditures for services received by all Medicaid beneficiaries received through an UIO for the eight fiscal quarters beginning April 1, 2021, and ending March 31, 2023. States were able to claim 100% FMAP for services received through these entities retroactively to April 1, 2021. UIOs that have a grant or contract with the Indian Health Service under Title V of the Indian Health Care Improvement Act were included.

Reason for Change:
The change from the prior estimate for General Fund (GF) savings, is an increase for FY 2023-24, due to using two additional quarters of actuals for projections. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease in GF savings due to adjustments that ended in December 2023.

Methodology:
1. Assume the Department began claiming 100% FFP for UIOs on January 1, 2022, including a retroactive adjustment for claims from April 2021 through December 2021.

2. Assume a three quarter lag for claims that were adjusted to 100% FFP.

URBAN INDIAN ORGANIZATIONS FUNDING SHIFT

REGULAR POLICY CHANGE NUMBER: 202

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2023-24	$0	($9,121)	$9,121

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

HCBS SP - ALW FUNDING SHIFT

REGULAR POLICY CHANGE NUMBER: 203
IMPLEMENTATION DATE: 7/2023
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2453

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$1,400,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$1,400,000	$0
FEDERAL FUNDS	$1,400,000	$0

Purpose:
This policy change estimates the technical adjustment in funding from Title XIX 50% General Fund (GF) to the Home & Community-Based Services American Rescue Plan (HCBS ARP) fund for Assisted Living Waiver (ALW) services.

Authority:
SB 840 (Chapter 29, Statutes of 2018)
American Rescue Plan Act (2021)
Families First Coronavirus Response Act (FFCRA), (P.L. 116-127), Section 6008
Coronavirus Aid Relief and Economic Security (CARES) Act, Public Law 116-136 (2020)

Interdependent Policy Changes:
Assisted Living Waiver Expansion

Background:
The ALW offers services in an assisted living or public subsidized housing setting to Medi-Cal members who would likely otherwise receive care in a skilled nursing facility. Eligibility into the ALW is based on a qualifying skilled nursing level of care which is captured through the assessment tool used by the Care Coordination Agencies to assess potential members.

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

HCBS SP - ALW FUNDING SHIFT
REGULAR POLICY CHANGE NUMBER: 203

- 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:
This is a new policy change.

Methodology:
1. Assume $141,908,000 will shift from GF to the HCBS ARP fund.

2. The Title XIX COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

(Dollars in Thousands)

FY 2023-24	TF	HCBS ARP Fund	GF	FF
HCBS ARP Funding Shift	$0	$141,908	($141,908)	$0
COVID-19 Title XIX Increased FMAP	$0	($1,400)	$0	$1,400
Total	**$0**	**$140,508**	**($141,908)**	**$1,400**

*Totals may differ due to rounding.

Funding:
100% State GF (4260-101-0001)
Home and Community-Based Services American Rescue Plan Fund (4260-101-8507)
COVID-19 Title XIX Increased FFP (4260-101-0890)

AUDIT SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 204
IMPLEMENTATION DATE: 7/2016
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 110

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$150,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$150,000	$0
FEDERAL FUNDS	-$150,000	$0

Purpose:
This policy change estimates the payments for audit settlements due to the Centers for Medicare and Medicaid Services.

Authority:
Public Law 95-452
42, Code of Federal Regulations 433.302

Interdependent Policy Changes:
Not Applicable

Background:
Internal Audits monitors the issuance of final audit reports by state and federal auditors (e.g., the California State Auditor, the Office of Inspector General, etc.). Audit reports will typically contain audit findings and recommendations which can include unallowable amounts due from the Department. Internal Audits reaches out to Divisions within the Department periodically to ensure findings and recommendations identified in the audit are addressed and corrective action is taken, including whether a Division will repay or appeal reported overpayments. Internal Audits confirms amounts owed and anticipated repayment dates.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due to a new audit finding requiring repayment. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to settlements being one-time payments.

AUDIT SETTLEMENTS
REGULAR POLICY CHANGE NUMBER: 204

Methodology:
List of audit settlements anticipated to be repaid in FY 2023-24:

No	Audit Number	Audit Title & Status	Program Responsible	Original Audit Amount	Adjusted Amount
1	Payment Error Rate Measurement (PERM) Audit for 2023 (22-15)	Review: 2023 CMS PERM to identify areas susceptible to significant payments and report the improper payment estimates to Congress. Final report anticipated by November 2023.	Audits and Investigations	$150,000	$150,000
				Total	**$150,000**

Fiscal Year	TF	GF	FF
FY 2023-24	**$0**	**$150,000**	**($150,000)**

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

IMD ANCILLARY SERVICES

REGULAR POLICY CHANGE NUMBER: 205
IMPLEMENTATION DATE: 4/2017
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 35

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$50,724,000	$68,936,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$50,724,000	$68,936,000
FEDERAL FUNDS	-$50,724,000	-$68,936,000

Purpose:
This policy change estimates the cost of federal fund (FF) repayments that the Department must make to the Centers for Medicare and Medicaid Services (CMS) for inappropriately claimed ancillary services for Medi-Cal members residing in Institutions for Mental Diseases (IMDs), both through Fee-For-Service (FFS) and Managed Care (MC) delivery systems.

Authority:
Title 42, Code of Federal Regulations 435.1009
Welfare & Institutions Code 14053.3

Interdependent Policy Changes:
Not Applicable

Background:
Ancillary services provided to Medi-Cal members who are ages 21 through 64 residing in IMDs are not eligible for federal reimbursement. Identifiers are currently not available in the Medi-Cal Eligibility Data System (MEDS) to indicate whether a Medi-Cal member is residing in an IMD. Consequently, the Department's Fiscal Intermediary (FI) may not deny any claims that are ineligible for reimbursement. The Department uses data from the mental health Client and Services Information (CSI) system to retrospectively identify the dates individuals were residents of an IMD for repayment of the FF, as required by CMS. This information is not known at the time the claims were processed and paid by the FI. The Department matches the data from the CSI system to the claims data to determine which claims were inappropriately reimbursed while the individual was a resident of an IMD.

While the Department intends to develop eligibility and claiming processes to stop inappropriate claiming and reimbursement for ancillary services, the current inappropriately paid services must be repaid to CMS.

Due to the Court of Appeals' decision for the County of Colusa case on July 9, 2014, the counties will not reimburse the State for IMD ancillary costs. The State is now financially

IMD ANCILLARY SERVICES
REGULAR POLICY CHANGE NUMBER: 205

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 from the prior estimate for FY 2023-24, is a decrease due to:
- Shifting the FY 2021-22 Q4 FFS repayment from FY 2022-23 to FY 2023-24,
- Revising the projected FFS and managed care repayments,
- Including the actual deferral for the October 2022 through December 2022 quarter and adding two additional quarters of deferral repayments based on the estimated deferral repayment timeline,
- CMS increased the IMD deferrals in the October 2022 through December 2022 quarter. It is estimated that CMS will continue the IMD deferrals at the higher level for the January 2023 through September 2023 deferrals, and
- Including actual resolved deferrals returned to the GF in FY 2023-24.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to:
- The estimated repayments that will occur in FY 2024-25, and
- FY 2023-24 includes actual resolved deferrals returned to the GF.

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 2023 Q1 in the amount of $8 million and estimates to repay $8 million per quarter for deferrals for FFY 2023 Q2 through FFY 2023 Q4 in FY 2023-24. The Departments estimates to repay $8 million per quarter for FFY 2024 Q1 through FFY 2024 Q4 in FY 2024-25.

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 2023-24 and FY 2024-25 are based on actual repayment amounts for the last fifteen quarters, using an average for estimated repayments to future quarters.

4. The Department determines the actual managed care repayment owed for each quarter and submits the actual repayments to CMS. CMS may later release the amounts previously repaid based on the quarterly deferral letter. The managed care estimated repayment amounts for FY 2023-24 and FY 2024-25 are based on estimates of the past quarters.

IMD ANCILLARY SERVICES
REGULAR POLICY CHANGE NUMBER: 205

5. For FY 2023-24, the Department estimates to repay ineligible FFS claims from April 2022 through June 2023 and ineligible managed care claims from July 2023 through June 2024.

6. For FY 2024-25, the Department estimates to repay ineligible FFS claims from July 2023 through June 2024 and ineligible managed care claims from July 2024 through June 2025.

7. In FY 2023-24, the Department has reclaimed $15.6 million in FF in resolved deferrals.

IMD ANCILLARY SERVICES
REGULAR POLICY CHANGE NUMBER: 205

8. The estimated IMD repayments are:

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
Fee-For-Service (FFS)			
FY 2021-22 Q4 (Apr-Jun 2022)	$0	$5,647	($5,647)
Subtotal FY 2021-22	$0	$5,647	($5,647)
FY 2022-23 Q1 (Jul-Sep 2022)	$0	$2,219	($2,219)
FY 2022-23 Q2 (Oct-Dec 2022)	$0	$6,715	($6,715)
FY 2022-23 Q3 (Jan-Mar 2023)	$0	$6,954	($6,954)
FY2022-23 Q4 (Apr-Jun 2023)	$0	$7,189	($7,189)
Subtotal FY 2022-23	$0	$23,077	($23,077)
Subtotal FFS	$0	$28,724	($28,724)
Managed Care			
FY 2023-24 Q1 and Q2 (Jul-Dec 2023)	$0	$2,800	($2,800)
FY 2023-24 Q3 and Q4 (Jan- Jun 2024)	$0	$2,800	($2,800)
Subtotal Managed Care	$0	$5,600	($5,600)
Deferral Repayments			
FFY 2023 Quarter 1 (Oct-Dec 2022)	$0	$8,000	($8,000)
FFY 2023 Quarter 2 (Jan-Mar 2023)	$0	$8,000	($8,000)
FFY 2023 Quarter 3 (Apr-Jun 2023)	$0	$8,000	($8,000)
FFY 2023 Quarter 4 (Jul-Sep 2023)	$0	$8,000	($8,000)
Resolved Deferrals	$0	($15,600)	$15,600
Subtotal Deferrals	$0	$16,400	($16,400)
Total FY 2023-24	**$0**	**$50,724**	**($50,724)**

IMD ANCILLARY SERVICES
REGULAR POLICY CHANGE NUMBER: 205

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
Fee-For-Service (FFS)			
FY 2023-24 Q1 (Jul-Sep 2023)	$0	$7,427	($7,427)
FY 2023-24 Q2 (Oct-Dec 2023)	$0	$7,664	($7,664)
FY 2023-24 Q3 (Jan-Mar 2024)	$0	$7,905	($7,905)
FY2024-24 Q4 (Apr-Jun 2024)	$0	$8,140	($8,140)
Subtotal FY 2023-24	$0	$31,136	($31,136)
Subtotal FFS	$0	$31,136	($31,136)
Managed Care			
FY 2024-25 Q1 and Q2 (Jul-Dec 2024)	$0	$2,900	($2,900)
FY 2024-25 Q3 and Q4 (Jan- Jun 2025)	$0	$2,900	($2,900)
Subtotal Managed Care	$0	$5,800	($5,800)
Deferral Repayments			
FFY 2024 Quarter 1 (Oct-Dec 2023)	$0	$8,000	($8,000)
FFY 2024 Quarter 2 (Jan-Mar 2024)	$0	$8,000	($8,000)
FFY 2024 Quarter 3 (Apr-Jun 2024)	$0	$8,000	($8,000)
FFY 2024 Quarter 4 (Jul-Sep 2024)	$0	$8,000	($8,000)
Subtotal Deferrals	$0	$32,000	($32,000)
Total FY 2024-25	**$0**	**$68,936**	**($68,936)**

Funding:
100% General Fund (4260-101-0001)
Title XIX FFP (4260-101-0890)

CIGARETTE AND TOBACCO SURTAX FUNDS

REGULAR POLICY CHANGE NUMBER: 206
IMPLEMENTATION DATE: 1/2006
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1087

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change reduces the General Fund and replaces those funds with Cigarette and Tobacco Products Surtax (CTPS/Proposition 99) funds from the Hospital Services, Physicians' Services, and Unallocated Accounts. This funding shift is identified in the management summary funding pages.

Authority:
California Tobacco Health Protection Act of 1988 (Proposition 99)
AB 75 (Chapter 1331, Statutes of 1989)

Interdependent Policy Changes:
Not Applicable

Background:
The CTPS/Proposition 99 funds are allocated to aid in the funding of the *Orthopaedic Hospital* settlement and other outpatient payments. The *Orthopaedic Hospital* settlement increased hospital outpatient rates by a total of 43.44% between 2001 and 2004.

This policy change supports healthcare coverage for beneficiaries in the Medi-Cal program.

Reason for Change:
Dollars were revised from prior estimate to reflect updated revenues and expenditures related to Proposition 99.

CIGARETTE AND TOBACCO SURTAX FUNDS

REGULAR POLICY CHANGE NUMBER: 206

Methodology:

FY 2023-24	
Hospital Services Account	$70,115,000
Physicians' Services Account	$19,901,000
Unallocated Account	$28,753,000
Total CTPS/Prop. 99	**$118,769,000**
GF	**($118,769,000)**
Net Impact	**$0**

FY 2024-25	
Hospital Services Account	$72,477,000
Physicians' Services Account	$20,693,000
Unallocated Account	$30,999,000
Total CTPS/Prop. 99	**$124,169,000**
GF	**($124,169,000)**
Net Impact	**$0**

Funding:
Proposition 99 Hospital Services Account (4260-101-0232)
Proposition 99 Physician Services Account (4260-101-0233)
Proposition 99 Unallocated Account (4260-101-0236)
Title XIX GF (4260-101-0001)

FUNDING ADJUST.—ACA OPT. EXPANSION

REGULAR POLICY CHANGE NUMBER: 207
IMPLEMENTATION DATE: 7/2015
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1915

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$4,654,480,400	-$4,888,713,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$4,654,480,400	-$4,888,713,200
FEDERAL FUNDS	$4,654,480,400	$4,888,713,200

Purpose:
This policy change estimates the adjustment to accurately reflect the enhanced percentage of federal funding match for the Affordable Care Act (ACA) optional expansion population.

Authority:
ACA

Interdependent Policy Changes:
COVID-19 Increased FMAP – DHCS

Background:
Effective January 1, 2014, the ACA expanded Medicaid coverage to previously ineligible persons, primarily childless adults at or below 138% of the federal poverty level. The expansion of Medicaid coverage to previously ineligible persons is referred to as the ACA optional expansion. Since January 2014, the Department has experienced significant growth in Medi-Cal enrollment as a result of the ACA optional expansions. The ACA provided an enhanced federal match for optional expansion adults of 100% through calendar year (CY) 2016, and then decreased the match in yearly phases to 90% by 2020.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase in general fund savings due to updated estimates and data. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase in general fund savings due to updated estimates and data.

Methodology:
1) The Department identified funds allocated to beneficiaries in the Newly aid category that were Title XIX funding with 50% federal match.

2) The federal match for FY 2023-24 and FY 2024-25 is 90%.

FUNDING ADJUST.—ACA OPT. EXPANSION
REGULAR POLICY CHANGE NUMBER: 207

3) The total amount of unadjusted ACA optional expansion funding in FY 2023-24 is estimated as $11,636,200,605 and $12,221,783,488 in FY 2024-25. These amounts are credited to the Title XIX fund.

4) The amounts adjusted are as follows:

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
50% Title XIX / 50%GF	($11,636,201)	($5,818,100)	($5,818,100)
90% Title XIX ACA FF / 10% GF	$11,636,201	$1,163,620	$10,472,581
Total	**$0**	**($4,654,480)**	**$4,654,480**

*Totals may differ due to rounding

FY 2024-25	TF	GF	FF
50% Title XIX / 50%GF	($12,221,783)	($6,110,892)	($6,110,892)
90% Title XIX ACA FF / 10% GF	$12,221,783	$1,222,178	$10,999,605
Total	**$0**	**($4,888,713)**	**$4,888,713**

*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)
COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

FUNDING ADJUST.—OTLICP

REGULAR POLICY CHANGE NUMBER: 208
IMPLEMENTATION DATE: 7/2015
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1926

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$106,386,000	-$108,033,750
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$106,386,000	-$108,033,750
FEDERAL FUNDS	$106,386,000	$108,033,750

Purpose:
This policy change estimates the adjustment to reflect the costs that should be charged to the Children's Health Insurance Program (CHIP).

Authority:
Affordable Care Act (ACA)

Interdependent Policy Changes:
COVID-19 Increased FMAP – DHCS

Background:
The Balanced Budget Act of 1997 added Title XXI to the Social Security Act creating CHIP to provide new coverage opportunities for children in families with incomes too high to qualify for Medicaid. States administer the CHIP program and they are jointly funded by federal and state governments.

The ACA provides enhanced federal funding to Title XXI. The California federal funding match was 65 percent through September 30, 2015. Effective October 1, 2015, the ACA extended and increased the enhanced federal matching rate for the CHIP program by 23 percent to 88 percent. Congress reauthorized the CHIP program in January, 2018, reducing the federal matching rate to 76.5 percent effective October 1, 2019, and further reducing the match rate to 65 percent effective October 1, 2020.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is a general fund savings decrease due to updated estimates and data. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a general fund savings increase due to updated estimates and data.

Methodology:
1) The Department identified funds allocated to CHIP beneficiaries in the OTLICP aid category that were not adjusted for additional Title XXI funding.

FUNDING ADJUST.—OTLICP
REGULAR POLICY CHANGE NUMBER: 208

2) The total amount of unadjusted CHIP funding in FY 2023-24 is estimated as $709,240,405 and $720,224,979 in FY 2024-25. These amounts are credited to the Title XIX fund.

3) The funds are then broken out according to reimbursement rates based on when the Department estimates the expenditure.
   a. In FY 2023-24, the Department estimates the additional CHIP funding will offset general fund spending by $106.4 million.
   b. In FY 2024-25, the Department estimates the additional CHIP funding will offset general fund spending by $108.0 million.

4) The amounts adjusted are as follows:

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
50% Title XIX / 50%GF	($709,240)	($354,620)	($354,620)
65% Title XXI FF / 35% GF	$709,240	$248,234	$461,006
Total	**$0**	**($106,386)**	**$106,386**

*Totals may differ due to rounding

FY 2024-25	TF	GF	FF
50% Title XIX / 50%GF	($720,225)	($360,112)	($360,112)
65% Title XXI FF / 35% GF	$720,225	$252,079	$468,146
Total	**$0**	**($108,034)**	**$108,034**

*Totals may differ due to rounding.

Funding:
50% Title XIX FF / 50% GF (4260-101-0890/0001)
65% Title XXI FF / 35% GF (4260-101-0890/0001)
COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 209
IMPLEMENTATION DATE: 4/2015
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 1760

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the funding for health care coverage for children in the Medi-Cal program due to the permanent extension of a quality assurance fee (QAF) for hospitals authorized under Proposition 52.

For more information about the Hospital QAF, 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 Hospital QAF program.

The Department received federal approval for the HQAF VI program period (July 1, 2019, through December 31, 2021) in February 2020. This QAF program period is referred to as HQAF VI.

The Department received federal approval for the QAF VII program period (January 1, 2022, through December 31, 2022) in September 2022. This QAF program period is referred to as HQAF VII.

The Department is currently developing the subsequent program period (HQAF VIII) which will include payments for the period beginning January 1, 2023. The Department is proposing a two-year program period for dates of service January 1, 2023, through December 31, 2024, which

HOSPITAL QAF - CHILDREN'S HEALTH CARE
REGULAR POLICY CHANGE NUMBER: 209

was submitted to the Centers for Medicare and Medicaid Services (CMS) in March 2023 via SPAs 23-0007 and 23-0008.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to:

- Updated FY 2023-24 FFS estimated payment amounts based on the current version of the HQAF VIII Fee & Payment model, which is under development and pending CMS approval.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to:

- The backlog of FY 2019-20 and 2020-21 delayed children's coverage payments are expected to be resolved in FY 2023-24.

Methodology:

1. Payments for children's health care are estimated through the period ending December 31, 2022, in this policy change.

2. The HQAF VI program period covers a 30-month period from July 1, 2019, through December 31, 2021.

3. SB 239 requires the Department to reconcile the funds for children's health care coverage based on the actual net benefit to the hospitals from the fee program.

4. HQAF VI payments are based on the HQAF VI model that was approved by CMS on In February 2020.

5. The HQAF VII program period covers a 12-month period from January 1, 2022, through December 31, 2022.

6. The HQAF VIII program period covers a 24-month period from January 1, 2023, through December 31, 2024.

7. HQAF VII payments are based on the HQAF VII model that was approved by CMS in September 2022.

8. HQAF VIII estimated payments are based current version of the HQAF VIII model which is pending CMS approval. Payment timing and amounts will change.

HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 209

9. On an accrual basis, annual funds for children's health care coverage are estimated to be:

(Dollars in Thousands)

Fiscal Year	Authority	HQAF VI Period (30 months)	Remaining Amount
FY 2019-20	Proposition 52	7/1/19 to 6/30/20	$489,000
FY 2020-21	Proposition 52	7/1/20 to 6/30/21	$201,896
FY 2021-22	Proposition 52	7/1/21 to 12/31/21	$0

(Dollars in Thousands)

Calendar Year (CY)	Authority	HQAF VIII Period (24 months - Pending)	Amount
CY 2023	Proposition 52	01/01/23 to 12/31/23	$1,266,000
CY 2024	Proposition 52	01/01/24 to 12/31/24	$1,254,000

10. Four quarters of HQAF VIII Children's Health Care payments will be paid in FY 2023-24 and four quarters of HQAF VIII Children's Health Care payments will be paid in FY 2024-25. Payment amounts and timing are subject to CMS review and approval and will change.

11. HQAF VI Children's Health Care coverage payments of approximately $690M for Cycles 1-7 were postponed due to the COVID-19 emergency. The payments are scheduled to be paid to the General Fund in Quarter 4 of FY 2023-24.

12. On a cash basis, the payments to health care coverage for children and the funding adjustment are:

(Dollars in Thousands)

FY 2023-24	TF	GF	Hosp. QA Rev Fund
FY 2019-20 & FY 2020-21	$0	($690,896)	$690,896
Calendar Year 2023	$0	($1,266,000)	$1,266,000
Total FY 2023-24	**$0**	**($1,956,896)**	**$1,956,896**

(Dollars in Thousands)

FY 2024-25	TF	GF	Hosp. QA Rev Fund
Calendar Year 2024	$0	($1,254,000)	$1,254,000
Total FY 2024-25	**$0**	**($1,254,000)**	**$1,254,000**

Funding:
100% GF (4260-101-0001)
100% Hospital Quality Assurance Revenue Fund (4260-611-3158)

CMS DEFERRED CLAIMS

REGULAR POLICY CHANGE NUMBER: 210
IMPLEMENTATION DATE: 4/2017
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 2034

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$704,530,000	-$2,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$704,530,000	-$2,000,000
FEDERAL FUNDS	$704,530,000	$2,000,000

Purpose:
This policy change estimates the repayment of deferred claims to the Centers for Medicare and Medicaid Services (CMS).

Authority:
California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)
Title 42, Code of Federal Regulations (CFR), 430.40

Interdependent Policy Changes:
Not Applicable

Background:
CMS reviews claims submitted by state Medicaid agencies to ensure federal financial participation (FFP) eligibility. Claims for which CMS questions the FFP eligibility are deferred and the state Medicaid agency is issued a deferral notice. Upon receipt of the deferral notice, the state Medicaid agency has 120 days to resolve the deferred claim.

When CMS issues a deferral to the state Medicaid agency, in accordance with the timelines set forth in 42 CFR 430.40, the state Medicaid agency must immediately return the deferred FFP to the applicable Payment Management System (PMS) subaccount while the deferral is being resolved. As part of the resolution process, the state Medicaid agency submits documentation in support of the deferred claim to CMS for review. If CMS determines the deferred claim is allowed, then the deferral is released, the funds are returned to the appropriate PMS subaccount, and the state Medicaid agency is notified that the funds are available to be redrawn.

The administrative deferral repayments are budgeted in a separate policy change. See the CMS Deferred Claims – Other Admin policy change for more information.

CMS DEFERRED CLAIMS
REGULAR POLICY CHANGE NUMBER: 210

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to:
- Updating FFY 2023 Q1 and FFY 2023 Q2 repayments based on actual deferrals for this quarter,
- Updating projected resolved deferrals returned to the GF in FY 2023-24,
- Including additional actual resolved deferrals returned to the GF in FY 2023-24, and
- Estimating an additional quarter of state only cost deferrals related to pharmacy claims.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to:
- Actual CMS deferral repayment amounts are included in FY 2023-24 while FY 2024-25 are projections,
- Actual resolved deferrals returned to the GF in FY 2023-24,
- Estimating state only cost deferrals related to the managed care proxy will not continue after FFY 2023 Q2 and the deferrals will be returned to the GF in FY 2023-24, and
- Estimating state only cost deferrals related to pharmacy claims will not continue after FFY 2024 Q1 and will be returned to the GF in FY 2024-25.

Methodology:
1. The Department received CMS deferrals for FFY 2015 Quarter 1 through FFY 2023 Quarter 2.

2. In FY 2023-24, the Department estimates to repay a total of $366.28 million FF, which includes $314.28 million of actual CMS deferrals issued for FFY 2023 Quarter 1 and FFY 2023 Quarter 2.

3. The repayment for state only costs deferrals for the managed care proxy in FY 2023-24 was $312.28 million for FFY 2023 Quarter 1 and FFY 2023 Quarter 2. Deferrals for the managed care proxy are not assumed for FFY 2023 Quarter 3 and later quarters, consistent with the expected implementation of correct claiming for these items. Repayments related to pharmacy claims were $1 million in FFY 2023 Quarter 1 and FFY 2023 Quarter 2 and are estimated to be $1 million for FFY 2023 Quarter 3 through FFY 2023 Quarter 4.

4. Repayments for state only cost deferrals for pharmacy claims are estimated to be $1 million in FY 2024-25 for FFY 2024 Quarter 1. Deferrals for pharmacy claims are not assumed for FFY 2024 Quarter 2 and later quarters, consistent with the expected implementation of correct claiming for these items.

5. An additional reserve amount of $25 million per quarter for future deferrals is estimated for all quarters from FFY 2023 Quarter 3 through FFY 2024 Quarter 4.

6. The Department has recovered $49.24 million in actual resolved deferrals and estimates recovering $1.022 billion in resolved deferrals related to the managed care proxy during FY 2023-24.

7. The Department estimates recovering $103 million in resolved deferrals during FY 2024-25 related to pharmacy claims.

CMS DEFERRED CLAIMS
REGULAR POLICY CHANGE NUMBER: 210

8. The Department will repay the following estimated deferred claims:

(Dollars in Thousands)

FY 2023-24	**Total Estimated Repayment**
FFY 2023 Quarter 1 (Oct-Dec 2022)	$157,138
FFY 2023 Quarter 2 (Jan-Mar 2023)	$157,138
FFY 2023 Quarter 3 (Apr-Jun 2023)	$26,000
FFY 2023 Quarter 4 (Jul-Sep 2023)	$26,000
Subtotal Estimated Repayments	$366,275
Estimated Resolved Deferrals	($1,070,806)
Total FY 2023-24	**($704,530)**

(Dollars in Thousands)

FY 2024-25	**Total Estimated Repayment**
FFY 2024 Quarter 1 (Oct-Dec 2023)	$26,000
FFY 2024 Quarter 2 (Jan-Mar 2024)	$25,000
FFY 2024 Quarter 3 (Apr-Jun 2024)	$25,000
FFY 2024 Quarter 4 (Jul-Sep 2024)	$25,000
Subtotal Estimated Repayments	$101,000
Estimated Resolved Deferrals	($103,000)
Total FY 2024-25	**($2,000)**

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

INDIAN HEALTH SERVICES FUNDING SHIFT

REGULAR POLICY CHANGE NUMBER: 211
IMPLEMENTATION DATE: 7/2019
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2156

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$29,278,000	-$30,821,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$29,278,000	-$30,821,000
FEDERAL FUNDS	$29,278,000	$30,821,000

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:
COVID-19 Increased FMAP – DHCS

Background:
The Department implemented the Indian Health Services/Memorandum of Agreement 638 Clinics (IHS/MOA) between the federal IHS and the Centers for Medicare & Medicaid Services (CMS) on April 21, 1998. The agreement permits the Department to be reimbursed at 100% FFP for payments made by the State for services rendered to AIs through IHS tribal facilities.

The Department implemented the enrollment and reimbursement of Youth Regional Treatment Centers (YRTCs) for services rendered to AI youths. Indian health clinics refer these youths to YRTCs for culturally appropriate in-patient substance use disorder treatment. The Department receives 100% FFP for YRTC services provided to eligible AI Medi-Cal members under the age of 21.

Federal policy permits retroactive claiming of 100% FFP to the date of the MOA, July 11, 1996, or at whatever later date a clinic qualifies and elects to participate as an IHS facility under the MOA.

The per visit rate payable to the Indian health clinics is adjusted annually through changes posted in the Federal Register. These rates are set by IHS with the concurrence of the Federal Office of Management and Budget and are based on cost reports compiled by IHS.

INDIAN HEALTH SERVICES FUNDING SHIFT
REGULAR POLICY CHANGE NUMBER: 211

Reason for Change:
There is no change in total funds for FY 2023-24 from the prior estimate, or from FY 2023-24 to FY 2024-25 in the current estimate.

The change from the prior estimate is an increase in General Fund (GF) for FY 2023-24, based on two additional quarters of actual expenditures, improved data collection, increased visits to providers, and the expansion of telehealth as a service modality. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase in GF 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 2023-24, it is estimated the Department will spend $58,556,000 TF ($29,278,000 GF). In FY 2024-25, it is estimated the Department will spend $61,642,000 TF ($30,821,000 GF).

3. Estimated expenditures for FY 2023-24 and FY 2024-25 are in the table below.

(Dollars in Thousands)

FY 2023-24	**TF**	**GF**	**FF**
IHS FY 2023-24 Base exp. (50% GF / 50% FF)	($58,556)	($29,278)	($29,278)
IHS total expenditures (100% FF)	$58,556	$0	$58,556
FY 2023-24 Total	**$0**	**($29,278)**	**$29,278**
FY 2024-25	**TF**	**GF**	**FF**
IHS FY 2024-25 Base exp. (50% GF / 50% FF)	($61,642)	($30,821)	($30,821)
IHS total expenditures (100% FF)	$61,642	$0	$61,642
FY 2024-25 Total	**$0**	**($30,821)**	**$30,821**

*Totals may differ due to rounding.

Funding:
50% Title XIX FFP/ 50% GF (4260-101-0890/0001)
Title XIX 100% FFP (4260-101-0890)
COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

CALAIM - DENTAL INITIATIVES

REGULAR POLICY CHANGE NUMBER: 212
IMPLEMENTATION DATE: 1/2022
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2188

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$250,903,000	$250,903,000
- STATE FUNDS	$120,224,950	$120,224,950
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	100.00 %	100.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the cost of the dental benefits and performance payments covered under the California Advancing and Innovating Medi-Cal (CalAIM) policy. These costs include the estimated performance payments for the provision of preventive services, caries risk assessment, continuity of care, and adding coverage of Silver Diamine Fluoride (SDF) as a dental benefit for specific populations.

Authority:
SPA 21-0019

Interdependent Policy Changes:
COVID-19 Increased FMAP – DHCS

Background:
Starting January 1, 2022, the CalAIM policy provides performance payments to improve dental health for Medi-Cal children and adults by focusing on high-value care, improved access, and utilization of performance measures to drive delivery system reform.

The Department has set an initial goal to achieve a 60 percent dental utilization rate for eligible Medi-Cal children as well as increase utilization for adults. In order to progress towards achieving that goal, the Department offers a performance payment at 75% of the Schedule of Maximum Allowances (SMA) for each paid preventive oral care service billed by a service office location. These performance payments are only applicable to specific preventive services Current Dental Terminology (CDT) codes for children and adults.

The four dental initiatives of the CalAIM program are as follows:

(1) Preventive Services
(2) Caries Risk Assessment
(3) Continuity of Care, and
(4) Adding coverage of Silver Diamine Fluoride (SDF) as a dental benefit for specific populations

CALAIM - DENTAL INITIATIVES
REGULAR POLICY CHANGE NUMBER: 212

Reason for Change:
There is no change from the prior estimate for FY 2023-24. There is no change from FY 2023-24 to FY 2024-25 in the current estimate.

Methodology:
1. For Preventive Services, a flat rate performance payment equivalent to 75% of the SMA is paid for specific preventive services rendered.

FY 2023-24	TF	GF	FF
Fee-for-service	$126,860,000	$63,430,000	$63,430,000
Dental Managed Care	$5,897,000	$1,987,000	$3,910,000
Total	**$132,757,000**	**$65,417,000**	**$67,340,000**

FY 2024-25	TF	GF	FF
Fee-for-service	$126,860,000	$63,430,000	$63,430,000
Dental Managed Care	$5,897,000	$1,987,000	$3,910,000
Total	**$132,757,000**	**$65,417,000**	**$67,340,000**

2. For Caries Risk Assessment, payment for utilizing codes D0601, D0602, and D0603 is offered for children ages 0-6 based on risk level associated with each member and varying frequencies of service.

FY 2023-24	TF	GF	FF
Fee-for-service	$45,208,000	$18,761,000	$26,447,000
Dental Managed Care	$2,035,000	$686,000	$1,349,000
Total	**$47,243,000**	**$19,447,000**	**$27,796,000**

FY 2024-25	TF	GF	FF
Fee-for-service	$45,208,000	$18,761,000	$26,447,000
Dental Managed Care	$2,035,000	$686,000	$1,349,000
Total	**$47,243,000**	**$19,447,000**	**$27,796,000**

3. For Continuity of Care, a flat rate performance payment of $55 is paid to service office locations for each returning beneficiary once per year period for exam codes D0120, D0150, or D0145. The performance payment is paid the second consecutive year. The performance payment is not applicable to dental managed care.

FY 2023-24	TF	GF	FF
Fee-for-service	$68,422,000	$34,211,000	$34,211,000
Dental Managed Care	$0	$0	$0
Total	**$68,422,000**	**$34,211,000**	**$34,211,000**

CALAIM - DENTAL INITIATIVES
REGULAR POLICY CHANGE NUMBER: 212

FY 2024-25	TF	GF	FF
Fee-for-service	$68,422,000	$34,211,000	$34,211,000
Dental Managed Care	$0	$0	$0
Total	**$68,422,000**	**$34,211,000**	**$34,211,000**

4. SDF is covered for children 0-6 as well as skilled nursing facilities, intermediate care facilities, disabled children ages 0-6, and disabled adults. The SDF benefit would provide two visits per member per year, up to ten teeth per visit, at a per tooth rate of $12.

FY 2023-24	TF	GF	FF
Fee-for-service	$2,183,000	$1,050,000	$1,133,000
Dental Managed Care	$298,000	$100,000	$198,000
Total	**$2,481,000**	**$1,150,000**	**$1,331,000**

FY 2024-25	TF	GF	FF
Fee-for-service	$2,183,000	$1,050,000	$1,133,000
Dental Managed Care	$298,000	$100,000	$198,000
Total	**$2,481,000**	**$1,150,000**	**$1,331,000**

5. On a cash basis, the FY 2023-24 and FY 2024-25 total costs are:

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF	$221,296,000	$110,648,000	$110,648,000
ACA 90% FF / 10% GF	$3,142,000	$314,000	$2,828,000
Title XXI 65% FF/35% GF	$26,465,000	$9,263,000	$17,202,000
Total	**$250,903,000**	**$120,225,000**	**$130,678,000**

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF	$221,296,000	$110,648,000	$110,648,000
ACA 90% FF / 10% GF	$3,142,000	$314,000	$2,828,000
Title XXI 65% FF/35% GF	$26,465,000	$9,263,000	$17,202,000
Total	**$250,903,000**	**$120,225,000**	**$130,678,000**

*Totals may differ due to rounding.

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
90% ACA Title XIX FF / 10% GF (4260-101-001/0890)
65% Title XXI / 35% GF (4260-101-0001/0890)
COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

DENTAL MANAGED CARE MLR RISK CORRIDOR

REGULAR POLICY CHANGE NUMBER: 213
IMPLEMENTATION DATE: 12/2021
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2356

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	-$9,800,000	$0
- STATE FUNDS	-$3,154,550	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$9,800,000	$0
STATE FUNDS	-$3,154,550	$0
FEDERAL FUNDS	-$6,645,450	$0

Purpose:
This policy change budgets recoveries from managed care plans related to the Medical Loss Ratio (MLR) risk corridor calculations applicable to the Medi-Cal Dental Managed Care (DMC) plans.

Authority:
Title 42, Code of Federal Regulations, Part 438.8
Access Dental Plan Contract #12-89341
Access Dental Plan Contract #13-90115
Health Net of California Contract #12-89342
Health Net of California Contract #13-90116
Liberty Dental Plan of California, Inc. Contract #12-89343
Liberty Dental Plan of California, Inc. Contract #13-90117
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
The DMC program provides a comprehensive approach to dental health care, combining clinical services and administrative procedures that are organized to provide timely access to primary care and other necessary services in a cost effective manner. The Department contracts with three Geographic Managed Care (GMC) plans and three Prepaid Health Plans (PHP). These plans provide dental services to Medi-Cal beneficiaries in Sacramento and Los Angeles counties.

Each dental plan receives a monthly per capita rate for every recipient enrolled in their plan. DMC program recipients enrolled in contracting plans are entitled to receive dental benefits from dentists within the plan’s provider network.

DENTAL MANAGED CARE MLR RISK CORRIDOR

REGULAR POLICY CHANGE NUMBER: 213

The Medi-Cal DMC plan contracts establish a single-sided risk corridor in the form of a minimum MLR of 85% beginning with the FY 2019-20 rating period. The Department will require DMC plans to remit necessary funds that do not meet the 85% threshold.

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 increased FMAP is effective January 1, 2020, and extended its availability through the last day of the calendar quarter of the national public health emergency.

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due to recoupments from prior years. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease in recoupments due to known recoupments being completed in FY 2023-24.

Methodology:

1. The Department estimates total collections of $9.8 million in FY 2023-24. Of this amount, $3 million is associated with the CY 2021 rating period, and the remaining $6.8 million is associated with the CY 2022 rating period.

2. The Title XIX and Title XXI COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

3. The Department estimates any remittances for the CY 2023 rating period will be collected in FY 2024-25. At this time, an estimated remittance amount is not available as the data needed to perform the calculations can be collected only after the end of the rating period.

DENTAL MANAGED CARE MLR RISK CORRIDOR

REGULAR POLICY CHANGE NUMBER: 213

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF	($5,068,000)	($2,534,000)	($2,534,000)
90% ACA Title XIX FF / 10% GF	($3,253,000)	($325,000)	($2,928,000)
65% Title XXI / 35% GF	($1,255,000)	($439,000)	($816,000)
COVID-19 Title XIX Increased FMAP	$0	$314,000	($314,000)
COVID-19 Title XXI Increased FMAP	$0	$54,000	($54,000)
100% GF	($224,000)	($224,000)	$0
Total	**($9,800,000)**	**($3,154,000)**	**($6,646,000)**

*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)
COVID-19 Title XIX Increased FFP (4260-101-0890)
COVID-19 Title XIX GF (4260-101-0001)
COVID-19 Title XXI Increased FFP (4260-101-0890)
COVID-19 Title XXI GF (4260-101-0001)
100% State GF (4260-101-0001)

COUNTY SHARE OF OTLICP-CCS COSTS

REGULAR POLICY CHANGE NUMBER: 214
IMPLEMENTATION DATE: 7/2014
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 1906

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	-$11,993,000	-$16,769,000
- STATE FUNDS	-$11,993,000	-$16,769,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$11,993,000	-$16,769,000
STATE FUNDS	-$11,993,000	-$16,769,000
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the reimbursement of county funds for the Optional Targeted Low Income Children's Program (OTLICP).

Authority:
AB 1494 (Chapter 28, Statutes of 2012)
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
AB 1494 authorized the transition of all Healthy Family Program (HFP) subscribers into the Medi-Cal OTLICP. Effective January 1, 2013, HFP subscribers transitioned into OTLICP through a phase-in methodology.

Of the subscribers, an estimated 23,381 California Children Services (CCS) – HFP eligibles shifted to CCS-OTLICP in FY 2013-14. CCS-HFP was funded with 65% FFP, 17.5% GF, and 17.5% county funds through September 30, 2015. From October 1, 2015, to September 30, 2019, CCS-HFP was funded with 88% FFP, 6% GF, and 6% county funds. From October 1, 2019, to September 30, 2020, CCS-HFP was funded with 76.5% FFP, 11.75% GF, and 11.75% county funds. Effective October 1, 2020, CCS-HFP is funded with 65% FFP, 17.5% GF, and 17.5% county funds. It is assumed that the county share will continue under OTLICP.

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).

COUNTY SHARE OF OTLICP-CCS COSTS

REGULAR POLICY CHANGE NUMBER: 214

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change from the prior estimate, is a decrease for FY 2023-24, in county share reimbursement for OTLICP-CCS due to updated actual expenditures. The change in the current estimate from FY 2023-24 to FY 2024-25, is an increase in county share reimbursement for OTLICP-CCS costs, due using historical actuals to project forward.

Methodology:

1. The county share reimbursement for OTLICP-CCS in FY 2023-24, at 17.5% for quarter 1 through 4, is estimated to be $11,993,000.

2. The county share reimbursement for OTLICP-CCS in FY 2024-25, at 17.5% for quarter 1 through 4, is estimated to be $16,769,000.

3. The increased FMAP reduces the county share of reimbursement for OTLICP-CCS costs by $245,000 in FY 2023-24 for this policy change.

4. The Title XXI COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

5. The county share of OTLICP-CCS costs is estimated in the table below:

Fiscal Year	TF	GF	CF*
FY 2023-24	**$11,993,000**	**$11,993,000**	($11,993,000)
FY 2024-25	**$16,769,000**	**$16,769,000**	($16,769,000)

* County Funds are not included in the Total Fund.

Funding:
100% Title XXI State GF (4260-101-0001)
COVID-19 Title XXI GF (4260-101-0001)

CCI IHSS RECONCILIATION

REGULAR POLICY CHANGE NUMBER: 215
IMPLEMENTATION DATE: 7/2022
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 1942

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	-$30,986,000	$0
- STATE FUNDS	$84,014,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$30,986,000	$0
STATE FUNDS	$84,014,000	$0
FEDERAL FUNDS	-$115,000,000	$0

Purpose:
This policy change estimates the reimbursement of In-Home Supportive Services (IHSS) overpayments and underpayments to the California Department of Social Services (CDSS) and the managed care plans.

Authority:
Welfare & Institutions Code (W&I) 14132.275

Interdependent Policy Changes:
Not Applicable

Background:
In coordination with Federal and State Government, the Coordinated Care Initiative (CCI) provided the benefits of coordinated care models to persons eligible for Medi-Cal. CCI aimed to improve service delivery for people with dual eligibility and Medi-Cal only beneficiaries who relied on long-term services and supports (LTSS) to maintain residence in their home or community. LTSS includes both home and community-based services, such as IHSS and institutional long-term care services. Services were provided through the managed care delivery system for all Medi-Cal beneficiaries who relied on such services. CDSS and the county social service offices were responsible for the administration and payment of IHSS expenditures. The cost of IHSS was built into the CCI capitated rates and paid to CDSS to reimburse IHSS providers for personal care services. The Department is responsible for the reconciliation of the IHSS category of service, which was a component of the capitated rate, to actual IHSS expenditures paid out to providers by CDSS for a specified period of time. The Department determined the overpayments or underpayments to CDSS or the managed care plans (MCPs) during the reconciliation process.

The 2017 Budget extended the Cal MediConnect program and the mandatory enrollment of dual eligibles and integration of LTSS, except IHSS, into managed care. IHSS was removed from capitation rate payments as of January 1, 2018.

CCI IHSS RECONCILIATION
REGULAR POLICY CHANGE NUMBER: 215

As part of the CalAIM Initiative's standardized mandatory enrollment of dual eligibles and statewide integration of long-term care into managed care, the CCI pilot program sunset December 31, 2022.

Reason for Change:
There is no total fund change from the prior estimate for FY 2023-24. However, due to the $115 million General Fund (GF) repayment to the Centers for Medicare and Medicaid Services (CMS) shifting from FY 2022-23 to FY 2023-24, there was an increase in GF and a decrease in Federal Funds. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to the repayment to the CMS and the recoupments from MCPs being completed in FY 2023-24.

Methodology:
1. The 2015, 2016, and 2017 reconciliation for CY 2015, CY 2016, and CY 2017 service months and reimbursement for overpayments and underpayments were completed in FY 2022-23.

2. Based on CY 2015, CY 2016, and CY 2017 data, the MCPs were owed a net of approximately $162,000,000 GF for IHSS managed care in the seven CCI counties.

3. Additionally, due to the difference between total claims paid by CDSS and claims for beneficiaries who were not flagged as receiving IHSS services for MCP capitation, the Department recorded an additional $86,000,000 million as a GF cost.

4. Total estimated net amount paid to MCPs in FY 2022-23 was $248,000,000 GF.

5. $115,000,000 GF will be used in FY 2023-24 to repay CMS for reduced capitation payments to the MCPs.

6. In FY 2023-24, $30,986,000 GF is estimated to be recouped from plans that no longer have active contracts with the state.

Funding:
100% State GF (4260-101-0001)
100% FFP (4260-001-0001)

COUNTY BH RECOUPMENTS

REGULAR POLICY CHANGE NUMBER: 216
IMPLEMENTATION DATE: 1/2024
ANALYST: Elena Susbilla
FISCAL REFERENCE NUMBER: 2343

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	-$64,160,000	-$64,160,000
- STATE FUNDS	-$64,160,000	-$64,160,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$64,160,000	-$64,160,000
STATE FUNDS	-$64,160,000	-$64,160,000
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the recoupments due to the Department from psychiatric inpatient hospital claims approved and paid through the Fiscal Intermediary, and overpayments of Federal Financial Participation (FFP) related to beneficiaries with unsatisfactory immigration status (UIS).

Authority:
AB 757 (Chapter 633, Statutes of 1994)

Interdependent Policy Changes:
Not Applicable

Background:
Psychiatric Inpatient Hospital Claims
The Department consolidated the responsibility to provide inpatient and outpatient specialty mental health services under county mental health plans (MHP) of outpatient Specialty Mental Health Services (SMHS) in 1994 and inpatient services in 1997. The majority of hospitals providing inpatient SMHS receive payment via Medi-Cal's Fee-for-Service claims adjudication system. Medi-Cal pays the federal and non-federal share for psychiatric inpatient hospital services. The non-federal share is initially funded by General Fund (GF) and later reimbursed by subtracting the expenditure amount from each county's Mental Health Subaccount in the Sales Tax Account of the Local Revenue Fund.

The Department routinely adds aid codes to the Medi-Cal program. The Department and the former Department of Mental Health did not add new aid codes to the reporting structure used to identify the expenditure amounts for the Mental Health Subaccount. As a result, the Department did not identify and was not fully reimbursed for all of the psychiatric inpatient hospital service expenditures between CY 2011 and 2020.

COUNTY BH RECOUPMENTS
REGULAR POLICY CHANGE NUMBER: 216

Medi-Cal Members with UIS
California provides state only full scope Medi-Cal services to certain immigrant populations who meet all Medi-Cal eligibility requirements except for their citizenship status. For these covered populations, FFP is only available for emergency and pregnancy-related services, and nonemergency and non-pregnancy related services are paid using state only funds. Affected populations include qualified non-citizens subject to the five-year bar, individuals who are Permanent Residents or Permanently Residing Under Color of Law, and individuals under 26 years of age who otherwise meet all Medi-Cal eligibility criteria (such as income and state residency) but for their citizenship status.

The Department has identified claiming for ineligible covered benefits and is required to return the federal funding to the Centers for Medicare and Medicaid Services (CMS). In FY 2020-21, the Department repaid the FFP amounts subject to repayment totaling $123.2 million, of which $61 million is GF and $62.2 million is assumed to be recouped from counties. 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). The recoupment associated with these claims is $255,000.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to the inclusion of additional identified UIS county recoupments and a slightly lower estimated psychiatric inpatient claim recoupments due to voided claims.

There is no change from FY 2023-24 to FY 2024-25, in the current estimate.

Methodology:
1. Assume recoupments for both psychiatric inpatient claims and Medi-Cal members with UIS will occur over four state fiscal years beginning FY 2023-24. The first recoupments will begin in the third quarter of FY 2023-24.

2. The psychiatric inpatient claim recoupments total $190,277,000.

3. The recoupment for claims related to Medi-Cal members with UIS is $66,361,000.

4. The Department will recoup funds over a four-year period.

COUNTY BH RECOUPMENTS

REGULAR POLICY CHANGE NUMBER: 216

(Dollars in Thousands)

Estimated Recoupment Schedule	Total	Psychiatric Inpatient	Specialty Mental Health UIS	Drug Medi-Cal UIS
FY 2023-24 – Q3	$32,080	$23,785	$8,018	$277
FY 2023-24 – Q4	$32,080	$23,785	$8,018	$277
FY 2024-25 – Q1	$16,040	$11,893	$4,008	$139
FY 2024-25 – Q2	$16,040	$11,892	$4,009	$139
FY 2024-25 – Q3	$16,040	$11,892	$4,009	$139
FY 2024-25 – Q4	$16,040	$11,892	$4,009	$139
Total	$128,320	$95,139	$32,071	$1,110

(Dollars in Thousands)

BH Recoupments	TF	GF
FY 2023-24	**($64,160)**	**($64,160)**
FY 2024-25	**($64,160)**	**($64,160)**

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

ADVISORY COUNCIL ON PHYS. FIT. & MENTAL WELL-BEING

REGULAR POLICY CHANGE NUMBER: 219
IMPLEMENTATION DATE: 1/2024
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 2441

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$2,000,000	$1,000,000
- STATE FUNDS	$2,000,000	$1,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,000,000	$1,000,000
STATE FUNDS	$2,000,000	$1,000,000
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the costs of contracting to support the implementation of the Governor's Advisory Council on Physical Fitness & Mental Well-Being's (Council) goals media campaign.

Authority:
Interagency Agreement (IA) Amendment (22-10854)

Interdependent Policy Changes:
Not Applicable

Background:
In 2021, the Governor's Office established the Council. The Council is tasked with exploring healthy strategies to ensure Californians can thrive with special emphasis on child physical and mental health. The Council also works on providing guidance on California's physical activity and wellness, and work to promote equitable access to outdoor and physical activity for underserved California communities. The California Department of Public Health (CDPH) currently works with the Governor's Council on Physical Fitness and Mental Well-Being to help spread the word and work of the Council.

The Department will be contracting with the CDPH through an IA to support the implementation of the Council's goals through a wide variety of media tactics to promote physical fitness and mental well-being to all Californians.

Reason for Change:
This is a new policy change.

Methodology:
1. In FY 2023-24, the Department will make payments for the FY 2022-23 and FY 2023-24 invoices received from CDPH.

ADVISORY COUNCIL ON PHYS. FIT. & MENTAL WELL-BEING
REGULAR POLICY CHANGE NUMBER: 219

2. In FY 2024-25, the Department will make payments for the FY 2024-25 invoices received from CDPH.

(Dollars in Thousands)

Fiscal Year	TF	Reimbursement
FY 2023-24	$2,000	$2,000
FY 2024-25	$1,000	$1,000

Funding:
Reimbursement GF (4260-601-0995)

ASSET LIMIT INCREASE & ELIM. - CNTY BH FUNDING

REGULAR POLICY CHANGE NUMBER: 220
IMPLEMENTATION DATE: 11/2024
ANALYST: Elena Susbilla
FISCAL REFERENCE NUMBER: 2443

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$6,084,000
- STATE FUNDS	$0	$6,084,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$6,084,000
STATE FUNDS	$0	$6,084,000
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the cost of reimbursing Mental Health Plans (MHPs), Drug Medi-Cal (DMC) State Plan counties and DMC-Organized Delivery System (ODS) counties the non-federal share of services provided to beneficiaries enrolled as a result of the asset limit test increase and elimination.

Authority:
AB 133 (Chapter 143, Statutes of 2021)
SPA 21-0053
Budget Act of 2024

Interdependent Policy Changes:
Not Applicable

Background:
Pursuant to Chapter 143, Statutes of 2021, the Department increased, effective July 1, 2022, the asset limit test for Medi-Cal members not subject to the Modified Adjusted Gross Income (MAGI) eligibility requirements to $130,000 and will fully eliminate the asset limit test effective January 1, 2024. This change has resulted in an increase in the number of people who qualify for full scope Medi-Cal benefits and receive services through the Medi-Cal behavioral health delivery systems. Payments will be provided to counties for the non-federal share of specialty mental health and substance use disorder services provided to the additional beneficiaries enrolled in Medi-Cal as a result of the asset limit test increase and elimination.

Reason for Change:
This is a new policy change.

Methodology:
1. Assume retroactive payments will be made for services provided since July 1, 2022, and payments are estimated to start by November 2024.

ASSET LIMIT INCREASE & ELIM. - CNTY BH FUNDING
REGULAR POLICY CHANGE NUMBER: 220

2. On a cash basis, the FY 2022-23 totaling $2.6 million GF and FY 2023-24 payments totaling $3.5 million GF are estimated to be paid in FY 2024-25. Beginning FY 2025-26, retroactive payments are expected to be made annually at $4.4 million GF for the previous year.

Asset Test Increase and Elimination	FY 2022-23	FY 2023-24
SMHS	$2,448,000	$3,314,000
DMC	$8,000	$10,000
DMC-ODS (Required Services)	$129,000	$175,000
Total	$2,585,000	$3,499,000

3. The estimated cost in FY 2024-25 for the asset test increase and elimination is as follows:

Asset Test Increase and Elimination	TF	GF
FY 2022-23	$2,585,000	$2,585,000
FY 2023-24	$3,499,000	$3,499,000
Total FY 2024-25	**$6,084,000**	**$6,084,000**

Funding:
General Fund (4260-101-0001)

CYBHI WELLNESS COACH BENEFIT

REGULAR POLICY CHANGE NUMBER: 222
IMPLEMENTATION DATE: 1/2025
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 2457

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$9,513,000
- STATE FUNDS	$0	$4,123,450
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$9,513,000
STATE FUNDS	$0	$4,123,450
FEDERAL FUNDS	$0	$5,389,550

Purpose:
This policy change estimates the costs to establish a new Medi-Cal benefit and provider type, Wellness Coach, as part of the Child and Youth Behavioral Health Initiative (CYBHI).

Authority:
Budget Act of 2024
State Plan Amendment (SPA)
AB 133 (Chapter 143, Statutes of 2021)

Interdependent Policy Changes:
Not Applicable

Background:
The 2021-22 California Budget authorized the Children and Youth Behavioral Health Initiative 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 Wellness Coach (formerly known as behavioral health coach) workforce. The Department, in partnership with HCAI will implement Wellness Coaches as a Medi-Cal benefit to improve access to services and supports to children and youth with existing and emerging behavioral health needs. This benefit will be available in Medi-Cal Fee-for-Service (FFS) and managed care for Medi-Cal members.

In accordance with the Health and Safety Code Section 127825, the 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. The Department will establish a pathway for Medi-Cal coverage of Wellness Coaches by developing a SPA to establish Wellness Coaches as a new distinct provider to provide new distinct service type or activities in the Medi-Cal program.

Wellness Coaches will primarily serve children and youth and operate as part of a care team, including in school-linked settings; however, Wellness Coach services could be provided across

CYBHI WELLNESS COACH BENEFIT
REGULAR POLICY CHANGE NUMBER: 222

the Medi-Cal behavioral delivery system. Wellness Coaches will offer six core services, including: 1) wellness promotion and education; 2) screening; 3) care coordination; 4) individual support; 5) group support; and 6) crisis referral. Furthermore, the Wellness Coach will operate under the direction of and coordination of a Pupil Personnel Services (PPS) credentialed or licensed behavioral health provider.

Reason for Change:
This is a new policy change.

Methodology:
1. Assume the effective date of the benefit is January 2025.

2. Assume FFS implementation will begin in January 2025 and managed care payments will begin February 2025.

3. Assume the benefit will increase annually over the next several years with an estimated annual cost of $78.0 million TF ($33.8 million GF) in FY 2027-28.

4. The estimated costs on a cash basis in FY 2024-25 are:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
FFS (Lagged)	$90	$39	$51
Managed Care	$9,423	$4,084	$5,339
Total	**$9,513**	**$4,123**	**$5,390**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX / 10% GF (4260-101-001/0890)
65% Title XXI / 35% GF (4260-101-0001/0890)

RESPIRATORY SYNCYTIAL VIRUS VACCINES

REGULAR POLICY CHANGE NUMBER: 223
IMPLEMENTATION DATE: 10/2023
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 2454

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$138,738,000	$215,762,000
- STATE FUNDS	$61,418,300	$95,516,350
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$138,738,000	$215,762,000
STATE FUNDS	$61,418,300	$95,516,350
FEDERAL FUNDS	$77,319,700	$120,245,650

Purpose:
This policy change estimates the costs for the Respiratory Syncytial Virus (RSV) vaccines and injectables.

Authority:
Inflation Reduction Act of 2022

Interdependent Policy Changes:
COVID-19 Increased FMAP - DHCS

Background:
RSV is a contagious virus causing lower respiratory infections and can lead to pneumonia or other infections. Older adults and young children are more susceptible to serious conditions due to RSV causing hospitalization and deaths. Two RSV vaccines and one injectable drug were approved by the Food and Drug Administration (FDA) and Centers for Disease Control and Prevention (CDC) for protecting this vulnerable population. The Inflation Reduction Act of 2022 mandated all Advisory Committee on Immunization Practices (ACIP) recommended vaccine coverage for Medicaid members ages 19 and over.

With the ACIP recommended coverage, the new RSV vaccines and injectable drug, Medi-Cal will offer this benefit to members. RSV can lead to hospitalization in infants, young children, and older adults and even lead to deaths. Until recently, vaccines for RSV have not existed. These vaccines are targeted to older adults and pregnant individuals. Healthy children have the option of the injectable drug.

Reason for Change:
This is a new policy change.

RESPIRATORY SYNCYTIAL VIRUS VACCINES

REGULAR POLICY CHANGE NUMBER: 223

Methodology:

1. Assume the RSV vaccines and injectables are available starting October 2023.
2. Assume approximately 1,034,000 Medi-Cal members will receive the RSV vaccines or injectable drug.
3. Assume 8.37% of members have Medicare Part D which covers the RSV vaccine resulting in Medi-Cal reimbursing for approximately 913,500 RSV vaccines and injectable drugs.
4. Assume the Vaccine for Children program will cover the ingredient cost for the injectable drug for Medi-Cal children. Medi-Cal will cover the ingredient costs for RSV vaccines for adults ages 19 and over.
5. Assume the average RSV vaccine ingredient reimbursement is $256.96 per dose.
6. Assume the RSV vaccine administration fee is $9.00 for all non-pharmacy providers and $7.65 for pharmacies.
7. Assume pharmacies receive an average dispensing fee of $11.63.
8. Total costs are estimated to be:

(Dollars in Thousands)	FY 2023-24	FY 2024-25
Administrative Fee	$5,161	$7,877
Dispensing Fee	$2,000	$2,868
Ingredient Fee	$131,577	$205,017
Total Cost	$138,738	$215,762

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
RSV (FFS lagged)	$138,738	$61,418	$77,320

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
RSV (FFS lagged)	$215,762	$95,516	$120,246

Funding:

50% title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX / 10% GF (420=60-101-0001/0890)
65% Title XXI / 35% GF (4260-101-0001/0890)

ENHANCED CARE MANAGEMENT RISK CORRIDOR

REGULAR POLICY CHANGE NUMBER: 225
IMPLEMENTATION DATE: 6/2025
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2452

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	-$45,359,000
- STATE FUNDS	$0	-$18,508,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$45,359,000
STATE FUNDS	$0	-$18,508,300
FEDERAL FUNDS	$0	-$26,850,700

Purpose:
This policy change estimates the costs or savings from the implementation of the Enhanced Care Management (ECM) two-sided risk corridor.

Authority:
California Advancing and Innovating Medi-Cal (CalAIM) Initiative
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2022, the Department implemented a new ECM benefit in the Medi-Cal managed care delivery system. Medi-Cal managed care plans (MCPs) in counties without Whole Person Care pilots and/or Health Homes Programs implemented the new ECM benefit on July 1, 2022, for certain mandated populations of focus.

To protect the MCPs and the State against excessive gains/losses due to the implementation of the new benefits, the Department has established a two-sided, symmetrical risk corridor for the calendar year (CY) 2022 rating period, subject to the Centers for Medicare and Medicaid Services approval. Calculations are anticipated to begin no sooner than January 1, 2024. A risk corridor will also be in place for the CY 2023 rating period, with calculations starting no sooner than January 1, 2025.

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. 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).

ENHANCED CARE MANAGEMENT RISK CORRIDOR

REGULAR POLICY CHANGE NUMBER: 225

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022, and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
This is a new policy change.

Methodology:
1. The CY 2022 rating period recoupments and repayments are anticipated to occur in FY 2024-25.

2. The Title XIX and Title XXI COVID-19 increased FMAP is assumed for expenditures through December 31, 2023, for this policy change.

3. The ECM risk corridor estimated recoupments are:

Fiscal Year	TF	GF	FF
FY 2024-25	($45,359,000)	($18,508,000)	($26,851,000)

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

MEDI-CAL PROVIDER RATE INCREASE 2025

REGULAR POLICY CHANGE NUMBER: 226
IMPLEMENTATION DATE: 2/2025
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2458

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	$1,921,950,000
- STATE FUNDS	$0	$773,859,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$1,921,950,000
STATE FUNDS	$0	$773,859,000
FEDERAL FUNDS	$0	$1,148,091,000

Purpose:
This policy change estimates the costs associated with increasing provider rates, effective January 1, 2025 or July 1, 2025.

Authority:
Budget Act of 2023 [AB 118 (Chapter 42, Statutes of 2023)]

Interdependent Policy Changes:
Not Applicable

Background:
In accordance with AB 118, this proposal would provide rate increases and other investments for the below domains in Phase 2, effective January 1, 2025.

- Additional investments in primary care, obstetric care, and non-specialty mental health services.
- Specialty care services.
- Community or hospital outpatient procedures and services.
- Family planning and women's health services.
- Services and supports for primary care, obstetric care, and non-specialty mental health services provided by federally qualified health centers and rural health clinics.
- Hospital-based emergency and emergency physician services.
- Ground emergency transport services.
- Designated public hospitals.
- Behavioral health care for beneficiaries in hospital and institutional long-term care settings.
- Additional investments to maintain and grow the health care workforce.

The Behavioral Health Facility Throughput is proposed to be implemented July 1, 2025.

MEDI-CAL PROVIDER RATE INCREASE 2025

REGULAR POLICY CHANGE NUMBER: 226

Similar to Phase 1, any AB 97 reductions still in effect for the services subject to the Phase 2 rate increases will be eliminated as part of the proposal. Similarly, Proposition 56 supplemental payments for the services subject to Phase 2 rate increases will be converted to base rate increases, with the Proposition 56 funding, subject to revenue availability, continuing to support the increases.

The non-federal share of these provider rate increases will be borne by the Medi-Cal Provider Payment Reserve Fund, item 4260-101-3431. This policy change identifies the use of General Fund (GF) for the rate increases. See the Medi-Cal Provider Payment Reserve Fund policy change for the shift from the GF to item 4260-101-3431.

Reason for Change:
This is a new policy change.

Methodology:
1. The effective date for the rate increases in both the Fee-for-Service and Managed Care delivery systems is January 1, 2025 except for the Behavioral Health Facility Throughput rate increases which are effective July 1, 2025.

2. Assume the annual impact is estimated to be $5,356,071,000 TF ($2,215,000,000 GF) in this policy change.

3. See the Medi-Cal Provider Payment Reserve Fund policy change for the additional workforce investment funding starting in FY 2024-25.

4. On a cash basis, the estimated costs in FY 2024-25 are:

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
Primary Care, OB, MH	$454,618	$181,847	$272,771
Specialty Care	$530,388	$212,155	$318,233
Community and Outpatient Procedures and Services	$198,010	$99,005	$99,005
Abortion/ Family Planning Access	$90,923	$36,369	$54,554
Services and Supports Primary Care, OB, BH	$50,513	$20,205	$30,308
Emergency Room - Facility	$294,419	$103,046	$191,372
Emergency Room - Physician	$101,026	$40,411	$60,616
Designated Public Hospitals	$151,540	$60,616	$90,924
Ground Emergency Transport	$50,513	$20,205	$30,308
Behavioral Health Facility Throughput (Effective 7/1/2025)	$0	$0	$0
Total	**$1,921,950**	**$773,859**	**$1,148,091**

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

PROP 56 - FUNDING REDUCTION

REGULAR POLICY CHANGE NUMBER: 231
IMPLEMENTATION DATE: 7/2023
ANALYST: Ryan Woolsey
FISCAL REFERENCE NUMBER: 2463

	FY 2023-24	FY 2024-25
FULL YEAR COST - TOTAL FUNDS	$0	-$193,405,000
- STATE FUNDS	$0	-$77,107,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$193,405,000
STATE FUNDS	$0	-$77,107,000
FEDERAL FUNDS	$0	-$116,298,000

Purpose:
This policy change reflects a reduction in Proposition 56 funding for Physician Services payments.

Authority:
Budget Act of 2024

Interdependent Policy Changes:
Proposition 56 Funding

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.

In recent years, Proposition 56 has not provided sufficient revenue to cover the estimated cost of supplemental payments to Medi-Cal providers, requiring the use of General Fund to maintain those supplemental payments.

The Budget Act of 2023 increases rates to at least 87.5 percent of Medicare for Primary Care (inclusive of Nurse Practitioners and Physician Assistants), Maternity Care (inclusive of OB/GYN and doulas), and non-specialty mental health services, effective January 1, 2024. AB 118 (Chapter 42, Statutes of 2023) provides for additional rate increases beginning January 1, 2025. These rate increases partially overlap with the physician services supplemental payments. The non-federal share of these rate increases is to be paid from the Medi-Cal Provider Payment Reserve Fund (MPPRF).

Due to the condition of the state budget and declining available Proposition 56 funding, the Governor’s Budget reduces $77 million in state costs in FY 2024-25 from Proposition 56 and reduces federal funding consistent with an overall lower level of payments.

PROP 56 - FUNDING REDUCTION
REGULAR POLICY CHANGE NUMBER: 231

Given the overlap between Proposition 56 supplemental payments and the proposed Medi-Cal provider rate increases, providers will still see an overall rate increase funded through the Medi-Cal Provider Payment Reserve Fund despite this reduction.

Similar to other Proposition 56 supplemental payment policy changes, this policy change shows the impact of the reduction as an impact to the General Fund. The Proposition 56 Funding policy change shifts the impact from the General Fund to Proposition 56 (Healthcare Treatment Fund).

Reason for Change:
This is a new policy change.

Methodology:
1. Assume a decrease of $77,107,000 in state costs for Physician Services.

2. By reducing the overall amount of state funding available for provider payments, this decrease results in an estimated reduction in federal funding of $116,298,000.

FY 2024-25	TF	GF	FF
Total	-$193,405,000	-$77,107,000	-$116,298,000

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

TABLE OF CONTENTS

COUNTY ADMINISTRATION

The County Administration section provides a detailed overview of estimated expenditures for counties to determine Medi-Cal eligibility for both current and budget years.

SUMMARY OF COUNTY ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2023-24

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER				
1	COUNTY ADMINISTRATION ALLOCATION	$2,360,315,000	$1,180,157,500	$1,180,157,500	$0
2	SAWS	$182,091,000	$181,561,500	$529,500	$0
3	COVID-19 FUNDING FOR COUNTY REDETERMINATIONS	$96,160,000	$48,080,000	$48,080,000	$0
4	CALWORKS APPLICATIONS	$84,693,000	$42,346,500	$42,346,500	$0
5	CASE MANAGEMENT FOR OTLICP	$40,954,000	$20,477,000	$20,477,000	$0
6	LOS ANGELES COUNTY HOSPITAL INTAKES	$38,261,000	$35,677,500	$2,583,500	$0
7	ENHANCED FEDERAL FUNDING	$0	$506,984,000	($506,984,000)	$0
8	SAVE	$0	$4,000,000	($4,000,000)	$0
	OTHER SUBTOTAL	**$2,802,474,000**	**$2,019,284,000**	**$783,190,000**	**$0**
	GRAND TOTAL	**$2,802,474,000**	**$2,019,284,000**	**$783,190,000**	**$0**

MEDI-CAL COUNTY ADMINISTRATION
POLICY CHANGE COST BREAKDOWN
FISCAL YEAR 2023-24

NO.	POLICY CHANGE TITLE	ONE-TIME CHANGES		ON-GOING CHANGES		TOTAL POLICY CHANGES	GENERAL FUNDS
		PROCEDURAL	CASELOAD	PROCEDURAL	CASELOAD		
	OTHER						
1	COUNTY ADMINISTRATION ALLOCATION	$0	$0	$2,360,315,000	$0	$2,360,315,000	$1,180,157,500
2	SAWS	$182,091,000	$0	$0	$0	$182,091,000	$529,500
3	COVID-19 FUNDING FOR COUNTY REDETERMINATIONS	$96,160,000	$0	$0	$0	$96,160,000	$48,080,000
4	CALWORKS APPLICATIONS	$0	$0	$84,693,000	$0	$84,693,000	$42,346,500
5	CASE MANAGEMENT FOR OTLICP	$0	$0	$0	$40,954,000	$40,954,000	$20,477,000
6	LOS ANGELES COUNTY HOSPITAL INTAKES	$0	$0	$0	$38,261,000	$38,261,000	$2,583,500
7	ENHANCED FEDERAL FUNDING	$0	$0	$0	$0	$0	($506,984,000)
8	SAVE	$0	$0	$0	$0	$0	($4,000,000)
	OTHER SUBTOTAL	**$278,251,000**	**$0**	**$2,445,008,000**	**$79,215,000**	**$2,802,474,000**	**$783,190,000**
	GRAND TOTAL	**$278,251,000**	**$0**	**$2,445,008,000**	**$79,215,000**	**$2,802,474,000**	**$783,190,000**

SUMMARY OF COUNTY ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2024-25

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER				
1	COUNTY ADMINISTRATION ALLOCATION	$2,429,472,000	$1,214,736,000	$1,214,736,000	$0
2	SAWS	$153,131,000	$153,131,000	$0	$0
4	CALWORKS APPLICATIONS	$90,460,000	$45,230,000	$45,230,000	$0
5	CASE MANAGEMENT FOR OTLICP	$41,440,000	$20,720,000	$20,720,000	$0
6	LOS ANGELES COUNTY HOSPITAL INTAKES	$38,261,000	$35,677,500	$2,583,500	$0
7	ENHANCED FEDERAL FUNDING	$0	$502,884,750	($502,884,750)	$0
8	SAVE	$0	$4,000,000	($4,000,000)	$0
	OTHER SUBTOTAL	**$2,752,764,000**	**$1,976,379,250**	**$776,384,750**	**$0**
	GRAND TOTAL	**$2,752,764,000**	**$1,976,379,250**	**$776,384,750**	**$0**

MEDI-CAL COUNTY ADMINISTRATION
POLICY CHANGE COST BREAKDOWN
FISCAL YEAR 2024-25

NO.	POLICY CHANGE TITLE	ONE-TIME CHANGES		ON-GOING CHANGES		TOTAL POLICY CHANGES	GENERAL FUNDS
		PROCEDURAL	CASELOAD	PROCEDURAL	CASELOAD		
	OTHER						
1	COUNTY ADMINISTRATION ALLOCATION	$0	$0	$2,429,472,000	$0	$2,429,472,000	$1,214,736,000
2	SAWS	$153,131,000	$0	$0	$0	$153,131,000	$0
4	CALWORKS APPLICATIONS	$0	$0	$90,460,000	$0	$90,460,000	$45,230,000
5	CASE MANAGEMENT FOR OTLICP	$0	$0	$0	$41,440,000	$41,440,000	$20,720,000
6	LOS ANGELES COUNTY HOSPITAL INTAKES	$0	$0	$0	$38,261,000	$38,261,000	$2,583,500
7	ENHANCED FEDERAL FUNDING	$0	$0	$0	$0	$0	($502,884,750)
8	SAVE	$0	$0	$0	$0	$0	($4,000,000)
	OTHER SUBTOTAL	**$153,131,000**	**$0**	**$2,519,932,000**	**$79,701,000**	**$2,752,764,000**	**$776,384,750**
	GRAND TOTAL	**$153,131,000**	**$0**	**$2,519,932,000**	**$79,701,000**	**$2,752,764,000**	**$776,384,750**

COMPARISON OF FISCAL IMPACTS OF COUNTY ADMINISTRATION POLICY CHANGES
NOVEMBER 2023 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2023-24

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2023-24 APPROPRIATION		NOV. 2023 EST. FOR 2023-24		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER						
1	1	COUNTY ADMINISTRATION ALLOCATION	$2,360,315,000	$1,180,157,500	$2,360,315,000	$1,180,157,500	$0	$0
2	2	SAWS	$169,935,000	$471,000	$182,091,000	$529,500	$12,156,000	$58,500
3	3	COVID-19 FUNDING FOR COUNTY REDETERMINATIONS	$106,160,000	$53,080,000	$96,160,000	$48,080,000	($10,000,000)	($5,000,000)
4	4	CALWORKS APPLICATIONS	$93,827,000	$46,913,500	$84,693,000	$42,346,500	($9,134,000)	($4,567,000)
5	5	CASE MANAGEMENT FOR OTLICP	$40,954,000	$20,477,000	$40,954,000	$20,477,000	$0	$0
6	6	LOS ANGELES COUNTY HOSPITAL INTAKES	$37,809,000	$3,027,500	$38,261,000	$2,583,500	$452,000	($444,000)
7	7	ENHANCED FEDERAL FUNDING	$0	($514,899,000)	$0	($506,984,000)	$0	$7,915,000
8	8	SAVE	$0	($4,000,000)	$0	($4,000,000)	$0	$0
		OTHER SUBTOTAL	**$2,809,000,000**	**$785,227,500**	**$2,802,474,000**	**$783,190,000**	**($6,526,000)**	**($2,037,500)**
		COUNTY ADMINISTRATION GRAND TOTAL	**$2,809,000,000**	**$785,227,500**	**$2,802,474,000**	**$783,190,000**	**($6,526,000)**	**($2,037,500)**

COMPARISON OF FISCAL IMPACTS OF COUNTY ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2023-24 AND 2024-25

NO.	POLICY CHANGE TITLE	NOV. 2023 EST. FOR 2023-24		NOV. 2023 EST. FOR 2024-25		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER						
1	COUNTY ADMINISTRATION ALLOCATION	$2,360,315,000	$1,180,157,500	$2,429,472,000	$1,214,736,000	$69,157,000	$34,578,500
2	SAWS	$182,091,000	$529,500	$153,131,000	$0	($28,960,000)	($529,500)
3	COVID-19 FUNDING FOR COUNTY REDETERMINATIONS	$96,160,000	$48,080,000	$0	$0	($96,160,000)	($48,080,000)
4	CALWORKS APPLICATIONS	$84,693,000	$42,346,500	$90,460,000	$45,230,000	$5,767,000	$2,883,500
5	CASE MANAGEMENT FOR OTLICP	$40,954,000	$20,477,000	$41,440,000	$20,720,000	$486,000	$243,000
6	LOS ANGELES COUNTY HOSPITAL INTAKES	$38,261,000	$2,583,500	$38,261,000	$2,583,500	$0	$0
7	ENHANCED FEDERAL FUNDING	$0	($506,984,000)	$0	($502,884,750)	$0	$4,099,250
8	SAVE	$0	($4,000,000)	$0	($4,000,000)	$0	$0
	OTHER SUBTOTAL	**$2,802,474,000**	**$783,190,000**	**$2,752,764,000**	**$776,384,750**	**($49,710,000)**	**($6,805,250)**
	COUNTY ADMINISTRATION GRAND TOTAL	**$2,802,474,000**	**$783,190,000**	**$2,752,764,000**	**$776,384,750**	**($49,710,000)**	**($6,805,250)**

MEDI-CAL COUNTY ADMINISTRATION
POLICY CHANGE INDEX

COUNTY ADMINISTRATION ALLOCATION

COUNTY ADMIN. POLICY CHANGE NUMBER: 1
IMPLEMENTATION DATE: 7/2012
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 1704

	FY 2023-24		FY 2024-25	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$2,360,315,000	$0	$2,429,472,000
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$2,360,315,000	$0	$2,429,472,000
STATE FUNDS	$0	$1,180,157,500	$0	$1,214,736,000
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	$0	$2,360,315,000	$0	$2,429,472,000
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$2,360,315,000	$0	$2,429,472,000
STATE FUNDS	$0	$1,180,157,500	$0	$1,214,736,000

Purpose:
This policy change reflects the allocation funded to counties for costs associated with Medi-Cal eligibility determination activities.

Authority:
Welfare & Institutions Code 14154

Interdependent Policy Changes:
Not Applicable

Background:
The Department is responsible for determining the appropriate allocation for funding county welfare department costs associated with Medi-Cal eligibility determinations. The Department establishes and maintains a cost control plan. The plan provides for the administrative costs that the counties incur for Medi-Cal eligibility determination activities. This estimate reflects the allocation to the counties utilizing recent workload data, county expenditure data, and other county-submitted information.

COUNTY ADMINISTRATION ALLOCATION

COUNTY ADMIN. POLICY CHANGE NUMBER: 1

Beginning in FY 2018-19, the Department began including funding for the implementation of 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 beneficiaries into the correct aid codes based on changes in circumstances, increase the percentage of completed and accurate eligibility determinations and annual redeterminations, and provide timely eligibility and enrollment data and reports to the Department.

Reason for Change:
There is no change for FY 2023-24 from the prior estimate. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to the Department increasing the total allocation by 2.93% for the projected California CPI, resulting in a $69 million change.

Methodology:
1. The total rounded estimated FY 2023-24 and FY 2024-25 county administration costs are:

(Dollars in Thousands)

Total Allocation	TF	GF	FF
FY 2023-24	$2,360,315	$1,180,158	$1,180,158
FY 2024-25	$2,429,472	$1,214,736	$1,214,735

* Totals may differ due to rounding.

Funding:
50% Title XIX FF / 50% GF (4260-101-0890/0001)
Medicaid Management Information Systems Enhanced Funding identified in the Enhanced Federal Funding policy change

SAWS

COUNTY ADMIN. POLICY CHANGE NUMBER: 2
IMPLEMENTATION DATE: 7/1987
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 214

	FY 2023-24		FY 2024-25	
	ONE-TIME	**ON-GOING**	**ONE-TIME**	**ON-GOING**
PROCEDURAL - TOT.	$182,091,000	$0	$153,131,000	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$182,091,000	$0	$153,131,000	$0
STATE FUNDS	$529,500	$0	$0	$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	$182,091,000	$0	$153,131,000	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$182,091,000	$0	$153,131,000	$0
STATE FUNDS	$529,500	$0	$0	$0

Purpose:
This policy change estimates and reimburses the California Department of Social Services (CDSS) federal financial participation (FFP) for automated Eligibility Determination and Automated Benefit Computation.

Authority:
Welfare & Institutions Code 14154
Interagency Agreement # 04-35639
Interagency Agreement CalHEERS # 14-90510
Affordable Care Act (ACA)
SIRFRA 1099

Interdependent Policy Changes:
Not Applicable

Background:
The Statewide Automated Welfare Systems (SAWS) consists of two county consortium systems: California Statewide Automated Welfare System (CalSAWS) and the CalWORKs Information Network (CalWIN). SAWS project management is now the responsibility of the Office of Systems Integration (OSI) within the Health and Human Services Agency. The Department provides expertise to OSI on program and technical system requirements for the Medi-Cal program and the Medi-Cal Eligibility Data System interfaces.

SAWS
COUNTY ADMIN. POLICY CHANGE NUMBER: 2

CalSAWS is the automated system used in Los Angeles County, 12 counties formerly on the CalWIN system, and the 39 counties that formerly used the Consortium-IV (C-IV) system; it is currently in the maintenance and operations phase. The CalWIN consortium is used by six counties and currently in the maintenance and operation phase.

The State Strategy for Eligibility Systems and ABX1 16 (Chapter 13, Statutes of 2011) dictate the migration of the 39 C-IV counties into a system jointly designed by the C-IV counties and Los Angeles County under the LRS contract. LRS was developed using the C-IV system as the baseline. The C-IV migration to a modified LRS in September 2021, resulted in a new consortium system called CalSAWS (originally named CalACES). CalSAWS replaced both LRS and C-IV.

After modifications were made to meet CalWIN county needs, the process of migrating the CalWIN counties to CalSAWS began in October 2022 and will continue through October 2023.

The Appeals Case Management System cost was removed from this policy change and is now located in the Department of Social Services Administrative Cost, Other Administration policy change.

With the passage of Affordable Care Act, federal and state statutes require California to first conduct an ex parte review at annual determination. If the ex parte review does not result in continued eligibility, a prepopulated annual redetermination form must be sent to the beneficiary at least 60 days before the annual redetermination date with populated information that the county has available to determine eligibility for both modified adjusted gross income (MAGI) and Non-MAGI programs.

To meet these requirements, the Department created the Non-MAGI prepopulated renewal form and has updated the MAGI prepopulated renewal form to meet Americans with Disabilities Act requirements. DHCS is also developing a prepopulated renewal form for mixed MAGI and Non-MAGI Medi-Cal households. With the introduction of the new forms, DHCS will be instructing CalSAWS to program forms and notices in six additional threshold languages (an increase from the current 12, plus English).

Reason for Change:
The change from the prior estimate, FY 2023-24, is an increase due to updated expenditure data provided by CDSS and due to shifting the Changes to 90 Day Cure line item into FY 2023-24.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease in total funds due to updated expenditure data provided by CDSS, with most one-time projects completing in FY 2023-24.

SAWS
COUNTY ADMIN. POLICY CHANGE NUMBER: 2

Methodology:
1. The following estimate was provided by CDSS on a cash basis:

(Dollars in Thousands)

Line Item	FY 2023-24	FY 2024-25
Californians Full Scope Expansion - Ages 26 through 49	$385	$0
CalSAWS Project	$147,575	$146,691
Cost of Annual Redetermination Forms	$4,668	$0
Medi-Cal Renewal Packet Printing	$291	$0
Medi-Cal Suspension for Incarcerated Adults	$1,038	$0
Medi-Cal Text Messaging Campaign	$4,341	$4,168
NOA Back Nine Revision	$73	$0
PHE Additional Contact Attempt	$1,238	$0
Resume Pre-Pandemic Medi-Cal Operations	$589	$0
SB 1341 Medi-Cal/SAWS	$4,816	$0
Shared Application Forms Revisions	$889	$0
Statewide Project Management	$2,293	$2,272
WCDS-CalWIN	$13,319	$0
Changes to 90 Day Cure	$579	$0
Total	**$182,091**	**$153,131**

*Totals may differ due to rounding.

2. There is a $529,000 GF expenditure in FY 2023-24 for the Californians Full Scope Expansion - Ages 26 through 49 and the Changes to 90 Day Cure.

3. Assume an estimated cost of **$182,091,000 TF ($529,000 GF)** in **FY 2023-24** and **$153,131,000 TF** in **FY 2024-25**.

Funding:
100% Title XIX FF (4260-101-0890)
100% State GF (4260-101-0001)
Enhanced CA 75/25 (4260-101-0890/0001)

COVID-19 FUNDING FOR COUNTY REDETERMINATIONS

COUNTY ADMIN. POLICY CHANGE NUMBER: 3
IMPLEMENTATION DATE: 7/2022
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 2282

	FY 2023-24		FY 2024-25	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$96,160,000	$0	$0	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$96,160,000	$0	$0	$0
STATE FUNDS	$48,080,000	$0	$0	$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	$96,160,000	$0	$0	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$96,160,000	$0	$0	$0
STATE FUNDS	$48,080,000	$0	$0	$0

Purpose:
This policy change estimates the one-time costs for counties resuming annual Medi-Cal redeterminations within 12 months at the end of the Coronavirus Disease 2019 (COVID-19) public health emergency (PHE).

Authority:
Families First Coronavirus Response Act (FFCRA)
Coronavirus Aid, Relief, and Economic Security (CARES) Act
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
On March 4, 2020, Governor Newsom declared a state of emergency in response to the developing pandemic of COVID-19. A statewide stay at home order was introduced on March 19, 2020. The federal government declared a national public health emergency on January 31, 2020, and a national emergency on March 13, 2020. These actions triggered the availability of Medicaid and Children's Health Insurance Program flexibilities, including under Section 1135 of the Social Security Act. Additionally, the President signed major federal legislation—including the FFCRA and the CARES Act—that provided increased federal funding in Medicaid and created new options for states to address the COVID-19 pandemic.

The FFCRA included a "continuous coverage requirement." Under the continuous coverage requirement, states halted most disenrollment for Medicaid eligibles. Those enrolled at the

COVID-19 FUNDING FOR COUNTY REDETERMINATIONS
COUNTY ADMIN. POLICY CHANGE NUMBER: 3

beginning of the enrollment period or those who would have enrolled during the emergency period could not be disenrolled until the end of the month the PHE ended if the Department was to receive a temporary increase in the federal medical assistance percentage (FMAP). When the Consolidated Appropriations Act of 2023, was passed on December 29, 2022, the caseload redeterminations were de-coupled from the FFCRA increased FMAP timeline. Counties started redetermination work effective April 1, 2023, based on a new March 31, 2023, unwinding date.

Reason for Change:
The change from the prior estimate is a decrease, for FY 2023-24, due to some county allocations that shifted from FY 2023-24 to FY 2022-23. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to the one-time COVID-19 PHE redeterminations costs ending in FY 2023-24.

Methodology:
1. Assume the PHE continued through May 11, 2023.

2. Assume all Medi-Cal redeterminations that were paused since the onset of the COVID-19 PHE were resumed and began processing per Department policies.

3. Assume the cost associated with processing the redeterminations caseload is:

(Dollars in Thousands)

Fiscal Years	TF	GF	FF
FY 2023-24	$96,160	$48,080	$48,080

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

CALWORKS APPLICATIONS

COUNTY ADMIN. POLICY CHANGE NUMBER: 4
IMPLEMENTATION DATE: 7/1998
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 217

	FY 2023-24		FY 2024-25	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$84,693,000	$0	$90,460,000
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$84,693,000	$0	$90,460,000
STATE FUNDS	$0	$42,346,500	$0	$45,230,000
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	$0	$84,693,000	$0	$90,460,000
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$84,693,000	$0	$90,460,000
STATE FUNDS	$0	$42,346,500	$0	$45,230,000

Purpose:
This policy change estimates the Medi-Cal portion of the shared costs for processing applications which are submitted through CalWORKS and/or CalFresh programs. These costs include staff and support costs.

Authority:
Welfare & Institutions Code 14154

Interdependent Policy Changes:
Not Applicable

Background:
Since 1998, the Department has shared in the costs for CalWORKS applications with the California Department of Social Services (CDSS). CDSS amended the claim forms and time study documents completed by the counties to allow CalWORKS application costs that are also necessary for Medi-Cal and CalFresh eligibility, to be shared between the three programs.

Reason for Change:
The change from the prior estimate for FY 2023-24, as well as the change in the current estimate from FY 2023-24 to FY 2024-25, is an increase based on the most recent quarters of available data provided by CDSS.

CALWORKS APPLICATIONS
COUNTY ADMIN. POLICY CHANGE NUMBER: 4

Methodology:
1. The estimated costs for FY 2023-24 and FY 2024-25 are provided on a cash basis by CDSS:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2023-24	$84,693	$42,347	$42,347
FY 2024-25	$90,460	$45,230	$45,230

Funding:
50% Title XIX FF/ 50% GF (4260-101-0890/0001)
Medicaid Management Information Systems Enhanced Funding identified in the Enhanced Federal Funding policy change.

CASE MANAGEMENT FOR OTLICP

COUNTY ADMIN. POLICY CHANGE NUMBER: 5
IMPLEMENTATION DATE: 12/2012
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 1598

	FY 2023-24		FY 2024-25	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$40,954,000	$0	$41,440,000
TOTAL FUNDS	$0	$40,954,000	$0	$41,440,000
STATE FUNDS	$0	$20,477,000	$0	$20,720,000
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$40,954,000	$0	$41,440,000
TOTAL FUNDS	$0	$40,954,000	$0	$41,440,000
STATE FUNDS	$0	$20,477,000	$0	$20,720,000

Purpose:
This policy change budgets the county administration costs associated with the ongoing costs for case management and redetermination of Optional Targeted Low Income Children's Program (OTLICP) beneficiaries.

Authority:
AB 1494 (Chapter 28, Statutes of 2012)

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2013, the Healthy Families Program (HFP) subscribers began transitioning into Medi-Cal through a phase-in methodology. HFP sent current subscribers' applications and information to the counties. The final group transitioned November 1, 2013. The program has since been renamed as the OTLICP.

Reason for Change:
There is no change for FY 2023-24 from the prior estimate. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a slight increase due to higher estimated eligible trends in FY 2024-25.

Methodology:
1. The Department currently estimates the case management and redetermination for the former OTLICP beneficiaries at $4.00 Per Member Per Month.

CASE MANAGEMENT FOR OTLICP
COUNTY ADMIN. POLICY CHANGE NUMBER: 5

2. The estimated average monthly OTLICP eligibles for FY 2023-24 is 853,206 and 863,342 for FY 2024-25.

3. The estimated costs are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2023-24	$40,954	$20,477	$20,477
FY 2024-25	$41,440	$20,720	$20,720

Funding:
50% Title XIX / 50% GF (4260-101-0890/0001)
Medicaid Management Information Systems Enhanced Funding identified in the Enhanced Federal Funding policy change

LOS ANGELES COUNTY HOSPITAL INTAKES

COUNTY ADMIN. POLICY CHANGE NUMBER: 6
IMPLEMENTATION DATE: 7/1994
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 213

	FY 2023-24		FY 2024-25	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$38,261,000	$0	$38,261,000
TOTAL FUNDS	$0	$38,261,000	$0	$38,261,000
STATE FUNDS	$0	$2,583,500	$0	$2,583,500
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$38,261,000	$0	$38,261,000
TOTAL FUNDS	$0	$38,261,000	$0	$38,261,000
STATE FUNDS	$0	$2,583,500	$0	$2,583,500

Purpose:
The policy change estimates the costs for Patient Financial Services Workers (PFSWs) to process Medi-Cal applications taken in Los Angeles County hospitals.

Authority:
Welfare & Institutions Code (W&I) 14154

Interdependent Policy Changes:
Not Applicable

Background:
Los Angeles County uses PFSWs to collect and process Medi-Cal applications taken in Los Angeles County hospitals. Los Angeles County hospitals send applications processed by the PFSWs to the Los Angeles County Human Services Agency for final eligibility determination. W&I Section 14154 limits the reimbursement amount for PFSW intakes to the amount paid to Los Angeles County Department of Social Services (DPSS) eligibility workers for regular Medi-Cal intakes. The Department passes through the federal share for any costs not covered by the DPSS rate to the county.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is a slight increase in total funds and a decrease in general funds due to higher actual expenditure data for FY 2021-22 reconciliations. There is no change from FY 2023-24 to FY 2024-25 in the current estimate.

LOS ANGELES COUNTY HOSPITAL INTAKES
COUNTY ADMIN. POLICY CHANGE NUMBER: 6

Methodology:

1. The reimbursement rate is $268 for both current year and budget year. Assume in FY 2023-24 and FY 2024-25, PFSWs will continue processing a base caseload of 2,215 per month.

   FY 2023-24: 2,215 x $268 x 12 = $7,123,000 TF ($3,562,000 GF)
   FY 2024-25: 2,215 x $268 x 12 = $7,123,000 TF ($3,562,000 GF)

2. The Department completed the FY 2021-22 reconciliation in FY 2022-23. The FY 2021-22 reconciliation amounts are final, and the FY 2022-23 reconciliation amounts are placeholders.

(Dollars in Thousands)

Line Item	FY 2023-24			FY 2024-25		
	TF	GF	FF	TF	GF	FF
PFSW Base	$7,123	$3,562	$3,562	$7,123	$3,562	$3,562
2021-22 Recon.	$15,080	($978)	$16,058			
2021-22 Pass.	$16,058	$0	$16,058			
2022-23 Recon.				$15,080	($978)	$16,058
2022-23 Pass.				$16,058	$0	$16,058
Total	**$38,261**	**$2,584**	**$35,678**	**$38,261**	**$2,584**	**$35,678**

* Totals may differ due to rounding.

Funding:

(Dollars in Thousands)

FY 2023-24	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	$32,116	$0	$32,116
100% GF	4260-101-0001	($978)	($978)	$0
Total		**$38,261**	**$2,584**	**$35,678**

FY 2024-25	Fund Number	TF	GF	FF
50% Title XIX FF/ 50% GF	4260-101-0890/0001	$7,123	$3,562	$3,562
100% Title XIX FF	4260-101-0890	$32,116	$0	$32,116
100% GF	4260-101-0001	($978)	($978)	$0
Total		**$38,261**	**$2,584**	**$35,678**

* Totals may differ due to rounding.

ENHANCED FEDERAL FUNDING

COUNTY ADMIN. POLICY CHANGE NUMBER: 7
IMPLEMENTATION DATE: 7/2022
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 1835

	FY 2023-24		FY 2024-25	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$0	$0	$0
STATE FUNDS	-$506,984,000	$0	-$502,884,750	$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$0	$0	$0
STATE FUNDS	-$506,984,000	$0	-$502,884,750	$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 and Medicaid Services (CMS) published guidance that allows for federal funding at 75% for some of these activities. CMS considers certain eligibility determination-related costs to fall under Medicaid Management Information Systems (MMIS) rules for approval of enhanced funding. The enhanced 75% federal funding is available for costs of the application, on-going case maintenance, and renewal functions. Funding remains at 50% for policy, outreach, and post-eligibility functions.

ENHANCED FEDERAL FUNDING
COUNTY ADMIN. POLICY CHANGE NUMBER: 7

There are various conditions required of a MMIS to secure the enhanced funding. There are also minimum critical success factors for accepting the new applications, making modified adjusted gross income determinations and coordination with Covered California. The Department submitted an Advanced Planning Document (APD) to secure CMS approval in January 2014, and received approval on September 29, 2014. The Department conducts an annual APD review and submits an update to CMS. CMS approved the APD for Federal Fiscal Year (FFY) 2023 on October 6, 2022.

Reason for Change:
The change from the prior estimate, FY 2023-24, is a decrease 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. Also, the GF savings decrease includes projecting the remaining FFY 2023 APD amounts for FY 2023-24 Quarters 3 through 4 and FFY 2024 APD amounts for Quarter 1.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease in GF savings due to updated estimated claim funding projections that utilize the expenditure trends from two quarters in FY 2022-23 and two quarters in FY 2023-24. Also, the GF savings decrease includes projecting the remaining FFY 2024 APD amounts for FY 2024-25 Quarters 2 through 4.

Methodology:
1. The effective date for the Department's APD was September 8, 2022.

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 2023-24, the Department will claim payments for FY 2022-23 Quarters 2 through 4 and FY 2023-24 Quarter 1. In FY 2024-25, the Department will claim payments for FY 2023-24 Quarters 2 through 4 and FY 2024-25 Quarter 1.

5. The savings are estimated to be:

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
Title XIX at 50% FFP	($2,027,936)	($1,013,968)	($1,013,968)
Title XIX at 75% FFP	$2,027,936	$506,984	$1,520,952
Total	**$0**	**($506,984)**	**$506,984**

ENHANCED FEDERAL FUNDING
COUNTY ADMIN. POLICY CHANGE NUMBER: 7

FY 2024-25	TF	GF	FF
Title XIX at 50% FFP	($2,011,539)	($1,005,770)	($1,005,770)
Title XIX at 75% FFP	$2,011,539	$502,885	$1,508,654
Total	**$0**	**($502,885)**	**$502,885**

*Totals may differ due to rounding.

Funding:
50% Title XIX FF/ 50% GF (4260-101-0890/0001)
75% Title XIX FF/ 25% GF (4260-101-0890/0001)

SAVE

COUNTY ADMIN. POLICY CHANGE NUMBER: 8
IMPLEMENTATION DATE: 10/1988
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 215

	FY 2023-24		FY 2024-25	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$0	$0	$0
STATE FUNDS	-$4,000,000	$0	-$4,000,000	$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$0	$0	$0
STATE FUNDS	-$4,000,000	$0	-$4,000,000	$0

Purpose:
The policy change estimates the technical adjustment in funding from Title XIX 50% Federal Financial Participation (FFP) to Title XIX 100% FFP for the Systematic Alien Verification for Entitlements (SAVE) system.

Authority:
Welfare & Institutions Code 14154

Interdependent Policy Changes:
Not Applicable

Background:
The Immigration Reform and Control Act of 1986 required states to use the SAVE system to verify immigrant status for Medi-Cal applicants beginning in October 1988. The counties complete time studies for eligibility workers and supervisors based on time spent for SAVE verifications. Beginning May of 2018, counties are federally required to use the web-based SAVE system for the third step of the SAVE process.

Reason for Change:
There is no change from the prior estimate for FY 2023-24, or in the current estimate from FY 2023-24 to FY 2024-25.

Methodology:
1. A reconciliation is completed 18 months after the end of each fiscal year to adjust funding received by counties from 50% FFP to 100% FFP.

SAVE
COUNTY ADMIN. POLICY CHANGE NUMBER: 8

2. The Medi-Cal accrual costs for SAVE reported over the last three years by the counties were:

Fiscal Year	Actual	Fiscal Year	Estimated
FY 2019-20	$7,514,685	FY 2022-23	$8,000,000
FY 2020-21	$6,311,532	FY 2023-24	$8,000,000
FY 2021-22	$8,890,711	FY 2024-25	$8,000,000

3. Based on claims through June 2021, federal funds will be:

(Dollars in Thousands)

FY 2023-24	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 2024-25	TF	GF	FF
50% Title XIX /50% GF 4260-101-0001/0890	($8,000)	($4,000)	($4,000)
100% Title XIX FFP 4260-101-0890	$8,000	$0	$8,000
Net Impact	**$0**	**($4,000)**	**$4,000**

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

TABLE OF CONTENTS

OTHER ADMINISTRATION

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

November 2023 Medi-Cal Estimate

OTHER ADMINISTRATION
FUNDING SUMMARY

Other Administration Tab contains funding for items under both the County Administration and the Fiscal Intermediary components of the Medi-Cal Estimate (located in the Management Summary Tab). The Fiscal Intermediary Tab of the Medi-Cal Estimate has been moved to the Other Administration Tab. These items continue to be budgeted in the Medi-Cal's Fiscal Intermediary component. The policy changes related to the Fiscal Intermediary can be found under the following subsections: DHCS-MEDICAL FI, DHCS-HEALTH CARE OPTIONS, AND DHCS-DENTAL FI.

FY 2023-2024 Estimate:	Total Funds	Federal Funds	General Funds	Other State Funds
OTHER ADMINISTRATION				
County Administration	$4,010,519,000	$3,108,152,000	$764,684,000	$137,683,000
Fiscal Intermediary	$576,367,000	$418,906,000	$157,428,000	$33,000
Total Other Administration Tab	**$4,586,886,000**	**$3,527,058,000**	**$922,112,000**	**$137,716,000**
Management Summary:				
COUNTY ADMINISTRATION	**$6,812,993,000**	**$5,127,437,000**	**$1,547,873,000**	**$137,683,000**
Shown in Other Administration Tab	$4,010,519,000	$3,108,152,000	$764,684,000	$137,683,000
Shown in County Administration Tab	$2,802,474,000	$2,019,285,000	$783,189,000	$0
FISCAL INTERMEDIARY	**$576,367,000**	**$418,906,000**	**$157,428,000**	**$33,000**
Shown in Other Administration Tab	$576,367,000	$418,906,000	$157,428,000	$33,000

FY 2024-2025 Estimate:	Total Funds	Federal Funds	General Funds	Other State Funds
OTHER ADMINISTRATION				
County Administration	$3,576,226,000	$2,882,875,000	$624,028,000	$69,323,000
Fiscal Intermediary	$547,427,000	$383,408,000	$164,008,000	$11,000
Total Other Administration Tab	**$4,123,653,000**	**$3,266,283,000**	**$788,036,000**	**$69,334,000**
Management Summary:				
COUNTY ADMINISTRATION	**$6,328,991,000**	**$4,859,255,000**	**$1,400,413,000**	**$69,323,000**
Shown in Other Administration Tab	$3,576,226,000	$2,882,875,000	$624,028,000	$69,323,000
Shown in County Administration Tab	$2,752,765,000	$1,976,380,000	$776,385,000	$0
FISCAL INTERMEDIARY	**$547,427,000**	**$383,408,000**	**$164,008,000**	**$11,000**
Shown in Other Administration Tab	$547,427,000	$383,408,000	$164,008,000	$11,000

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2023-24

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	DHCS-OTHER				
1	CALAIM - PATH	$1,045,000,000	$523,165,000	$426,500,000	$95,335,000
2	COUNTY SPECIALTY MENTAL HEALTH ADMIN	$268,778,000	$260,300,000	$8,478,000	$0
3	CYBHI - BH SERVICES AND SUPPORTS PLATFORM	$247,172,000	$0	$247,172,000	$0
4	CCS CASE MANAGEMENT	$191,475,000	$124,717,650	$66,757,350	$0
5	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	$139,325,000	$139,325,000	$0	$0
6	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	$111,244,000	$111,244,000	$0	$0
7	MEDI-CAL RX - ADMINISTRATIVE COSTS	$108,113,000	$96,877,400	$11,235,600	$0
8	SMH MAA	$65,188,000	$65,188,000	$0	$0
9	MHSF - PROVIDER ACES TRAININGS	$54,614,000	$27,307,000	$0	$27,307,000
10	DRUG MEDI-CAL COUNTY ADMINISTRATION	$51,565,000	$51,565,000	$0	$0
11	CALAIM - POPULATION HEALTH MANAGEMENT	$49,601,000	$44,640,900	$4,960,100	$0
12	COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE	$48,143,000	$19,201,000	$28,942,000	$0
13	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	$46,045,000	$22,732,650	$23,312,350	$0
14	INTERIM AND FINAL COST SETTLEMENTS-SMHS	$39,627,000	$39,627,000	$0	$0
15	ACTUARIAL COSTS FOR RATE DEVELOPMENT	$34,275,000	$17,137,500	$16,987,500	$150,000
16	CHDP COUNTY ALLOCATION	$33,962,000	$23,387,000	$10,575,000	$0
17	ENTERPRISE DATA ENVIRONMENT	$33,555,000	$24,566,700	$8,988,300	$0
18	POSTAGE & PRINTING	$33,425,000	$16,584,000	$16,841,000	$0
19	MEDI-CAL RECOVERY CONTRACTS	$21,175,000	$15,881,250	$5,293,750	$0
20	HCBA WAIVER ADMINISTRATIVE COST	$20,721,000	$10,360,500	$10,360,500	$0
21	CAPMAN	$20,113,000	$14,859,000	$5,254,000	$0
22	PAVE SYSTEM	$17,272,000	$12,560,000	$4,712,000	$0
23	HEALTH ENROLLMENT NAVIGATORS	$16,850,000	$8,425,000	$8,425,000	$0
24	EMSA - CALIFORNIA POISON CONTROL SYSTEM SVCS.	$15,770,000	$15,770,000	$0	$0
25	CARE ACT - OTHER ADMIN	$15,000,000	$0	$15,000,000	$0
26	MITA	$12,257,000	$10,700,400	$1,556,600	$0
27	PASRR	$9,643,000	$7,232,250	$2,410,750	$0
28	OUTREACH & ENROLLMENT ASSIST. FOR DUAL BENES	$8,600,000	$4,300,000	$4,300,000	$0
29	LA COUNTY PUBLIC HEALTH NURSING PILOT	$8,250,000	$8,250,000	$0	$0

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2023-24

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	DHCS-OTHER				
30	CALAIM MLTSS & D-SNP INTEGRATION ACTIVITIES	$7,100,000	$3,550,000	$3,550,000	$0
31	NEWBORN HEARING SCREENING PROGRAM	$6,303,000	$3,151,500	$3,151,500	$0
32	STATEWIDE VERIFICATION HUB	$4,467,000	$4,020,300	$446,700	$0
33	DRUG MEDI-CAL PARITY RULE ADMINISTRATION	$4,407,000	$2,938,000	$1,469,000	$0
34	ELECTRONIC ASSET VERIFICATION PROGRAM	$4,068,000	$2,034,000	$2,034,000	$0
35	SDMC SYSTEM M&O SUPPORT	$3,898,000	$1,949,000	$1,949,000	$0
36	PACES	$3,732,000	$2,750,900	$981,100	$0
37	HCBS SP - CONTINGENCY MANAGEMENT ADMIN	$2,768,000	$1,582,000	$0	$1,186,000
38	CALAIM - INMATE PRE-RELEASE PROGRAM ADMIN	$2,746,000	$1,373,000	$1,373,000	$0
39	PUBLIC HEALTH REGISTRIES SUPPORT	$2,737,000	$2,737,000	$0	$0
40	T-MSIS	$2,708,000	$2,324,550	$383,450	$0
41	HEALTH INFORMATION EXCHANGE INTEROPERABILITY	$2,017,000	$50,000	$1,967,000	$0
42	MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM	$2,000,000	$1,000,000	$1,000,000	$0
43	FIELD TESTING OF MEDI-CAL MATERIALS	$2,000,000	$1,000,000	$1,000,000	$0
44	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$1,984,000	$1,180,000	$804,000	$0
45	MFP/CCT SUPPLEMENTAL FUNDING	$1,950,000	$1,950,000	$0	$0
46	CALIFORNIA HEALTH INTERVIEW SURVEY	$1,757,000	$1,578,500	$178,500	$0
47	PROTECTION OF PHI DATA	$1,656,000	$828,000	$828,000	$0
48	GENDER-AFFIRMING CARE	$1,500,000	$750,000	$750,000	$0
49	MEDCOMPASS SOLUTION	$1,365,000	$1,006,400	$358,600	$0
50	SSA COSTS FOR HEALTH COVERAGE INFO.	$1,266,000	$633,000	$633,000	$0
51	FAMILY PACT PROGRAM ADMIN.	$965,000	$868,500	$96,500	$0
52	MMA - DSH ANNUAL INDEPENDENT AUDIT	$747,000	$373,500	$373,500	$0
53	CCT OUTREACH - ADMINISTRATIVE COSTS	$340,000	$340,000	$0	$0
54	HEALTH PLAN OF SAN MATEO DENTAL INTEGRATION EVAL	$68,000	$34,000	$0	$34,000
58	CMS DEFERRED CLAIMS - OTHER ADMIN	$0	$3,932,000	($3,932,000)	$0
59	COVID-19 INCREASED FMAP - OTHER ADMIN	$0	$223,000	($223,000)	$0
98	DESIGNATED STATE HEALTH PROGRAMS	$0	$209,091,000	($209,091,000)	$0
	DHCS-OTHER SUBTOTAL	**$2,831,307,000**	**$1,969,152,350**	**$738,142,650**	**$124,012,000**

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2023-24

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	DHCS-MEDICAL FI				
60	MEDICAL FI BO & IT COST REIMBURSEMENT	$53,316,000	$38,470,450	$14,845,550	$0
61	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	$42,039,000	$30,989,100	$11,049,900	$0
62	MEDICAL FI BO & IT CHANGE ORDERS	$41,918,000	$30,900,750	$11,017,250	$0
63	MEDICAL FI IT INFRASTRUCTURE SERVICES	$32,412,000	$23,890,550	$8,521,450	$0
64	MEDICAL FI BO OTHER ESTIMATED COSTS	$24,859,000	$17,390,350	$7,468,650	$0
65	MEDICAL FI BO TELEPHONE SERVICE CENTER	$18,185,000	$12,741,700	$5,443,300	$0
66	MEDICAL FI BUSINESS OPERATIONS	$16,603,000	$12,214,500	$4,355,500	$33,000
67	MEDICAL FI BO HOURLY REIMBURSEMENT	$11,989,000	$8,836,800	$3,152,200	$0
68	MEDICAL FI BO MISCELLANEOUS EXPENSES	$2,446,000	$1,738,650	$707,350	$0
	DHCS-MEDICAL FI SUBTOTAL	**$243,767,000**	**$177,172,850**	**$66,561,150**	**$33,000**
	DHCS-HEALTH CARE OPT				
69	HCO COST REIMBURSEMENT 2017 CONTRACT	$31,939,000	$16,209,050	$15,729,950	$0
70	HCO OPERATIONS 2017 CONTRACT	$31,427,000	$15,949,300	$15,477,700	$0
71	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	$14,474,000	$7,345,600	$7,128,400	$0
	DHCS-HEALTH CARE OPT SUBTOTAL	**$77,840,000**	**$39,503,950**	**$38,336,050**	**$0**
	DHCS-DENTAL FI				
72	DENTAL FI-DBO ADMIN 2022 CONTRACT	$61,652,000	$48,835,200	$12,816,800	$0
73	DENTAL ASO ADMINISTRATION 2016 CONTRACT	$60,683,000	$38,940,250	$21,742,750	$0
74	DENTAL FI ADMINISTRATION 2016 CONTRACT	$22,521,000	$16,051,250	$6,469,750	$0
	DHCS-DENTAL FI SUBTOTAL	**$144,856,000**	**$103,826,700**	**$41,029,300**	**$0**
	OTHER DEPARTMENTS				
75	PERSONAL CARE SERVICES	$473,549,000	$473,549,000	$0	$0
76	HEALTH-RELATED ACTIVITIES - CDSS	$358,010,000	$358,010,000	$0	$0
77	CALHEERS DEVELOPMENT	$146,038,000	$108,625,050	$37,412,950	$0
78	MATERNAL AND CHILD HEALTH	$45,037,000	$45,037,000	$0	$0
79	CDDS ADMINISTRATIVE COSTS	$113,674,000	$113,674,000	$0	$0
80	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$55,882,000	$55,882,000	$0	$0

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2023-24

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER DEPARTMENTS				
81	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	$54,682,000	$41,011,000	$0	$13,671,000
82	FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG	$9,297,000	$9,297,000	$0	$0
83	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$6,582,000	$6,582,000	$0	$0
84	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	$12,502,000	$12,502,000	$0	$0
85	CLPP CASE MANAGEMENT SERVICES	$3,517,000	$3,517,000	$0	$0
86	CALIFORNIA SMOKERS' HELPLINE	$1,518,000	$1,518,000	$0	$0
87	HCBS SP CDDS - OTHER ADMIN	$2,457,000	$2,457,000	$0	$0
88	CALHHS AGENCY HIPAA FUNDING	$1,367,000	$1,367,000	$0	$0
89	MEDI-CAL INPATIENT SERVICES FOR INMATES	$1,165,000	$1,165,000	$0	$0
90	VETERANS BENEFITS	$1,100,000	$1,100,000	$0	$0
91	VITAL RECORDS	$883,000	$879,000	$4,000	$0
92	KIT FOR NEW PARENTS	$604,000	$604,000	$0	$0
93	MERIT SYSTEM SERVICES FOR COUNTIES	$190,000	$95,000	$95,000	$0
96	PIA EYEWEAR COURIER SERVICE	$1,062,000	$531,000	$531,000	$0
	OTHER DEPARTMENTS SUBTOTAL	**$1,289,116,000**	**$1,237,402,050**	**$38,042,950**	**$13,671,000**
	GRAND TOTAL	**$4,586,886,000**	**$3,527,057,900**	**$922,112,100**	**$137,716,000**

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2024-25

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	DHCS-OTHER				
1	CALAIM - PATH	$478,800,000	$239,400,000	$207,400,000	$32,000,000
2	COUNTY SPECIALTY MENTAL HEALTH ADMIN	$268,885,000	$259,975,000	$8,910,000	$0
3	CYBHI - BH SERVICES AND SUPPORTS PLATFORM	$209,964,000	$0	$209,964,000	$0
4	CCS CASE MANAGEMENT	$195,437,000	$127,705,400	$67,731,600	$0
5	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	$113,719,000	$113,719,000	$0	$0
6	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	$98,368,000	$98,368,000	$0	$0
7	MEDI-CAL RX - ADMINISTRATIVE COSTS	$97,701,000	$72,019,300	$25,681,700	$0
8	SMH MAA	$63,458,000	$63,458,000	$0	$0
9	MHSF - PROVIDER ACES TRAININGS	$45,500,000	$22,750,000	$0	$22,750,000
10	DRUG MEDI-CAL COUNTY ADMINISTRATION	$62,220,000	$62,220,000	$0	$0
11	CALAIM - POPULATION HEALTH MANAGEMENT	$52,668,000	$47,401,200	$5,266,800	$0
12	COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE	$51,152,000	$20,401,000	$30,751,000	$0
13	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	$43,345,000	$21,434,200	$21,910,800	$0
14	INTERIM AND FINAL COST SETTLEMENTS-SMHS	$40,577,000	$40,577,000	$0	$0
15	ACTUARIAL COSTS FOR RATE DEVELOPMENT	$37,275,000	$18,637,500	$18,487,500	$150,000
17	ENTERPRISE DATA ENVIRONMENT	$44,232,000	$32,431,850	$11,800,150	$0
18	POSTAGE & PRINTING	$33,425,000	$16,584,000	$16,841,000	$0
19	MEDI-CAL RECOVERY CONTRACTS	$19,589,000	$14,691,750	$4,897,250	$0
20	HCBA WAIVER ADMINISTRATIVE COST	$23,776,000	$11,888,000	$11,888,000	$0
21	CAPMAN	$20,599,000	$15,451,900	$5,147,100	$0
22	PAVE SYSTEM	$18,431,000	$13,412,950	$5,018,050	$0
23	HEALTH ENROLLMENT NAVIGATORS	$21,250,000	$10,625,000	$10,625,000	$0
24	EMSA - CALIFORNIA POISON CONTROL SYSTEM SVCS.	$15,905,000	$15,905,000	$0	$0
26	MITA	$20,404,000	$17,812,600	$2,591,400	$0
27	PASRR	$9,643,000	$7,232,250	$2,410,750	$0
28	OUTREACH & ENROLLMENT ASSIST. FOR DUAL BENES	$2,000,000	$1,000,000	$1,000,000	$0
29	LA COUNTY PUBLIC HEALTH NURSING PILOT	$8,250,000	$8,250,000	$0	$0
31	NEWBORN HEARING SCREENING PROGRAM	$6,392,000	$3,196,000	$3,196,000	$0
32	STATEWIDE VERIFICATION HUB	$2,315,000	$2,083,500	$231,500	$0

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2024-25

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	DHCS-OTHER				
33	DRUG MEDI-CAL PARITY RULE ADMINISTRATION	$5,875,000	$3,917,000	$1,958,000	$0
34	ELECTRONIC ASSET VERIFICATION PROGRAM	$227,000	$113,500	$113,500	$0
35	SDMC SYSTEM M&O SUPPORT	$2,492,000	$1,246,000	$1,246,000	$0
36	PACES	$3,745,000	$2,760,550	$984,450	$0
37	HCBS SP - CONTINGENCY MANAGEMENT ADMIN	$6,119,000	$6,119,000	$0	$0
38	CALAIM - INMATE PRE-RELEASE PROGRAM ADMIN	$2,746,000	$1,373,000	$1,373,000	$0
39	PUBLIC HEALTH REGISTRIES SUPPORT	$5,475,000	$5,475,000	$0	$0
40	T-MSIS	$1,851,000	$1,562,800	$288,200	$0
41	HEALTH INFORMATION EXCHANGE INTEROPERABILITY	$250,000	$125,000	$125,000	$0
42	MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM	$2,000,000	$1,000,000	$1,000,000	$0
43	FIELD TESTING OF MEDI-CAL MATERIALS	$200,000	$100,000	$100,000	$0
44	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$1,984,000	$1,180,000	$804,000	$0
45	MFP/CCT SUPPLEMENTAL FUNDING	$1,950,000	$1,950,000	$0	$0
46	CALIFORNIA HEALTH INTERVIEW SURVEY	$1,785,000	$1,592,500	$192,500	$0
47	PROTECTION OF PHI DATA	$1,408,000	$704,000	$704,000	$0
48	GENDER-AFFIRMING CARE	$1,500,000	$750,000	$750,000	$0
49	MEDCOMPASS SOLUTION	$5,320,000	$3,921,150	$1,398,850	$0
50	SSA COSTS FOR HEALTH COVERAGE INFO.	$1,321,000	$660,500	$660,500	$0
51	FAMILY PACT PROGRAM ADMIN.	$915,000	$823,500	$91,500	$0
52	MMA - DSH ANNUAL INDEPENDENT AUDIT	$800,000	$400,000	$400,000	$0
53	CCT OUTREACH - ADMINISTRATIVE COSTS	$340,000	$340,000	$0	$0
54	HEALTH PLAN OF SAN MATEO DENTAL INTEGRATION EVAL	$164,000	$82,000	$0	$82,000
56	CALAIM - JUSTICE INVOLVED MAA	$12,000,000	$6,000,000	$6,000,000	$0
57	CALAIM - BH - CONNECT DEMONSTRATION ADMIN	$1,554,000	$777,000	$107,000	$670,000
97	REPRODUCTIVE HEALTH ACCESS DEMO 1115 WAIVER	$200,000,000	$100,000,000	$100,000,000	$0
98	DESIGNATED STATE HEALTH PROGRAMS	$0	$189,939,000	($189,939,000)	$0
	DHCS-OTHER SUBTOTAL	**$2,367,301,000**	**$1,711,541,900**	**$600,107,100**	**$55,652,000**

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2024-25

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	DHCS-MEDICAL FI				
60	MEDICAL FI BO & IT COST REIMBURSEMENT	$73,096,000	$53,312,900	$19,783,100	$0
61	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	$36,652,000	$27,017,750	$9,634,250	$0
62	MEDICAL FI BO & IT CHANGE ORDERS	$41,803,000	$30,814,500	$10,988,500	$0
63	MEDICAL FI IT INFRASTRUCTURE SERVICES	$22,096,000	$16,288,450	$5,807,550	$0
64	MEDICAL FI BO OTHER ESTIMATED COSTS	$26,228,000	$18,350,050	$7,877,950	$0
65	MEDICAL FI BO TELEPHONE SERVICE CENTER	$19,186,000	$13,444,050	$5,741,950	$0
66	MEDICAL FI BUSINESS OPERATIONS	$17,492,000	$12,886,000	$4,595,000	$11,000
67	MEDICAL FI BO HOURLY REIMBURSEMENT	$12,648,000	$9,323,550	$3,324,450	$0
68	MEDICAL FI BO MISCELLANEOUS EXPENSES	$2,161,000	$1,593,400	$567,600	$0
	DHCS-MEDICAL FI SUBTOTAL	**$251,362,000**	**$183,030,650**	**$68,320,350**	**$11,000**
	DHCS-HEALTH CARE OPT				
69	HCO COST REIMBURSEMENT 2017 CONTRACT	$32,740,000	$16,615,550	$16,124,450	$0
70	HCO OPERATIONS 2017 CONTRACT	$31,940,000	$16,209,550	$15,730,450	$0
71	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	$13,153,000	$6,675,350	$6,477,650	$0
	DHCS-HEALTH CARE OPT SUBTOTAL	**$77,833,000**	**$39,500,450**	**$38,332,550**	**$0**
	DHCS-DENTAL FI				
72	DENTAL FI-DBO ADMIN 2022 CONTRACT	$84,920,000	$63,063,500	$21,856,500	$0
73	DENTAL ASO ADMINISTRATION 2016 CONTRACT	$11,352,000	$8,514,000	$2,838,000	$0
74	DENTAL FI ADMINISTRATION 2016 CONTRACT	$22,329,000	$15,952,500	$6,376,500	$0
	DHCS-DENTAL FI SUBTOTAL	**$118,601,000**	**$87,530,000**	**$31,071,000**	**$0**
	OTHER DEPARTMENTS				
75	PERSONAL CARE SERVICES	$488,212,000	$488,212,000	$0	$0
76	HEALTH-RELATED ACTIVITIES - CDSS	$359,692,000	$359,692,000	$0	$0
77	CALHEERS DEVELOPMENT	$164,180,000	$121,171,600	$43,008,400	$0
78	MATERNAL AND CHILD HEALTH	$69,111,000	$69,111,000	$0	$0
79	CDDS ADMINISTRATIVE COSTS	$76,198,000	$76,198,000	$0	$0
80	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$48,265,000	$48,265,000	$0	$0

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2024-25

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER DEPARTMENTS				
81	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	$54,682,000	$41,011,000	$0	$13,671,000
82	FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG	$8,058,000	$8,058,000	$0	$0
83	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$7,673,000	$7,673,000	$0	$0
84	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	$6,880,000	$6,880,000	$0	$0
85	CLPP CASE MANAGEMENT SERVICES	$3,546,000	$3,546,000	$0	$0
86	CALIFORNIA SMOKERS' HELPLINE	$2,500,000	$2,500,000	$0	$0
88	CALHHS AGENCY HIPAA FUNDING	$1,386,000	$1,386,000	$0	$0
89	MEDI-CAL INPATIENT SERVICES FOR INMATES	$1,212,000	$1,212,000	$0	$0
90	VETERANS BENEFITS	$1,100,000	$1,100,000	$0	$0
91	VITAL RECORDS	$883,000	$879,000	$4,000	$0
92	KIT FOR NEW PARENTS	$593,000	$593,000	$0	$0
93	MERIT SYSTEM SERVICES FOR COUNTIES	$190,000	$95,000	$95,000	$0
95	HEALTH FOR FOSTER CARE CHILDREN ADMIN COSTS	$13,133,000	$6,566,500	$6,566,500	$0
96	PIA EYEWEAR COURIER SERVICE	$1,062,000	$531,000	$531,000	$0
	OTHER DEPARTMENTS SUBTOTAL	**$1,308,556,000**	**$1,244,680,100**	**$50,204,900**	**$13,671,000**
	GRAND TOTAL	**$4,123,653,000**	**$3,266,283,100**	**$788,035,900**	**$69,334,000**

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2023 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2023-24

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2023-24 APPROPRIATION		NOV. 2023 EST. FOR 2023-24		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		DHCS-OTHER						
1	1	CALAIM - PATH	$767,600,000	$302,300,000	$1,045,000,000	$426,500,000	$277,400,000	$124,200,000
3	2	COUNTY SPECIALTY MENTAL HEALTH ADMIN	$314,128,000	$8,478,000	$268,778,000	$8,478,000	($45,350,000)	$0
2	3	CYBHI - BH SERVICES AND SUPPORTS PLATFORM	$294,900,000	$294,900,000	$247,172,000	$247,172,000	($47,728,000)	($47,728,000)
4	4	CCS CASE MANAGEMENT	$191,234,000	$66,620,300	$191,475,000	$66,757,350	$241,000	$137,050
5	5	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	$132,805,000	$0	$139,325,000	$0	$6,520,000	$0
8	6	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	$113,418,000	$0	$111,244,000	$0	($2,174,000)	$0
9	7	MEDI-CAL RX - ADMINISTRATIVE COSTS	$101,728,000	$4,756,250	$108,113,000	$11,235,600	$6,385,000	$6,479,350
11	8	SMH MAA	$61,664,000	$0	$65,188,000	$0	$3,524,000	$0
96	9	MHSF - PROVIDER ACES TRAININGS	$55,090,000	$0	$54,614,000	$0	($476,000)	$0
13	10	DRUG MEDI-CAL COUNTY ADMINISTRATION	$54,121,000	$0	$51,565,000	$0	($2,556,000)	$0
6	11	CALAIM - POPULATION HEALTH MANAGEMENT	$52,668,000	$5,266,800	$49,601,000	$4,960,100	($3,067,000)	($306,700)
12	12	COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE	$48,143,000	$19,201,000	$48,143,000	$28,942,000	$0	$9,741,000
14	13	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	$36,441,000	$18,177,750	$46,045,000	$23,312,350	$9,604,000	$5,134,600
7	14	INTERIM AND FINAL COST SETTLEMENTS-SMHS	$41,780,000	$0	$39,627,000	$0	($2,153,000)	$0
18	15	ACTUARIAL COSTS FOR RATE DEVELOPMENT	$32,175,000	$15,937,500	$34,275,000	$16,987,500	$2,100,000	$1,050,000
16	16	CHDP COUNTY ALLOCATION	$33,962,000	$10,575,000	$33,962,000	$10,575,000	$0	$0
15	17	ENTERPRISE DATA ENVIRONMENT	$29,189,000	$7,712,200	$33,555,000	$8,988,300	$4,366,000	$1,276,100
17	18	POSTAGE & PRINTING	$32,341,000	$16,299,000	$33,425,000	$16,841,000	$1,084,000	$542,000
21	19	MEDI-CAL RECOVERY CONTRACTS	$17,422,000	$4,355,500	$21,175,000	$5,293,750	$3,753,000	$938,250
22	20	HCBA WAIVER ADMINISTRATIVE COST	$21,202,000	$10,601,000	$20,721,000	$10,360,500	($481,000)	($240,500)
24	21	CAPMAN	$21,608,000	$5,558,750	$20,113,000	$5,254,000	($1,495,000)	($304,750)
23	22	PAVE SYSTEM	$13,959,000	$3,812,700	$17,272,000	$4,712,000	$3,313,000	$899,300

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2023 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2023-24

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2023-24 APPROPRIATION		NOV. 2023 EST. FOR 2023-24		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		DHCS-OTHER						
20	23	HEALTH ENROLLMENT NAVIGATORS	$18,926,000	$9,463,000	$16,850,000	$8,425,000	($2,076,000)	($1,038,000)
90	24	EMSA - CALIFORNIA POISON CONTROL SYSTEM SVCS.	$15,770,000	$0	$15,770,000	$0	$0	$0
50	25	CARE ACT - OTHER ADMIN	$15,000,000	$15,000,000	$15,000,000	$15,000,000	$0	$0
25	26	MITA	$13,123,000	$1,666,950	$12,257,000	$1,556,600	($866,000)	($110,350)
27	27	PASRR	$12,398,000	$3,099,500	$9,643,000	$2,410,750	($2,755,000)	($688,750)
93	28	OUTREACH & ENROLLMENT ASSIST. FOR DUAL BENES	$8,600,000	$4,300,000	$8,600,000	$4,300,000	$0	$0
28	29	LA COUNTY PUBLIC HEALTH NURSING PILOT	$8,250,000	$0	$8,250,000	$0	$0	$0
31	30	CALAIM MLTSS & D-SNP INTEGRATION ACTIVITIES	$6,600,000	$3,300,000	$7,100,000	$3,550,000	$500,000	$250,000
30	31	NEWBORN HEARING SCREENING PROGRAM	$6,392,000	$3,196,000	$6,303,000	$3,151,500	($89,000)	($44,500)
32	32	STATEWIDE VERIFICATION HUB	$1,481,000	$148,100	$4,467,000	$446,700	$2,986,000	$298,600
35	33	DRUG MEDI-CAL PARITY RULE ADMINISTRATION	$7,345,000	$1,959,000	$4,407,000	$1,469,000	($2,938,000)	($490,000)
29	34	ELECTRONIC ASSET VERIFICATION PROGRAM	$3,955,000	$1,977,500	$4,068,000	$2,034,000	$113,000	$56,500
40	35	SDMC SYSTEM M&O SUPPORT	$2,082,000	$1,041,000	$3,898,000	$1,949,000	$1,816,000	$908,000
37	36	PACES	$3,595,000	$897,250	$3,732,000	$981,100	$137,000	$83,850
41	37	HCBS SP - CONTINGENCY MANAGEMENT ADMIN	$5,000,000	$0	$2,768,000	$0	($2,232,000)	$0
95	38	CALAIM - INMATE PRE-RELEASE PROGRAM ADMIN	$2,746,000	$1,373,000	$2,746,000	$1,373,000	$0	$0
19	39	PUBLIC HEALTH REGISTRIES SUPPORT	$4,606,000	$2,069,000	$2,737,000	$0	($1,869,000)	($2,069,000)
39	40	T-MSIS	$2,815,000	$410,800	$2,708,000	$383,450	($107,000)	($27,350)
38	41	HEALTH INFORMATION EXCHANGE INTEROPERABILITY	$334,000	$250,000	$2,017,000	$1,967,000	$1,683,000	$1,717,000
48	42	MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM	$2,000,000	$1,000,000	$2,000,000	$1,000,000	$0	$0
42	43	FIELD TESTING OF MEDI-CAL MATERIALS	$2,000,000	$1,000,000	$2,000,000	$1,000,000	$0	$0

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2023 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2023-24

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2023-24 APPROPRIATION		NOV. 2023 EST. FOR 2023-24		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		DHCS-OTHER						
33	44	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$969,000	$337,250	$1,984,000	$804,000	$1,015,000	$466,750
34	45	MFP/CCT SUPPLEMENTAL FUNDING	$1,503,000	$0	$1,950,000	$0	$447,000	$0
44	46	CALIFORNIA HEALTH INTERVIEW SURVEY	$1,653,000	$126,500	$1,757,000	$178,500	$104,000	$52,000
43	47	PROTECTION OF PHI DATA	$1,624,000	$812,000	$1,656,000	$828,000	$32,000	$16,000
92	48	GENDER-AFFIRMING CARE	$1,500,000	$750,000	$1,500,000	$750,000	$0	$0
36	49	MEDCOMPASS SOLUTION	$4,350,000	$1,143,350	$1,365,000	$358,600	($2,985,000)	($784,750)
45	50	SSA COSTS FOR HEALTH COVERAGE INFO.	$1,229,000	$614,500	$1,266,000	$633,000	$37,000	$18,500
46	51	FAMILY PACT PROGRAM ADMIN.	$1,207,000	$120,700	$965,000	$96,500	($242,000)	($24,200)
47	52	MMA - DSH ANNUAL INDEPENDENT AUDIT	$800,000	$400,000	$747,000	$373,500	($53,000)	($26,500)
49	53	CCT OUTREACH - ADMINISTRATIVE COSTS	$340,000	$0	$340,000	$0	$0	$0
--	54	HEALTH PLAN OF SAN MATEO DENTAL INTEGRATION EVAL	$0	$0	$68,000	$0	$68,000	$0
--	58	CMS DEFERRED CLAIMS - OTHER ADMIN	$0	$0	$0	($3,932,000)	$0	($3,932,000)
52	59	COVID-19 INCREASED FMAP - OTHER ADMIN	$0	($254,000)	$0	($223,000)	$0	$31,000
--	98	DESIGNATED STATE HEALTH PROGRAMS	$0	$0	$0	($209,091,000)	$0	($209,091,000)
26	--	LITIGATION RELATED SERVICES	$9,980,000	$4,990,000	$0	$0	($9,980,000)	($4,990,000)
89	--	BH - CONNECT DEMONSTRATION ADMIN	$1,706,000	$216,000	$0	$0	($1,706,000)	($216,000)
97	--	RECONCILIATION - ADMINISTRATION	$10,000,000	$10,000,000	$0	$0	($10,000,000)	($10,000,000)
		DHCS-OTHER SUBTOTAL	**$2,647,457,000**	**$865,959,150**	**$2,831,307,000**	**$738,142,650**	**$183,850,000**	**($127,816,500)**
		DHCS-MEDICAL FI						
53	60	MEDICAL FI BO & IT COST REIMBURSEMENT	$54,552,000	$15,277,400	$53,316,000	$14,845,550	($1,236,000)	($431,850)

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2023 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2023-24

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2023-24 APPROPRIATION		NOV. 2023 EST. FOR 2023-24		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		DHCS-MEDICAL FI						
54	61	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	$47,795,000	$12,562,500	$42,039,000	$11,049,900	($5,756,000)	($1,512,600)
56	62	MEDICAL FI BO & IT CHANGE ORDERS	$40,981,000	$10,770,850	$41,918,000	$11,017,250	$937,000	$246,400
55	63	MEDICAL FI IT INFRASTRUCTURE SERVICES	$22,325,000	$5,869,900	$32,412,000	$8,521,450	$10,087,000	$2,651,550
57	64	MEDICAL FI BO OTHER ESTIMATED COSTS	$24,881,000	$7,473,450	$24,859,000	$7,468,650	($22,000)	($4,800)
58	65	MEDICAL FI BO TELEPHONE SERVICE CENTER	$18,197,000	$5,446,400	$18,185,000	$5,443,300	($12,000)	($3,100)
59	66	MEDICAL FI BUSINESS OPERATIONS	$16,582,000	$4,358,600	$16,603,000	$4,355,500	$21,000	($3,100)
60	67	MEDICAL FI BO HOURLY REIMBURSEMENT	$12,000,000	$3,154,400	$11,989,000	$3,152,200	($11,000)	($2,200)
61	68	MEDICAL FI BO MISCELLANEOUS EXPENSES	$2,737,000	$848,050	$2,446,000	$707,350	($291,000)	($140,700)
		DHCS-MEDICAL FI SUBTOTAL	**$240,050,000**	**$65,761,550**	**$243,767,000**	**$66,561,150**	**$3,717,000**	**$799,600**
		DHCS-HEALTH CARE OPT						
63	69	HCO COST REIMBURSEMENT 2017 CONTRACT	$39,549,000	$19,477,950	$31,939,000	$15,729,950	($7,610,000)	($3,748,000)
62	70	HCO OPERATIONS 2017 CONTRACT	$32,842,000	$16,174,700	$31,427,000	$15,477,700	($1,415,000)	($697,000)
64	71	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	$13,614,000	$6,705,000	$14,474,000	$7,128,400	$860,000	$423,400
		DHCS-HEALTH CARE OPT SUBTOTAL	**$86,005,000**	**$42,357,650**	**$77,840,000**	**$38,336,050**	**($8,165,000)**	**($4,021,600)**
		DHCS-DENTAL FI						
67	72	DENTAL FI-DBO ADMIN 2022 CONTRACT	$81,950,000	$17,260,750	$61,652,000	$12,816,800	($20,298,000)	($4,443,950)
65	73	DENTAL ASO ADMINISTRATION 2016 CONTRACT	$57,044,000	$20,687,000	$60,683,000	$21,742,750	$3,639,000	$1,055,750
66	74	DENTAL FI ADMINISTRATION 2016 CONTRACT	$22,024,000	$6,237,250	$22,521,000	$6,469,750	$497,000	$232,500
		DHCS-DENTAL FI SUBTOTAL	**$161,018,000**	**$44,185,000**	**$144,856,000**	**$41,029,300**	**($16,162,000)**	**($3,155,700)**

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2023 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2023-24

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2023-24 APPROPRIATION		NOV. 2023 EST. FOR 2023-24		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER DEPARTMENTS						
68	75	PERSONAL CARE SERVICES	$480,696,000	$0	$473,549,000	$0	($7,147,000)	$0
69	76	HEALTH-RELATED ACTIVITIES - CDSS	$321,169,000	$0	$358,010,000	$0	$36,841,000	$0
70	77	CALHEERS DEVELOPMENT	$137,020,000	$36,104,150	$146,038,000	$37,412,950	$9,018,000	$1,308,800
85	78	MATERNAL AND CHILD HEALTH	$102,975,000	$0	$45,037,000	$0	($57,938,000)	$0
71	79	CDDS ADMINISTRATIVE COSTS	$70,556,000	$0	$113,674,000	$0	$43,118,000	$0
73	80	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$56,984,000	$0	$55,882,000	$0	($1,102,000)	$0
72	81	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	$54,682,000	$0	$54,682,000	$0	$0	$0
77	82	FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG	$9,297,000	$0	$9,297,000	$0	$0	$0
75	83	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$7,502,000	$0	$6,582,000	$0	($920,000)	$0
74	84	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	$7,280,000	$0	$12,502,000	$0	$5,222,000	$0
76	85	CLPP CASE MANAGEMENT SERVICES	$3,645,000	$0	$3,517,000	$0	($128,000)	$0
79	86	CALIFORNIA SMOKERS' HELPLINE	$2,768,000	$0	$1,518,000	$0	($1,250,000)	$0
78	87	HCBS SP CDDS - OTHER ADMIN	$2,472,000	$0	$2,457,000	$0	($15,000)	$0
83	88	CALHHS AGENCY HIPAA FUNDING	$1,367,000	$0	$1,367,000	$0	$0	$0
81	89	MEDI-CAL INPATIENT SERVICES FOR INMATES	$1,166,000	$0	$1,165,000	$0	($1,000)	$0
82	90	VETERANS BENEFITS	$1,100,000	$0	$1,100,000	$0	$0	$0
84	91	VITAL RECORDS	$883,000	$4,000	$883,000	$4,000	$0	$0
80	92	KIT FOR NEW PARENTS	$593,000	$0	$604,000	$0	$11,000	$0
86	93	MERIT SYSTEM SERVICES FOR COUNTIES	$190,000	$95,000	$190,000	$95,000	$0	$0
88	96	PIA EYEWEAR COURIER SERVICE	$1,062,000	$531,000	$1,062,000	$531,000	$0	$0
87	--	CDPH I&E PROGRAM AND EVALUATION	$187,000	$0	$0	$0	($187,000)	$0

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2023 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2023-24

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2023-24 APPROPRIATION		NOV. 2023 EST. FOR 2023-24		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER DEPARTMENTS SUBTOTAL	$1,263,594,000	$36,734,150	$1,289,116,000	$38,042,950	$25,522,000	$1,308,800
		OTHER ADMINISTRATION TOTAL	$4,398,124,000	$1,054,997,500	$4,586,886,000	$922,112,100	$188,762,000	($132,885,400)
		GRAND TOTAL COUNTY AND OTHER ADMINISTRATION	$7,207,124,000	$1,840,225,000	$7,389,360,000	$1,705,302,100	$182,236,000	($134,922,900)

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2023-24 AND 2024-25

NO.	POLICY CHANGE TITLE	NOV. 2023 EST. FOR 2023-24		NOV. 2023 EST. FOR 2024-25		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	DHCS-OTHER						
1	CALAIM - PATH	$1,045,000,000	$426,500,000	$478,800,000	$207,400,000	($566,200,000)	($219,100,000)
2	COUNTY SPECIALTY MENTAL HEALTH ADMIN	$268,778,000	$8,478,000	$268,885,000	$8,910,000	$107,000	$432,000
3	CYBHI - BH SERVICES AND SUPPORTS PLATFORM	$247,172,000	$247,172,000	$209,964,000	$209,964,000	($37,208,000)	($37,208,000)
4	CCS CASE MANAGEMENT	$191,475,000	$66,757,350	$195,437,000	$67,731,600	$3,962,000	$974,250
5	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	$139,325,000	$0	$113,719,000	$0	($25,606,000)	$0
6	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	$111,244,000	$0	$98,368,000	$0	($12,876,000)	$0
7	MEDI-CAL RX - ADMINISTRATIVE COSTS	$108,113,000	$11,235,600	$97,701,000	$25,681,700	($10,412,000)	$14,446,100
8	SMH MAA	$65,188,000	$0	$63,458,000	$0	($1,730,000)	$0
9	MHSF - PROVIDER ACES TRAININGS	$54,614,000	$0	$45,500,000	$0	($9,114,000)	$0
10	DRUG MEDI-CAL COUNTY ADMINISTRATION	$51,565,000	$0	$62,220,000	$0	$10,655,000	$0
11	CALAIM - POPULATION HEALTH MANAGEMENT	$49,601,000	$4,960,100	$52,668,000	$5,266,800	$3,067,000	$306,700
12	COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE	$48,143,000	$28,942,000	$51,152,000	$30,751,000	$3,009,000	$1,809,000
13	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	$46,045,000	$23,312,350	$43,345,000	$21,910,800	($2,700,000)	($1,401,550)
14	INTERIM AND FINAL COST SETTLEMENTS-SMHS	$39,627,000	$0	$40,577,000	$0	$950,000	$0
15	ACTUARIAL COSTS FOR RATE DEVELOPMENT	$34,275,000	$16,987,500	$37,275,000	$18,487,500	$3,000,000	$1,500,000
16	CHDP COUNTY ALLOCATION	$33,962,000	$10,575,000	$0	$0	($33,962,000)	($10,575,000)
17	ENTERPRISE DATA ENVIRONMENT	$33,555,000	$8,988,300	$44,232,000	$11,800,150	$10,677,000	$2,811,850
18	POSTAGE & PRINTING	$33,425,000	$16,841,000	$33,425,000	$16,841,000	$0	$0
19	MEDI-CAL RECOVERY CONTRACTS	$21,175,000	$5,293,750	$19,589,000	$4,897,250	($1,586,000)	($396,500)
20	HCBA WAIVER ADMINISTRATIVE COST	$20,721,000	$10,360,500	$23,776,000	$11,888,000	$3,055,000	$1,527,500
21	CAPMAN	$20,113,000	$5,254,000	$20,599,000	$5,147,100	$486,000	($106,900)
22	PAVE SYSTEM	$17,272,000	$4,712,000	$18,431,000	$5,018,050	$1,159,000	$306,050
23	HEALTH ENROLLMENT NAVIGATORS	$16,850,000	$8,425,000	$21,250,000	$10,625,000	$4,400,000	$2,200,000

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2023-24 AND 2024-25

NO.	POLICY CHANGE TITLE	NOV. 2023 EST. FOR 2023-24		NOV. 2023 EST. FOR 2024-25		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	DHCS-OTHER						
24	EMSA - CALIFORNIA POISON CONTROL SYSTEM SVCS.	$15,770,000	$0	$15,905,000	$0	$135,000	$0
25	CARE ACT - OTHER ADMIN	$15,000,000	$15,000,000	$0	$0	($15,000,000)	($15,000,000)
26	MITA	$12,257,000	$1,556,600	$20,404,000	$2,591,400	$8,147,000	$1,034,800
27	PASRR	$9,643,000	$2,410,750	$9,643,000	$2,410,750	$0	$0
28	OUTREACH & ENROLLMENT ASSIST. FOR DUAL BENES	$8,600,000	$4,300,000	$2,000,000	$1,000,000	($6,600,000)	($3,300,000)
29	LA COUNTY PUBLIC HEALTH NURSING PILOT	$8,250,000	$0	$8,250,000	$0	$0	$0
30	CALAIM MLTSS & D-SNP INTEGRATION ACTIVITIES	$7,100,000	$3,550,000	$0	$0	($7,100,000)	($3,550,000)
31	NEWBORN HEARING SCREENING PROGRAM	$6,303,000	$3,151,500	$6,392,000	$3,196,000	$89,000	$44,500
32	STATEWIDE VERIFICATION HUB	$4,467,000	$446,700	$2,315,000	$231,500	($2,152,000)	($215,200)
33	DRUG MEDI-CAL PARITY RULE ADMINISTRATION	$4,407,000	$1,469,000	$5,875,000	$1,958,000	$1,468,000	$489,000
34	ELECTRONIC ASSET VERIFICATION PROGRAM	$4,068,000	$2,034,000	$227,000	$113,500	($3,841,000)	($1,920,500)
35	SDMC SYSTEM M&O SUPPORT	$3,898,000	$1,949,000	$2,492,000	$1,246,000	($1,406,000)	($703,000)
36	PACES	$3,732,000	$981,100	$3,745,000	$984,450	$13,000	$3,350
37	HCBS SP - CONTINGENCY MANAGEMENT ADMIN	$2,768,000	$0	$6,119,000	$0	$3,351,000	$0
38	CALAIM - INMATE PRE-RELEASE PROGRAM ADMIN	$2,746,000	$1,373,000	$2,746,000	$1,373,000	$0	$0
39	PUBLIC HEALTH REGISTRIES SUPPORT	$2,737,000	$0	$5,475,000	$0	$2,738,000	$0
40	T-MSIS	$2,708,000	$383,450	$1,851,000	$288,200	($857,000)	($95,250)
41	HEALTH INFORMATION EXCHANGE INTEROPERABILITY	$2,017,000	$1,967,000	$250,000	$125,000	($1,767,000)	($1,842,000)
42	MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM	$2,000,000	$1,000,000	$2,000,000	$1,000,000	$0	$0
43	FIELD TESTING OF MEDI-CAL MATERIALS	$2,000,000	$1,000,000	$200,000	$100,000	($1,800,000)	($900,000)
44	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$1,984,000	$804,000	$1,984,000	$804,000	$0	$0
45	MFP/CCT SUPPLEMENTAL FUNDING	$1,950,000	$0	$1,950,000	$0	$0	$0
46	CALIFORNIA HEALTH INTERVIEW SURVEY	$1,757,000	$178,500	$1,785,000	$192,500	$28,000	$14,000

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2023-24 AND 2024-25

NO.	POLICY CHANGE TITLE	NOV. 2023 EST. FOR 2023-24		NOV. 2023 EST. FOR 2024-25		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	DHCS-OTHER						
47	PROTECTION OF PHI DATA	$1,656,000	$828,000	$1,408,000	$704,000	($248,000)	($124,000)
48	GENDER-AFFIRMING CARE	$1,500,000	$750,000	$1,500,000	$750,000	$0	$0
49	MEDCOMPASS SOLUTION	$1,365,000	$358,600	$5,320,000	$1,398,850	$3,955,000	$1,040,250
50	SSA COSTS FOR HEALTH COVERAGE INFO.	$1,266,000	$633,000	$1,321,000	$660,500	$55,000	$27,500
51	FAMILY PACT PROGRAM ADMIN.	$965,000	$96,500	$915,000	$91,500	($50,000)	($5,000)
52	MMA - DSH ANNUAL INDEPENDENT AUDIT	$747,000	$373,500	$800,000	$400,000	$53,000	$26,500
53	CCT OUTREACH - ADMINISTRATIVE COSTS	$340,000	$0	$340,000	$0	$0	$0
54	HEALTH PLAN OF SAN MATEO DENTAL INTEGRATION EVAL	$68,000	$0	$164,000	$0	$96,000	$0
56	CALAIM - JUSTICE INVOLVED MAA	$0	$0	$12,000,000	$6,000,000	$12,000,000	$6,000,000
57	CALAIM - BH - CONNECT DEMONSTRATION ADMIN	$0	$0	$1,554,000	$107,000	$1,554,000	$107,000
58	CMS DEFERRED CLAIMS - OTHER ADMIN	$0	($3,932,000)	$0	$0	$0	$3,932,000
59	COVID-19 INCREASED FMAP - OTHER ADMIN	$0	($223,000)	$0	$0	$0	$223,000
97	REPRODUCTIVE HEALTH ACCESS DEMO 1115 WAIVER	$0	$0	$200,000,000	$100,000,000	$200,000,000	$100,000,000
98	DESIGNATED STATE HEALTH PROGRAMS	$0	($209,091,000)	$0	($189,939,000)	$0	$19,152,000
	DHCS-OTHER SUBTOTAL	**$2,831,307,000**	**$738,142,650**	**$2,367,301,000**	**$600,107,100**	**($464,006,000)**	**($138,035,550)**
	DHCS-MEDICAL FI						
60	MEDICAL FI BO & IT COST REIMBURSEMENT	$53,316,000	$14,845,550	$73,096,000	$19,783,100	$19,780,000	$4,937,550
61	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	$42,039,000	$11,049,900	$36,652,000	$9,634,250	($5,387,000)	($1,415,650)
62	MEDICAL FI BO & IT CHANGE ORDERS	$41,918,000	$11,017,250	$41,803,000	$10,988,500	($115,000)	($28,750)
63	MEDICAL FI IT INFRASTRUCTURE SERVICES	$32,412,000	$8,521,450	$22,096,000	$5,807,550	($10,316,000)	($2,713,900)
64	MEDICAL FI BO OTHER ESTIMATED COSTS	$24,859,000	$7,468,650	$26,228,000	$7,877,950	$1,369,000	$409,300
65	MEDICAL FI BO TELEPHONE SERVICE CENTER	$18,185,000	$5,443,300	$19,186,000	$5,741,950	$1,001,000	$298,650
66	MEDICAL FI BUSINESS OPERATIONS	$16,603,000	$4,355,500	$17,492,000	$4,595,000	$889,000	$239,500
67	MEDICAL FI BO HOURLY REIMBURSEMENT	$11,989,000	$3,152,200	$12,648,000	$3,324,450	$659,000	$172,250

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2023-24 AND 2024-25

NO.	POLICY CHANGE TITLE	NOV. 2023 EST. FOR 2023-24		NOV. 2023 EST. FOR 2024-25		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	DHCS-MEDICAL FI						
68	MEDICAL FI BO MISCELLANEOUS EXPENSES	$2,446,000	$707,350	$2,161,000	$567,600	($285,000)	($139,750)
	DHCS-MEDICAL FI SUBTOTAL	**$243,767,000**	**$66,561,150**	**$251,362,000**	**$68,320,350**	**$7,595,000**	**$1,759,200**
	DHCS-HEALTH CARE OPT						
69	HCO COST REIMBURSEMENT 2017 CONTRACT	$31,939,000	$15,729,950	$32,740,000	$16,124,450	$801,000	$394,500
70	HCO OPERATIONS 2017 CONTRACT	$31,427,000	$15,477,700	$31,940,000	$15,730,450	$513,000	$252,750
71	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	$14,474,000	$7,128,400	$13,153,000	$6,477,650	($1,321,000)	($650,750)
	DHCS-HEALTH CARE OPT SUBTOTAL	**$77,840,000**	**$38,336,050**	**$77,833,000**	**$38,332,550**	**($7,000)**	**($3,500)**
	DHCS-DENTAL FI						
72	DENTAL FI-DBO ADMIN 2022 CONTRACT	$61,652,000	$12,816,800	$84,920,000	$21,856,500	$23,268,000	$9,039,700
73	DENTAL ASO ADMINISTRATION 2016 CONTRACT	$60,683,000	$21,742,750	$11,352,000	$2,838,000	($49,331,000)	($18,904,750)
74	DENTAL FI ADMINISTRATION 2016 CONTRACT	$22,521,000	$6,469,750	$22,329,000	$6,376,500	($192,000)	($93,250)
	DHCS-DENTAL FI SUBTOTAL	**$144,856,000**	**$41,029,300**	**$118,601,000**	**$31,071,000**	**($26,255,000)**	**($9,958,300)**
	OTHER DEPARTMENTS						
75	PERSONAL CARE SERVICES	$473,549,000	$0	$488,212,000	$0	$14,663,000	$0
76	HEALTH-RELATED ACTIVITIES - CDSS	$358,010,000	$0	$359,692,000	$0	$1,682,000	$0
77	CALHEERS DEVELOPMENT	$146,038,000	$37,412,950	$164,180,000	$43,008,400	$18,142,000	$5,595,450
78	MATERNAL AND CHILD HEALTH	$45,037,000	$0	$69,111,000	$0	$24,074,000	$0
79	CDDS ADMINISTRATIVE COSTS	$113,674,000	$0	$76,198,000	$0	($37,476,000)	$0
80	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$55,882,000	$0	$48,265,000	$0	($7,617,000)	$0
81	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	$54,682,000	$0	$54,682,000	$0	$0	$0

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2023-24 AND 2024-25

NO.	POLICY CHANGE TITLE	NOV. 2023 EST. FOR 2023-24		NOV. 2023 EST. FOR 2024-25		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER DEPARTMENTS						
82	FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG	$9,297,000	$0	$8,058,000	$0	($1,239,000)	$0
83	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$6,582,000	$0	$7,673,000	$0	$1,091,000	$0
84	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	$12,502,000	$0	$6,880,000	$0	($5,622,000)	$0
85	CLPP CASE MANAGEMENT SERVICES	$3,517,000	$0	$3,546,000	$0	$29,000	$0
86	CALIFORNIA SMOKERS' HELPLINE	$1,518,000	$0	$2,500,000	$0	$982,000	$0
87	HCBS SP CDDS - OTHER ADMIN	$2,457,000	$0	$0	$0	($2,457,000)	$0
88	CALHHS AGENCY HIPAA FUNDING	$1,367,000	$0	$1,386,000	$0	$19,000	$0
89	MEDI-CAL INPATIENT SERVICES FOR INMATES	$1,165,000	$0	$1,212,000	$0	$47,000	$0
90	VETERANS BENEFITS	$1,100,000	$0	$1,100,000	$0	$0	$0
91	VITAL RECORDS	$883,000	$4,000	$883,000	$4,000	$0	$0
92	KIT FOR NEW PARENTS	$604,000	$0	$593,000	$0	($11,000)	$0
93	MERIT SYSTEM SERVICES FOR COUNTIES	$190,000	$95,000	$190,000	$95,000	$0	$0
95	HEALTH FOR FOSTER CARE CHILDREN ADMIN COSTS	$0	$0	$13,133,000	$6,566,500	$13,133,000	$6,566,500
96	PIA EYEWEAR COURIER SERVICE	$1,062,000	$531,000	$1,062,000	$531,000	$0	$0
	OTHER DEPARTMENTS SUBTOTAL	**$1,289,116,000**	**$38,042,950**	**$1,308,556,000**	**$50,204,900**	**$19,440,000**	**$12,161,950**
	OTHER ADMINISTRATION TOTAL	**$4,586,886,000**	**$922,112,100**	**$4,123,653,000**	**$788,035,900**	**($463,233,000)**	**($134,076,200)**
	GRAND TOTAL COUNTY AND OTHER ADMINISTRATION	**$7,389,360,000**	**$1,705,302,100**	**$6,876,417,000**	**$1,564,420,650**	**($512,943,000)**	**($140,881,450)**

MEDI-CAL OTHER ADMINISTRATION
POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	DHCS-OTHER
1	CALAIM - PATH
2	COUNTY SPECIALTY MENTAL HEALTH ADMIN
3	CYBHI - BH SERVICES AND SUPPORTS PLATFORM
4	CCS CASE MANAGEMENT
5	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES
6	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES
7	MEDI-CAL RX - ADMINISTRATIVE COSTS
8	SMH MAA
9	MHSF - PROVIDER ACES TRAININGS
10	DRUG MEDI-CAL COUNTY ADMINISTRATION
11	CALAIM - POPULATION HEALTH MANAGEMENT
12	COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE
13	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS
14	INTERIM AND FINAL COST SETTLEMENTS-SMHS
15	ACTUARIAL COSTS FOR RATE DEVELOPMENT
16	CHDP COUNTY ALLOCATION
17	ENTERPRISE DATA ENVIRONMENT
18	POSTAGE & PRINTING
19	MEDI-CAL RECOVERY CONTRACTS
20	HCBA WAIVER ADMINISTRATIVE COST
21	CAPMAN
22	PAVE SYSTEM
23	HEALTH ENROLLMENT NAVIGATORS
24	EMSA - CALIFORNIA POISON CONTROL SYSTEM SVCS.
25	CARE ACT - OTHER ADMIN
26	MITA
27	PASRR
28	OUTREACH & ENROLLMENT ASSIST. FOR DUAL BENES
29	LA COUNTY PUBLIC HEALTH NURSING PILOT
30	CALAIM MLTSS & D-SNP INTEGRATION ACTIVITIES
31	NEWBORN HEARING SCREENING PROGRAM
32	STATEWIDE VERIFICATION HUB
33	DRUG MEDI-CAL PARITY RULE ADMINISTRATION
34	ELECTRONIC ASSET VERIFICATION PROGRAM
35	SDMC SYSTEM M&O SUPPORT
36	PACES
37	HCBS SP - CONTINGENCY MANAGEMENT ADMIN
38	CALAIM - INMATE PRE-RELEASE PROGRAM ADMIN

MEDI-CAL OTHER ADMINISTRATION
POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	DHCS-OTHER
39	PUBLIC HEALTH REGISTRIES SUPPORT
40	T-MSIS
41	HEALTH INFORMATION EXCHANGE INTEROPERABILITY
42	MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM
43	FIELD TESTING OF MEDI-CAL MATERIALS
44	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)
45	MFP/CCT SUPPLEMENTAL FUNDING
46	CALIFORNIA HEALTH INTERVIEW SURVEY
47	PROTECTION OF PHI DATA
48	GENDER-AFFIRMING CARE
49	MEDCOMPASS SOLUTION
50	SSA COSTS FOR HEALTH COVERAGE INFO.
51	FAMILY PACT PROGRAM ADMIN.
52	MMA - DSH ANNUAL INDEPENDENT AUDIT
53	CCT OUTREACH - ADMINISTRATIVE COSTS
54	HEALTH PLAN OF SAN MATEO DENTAL INTEGRATION EVAL
56	CALAIM - JUSTICE INVOLVED MAA
57	CALAIM - BH - CONNECT DEMONSTRATION ADMIN
58	CMS DEFERRED CLAIMS - OTHER ADMIN
59	COVID-19 INCREASED FMAP - OTHER ADMIN
97	REPRODUCTIVE HEALTH ACCESS DEMO 1115 WAIVER
98	DESIGNATED STATE HEALTH PROGRAMS
	DHCS-MEDICAL FI
60	MEDICAL FI BO & IT COST REIMBURSEMENT
61	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES
62	MEDICAL FI BO & IT CHANGE ORDERS
63	MEDICAL FI IT INFRASTRUCTURE SERVICES
64	MEDICAL FI BO OTHER ESTIMATED COSTS
65	MEDICAL FI BO TELEPHONE SERVICE CENTER
66	MEDICAL FI BUSINESS OPERATIONS
67	MEDICAL FI BO HOURLY REIMBURSEMENT
68	MEDICAL FI BO MISCELLANEOUS EXPENSES
	DHCS-HEALTH CARE OPT
69	HCO COST REIMBURSEMENT 2017 CONTRACT
70	HCO OPERATIONS 2017 CONTRACT
71	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT

MEDI-CAL OTHER ADMINISTRATION
POLICY CHANGE INDEX

CALAIM - PATH

OTHER ADMIN. POLICY CHANGE NUMBER: 1
IMPLEMENTATION DATE: 1/2022
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2389

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$1,045,000,000	$478,800,000
STATE FUNDS	$521,835,000	$239,400,000
FEDERAL FUNDS	$523,165,000	$239,400,000

Purpose:
This policy change estimates the funding available for the CalAIM Providing Access and Transforming Health (PATH) Initiative.

Authority:
Penal Code Section 4011.11
Welfare & Institutions Code Sections 14011.10, 14132.275, 14184.800, and 14186
AB 133 (Chapter 133, Statutes of 2021)
AB 128 (Chapter 21, Statutes of 2021)
CalAIM Section 1115(a) Medicaid Demonstration

Interdependent Policy Changes:
Not Applicable

Background:
On December 29, 2021, the Centers for Medicare and Medicaid Services (CMS) approved the CalAIM Section 1115 Wavier Demonstration, which provided funding for the CalAIM PATH Initiative through December 31, 2026. PATH was previously approved for $1.44 billion. On January 26, 2023, the Department received federal approval under its CalAIM Section 1115 Waiver Demonstration for PATH capacity building funds to support the Justice-Involved Reentry Initiative for an additional $410 million in capacity building funds to support the planning and implementation of pre-release and reentry services in the 90 days prior to an individual's release into the community, for a total budget of $1.85 billion. The PATH Initiative is to build up the capacity and infrastructure of on-the-ground partners and providers to successfully participate in CalAIM Enhanced Care Management (ECM) and Community Supports, and Justice Involved Services. PATH is comprised of the following efforts.

ECM and Community Supports Capacity and Infrastructure Building
PATH will provide funding to transition, build, expand, and maintain infrastructure/capacity to support the implementation of ECM and Community Supports. This goal will be achieved through four initiatives:

- Technical Assistance (TA) Initiative: Virtual "marketplace" will be developed to provide technical support and off-the-shelf resources from vendors to establish the infrastructure development.
- Collaborative Planning and Implementation Initiative: Provide funding to regional facilitators approved by the Department. Support for regional collaborative planning and implementation efforts will include among managed care plans, providers,

CALAIM - PATH
OTHER ADMIN. POLICY CHANGE NUMBER: 1

Community-Based Organizations (CBOs), county agencies, public hospitals, tribes, and others to assess gaps and promote readiness.

- Capacity and Infrastructure Transition, Expansion and Development (CITED) Initiative: Direct funding to support the delivery of services. Entities, such as providers, CBOs, county agencies, public hospitals, tribes, and other, that are contracted or plan to contract with a managed care plan can apply to receive funding for specific capacity needs to support the transition, expansion, and development of these specific services.

PATH initiatives consider other efforts such as the Incentive Payment Program and the Housing and Homeless Incentive Program to ensure alignment and nonduplication of funding. The CITED Initiative supports are aligned with the Homeless and Home and Community Based Service Provider Investments Program, to contribute to the investment goal of expanding workforce by creating over 2,000 direct service jobs for those providing services to homeless and formerly homeless individuals through investments in California Department of Social Services programs.

Justice-Involved Capacity Building Program

PATH funding will support the implementation of statewide CalAIM justice-involved initiatives. This includes support for implementation of pre-release Medi-Cal applications, enrollment, and suspension processes, as well as the delivery of Medi-Cal services in the 90 days prior to release. This goal will be achieved through two parts:

- Collaborative planning: Support for correctional agencies, county social services departments, county behavioral health agencies, managed care plans, and others so they can jointly design, modify, and launch new processes aimed at increasing enrollment in Medi-Cal and continuous access to care for justice-involved youths and adults.
- Capacity and Infrastructure: Support for correctional agencies, institutions, and other justice-involved stakeholders as they implement pre-release Medi-Cal enrollment and suspension processes.

Overall Program

Effective July 1, 2022, the Department has contracted with a Third-Party Administrator (TPA) to support the implementation of the PATH initiatives and serve as a fiscal administrator for all PATH initiative except the Whole Person Care (WPC) Mitigation initiative.

Reason for Change:

The change from the prior estimate, for FY 2023-24, is an increase due to funding from FY 2022-23 shifting into FY 2023-24. There is also an increase in estimated costs for FY 2023-24 due to the TPA contract amendment. Additionally, some funding that was initially projected to be spent in FY 2024-25 has shifted forward into FY 2023-24. The change from FY 2023-24 to FY 2024-25, in the current estimates, is a decrease due to funding from FY 2022-23 and FY 2024-25 shifting into FY 2023-24.

CALAIM - PATH
OTHER ADMIN. POLICY CHANGE NUMBER: 1

Methodology:

Third Party Administrator and Fiscal Intermediary

1. The PATH TPA will facilitate the implementation and administration several initiatives, as well as serve as the fiscal intermediary for: TA Initiative, Collaborative Planning and Implementation Initiative, CITED Initiative, and the Justice-Involved Capacity Building Program Capacity and Infrastructure. PCG has been contracted to provide these services from July 1, 2022, through June 30, 2027. Payment for the TPA services will be based on completion of deliverables, and milestone accomplishments.

TA Marketplace Initiative

2. The TA Marketplace is an online portal that will serve as a virtual marketplace for TA services, a one-stop-shop website where entities can access TA resources from curated and approved vendors. TA offerings will include the option to request custom, hands-on technical support or to request off-the-shelf TA projects, which are packaged and ready for implementation. TA Vendors have been vetted through the TPA and the Department and services are posted on the marketplace.
3. There will be a three-step process for eligible applicants to initiate services from TA Vendors.
    a. TA Recipients must complete an Eligibility Registration and be approved as an eligible TA recipient.
    b. TA Recipients must complete a TA Project Eligibility Application and be approved for their requested TA Project.
    c. TA Recipients and TA Vendor must complete a scope of work and budget. The scope of work and budget must be approved by the Department.
4. Once the TA project is completed, the TA Vendor must submit an invoice packet and report to document services provided. This includes an attestation from the TA Recipient that their project is complete and satisfactory.
5. Once the invoice packet and reporting have been approved by the Department, the payment process will be initiated with PCG.
6. Payment will be made through a passthrough invoice process with PCG. PCG will invoice the Department for the approved TA Marketplace budget amount and provide the scope of work as back up documentation. The Department will process the passthrough invoice and make payment to PCG. PCG will have up to 4 business days to make that payment to the TA Vendor once funds are received from the Department.

Collaborative Planning and Implementation Initiative

7. Collaborative budget methodology assigns a weight percentage for each county based on the number of Medi-Cal managed care plan members, managed care plan revenue, prevalence of homelessness, cost of rent, and additional adjustments such as if it is a non-WPC county. An overall average weight percentage is assigned to each Collaborative Group based on the average weight percentage of the counties within the group. Lastly, the average weight percentage is then grouped into Tiers.
    a. Tier 1 $250,000
    b. Tier 2 $500,000
    c. Tier 3 $750,000
    d. Tier 4 $1,000,000
    e. Tier 5 $2,000,000
8. Each Collaborative Group was assigned an approved Collaborative Facilitator and budget. Some facilitators were assigned to multiple Collaborative groups based on capacity and previous relations working with the Medi-Cal managed care plan in that area.

CALAIM - PATH
OTHER ADMIN. POLICY CHANGE NUMBER: 1

9. The Collaborative Facilitators will earn 10% of their budgeted contract upon contract execution and 18% of their budgeted contract is earned after the set milestones for the following quarter is complete.
10. Payment will be made through a passthrough invoice process with PCG. PCG will invoice the Department for the approved Collaborative Facilitator budget amount and provide documentation of the completed milestones. The Department will process the passthrough invoice and make payment to PCG. PCG will have up to 4 business days to make that payment to the Collaborative Facilitator once funds are received from the Department.

CITED Initiative

11. Round 1 application window opened in August 2022 and closed September 30, 2022. Due to the high number of applications received, Round 1 was separated into 2 phases: 1a and 1b. Round 1a awards were announced on January 31, 2023, and Round 1b awardees were announced in March 2023. The Round 2 application window opened in February 2023.
12. Approved applicants will be paid based on completion of milestones and quarterly reporting. PCG will review and provide approval recommendation to the Department. The Department will review and once approved, the payment process can be initiated.
13. Payment will be made through a passthrough invoice process with PCG. PCG will invoice the Department for the approved invoice amount and provide documentation of the completed milestones. The Department will process the passthrough invoice and make payment to PCG. PCG will have up to 4 business days to make that payment to the CITED grantee once funds are received from the Department.

Justice-Involved (JI) Capacity Building Program

14. JI Capacity Building Program will award funds in multiple rounds to align with its two-part initiative. Round 1 will be focused on collaborative planning. Rounds 2 and 3 will be focused on capacity and infrastructure development, building off of the planning from the initial round of funding.
15. Round 1 of the Justice Involved collaborative planning funds have been awarded. Payments are made within 60 days of application approval. Total awarded is approximately $4,551,000.
16. Round 2 Application was released in January 2023 and closed March 31, 2023. Payments are made within 45 days of Grant Agreement execution. From the applications submitted, approximately $61,234,000 was requested. Applications are still in review and approximately $36,497,000 has been approved.
17. Payment will be made through a passthrough invoice process with PCG. PCG will invoice the Department for the approved invoice amount and provide documentation of the completed milestones. The Department will process the passthrough invoice and make payment to PCG. PCG will have up to 4 business days to make that payment to the JI grantee once funds are received from the Department.
18. As a result of AB 128, the Department received an appropriation for $100,000,000 General Fund ($100,000,000 Federal Fund) for Justice-Involved initiatives within the Medi-Cal PATH program and is available to spend through June 30, 2024. The table below displays the estimated spending and remaining funds by Appropriation Years:

CALAIM - PATH
OTHER ADMIN. POLICY CHANGE NUMBER: 1

(Dollars in Thousands)

Appropriation Year 2021-22	TF	GF	FF*
Prior Years	$3,300	$1,650	$1,650
Estimated in FY 2023-24	$135,000	$67,500	$67,500
Estimated in FY 2024-25	$61,700	$30,850	$30,850
Total Estimated Remaining	$0	$0	$0

*Federal funds authority is newly requested for the fiscal year in which funds are anticipated to be expended. Totals may differ due to rounding.

19. The table below estimates the funding for the remaining PATH initiatives:

(Dollars in Thousands)

Fiscal Year	TF	GF	GF Reimb.	SF	FF
FY 2023-24	$910,001	$359,001	$64,000	$31,335	$455,666
FY 2024-25	$417,100	$176,550	$32,000	$0	$208,550

*Totals may differ due to rounding.

20. On a cash basis, all PATH Program costs are estimated to be:

(Dollars in Thousands)

Fiscal Years	TF	GF	GF Reimb.	SF	FF
FY 2023-24	**$1,045,000**	**$426,500**	**$64,000**	**$31,335**	**$523,165**
FY 2024-25	**$478,800**	**$207,400**	**$32,000**	**$0**	**$239,400**

Funding:

(Dollars in Thousands)

FY 2023-24	TF	GF	GF Reimb.	SF	FF
100% Title XIX FF (4260-101-0890)	$96,665	$0	$0	$0	$96,665
HCBS ARP Fund (4260-101-8507)	$31,335	$0	$0	$31,335	$0
50% Title XIX / 50% GF (4260-101-0890/0001)	$853,000	$426,500	$0	$0	$426,500
Reimbursement GF (4260-601-0995)	$64,000	$0	$64,000	$0	$0
Total	**$1,045,000**	**$426,500**	**$64,000**	**$31,335**	**$523,165**
FY 2024-25	**TF**	**GF**	**GF Reimb.**	**SF**	**FF**
100% Title XIX FF (4260-101-0890)	$32,000	$0	$0	$0	$32,000
50% Title XIX / 50% GF (4260-101-0890/0001)	$414,800	$207,400	$0	$0	$207,400
Reimbursement GF (4260-601-0995)	$32,000	$0	$32,000	$0	$0
Total	**$478,800**	**$207,400**	**$32,000**	**$0**	**$239,400**

COUNTY SPECIALTY MENTAL HEALTH ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 2
IMPLEMENTATION DATE: 7/2012
ANALYST: Elena Susbilla
FISCAL REFERENCE NUMBER: 1721

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$268,778,000	$268,885,000
STATE FUNDS	$8,478,000	$8,910,000
FEDERAL FUNDS	$260,300,000	$259,975,000

Purpose:
This policy change estimates the reimbursement for the county administrative costs for the Specialty Mental Health Services (SMHS) in the Medi-Cal (MC) program and the Children's Health Insurance Program (CHIP) administered by county mental health departments.

Authority:
Welfare & Institutions Code 14707.5
Welfare & Institutions Code 14711(c)
California Constitution Article XIII Section 36
CMS Final Rule (CMS-2333-F) (Parity Final Rule)
Title 42, Code of Federal Regulations Part 438
Families First Coronavirus Response Act (FFCRA)
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
Counties may obtain federal reimbursement for costs associated with administering a county's mental health program. Counties must report their administration costs and direct facility expenditures quarterly. Along with administration costs, counties can claim reimbursement costs for county Utilization Review and Quality Assurance (QAUR), Performance Outcomes System (POS), Managed Care Regulations – Mental Health, and MH Parity Final Rule.

The QAUR and POS responsibility for SMHS was realigned to the counties in 2011 as part of 2011 Public Safety Realignment. Pursuant to Proposition 30, state requirements enacted after September 30, 2012, that have an overall effect of increasing the costs already borne by a local agency for programs or levels of service mandated by 2011 Realignment shall apply to local agencies only to the extent that the state provides funding for the cost increase.

The Centers for Medicare and Medicaid Services (CMS) issued Final Rule CMS-2390-P on May 6, 2016. Final Rule 2390-P changes the Medicaid managed care regulations to reflect changes in the utilization of managed care delivery systems. And on March 30, 2017, CMS issued the Parity Final Rule, to strengthen access to mental health and substance use disorder services for Medicaid beneficiaries.

COUNTY SPECIALTY MENTAL HEALTH ADMIN
OTHER ADMIN. POLICY CHANGE NUMBER: 2

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid. 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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline.
The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
The change from the prior estimate, for FY 2023-24 is due to removing Intergovernmental Transfers (IGT) from the calculation since CMS did not approve the transition of administrative claiming from a CPE to IGT structure.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to claims projected to increase in dollars based on historical data forecasted forward.

COUNTY SPECIALTY MENTAL HEALTH ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 2

Methodology:

1. Mental Health administration costs are based on historical claims payment data. Assume 18.33% of each fiscal year claims will be paid in the year the services occur, 74.17% is paid in the following year, and 7.50% in the third year. The estimate costs are:

(Dollars in Thousands)

Fiscal Year	Type	Accrual	FY 2023-24	FY 2023-24
FY 2021-22	Other Admin	$334,769	$25,109	$0
	MCHIP	$26,059	$1,955	$0
	QAUR	$60,652	$4,549	$0
	POS	$3,398	$255	$0
	Parity	$24,726	$1,855	$0
	Managed Care	$11,362	$852	$0
Subtotal		$460,966	$34,575	$0
FY 2022-23	Other Admin	$351,836	$260,951	$26,389
	MCHIP	$27,388	$20,313	$2,054
	QAUR	$63,745	$47,279	$4,781
	POS	$3,571	$2,649	$268
	Parity	$25,987	$19,274	$1,949
	Managed Care	$11,942	$8,857	$896
Subtotal		$484,469	$359,323	$36,337

COUNTY SPECIALTY MENTAL HEALTH ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 2

FY 2023-24	Other Admin	$346,787	$63,570	$257,207
	MCHIP	$18,654	$3,419	$13,835
	QAUR	$66,996	$12,281	$49,690
	POS	$3,753	$688	$2,784
	Parity	$27,312	$5,007	$20,257
	Managed Care	$12,551	$2,301	$9,309
Subtotal		$476,054	$87,266	$353,082
	Other Admin	$364,466	$0	$66,810
	MCHIP	$19,605	$0	$3,594
	QAUR	$70,413	$0	$12,907
	POS	$3,945	$0	$723
	Parity	$28,705	$0	$5,262
	Managed Care	$13,191	$0	$2,418
Subtotal		$500,325	$0	$91,715
Total	Other Admin	$1,921,814	$481,164	$481,134

2. Mental Health administration costs are shared between federal funds (FF) and county funds (CF). MC claims are eligible for 50% federal reimbursement. CHIP claims are eligible for 65% federal enhanced reimbursement.

3. QAUR expenditures are shared between FF and CF. Pursuant to Proposition 30, GF funding is provided for levels of service that are provided above those levels mandated by the 2011 Realignment. Skilled professional medical personnel (SPMP) are eligible for enhanced federal reimbursement of 75%. All other personnel are eligible for 50% federal reimbursement.

4. POS expenditures are eligible for reimbursement at 50%, and costs for clinical staffing is eligible for enhanced FF at 75%.

5. Managed Care Parity related to pre-authorizations of outpatient services and concurrent reviews of SMHS inpatient admissions, must be conducted by a licensed mental health professional, which assumes a 75% / 25% Federal Medical Assistance Percentage (FMAP). The non-federal share is assumed to be funded with 50% CF and 50% General Funds (GF) pursuant to the California Constitution, Article 13, Section 36(c)(5)(A).

6. For the Managed Care Regulations Final Rule claims, the non-federal share is funded with CF and GF, consistent with the California Constitution, Article 13, Section 36 (c)(5)(A).

COUNTY SPECIALTY MENTAL HEALTH ADMIN
OTHER ADMIN. POLICY CHANGE NUMBER: 2

7. The Title XXI COVID-19 increased FMAP is assumed for expenditures through December 31, 2023 for this policy change.

(Dollars in Thousands)

Claim Type	FY 2023-24				
	TF	FF	GF	CF	FFCRA
Other Admin	$349,630	$174,815	$0	$174,815	$0
MCHIP	$25,867	$16,697	$0	$8,991	$179
QAUR	$64,109	$42,184	$0	$21,926	$0
POS	$3,592	$1,948	$1,643	$0	$0
Parity	$26,135	$18,231	$3,953	$3,952	$0
Managed Care Regulations	$12,010	$6,246	$2,882	$2,883	$0
Total	$481,164	**$260,121**	**$8,478**	$212,386	**$179**

(Dollars in Thousands)

Claim Type	FY 2024-25			
	TF	FF	GF	CF
Other Admin	$350,406	$175,203	$0	$175,203
MCHIP	$19,483	$12,664	$0	$6,819
QAUR	$67,379	$44,335	$0	$23,044
POS	$3,775	$2,048	$1,727	$0
Parity	$27,468	$19,161	$4,154	$4,153
Managed Care Regulations	$12,623	$6,564	$3,029	$3,030
Total	$481,134	**$259,975**	**$8,910**	$212,249

Funding:
100% Title XIX FFP (4260-101-0890)
100% Title XXI FFP (4260-113-0890)
100% Title XIX GF (4260-101-0001)
Medi-Cal County Behavioral Health Fund* (4260-601-3420)

CYBHI - BH SERVICES AND SUPPORTS PLATFORM

OTHER ADMIN. POLICY CHANGE NUMBER: 3
IMPLEMENTATION DATE: 1/2022
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2289

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$247,172,000	$209,964,000
STATE FUNDS	$247,172,000	$209,964,000
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the cost for procuring a business services vendors to implement a statewide, app-based behavioral health (BH) virtual services platforms that will provide children and youth 25 and younger, and their families access to services and supports. This policy changes also estimates costs for integrating a statewide e-consult service and providing related provider training.

Authority:
AB 133 (Chapter 143, Statutes of 2021)
W&I Code 5961.1
Agreement Number 2021-51-CHHS

Interdependent Policy Changes:
Not applicable

Background:
Established as part of the Budget Act of 2021, the Children and Youth Behavioral Health Initiative (CYBHI) is a multiyear package of investments. The CYBHI intends to transform California's BH system for children and youth aged 0-25 into a world-class, innovative, up-stream focused, ecosystem where all children and young adults are routinely screened, supported, and served for emerging behavioral health needs.

The Department has procured a business services vendor to deliver and monitor BH wellness services and treatments so the most effective, least resource-intensive services and treatments are available to children and youth 25 years of age and younger who may not need individual counseling, but need help managing stress and building resilience, through a direct service, virtual platform.

These direct services and supports platforms support regular automated age appropriate assessments/screenings and self-monitoring tools, and develops tools to help families navigate how to access help, regardless of payer source. The direct services and supports platform provides age appropriate and culturally competent support and resources, such as interactive education, self-monitoring tools, app-based games, videos, book suggestions, automated cognitive behavioral therapy and mindfulness exercises, all designed to build skills and enhance well-being. Children and youth 25 years of age and younger with more significant needs would be guided to peers or coaches. Those whose interactions with the platform show they may need clinical services for mental health conditions and/or substance use disorders will be guided to their health plan to set up assessment visits, allowing ongoing, continuous relationships with

CYBHI - BH SERVICES AND SUPPORTS PLATFORM
OTHER ADMIN. POLICY CHANGE NUMBER: 3

licensed clinicians through telehealth or in-person. The direct service platform also builds in coverage by licensed behavioral health providers, so assessments can be performed to determine which children and youth need ongoing clinical services, and which have needs that can be met by peers or coaches. The direct services and supports platform also includes e-consult and e-referrals, to ensure primary care providers can coordinate care with mental health and substance use disorder specialists (e.g., psychiatrists) and clients may have seamless referrals, when needed. In addition, training for pediatric and other primary care providers is offered to support use of the platform in care of their patients.

Reason for Change:
The change from the prior estimate, in FY 2023-24, is a decrease due to updated timing of contract execution and payments to vendors. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to an updated timeline for contracted activities.

Methodology:
1. The Budget Act for FY 2022-23 provided $230 million GF, available for expenditure through June 30, 2025. An additional $124.9 million GF is available for FY 2023-24. An additional $143.9 million GF is proposed for FY 2024-245. The table below displays the estimated spending and remaining funds by Appropriation Year:

	TF	GF	FF
Appropriation Year 2022-23			
Prior Years	$28,050,000	$28,050,000	$0
Estimated in FY 2023-24	$201,950,000	$201,950,000	$0
Total Estimated Remaining	$0	$0	$0
Appropriation Year 2023-24			
Prior Years	$0	$0	$0
Estimated in FY 2023-24	$45,222,000	$45,222,000	$0
Estimated in FY 2024-25	$79,678,000	$79,678,000	$0
Total Estimated Remaining	$0	$0	$0
Appropriation Year 2024-25			
Prior Years	$0	$0	$0
Estimated in FY 2023-24	$0	$0	$0
Estimated in FY 2024-25	$130,286,000	$130,286,000	$0
Total Estimated Remaining	$13,614,000	$13,614,000	$0

2. Total costs are estimated to be:

Fiscal Year	TF	GF	FF
FY 2023-24	**$247,172,000**	**$247,172,000**	**$0**
FY 2024-25	**$209,964,000**	**$209,964,000**	**$0**

Funding:
100% General Fund (4260-101-0001)

CCS CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 4
IMPLEMENTATION DATE: 7/1999
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 230

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$191,475,000	$195,437,000
STATE FUNDS	$66,757,350	$67,731,600
FEDERAL FUNDS	$124,717,650	$127,705,400

Purpose:
This policy change estimates the California Children's Services (CCS) case management cost.

Authority:
Health & Safety Code, sections 123800-123995
AB 2724 (Chapter 73, Statutes of 2022)
AB 133 (Chapter 143, Statutes of 2022)
AB 118 (Chapter 42, Statutes of 2023)

Interdependent Policy Changes:
COVID-19 Increased FMAP – Other Admin

Background:
CCS county staff performs case management for clients who reside in counties with populations greater than 200,000 (independent counties). Case management includes performing all phases of program eligibility determination, evaluating, and adjudicating the medical need for specific services, and determining appropriate providers. For counties with populations under 200,000 (dependent counties), the state shares case management activities. Dependent counties are responsible for the financial and residential verification and the CCS state employees in Sacramento and Los Angeles are responsible for the review and adjudication of service authorization requests. The Children's Medical Services Network (CMS Net) automated system is utilized by the CCS Medi-Cal program to assure case management activities.

On July 1, 2018, the Department began transitioning some of the case management administrative functions from the county to the County Organized Health Systems (COHS) health plans under the Whole Child Model (WCM). The WCM transition was completed on July 1, 2019.

AB 2724 authorizes the Department to contract with Kaiser Permanente as an alternative health care service plan in select WCM counties. Starting January 1, 2024, the Department will implement Kaiser Permanente in the following eight WCM counties: Marin, Napa, Orange, San Mateo, Santa Cruz, Solano, Sonoma, and Yolo.

Starting January 1, 2025, as authorized by AB 118, the Department will begin transitioning most of the case management administrative function from the county to the COHS health plans under the WCM in the following 12 counties: Butte, Colusa, Glenn, Mariposa, Nevada, Placer, Plumas, San Benito, Sierra, Sutter, Tehama, and Yuba. Case management administrative

CCS CASE MANAGEMENT
OTHER ADMIN. POLICY CHANGE NUMBER: 4

functions will also transition to Kaiser Permanente which will operate as an alternate health care service plan in Mariposa, Placer, Sutter, and Yuba counties.

SB 184 sunsets the Child Health and Disability Prevention (CHDP) program on June 30, 2024. Effective July 1, 2024, the Department will redirect portions of the CHDP county budget allocation to fund the administrative and service costs of the Health Oversight and Coordination for Foster Care Children (HCPCFC) program, making HCPCFC a standalone program. Remaining portions of the CHDP county budget allocation will be redirected to the CCS to fund new county workload created due to the implementation of CCS County Monitoring and Oversight effective July 1, 2024.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is a slight increase due to an increase in CMS Net expenditures. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a net increase based on a one-time addition to the CCS case management costs for CCS County Monitoring and Oversight.

Methodology:
1. The county administrative estimate for the budget year is updated every May based on additional data collected.

2. The CCS case management costs for FY 2023-24 are $185,209,000 and $188,008,000 for FY 2024-25.

3. Assume administrative costs of $1,057,000 in both FY 2023-24 and FY 2024-25 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 $3,537,000 in FY 2023-24 and $3,535,000 in FY 2024-25.

5. Medi-Cal Optional Targeted Low Income Children Program (OTLICP) costs are separate from other Medi-Cal costs. Total Medi-Cal OTLICP costs listed below do not include county share of cost:

	FY 2023-24	FY 2024-25
County Administration:	$30,915,000	$34,245,000
County share of cost:	($2,504,000)	($2,774,000)
Total Medi-Cal OTLICP:	$28,411,000	$31,471,000

6. County data processing costs associated with CMS Net for OTLICP are estimated to be $418,000 in FY 2023-24 and FY 2024-25.

7. Payments to the COHS under the WCM are applied against CCS Case Management. The expenditures using a cash basis accounting are estimated to be $24,000,000 in FY 2023-24 and $25,625,000 in FY 2024-25. The additional $1,625,000 in FY 2024-25 relates to the impacts of transitioning 12 additional counties to WCM beginning in January 1, 2025.

8. Enhanced, Title XIX (75% FFP), funding is available for Skilled Professional Medical Personnel for the Medi-Cal and OTLICP populations in FY 2023-24 and FY 2024-25.

CCS CASE MANAGEMENT
OTHER ADMIN. POLICY CHANGE NUMBER: 4

9. To support increased county administrative workload associated with new reporting requirements as specified by AB 133, the Department will proportionately reallocate the CHDP funding to counties utilizing a stratified methodology based on county specific CCS beneficiary caseload. The CCS Monitoring and Oversight cost is estimated at $20,762,000 for FY 2024-25.

FY 2023-24				
CCS Medi-Cal/OTLICP	**TF***	**GF**	**FF**	**CF****
CCS Case Management	$25,907,000	$6,030,000	$19,877,000	$2,504,000
CMS Net	$418,000	$146,000	$272,000	$0
Subtotal	$26,325,000	$6,176,000	$20,149,000	$2,504,000
CCS Medi-Cal				
CCS Case Management	$185,209,000	$69,620,000	$115,589,000	$0
Medi-Cal Expansion	$1,057,000	$1,057,000	$0	$0
CMS Net	$2,884,000	$1,442,000	$1,442,000	$0
Subtotal	$189,150,000	$72,119,000	$117,031,000	$0
WCM Implementation	($24,000,000)	($11,538,000)	($12,462,000)	$0
Total	**$191,475,000**	**$66,757,000**	**$124,718,000**	$2,504,000

FY 2024-25				
CCS Medi-Cal/OTLICP	**TF***	**GF**	**FF**	**CF****
CCS Case Management	$28,697,000	$6,679,000	$22,018,000	$2,774,000
CMS Net	$418,000	$146,000	$272,000	$0
Subtotal	$29,115,000	$6,825,000	$22,290,000	$2,774,000
CCS Medi-Cal				
CCS Case Management	$188,008,000	$70,672,000	$117,336,000	$0
Medi-Cal Expansion	$1,057,000	$1,057,000	$0	$0
CMS Net	$2,882,000	$1,441,000	$1,441,000	$0
Subtotal	$191,947,000	$73,170,000	$118,777,000	$0
WCM Implementation	($25,625,000)	($12,264,000)	($13,361,000)	$0
Total*	**$195,437,000**	**$67,731,000**	**$127,706,000**	$2,774,000

* Totals may differ due to rounding
** County Funds are not included in the Total Fund

CCS CASE MANAGEMENT
OTHER ADMIN. POLICY CHANGE NUMBER: 4

Funding:

FY 2023-24	TF*	GF	FF	CF**
50% FF Title XIX/50% GF (4260-101-0890/0001)	$75,237,000	$37,619,000	$37,619,000	$0
100% FF Title XXI (4260-113-0890)	$9,300,000	$0	$9,300,000	$0
100% GF Title XXI (4260-113-0001)	$2,504,000	$2,504,000	$0	$2,504,000
75% FF Title XIX/25% GF (4260-101-0890/0001)	$106,041,000	$26,510,000	$79,531,000	$0
100% GF Title XIX (4260-101-0001)	$1,057,000	$1,057,000	$0	$0
65% FF Title XXI/35% GF (4260-113-0890/0001)	($2,664,000)	($932,000)	($1,732,000)	$0
Total	**$191,475,000**	**$66,757,000**	**$124,718,000**	$2,504,000

FY 2024-25	TF*	GF	FF	CF**
50% FF Title XIX/50% GF (4260-101-0890/0001)	$75,594,000	$37,797,000	$37,797,000	$0
100% FF Title XXI (4260-101-0890)	$10,302,000	$0	$10,302,000	$0
100% GF Title XXI (4260-101-0001)	$2,774,000	$2,774,000	$0	$2,774,000
75% FF Title XIX/25% GF (4260-101-0890/0001)	$108,949,000	$27,237,000	$81,712,000	$0
100% GF Title XIX (4260-101-0001)	$1,057,000	$1,057,000	$0	$0
65% FF Title XXI/35% GF (4260-101-0890/0001)	($3,239,000)	($1,134,000)	($2,105,000)	$0
Total	**$195,437,000**	**$67,731,000**	**$127,706,000**	$2,774,000

* Totals differ due to rounding.
** County Funds are not included in the Total Fund
*** COVID-19 funding is identified in the COVID-19 Increased FMAP – Other Admin policy change

SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 5
IMPLEMENTATION DATE: 7/1992
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 235

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$139,325,000	$113,719,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$139,325,000	$113,719,000

Purpose:
This policy change budgets the federal financial participation (FFP) for claims submitted on behalf of Local Governmental Agencies (LGAs), Local Educational Consortia (LECs) and Local Educational Agencies (LEAs) for costs incurred through performing Medicaid administrative activities.

Authority:
AB 2377 (Chapter 147, Statutes of 1994)
AB 2780 (Chapter 310, Statutes of 1998)
Welfare and Institutions (W&I) Code 14132.47

Interdependent Policy Changes:
Not Applicable

Background:
AB 2377 authorized the State to implement the Medi-Cal Administrative Activities (MAA) claiming process. The Department submits claims on behalf of LGAs, which include counties and chartered cities, to obtain FFP for certified public expenditures incurred through performing Medicaid administrative activities. These activities assist Medi-Cal eligible persons to learn about, enroll in, and access services of the Medi-Cal program. AB 2780 allowed LEAs (including school districts and County Offices of Education) the option of claiming MAA through either their LECs (one of the State's eleven administrative districts) or through their LGAs.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to:

- Including the FY 2021-22 Q1 invoices that were budgeted to be paid in FY 2022-23 and will now be paid in FY 2023-24.
- Actual invoice claims received for FY 2020-21 Q2-Q4, were lower than estimated for FY 2021-22 Q2-Q4.
- Reducing the impact of the Medi-Cal Eligibility Rate (MER) percentage to only effect two quarters, which resulted in a higher estimate for FY 2023-24.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to:

- Including the FY 2021-22 Q1 invoices that were budgeted to be paid in FY 2022-23 that will be paid in FY 2023-24, which will result in five quarters being paid in FY 2023-24 and only four quarters being paid in FY 2024-25.
- Including the reduction in MER percentage to three quarters during FY 2023-24 instead of applying a reduction to four quarters.

SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 5

Methodology:

The FY 2023-24 estimate includes:

1. The FY 2021-22 Q1-Q2 amount is based on the actual invoice claims for FY 2020-21 Q1-Q2, plus a 2.77% Employment Cost Index (ECI) adjustment factor.

2. The FY 2021-22 Q3-Q4 amount is based on the actual invoice claims for FY 2020-21 Q3-Q4, plus a 2.77% ECI adjustment factor and an estimated 5% reduction due to MER percentage refinements.

3. The FY 2022-23 Q1 amounts is based on the estimated invoice claims for FY 2021-22 Q1, plus a 2.77% ECI adjustment factor and an estimated 5% reduction due to the MER percentage refinements.

The FY 2024-25 estimate includes:

1. The FY 2022-23 Q2-Q4 and FY 2023-24 Q1 amount are based on the estimated invoice claims for FY 2021-22 Q2-Q4 and FY 2022-23 Q1, plus a 2.77% ECI adjustment factor and an estimated 5% reduction due to the MER percentage refinements.

FY 2023-24	**TF**	**FF**
FY 2021-22 Q1, Q2, Q3, Q4	$117,021,000	$117,021,000
FY 2022-23 Q1	$22,304,000	$22,304,000
Total	**$139,325,000**	**$139,325,000**

FY 2024-25	**TF**	**FF**
FY 2022-23 Q2, Q3, Q4	$91,944,000	$91,944,000
FY 2023-24 Q1	$21,775,000	$21,775,000
Total	**$113,719,000**	**$113,719,000**

Funding:

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

COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 6
IMPLEMENTATION DATE: 7/1992
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 1963

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$111,244,000	$98,368,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$111,244,000	$98,368,000

Purpose:
This policy change budgets the federal financial participation (FFP) for claims submitted on behalf of local government agencies (LGAs) including Native American Indian tribes for Medicaid administrative activities.

Authority:
Welfare & Institutions Code (WIC) 14132.47

Interdependent Policy Changes:
Not Applicable

Background:
WIC 14132.47 authorizes the State to administer the County-based Medi-Cal Administrative Activities (CMAA) and Tribal Medi-Cal Administrative Activities (TMAA) claiming processes. CMAA and TMAA are voluntary programs that allow LGAs to receive federal reimbursement for allowable administrative activities upon entering into a contract with the Department. The Department submits claims on behalf of the LGAs, which includes counties and chartered cities, and Native American Indian tribes and tribal organizations to obtain FFP for certified public expenditures incurred through performing CMAA and TMAA. These activities assist Medi-Cal eligible persons to learn about, enroll in, and access services of the Medi-Cal program.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is a net decrease:

- Due to the actual billings received for reimbursement for CMAA and TMAA for FY 2021-22 Q1, and a resulting decrease in CMAA and TMAA payments expected in FY 2023-24.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is a net decrease:

- Due to actual billings received for reimbursement for CMAA and TMAA for FY 2021-22 Q1 and a resulting projected decrease in CMAA and TMAA invoices expected in FY 2024-25, as well as some FY 2021-22 Q1 invoices that were processed during the FY 2022-23 with payment dates that rolled over to FY 2023-24.

COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 6

Methodology:

County Medi-Cal Administrative Activities

1. The CMAA FY 2023-24 estimate includes the remaining FY 2021-22 Q1 to Q4 claims along with the first quarter of the FY 2022-23 claims. The FY 2021-22 Q1 to Q4 claims are based on actual claims received for Q1. The estimated base payments for FY 2022-23 claims assume a 3% growth factor from FY 2021-22, based on growth in CMAA claims from FY 2016-17 through FY 2020-21.

CMAA FY 2023-24 Estimated Payments	
FY 2021-22	$86,453,000
FY 2022-23	$24,277,000
Total	**$110,730,000**

2. The CMAA FY 2024-25 estimate includes FY 2022-23 Q2 to Q4 claims and FY 2023-24 Q1 claims. The estimated base payments for FY 2022-23 and FY 2023-24 claims assume a 3% growth factor, based on CMAA growth in claims from FY 2016-17 through FY 2020-21.

CMAA FY 2024-25 Estimated Payments	
FY 2022-23	$72,831,000
FY 2023-24	$25,006,000
Total	**$97,837,000**

Tribal Medi-Cal Administrative Activities

1. The TMAA FY 2023-24 estimate includes actual FY 2021-22 Q4 invoices and FY 2022-23 Q1, Q2 and Q3 invoices. The estimated base payments for FY 2022-23 invoices assume a 3% growth factor for FY 2022-23 Q2 based on the growth in TMAA claims from FY 2016-17 to FY 2020-21.

TMAA FY 2023-24 Estimated Payments	
FY 2021-22	$124,000
FY 2022-23	$390,000
Total	**$514,000**

COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES
OTHER ADMIN. POLICY CHANGE NUMBER: 6

2. The TMAA FY 2024-25 estimate includes FY 2022-23 Q4 and FY 2023-24 Q1, Q2, and Q3 claims. The estimated base payments for FY 2022-23 and FY 2023-24 claims assume a 3% growth factor based on growth in TMAA claims from FY 2016-2017 through FY 2020-21.

TMAA FY 2024-25 Estimated Payments	
FY 2022-23	$130,000
FY 2023-24	$401,000
Total	**$531,000**

3. Total CMAA and TMAA reimbursements for FY 2023-24 and FY 2024-25 on a cash basis are:

FY 2023-24	**TF**	**FF**
County MAA	$110,730,000	$110,730,000
Tribal MAA	$514,000	$514,000
Total	**$111,244,000**	**$111,244,000**

FY 2024-25	**TF**	**FF**
County MAA	$97,837,000	$97,837,000
Tribal MAA	$531,000	$531,000
Total	**$98,368,000**	**$98,368,000**

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

MEDI-CAL RX - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 7
IMPLEMENTATION DATE: 7/2020
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 2167

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$108,113,000	$97,701,000
STATE FUNDS	$11,235,600	$25,681,700
FEDERAL FUNDS	$96,877,400	$72,019,300

Purpose:
This policy change estimates the net cost impact of the cost of the Medi-Cal Rx administrative services contract and the prior Fee-for-Service (FFS) pharmacy claims administrator.

Authority:
Executive Order N-01-19
Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:
Medical Supply Rebates

Background:
Executive Order N-01-19 required the Department to transition Medi-Cal pharmacy services into a FFS benefit. With this change, Medi-Cal pharmacy benefits are provided and managed through Medi-Cal Rx. To facilitate and support the managed care carve-out and ongoing management of the Medi-Cal pharmacy benefit, the Department procured, Magellan Medicaid Administration, Inc., to provide administrative services for Medi-Cal Rx.

Medi-Cal Rx will provide modern pharmacy support systems, including:

- claims administration and utilization management services,
- pharmacy drug rebate administration, and
- provider and beneficiary support.

The Medi-Cal Rx Assumption of Operations (AOO) began January 1, 2022, and the Medi-Cal Rebate component is anticipated to begin no sooner than 2025.

The Department estimates a cost savings for the administrative services compared to the prior FFS pharmacy claims administration. 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 will be extended through FY 2023-24 and estimated for FY 2024-25. An additional consultant will provide contract evaluation services.

MEDI-CAL RX - ADMINISTRATIVE COSTS
OTHER ADMIN. POLICY CHANGE NUMBER: 7

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).

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

The Department will be seeking necessary federal approvals for enhanced federal funding for applicable periods and costs, as outlined below:

Vendor
FY 2023-24 and FY 2024-25:

- Vendor costs are allocated to all programs administered by Medi-Cal Rx. For Medi-Cal, the following funding is used: Title XIX at 50% FF / 50% GF, 75% FF / 25% GF, and 90% FF / 10% GF; Title XXI 65% FF / 35% GF; and 100% GF.

Consulting
FY 2023-24 and FY 2024-25:

- Consulting costs are funded at Title XIX 50% FF / 50% GF and 75% FF / 25% GF.

The policy changes (PC) related to Medi-Cal Rx are:

Regular

- Medical Supply Rebates
- Non-Hospital 340B Clinic Supplemental Payments

Other Admin

- Medi-Cal Rx – Administrative Costs

Reason for Change:
The change in FY 2023-24, from the prior estimate is due to shifting costs estimated to be paid in FY 2022-23 to be paid in FY 2023-24.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to:

- Decreased estimated expenditures due to less prior year payments in FY 2024-25, and
- An increase in FFS related administrative cost savings.

MEDI-CAL RX - ADMINISTRATIVE COSTS
OTHER ADMIN. POLICY CHANGE NUMBER: 7

Methodology:

1. Assume the prior FFS related administrative cost is an annual savings of $2,500,000 TF.

2. Contractor costs are included in FY 2023-24 and FY 2024-25.

3. Assume the federal certification of the claims operations and the rebate operations will occur separately. Assume the claims operation certification will occur by October 2023 and will be retroactive to January 2022. This allows the retroactive claiming of the claims services and the supporting contractor services to receive Title XIX 75% FF / 25% GF. This retroactive claiming for the initial claiming of Title XIX 50% FF / 50% GF is estimated to occur in March 2024.

4. The estimated cost for FY 2023-24 and FY 2024-25 is:

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
FFS Related Administrative Cost Savings	($1,150)	($287)	($863)
New Pharmacy Related Administrative Costs	$109,263	$11,523	$97,740
Total	**$108,113**	**$11,236**	**$96,877**

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
FFS Related Administrative Cost Savings	($2,500)	($625)	($1,875)
New Pharmacy Related Administrative Costs	$100,201	$26,307	$73,894
Total	**$97,701**	**$25,682**	**$72,019**

MEDI-CAL RX - ADMINISTRATIVE COSTS
OTHER ADMIN. POLICY CHANGE NUMBER: 7

Funding:
(Dollars in Thousands)

FY 2023-24	TF	GF	FF
FI 75% Title XIX / 25% GF	($1,150)	($287)	($863)
FI 75% Title XIX / 25% GF	$70,903	$17,726	$53,177
FI 50% Title XIX / 50% GF	$25,074	$12,537	$12,537
Certification -FI 50/50	($94,114)	($47,057)	($47,057)
Certification +FI 75/25	$94,114	$23,528	$70,586
FI T21 65/35	$9,386	$3,285	$6,101
FI 100% GF	$519	$519	$0
75% Title XIX / 25% GF	$2,403	$601	$1,802
65% Title XXI / 35% GF	$300	$105	$195
50% Title XIX / 50% GF	$662	$331	$331
100% GF	$16	$16	$0
FI 4.34% Title XXI FFCRA	$0	($66)	$66
4.34% Title XXI FFCRA	$0	($2)	$2
Total	**$108,113**	**$11,236**	**$96,877**

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
FI 75% Title XIX / 25% GF	($2,500)	($625)	($1,875)
FI 75% Title XIX / 25% GF	$87,701	$21,925	$65,776
FI T21 65/35	$8,576	$3,002	$5,574
FI 100% GF	$474	$474	$0
75% Title XIX / 25% GF	$3,127	$782	$2,345
65% Title XXI / 35% GF	$306	$107	$199
100% GF	$17	$17	$0
Total	**$97,701**	**$25,682**	**$72,019**

SMH MAA

OTHER ADMIN. POLICY CHANGE NUMBER: 8
IMPLEMENTATION DATE: 7/2012
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1722

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$65,188,000	$63,458,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$65,188,000	$63,458,000

Purpose:
This policy change budgets the federal funds (FF) for claims submitted on behalf of specialty mental health plans (MHPs) for Medi-Cal Administrative Activities (MAA).

Authority:
Welfare & Institutions (W&I) Code 14132.47
Assembly Bill (AB) 2377 (Chapter 147, Statutes of 1994)

Interdependent Policy Changes:
Not Applicable

Background:
AB 2377 authorized the State to implement the MAA Claiming Process. The Specialty Mental Health (SMH) waiver program submits claims on behalf of MHPs to obtain federal financial participation (FFP) for MAA necessary for the proper and efficient administration of the SMH waiver program. These activities ensure that assistance is provided to Medi-Cal eligible individuals and their families for the receipt of SMH services.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is a net increase due to:

- Lower actuals from Sacramento County;
- San Francisco County did not submit claims for FY 2021-22; and
- Alameda and San Diego Counties submitted late claims that will be paid in FY 2023-24.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to a reduced projected growth rate based on actuals.

Methodology:
1. County MHPs submit claims for reimbursement on a quarterly basis. Claims may be submitted up to six months after the close of a fiscal year.

2. Estimates for SMH MAA is based on seven years of actual claims data (from FY 2014-2015 to FY 2020-2021) and then projected out to future fiscal years using Excel's forecast model, which uses exponential smoothing.

3. Adjustments for the expected reduction in claiming for Unsatisfactory Immigration Status (UIS) population members are reflected in the State Only Claiming Adjustments policy change.

SMH MAA
OTHER ADMIN. POLICY CHANGE NUMBER: 8

4. This policy change will continue to use the current Certified Public Expenditure methodology and will not be included in the Intergovernmental Transfer methodology being implemented for the California Advancing and Innovating Medi-Cal (CalAIM).

5. Based on payment lag data and historical claims received, assume 1.60% of claims will be paid in the year services occur and 98.40% are paid in the following year. For FY 2021-22 only, claims were paid across FY 2021-22, FY 2022-23, and FY 2023-24. This is due to San Diego and Alameda counties submitting their FY 2021-22 claims late; 2 counties will have their Q3 and Q4 FY 2021-22 claims paid in FY 2023-24. Note that this only changed the cash flow for FY 2021-22; the accrual amount for FY 2021-22 is calculated as normal.

(Dollars in Thousands)

Fiscal Years	Accrual	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25
2021-22	$94,852	$1,513	$82,135	$11,204	$0
2022-23	$105,136	$0	$1,677	$103,459	$0
2023-24	$113,250	$0	$0	$1,807	$111,443
2024-25	$121,363	$0	$0	$0	$1,936
Total	$434,601	$1,513	$83,813	$116,470	$113,379

*Totals may differ due to rounding

6. The SPMP are eligible for enhanced federal reimbursement of 75%. All other personnel are eligible for 50% federal reimbursement. Based on actual claims submitted for costs incurred in FY 2021-22, assume 24.21% of costs are eligible for 75% reimbursement and the remaining 75.79% are eligible for 50% reimbursement. SMH MAA total expenditures are shared between federal funds (FF) and county funds (CF).

(Dollars in Thousands)

	FY 2023-24			FY 2024-25		
Expenditures	**TF**	**FF**	**CF**	**TF**	**FF**	**CF**
SPMP (75/25)	$27,813	$20,860	$6,953	$27,075	$20,306	$6,769
Other (50/50)	$88,656	$44,328	$44,328	$86,304	$43,152	$43,152
Total	$116,469	**$65,188**	$51,281	$113,379	**$63,458**	$49,921

*Totals may differ due to rounding

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

MHSF - PROVIDER ACES TRAININGS

OTHER ADMIN. POLICY CHANGE NUMBER: 9
IMPLEMENTATION DATE: 9/2022
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 2414

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$54,614,000	$45,500,000
STATE FUNDS	$27,307,000	$22,750,000
FEDERAL FUNDS	$27,307,000	$22,750,000

Purpose:
This policy change estimates the cost to train providers on delivering Adverse Childhood Experiences (ACEs) screenings funded with Mental Health Services Funds (MHSF).

Authority:
AB 178 (Chapter 45, Statutes of 2022)

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 MHSF. A total of $135.1 million TF ($67.55 million MHSF) was estimated over a three-year period with $44.1 million TF ($22.05 million MHSF) in FY 2022-23, $45.5 million TF ($22.75 MHSF) in FY 2023-24, and $45.5 million TF ($22.75 million MHSF) in FY 2024-25.

See the Prop 56 – Provider ACEs Trainings policy change for the training costs funded with Proposition 56 funds.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to slightly more payments were paid in FY 2022-23 resulting in slightly less payments in FY 2023-24.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to shifting the funding from FY 2022-23 to FY 2023-24 to be spent on grants for community clinics, to evaluate the grants impact and effectiveness, update clinical tools to screen in new settings, and increase capacity of ACEs Aware conference, which resulted in a higher amount of funding for FY 2023-24 compared to FY 2024-25.

MHSF - PROVIDER ACES TRAININGS

OTHER ADMIN. POLICY CHANGE NUMBER: 9

Methodology:

1. The table below displays the estimated spending and remaining funds by Appropriation Year.

	TF	MHSF	FF*
Appropriation Year 2022-23			
Prior Years	$34,986,000	$17,493,000	$17,493,000
Estimated in FY 2023-24	$9,114,000	$4,557,000	$4,557,000
Total Estimated Remaining	$0	$0	$0
Appropriation Year 2023-24			
Estimated in FY 2023-24	$45,500,000	$22,750,000	$22,750,000
Total Estimated Remaining	$0	$0	$0
Appropriation Year 2024-25			
New in FY 2024-25	$45,500,000	$22,750,000	$22,750,000
Total Estimated Remaining	$0	$0	$0

2. The provider trainings costs, funded with MHSF, are estimated to be $54,614,000 TF ($27,307,000 SF) in FY 2023-24 and $45,500,000 TF ($22,750,000 SF) in FY 2024-25.

FY 2023-24	TF	MHSF	FF*
Appropriation Year 2022-23	$9,114,000	$4,557,000	$4,557,000
Appropriation Year 2023-24	$45,500,000	$22,750,000	$22,750,000
Total FY 2023-24	**$54,614,000**	**$27,307,000**	**$27,307,000**

FY 2024-25	TF	MHSF	FF*
Appropriation Year 2024-25	$45,500,000	$22,750,000	$22,750,000
Total FY 2024-25	**$45,500,000**	**$22,750,000**	**$22,750,000**

*Federal funds authority is newly requested for the fiscal year in which funds are anticipated to be expended.

Funding:

Mental Health Services Fund (4260-101-3085)
100% Title XIX (4260-101-0890)

DRUG MEDI-CAL COUNTY ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER: 10
IMPLEMENTATION DATE: 7/2014
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 1813

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$51,565,000	$62,220,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$51,565,000	$62,220,000

Purpose:
This policy change estimates the administrative costs reimbursements for counties who provide Drug Medi-Cal (DMC) services, and Utilization Review (UR) and Quality Assurance (QA) administrative costs under the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver.

Authority:
Welfare & Institutions Code, Section 14711 and Section 14124.24(a)(6)
State Plan Amendment #09-022
Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver

Interdependent Policy Changes:
Not Applicable

Background:
The DMC program provides certain medically necessary substance use disorder (SUD) treatment services. These services are provided by providers under contract with the counties or with the State. This policy change budgets administrative costs for SUD services under the state plan and the DMC-ODS waiver.

On August 13, 2015, the Department received approval from the Centers for Medicare and Medicaid Services (CMS) to implement the DMC-ODS waiver.

DMC County Administrative Costs
Starting July 1, 2014, as instructed by the Centers for Medicare & Medicaid Services (CMS), the Department changed its process for reimbursing counties for their administrative expenses through a quarterly claims and cost settlement process. Prior to that, counties were paid for their DMC expenses (services and administration) through certified public expenditure (CPE) as part of an all-inclusive rate.

Effective FY 2014-15, the DMC county administrative reimbursement process was changed as follows:

- Quarterly Interim Claims – Counties send their quarterly claims invoices no later than 60 days after the end of the quarter and were reimbursed federal financial participation (FFP) based on their total expenses. Costs are limited to a maximum of 15% of services provided. This process is optional for participating counties.

DRUG MEDI-CAL COUNTY ADMINISTRATION
OTHER ADMIN. POLICY CHANGE NUMBER: 10

- Annual Cost Settlement - At the end of the fiscal year, counties are required to submit their cost report and year-end administrative expense report. Cost settlements are based on comparing actual expenditures against the audited cost reports.
- Audit Settlement – The Department has the authority to audit the cost reports within three years of the cost settlement.

DMC County UR and QA Administrative Costs
DMC-ODS waiver services include the existing treatment modalities (ODF, IOT, NTP, and Perinatal RTS), and the additional new and expanded services. Participation in the waiver is voluntary for counties and implementation is estimated on a phase-in basis beginning February 2017. Counties that opt-in to participate in the DMC-ODS waiver may also opt-in to implement UR and QA activities to safeguard against unnecessary and inappropriate medical care and expenses. Federal funds (FF) reimbursement for these costs is available at 75% for skilled professional medical personnel (SPMP) and 50% for all other personnel.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is a net decrease due to the following:
- Higher county admin and UR and QA admin claims projections based on actual claims received.
- Decreased annual settlement claims due to claims originally forecasted to be paid in FY 2022-23 shifting to FY 2023-24, due to a delay in processing the audited cost reports.
- Removal of the inter-governmental transfers (IGTs) which were previously budgeted to fund for costs incurred beginning July 1, 2023.

The change in the current estimate, from FY 2023-24 to FY 2024-25, is an increase due to FY 2024-25 including more prior year claims.

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. The estimated DMC county administration, annual settlement, and UR and QA administration costs for FY 2023-24 and FY 2024-25 are:

(Dollars in Thousands)

DMC County Admin.	Accrual	FY 2023-24	FY 2024-25
FY 2021-22 Claims	$16,684	$8,759	$1,668
FY 2022-23 Claims	$18,205	$6,827	$9,558
FY 2023-24 Claims	$19,726	$10,356	$7,397
FY 2024-25 Claims	$21,248	$0	$7,968
Total		$25,942	$26,591

DRUG MEDI-CAL COUNTY ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER: 10

(Dollars in Thousands)

Annual Settlements	Accrual	FY 2023-24	FY 2024-25
FY 2016-17 Claims	$26,366	$15,820	$0
FY 2017-18 Claims	$27,157	$13,340	$13,817
FY 2018-19 Claims	$27,972	$12,268	$15,703
FY 2019-20 Claims	$28,811	$0	$28,811
Total		$41,428	$58,331

(Dollars in Thousands)

DMC UR and QA Admin.	Accrual	FY 2023-24	FY 2024-25
FY 2021-22 Claims	$14,694	$7,714	$1,469
FY 2022-23 Claims	$18,251	$6,844	$9,582
FY 2023-24 Claims	$21,808	$11,449	$8,178
FY 2024-25 Claims	$25,366	$0	$9,512
Total		$26,007	$28,741

(Dollars in Thousands)

FY 2023-24	TF	FF	CF
County Administration	$25,942	$12,971	$12,971
UR and QA Administration	$26,007	$17,880	$8,127
Annual Settlements	$41,428	$20,714	$20,714
Total	$93,377	**$51,565**	$41,812

(Dollars in Thousands)

FY 2024-25	TF	FF	CF
County Administration	$26,591	$13,295	$13,296
UR and QA Administration	$28,741	$19,759	$8,982
Annual Settlements	$58,331	$29,166	$29,165
Total	$113,663	**$62,220**	$51,443

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

CALAIM - POPULATION HEALTH MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 11
IMPLEMENTATION DATE: 7/2022
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 2288

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$49,601,000	$52,668,000
STATE FUNDS	$4,960,100	$5,266,800
FEDERAL FUNDS	$44,640,900	$47,401,200

Purpose:
This policy change estimates the cost for creating the Population Health Management (PHM) service under the California Advancing and Innovating Medi-Cal (CalAIM) policy.

Authority:
SB 129 (Chapter 69, Statutes of 2021)

Interdependent Policy Changes:
Not applicable

Background:
In alignment with the CalAIM Population Health Management strategy, the Department implemented a Medi-Cal Population Health Management service that utilizes Medi-Cal administrative and clinical data and information for the Department, Managed Care Plans, counties, providers, members, and other Department partners to use in support of the delivery of care for all of Medi-Cal members. Information is available from many Medi-Cal delivery systems and programs, including but not limited to managed care, fee-for-service, specialty mental health, substance use disorder, dental services, long term services & supports, developmental disability services, in-home supportive services (IHSS), 1915c Waivers, Supplemental Nutrition Assistance Program (SNAP), Women, Infants, and Children (WIC), In Lieu of Services (ILOS), and Lab links. This service provides the Department and others with access to identifications of potential gaps in care, provider/care manager information, information on social determinates of health, population health analytics, health education, and tips for members. Additionally, the service provides Medi-Cal members with access to their administrative and clinical information, as appropriate. Clinical data will phase in over time.

Throughout the Medi-Cal program many of the services provided are provided and maintained through individual administrative functions and there is not currently a single process to bring these services together and provide a holistic approach to delivering Medi-Cal to Californians.

Population Health Management provides a service to access necessary information for many different parties and utilizing standard policies. The service will limit the burden on Medi-Cal members when receiving services and support many programs in Medi-Cal through a standardized approach. Additionally, this service with allow the Department to have an elevated view of the care provided to Medi-Cal members.

CALAIM - POPULATION HEALTH MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 11

Reason for Change:
The change from the prior estimate, for FY 2023-24, is a decrease due to updated contract costs. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to the inclusion of a full year of contract-related expenditures.

Methodology:

1. The Budget Act for 2021-22 provides $30 million from the General Fund and $270 million in federal funds for this service, available to be spent through June 30, 2024. The table below displays the estimated spending and remaining funds by Appropriation Year:

	TF	GF	FF
Appropriation Year 2021-22			
Estimated in FY 2023-24	$49,601,000	$4,960,000	$44,641,000
Estimated in FY 2024-25*	$52,668,000	$5,267,000	$47,401,000
Total Estimated Remaining*	$197,731,000	$19,773,000	$177,958,000

*Funds estimated for FY 2024-25 as well as any remaining funds originally appropriated in FY 2021-22 will need to be reappropriated for use through calendar year 2026.

2. On a cash basis, costs for the procurement of this service and initial implementation cost assumed for the vendor are estimated to be:

Fiscal Year	TF	GF	FF
FY 2023-24	**$49,601,000**	**$4,960,000**	**$44,641,000**
FY 2024-25	**$52,668,000**	**$5,267,000**	**$47,401,000**

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

COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE

OTHER ADMIN. POLICY CHANGE NUMBER: 12
IMPLEMENTATION DATE: 10/2023
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2334

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$48,143,000	$51,152,000
STATE FUNDS	$28,942,000	$30,751,000
FEDERAL FUNDS	$19,201,000	$20,401,000

Purpose:
This policy change estimates the costs for funding counties to implement changes to stay in compliance with the federal data exchange standards and regulations of the Interoperability Final Rule.

Authority:
Interoperability Final Rule (CMS-9115-F)
Behavioral Health Information Notice (BHIN): 22-068

Interdependent Policy Changes:
Not Applicable

Background:
On May 1, 2020, the Centers for Medicare and Medicaid Services (CMS) published the "Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, and Health Care Providers," (referred to as "CMS Interoperability and Patient Access final rule") to further advance interoperability for Medicaid and CHIP providers and improve members access to their data. State Medicaid agencies, Medicaid managed care plans, CHIP agencies, and CHIP managed care entities must implement this final rule in a manner consistent with existing guidance and the recently published "21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program" final rule (referred to as the ONC 21st Century Cures Act final rule), by the Office of the National Coordinator for Health Information Technology, published in the Federal Register on May 1, 2020.

The CMS Interoperability Rule requires Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) counties, hereafter referred to as Behavioral Health Plans (BHPs), to implement and maintain a secure, standards-based Patient Access Application Programming Interface (API) and a publicly accessible, standards-based Provider Directory API that can connect to mobile applications and be available through a public-facing digital endpoint on each BHP's website. BHPs must also comply with 42 Code of Federal Regulations (CFR) 438.242, 45 CFR 170.215, the provider directory information requirements specified in 42 CFR 438.10, and the public reporting and information blocking components of the CMS Interoperability Rule 45 CFR Part 171.

COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE

OTHER ADMIN. POLICY CHANGE NUMBER: 12

The CMS Interoperability and Patient Access final rule requires Medicaid managed care plans and CHIP managed care entities to comply with a members request to have their health data transferred from payer to payer by January 1, 2022. Given the federal mandate, this proposal results in a Proposition 30 impact where the non-federal share of costs for counties to come into compliance is split between counties and the state. Federal law already requires Medicaid managed care plans to comply with the data exchange standards and regulations, which includes various Medi-Cal programs including the Medi-Cal BHPs. The Department began verifying compliance for these requirements starting July 1, 2023.

Reason for Change:
There is no change, from the prior estimate, in FY 2023-24. The change in the current estimate, from FY 2023-24 to FY 2024-25, is due to FY 2024-25 including a full year's cost.

Methodology:
1. Assume reimbursements to counties for incurred expenses began in October 2023.

2. Total estimated costs to implement interoperability final rule is estimated to be $168,358,000 TF ($48,002,000 GF).

3. The estimated payments in FY 2023-24 and FY 2024-25, on a cash basis, is as follows:

(Dollars in Thousands)

Interoperability Final Rule	TF	GF	FF	CF
FY 2023-24	$67,344	**$28,942**	**$19,201**	$19,201
FY 2024-25	$71,553	**$30,751**	**$20,401**	$20,401

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

OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 13
IMPLEMENTATION DATE: 1/2013
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 1748

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$46,045,000	$43,345,000
STATE FUNDS	$23,312,350	$21,910,800
FEDERAL FUNDS	$22,732,650	$21,434,200

Purpose:
This policy change estimates the contract costs and other administrative vendor services for the Optional Targeted Low Income Children Program (OTLICP), Medi-Cal Access Program (MCAP), and Medi-Cal special populations.

Authority:
AB 1494 (Chapter 28, Statutes of 2012)
AB 89 (Chapter 7, Statutes of 2020)
AB 179 (Chapter 249, Statutes of 2022)
Health Services Advisory Group, Inc. Contract 20-10359
Maximus Contract 12-89315 A12

Interdependent Policy Changes:
COVID-19 Increased FMAP – Other Admin

Background:
Effective January 1, 2013, the Managed Risk Medical Insurance Board (MRMIB) contracted with MAXIMUS for Single Point of Entry (SPE) application services and other administrative vendor services for the Healthy Families Program (HFP), Access for Infants and Mothers (AIM), and Child Health and Disability Prevention (CHDP) Gateway.

HFP subscribers began transitioning into Medi-Cal as OTLICP starting January 1, 2013. Completed applications were sent to the SPE for screening and forwarded to the county welfare departments (CWD) for a Medi-Cal eligibility determination for the children's percent programs or to the new OTLICP.

The AIM infants above 250% of the federal poverty level began transitioning into Medi-Cal Access Infants Program beginning November 1, 2013, through February 1, 2014. The AIM Program was transitioned from MRMIB to the Department as of July 1, 2014, and renamed MCAP.

The Department instructed MAXIMUS to close out SPE for HFP and CHDP Gateway effective January 1, 2014, and to refer applicants to the application portal and toll-free line to Covered California. MAXIMUS completed the shutdown process in FY 2013-14.

Effective July 1, 2014, all MRMIB programs, including the MAXIMUS contract, transitioned to the Department. Since the transition, MAXIMUS has provided administrative vendor services for MCAP and OTLICP. Due to application availability in the community, MAXIMUS forwards any

OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS
OTHER ADMIN. POLICY CHANGE NUMBER: 13

HFP applications it receives to the appropriate CWDs for a determination without the benefit of screening for accelerated enrollment.

The Department transitioned the HFP and Children's Health Insurance Program (CHIP) into the Medi-Cal program in September 2013. The Title XXI CHIP program requires the State to contract with an External Quality Review Organization (EQRO) to validate performance measures, evaluate performance improvement projects, conduct focus studies, monitor encounter data activities, conduct an annual survey, and perform other EQRO activities for the duration of the contract. In July 2014, the Department became responsible for having the EQRO conduct the annual survey and other EQRO activities under the terms of the contract.

Administrative vendor services include costs for the following services: application processing, call center rate per minute, transaction forwarding fee, processing letters and notices, printing and courier fees, and implementation costs. Effective January 2017, administrative costs include publication costs for Medi-Cal special populations. Publication costs include developing, editing, updating, and performing readability evaluation of beneficiary materials as well as translation, printing, mailing, shipping, and focus group testing services that were previously budgeted in the HCO Cost Reimbursement policy change. Per AB 128 (Chapter 21, Statutes of 2021), the Department will look to include contract support to conduct field testing of Medi-Cal materials into other threshold languages for cultural accuracy and appropriateness.

Effective October 1, 2019, the Department transitioned the administrative functions for the County Children Health Initiative Program (CCHIP) to the state's administrative vendor, MAXIMUS. These administrative functions include case management and premium collection for CCHIP. The additional costs for the increased scope of work is budgeted through the current MAXIMUS contract through this policy change.

Effective July 1, 2021, AB 89 (Chapter 7, Statutes of 2020) authorized the Hearing Aid Coverage for Children Program (HACCP). This new state-only program serves California children who are not eligible for Medi-Cal and/or hearing-related coverage through California Children's Services Program (CCS) and live in a household with income up to 600% of the federal poverty level. HACCP was initially available to children under 18 without insurance or whose insurance does not cover hearing aids and related services. Effective January 1, 2023, AB 179 (Chapter 249, Statutes of 2022) expanded the age criteria for HACCP to children under the age of 21, and broadened coverage to children who had other insurance with coverage of $1,500 or less for hearing aids. Effective July 1, 2021, the Department awarded a Non-Competitive Bid to the existing vendor to administer this program.

The MAXIMUS contract was amended to remove premium collection services due to SB 184 (Omnibus Health Bill 2022), which authorized the Department to reduce premiums for Medi-Cal programs to zero.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is an increase due to funds shifting from FY 2022-23 for invoice processing delays related to member mailings for the public health emergency unwinding. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to projected lower overall contract costs.

OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 13

Methodology:

1. This estimate is based on an average of actual usage and processing of the applications, postage, and vendor contract rates and services.

2. Contract costs are eligible for Title XXI 65/35 FMAP, and Title XIX 50/50 FMAP. The EQRO contract cost is eligible for Title XIX 50/50 FMAP only. The HACCP costs are eligible for 100% GF.

2. Administrative vendor services costs are eligible for Title XIX 50/50 FMAP.

3. Contract costs and administrative vendor service costs by program are as follows:

(Dollars in Thousands)

Program	FY 2023-24	FY 2024-25
OTLICP	$10,537	$9,783
MCAP	$5,397	$5,138
CCHIP	$4,418	$4,241
HACCP	$3,961	$3,656

4. Contract costs and administrative vendor service costs by cost category are as follows:

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
Applications Processing, Printing and Courier Services, Letters and Notices, Transaction Forwarding Fee	$3,113	$1,556	$1,556
Call Minute Rate per Minute	$3,238	$1,619	$1,619
Contract Costs	$12,001	$4,310	$7,691
Hearing Aid Coverage for Children Program	$3,961	$3,961	$0
Implementation Costs	$2,000	$1,000	$1,000
Medi-Cal Publications	$21,732	$10,866	$10,866
Total	**$46,045**	**$23,312**	**$22,732**

OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 13

FY 2024-25	TF	GF	FF
Applications Processing, Printing and Courier Services, Letters and Notices, Transaction Forwarding Fee	$2,846	$1,423	$1,423
Call Minute Rate per Minute	$2,989	$1,494	$1,494
Contract Costs	$11,328	$4,074	$7,253
Hearing Aid Coverage for Children Program	$3,656	$3,656	$0
Implementation Costs	$2,000	$1,000	$1,000
Medi-Cal Publications	$20,526	$10,263	$10,263
Total	**$43,345**	**$21,910**	**$21,433**

* Totals may differ due to rounding.

Funding:

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890/0001)	$30,813	$15,406	$15,406
65% Title XXI / 35% GF (4260-101-0890/0001)	$11,271	$3,945	$7,326
100% GF (4260-101-0001)	$3,961	$3,961	$0
Total	**$46,045**	**$23,312**	**$22,732**

FY 2024-25	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890/0001)	$29,091	$14,545	$14,545
65% Title XXI / 35% GF (4260-101-0890/0001)	$10,598	$3,709	$6,889
100% GF (4260-101-0001)	$3,656	$3,656	$0
Total	**$43,345**	**$21,910**	**$21,433**

* Totals may differ due to rounding.

** COVID-19 funding is identified in the COVID-19 Increased FMAP – Other Admin policy change

INTERIM AND FINAL COST SETTLEMENTS-SMHS

OTHER ADMIN. POLICY CHANGE NUMBER: 14
IMPLEMENTATION DATE: 7/2016
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1757

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$39,627,000	$40,577,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$39,627,000	$40,577,000

Purpose:
This policy change estimates the federal funds (FF) for the interim and final cost settlements on Specialty Mental Health Services (SMHS) administrative expenditures.

Authority:
Welfare & Institutions (W&I) Code 14705(c)

Interdependent Policy Changes:
Not Applicable

Background:
The Department reconciles interim payments to county cost reports for mental health plans (MHPs) for utilization review/quality assurance (UR/QA), mental health Medi-Cal administrative activities (MH MAA), and administration. The Department completes these interim settlements within two years of the end of the fiscal year. Final settlements are completed within three years of the last amended cost report the county MHPs submit to the Department.

The reconciliation process for each fiscal year may result in an overpayment or an underpayment to the county and will be handled as follows:

- For counties that have been determined to be overpaid, the Department will recoup any overpayments.
- For counties that have been determined to be underpaid, the Department will reimburse the federal funds.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is a decrease due to lower than expected actual interim and final audit settlements received, so projected settlements were reduced.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is a slight increase due to an expected higher cost per settlement.

Methodology:
1. Interim cost settlements are based on the difference between each county MHP's filed cost report and the payments they received from the Department.

2. Final audit settlements are based on the difference between each county MHP's final audited cost report and the payments they received from the Department.

INTERIM AND FINAL COST SETTLEMENTS-SMHS
OTHER ADMIN. POLICY CHANGE NUMBER: 14

3. Cost settlements for administration, UR/QA, and MH MAA are each determined separately.

4. To estimate the expected expenditures for FY 2023-24 and FY 2024-25 for interim and final audit settlements not yet received, the following procedures are used:

   - The average expenditure of $1,043,000 per interim settlement is determined by dividing the actual net outflow of $84,537,000 from FY 2020-21 by 81, the number of interim settlements processed in FY 2020-21. The average recoupment of $155,000 per final audit settlement is determined by dividing the net inflow, $5,564,000, by 36, the number of final audit settlements processed in FY 2020-21. This average expenditure was reduced by $150,000 to account for a reduction in recoupable amounts resulting from the narrowing of final audits by Audits and Investigations (A&I). The resulting recoupment amount per final audit settlement is estimated to be $5,000 per settlement.

   - 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.

   - The percentage of each fund type of settlements processed in FY 2020-21 was used to determine the estimated amounts of Title XIX and Title XXI for the interim and final audit settlement types for FY 2023-24 and FY 2024-25. Assuming that FY 2023-24 and FY 2024-25 estimated settlements will follow the same funding trends, the total estimated amount for each settlement type per fiscal year is multiplied by the percentages representing the Title XIX and Title XXI funding splits.

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 2023-24 and FY 2024-25.

6. The net FF to be reimbursed and/or recouped in FY 2023-24 for interim settlements and final audit settlements is shown below:

(Dollars in Thousands)

Interim Settlements	Total FF	Title XIX FF	Title XXI FF
FY 2015-16	$15,050	$15,081	($31)
FY 2016-17	$19,930	$19,971	($41)
FY 2018-19	$2,349	$2,354	($5)
FY 2019-20	$2,420	$2,425	($5)
Subtotal	$39,749	$39,831	($82)

INTERIM AND FINAL COST SETTLEMENTS-SMHS
OTHER ADMIN. POLICY CHANGE NUMBER: 14

(Dollars in Thousands)

Final Audit Settlements	Total FF	Title XIX FF	Title XXI FF
FY 2015-16	($105)	($107)	$2
FY 2018-19	($11)	($11)	$0
FY 2019-20	($6)	($6)	$0
Subtotal	($122)	($124)	$2
Total FY 2023-24	**$39,627**	**$39,707**	**($80)**

7. The net FF to be reimbursed and/or recouped in FY 2024-25 for interim settlements and final audit settlements is shown below:

(Dollars in Thousands)

Interim Settlements	Total FF	Title XIX FF	Title XXI FF
FY 2015-16	$17,200	$17,235	($35)
FY 2016-17	$2,214	$2,219	($5)
FY 2018-19	$16,445	$16,479	($34)
FY 2019-20	$4,840	$4,850	($10)
Subtotal	$40,699	$40,783	($84)

(Dollars in Thousands)

Final Audit Settlements	Total FF	Title XIX FF	Title XXI FF
FY 2015-16	($99)	($102)	$3
FY 2018-19	($17)	($17)	$0
FY 2019-20	($6)	($6)	$0
Subtotal	($122)	($125)	$3
Total FY 2024-25	**$40,577**	**$40,658**	**($81)**

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

ACTUARIAL COSTS FOR RATE DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 15
IMPLEMENTATION DATE: 8/2015
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1937

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$34,275,000	$37,275,000
STATE FUNDS	$17,137,500	$18,637,500
FEDERAL FUNDS	$17,137,500	$18,637,500

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:
The change from the prior estimate, for FY 2023-24, is an increase due to the inclusion of consulting actuaries' expenses for litigation-related matters beginning in FY 2023-24. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to an increase in actuarial workload related to rate development and the shift of covered services and populations into the managed care delivery system.

ACTUARIAL COSTS FOR RATE DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 15

Methodology:

1. This policy change collectively budgets for all actuarial services received for different managed care programs.

2. Per payment terms, 10% of the contractor's fees are withheld for six months pending completion of outstanding projects.

3. Per payment terms, the contractor fees overlap fiscal years due to billing for projects in the subsequent invoice month.

4. Specific costs are identified for existing workloads Hospital Quality Assurance Fee (HQAF) program and Consulting Actuaries costs; however, ongoing actuarial services are needed as these, and other new programs are integrated into the overall managed care delivery system rate setting process.

5. Actuarial costs related to the AB 1705 GEMT Public Provider IGT Program are paid using State GF, but supported by a 10% administrative fee that applies to AB 1705 IGT collections. These amounts are captured in Ongoing Actuarial Services.

6. The FY 2023-24 and FY 2024-25 amounts on an accrual basis are estimated to be:

Policy	FY 2023-24	FY 2024-25
Ongoing Actuarial Services	$32,700,000	$35,700,000
HQAF Program	$300,000	$300,000
Consulting Actuaries	$2,100,000	$2,100,000
Total	**$35,100,000**	**$38,100,000**

The FY 2023-24 and FY 2024-25 amounts on a cash basis are estimated to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	HQAF	FF
FY 2023-24	**$34,275**	**$16,988**	**$150**	**$17,138**
FY 2024-25	**$37,275**	**$18,488**	**$150**	**$18,638**

Funding:

50% Title XIX FF / 50% GF (4260-101-0890/0001)
Hospital Quality Assurance Revenue Fund (4260-611-3158)

CHDP COUNTY ALLOCATION

OTHER ADMIN. POLICY CHANGE NUMBER: 16
IMPLEMENTATION DATE: 7/1996
ANALYST: Celine Donaldson
FISCAL REFERENCE NUMBER: 229

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$33,962,000	$0
STATE FUNDS	$10,575,000	$0
FEDERAL FUNDS	$23,387,000	$0

Purpose:
This policy change estimates the county allocation for the Child Health and Disability Prevention (CHDP) Program activities.

Authority:
Health & Safety Code 124075(a), 124025-124110
California Code of Regulations Subchapter 13
SB 75 (Chapter 709, Statutes of 2015)

Interdependent Policy Changes:
CLPP Fund

Background:
The CHDP County Allocation is provided to individual local government agencies and controlled on an accrual basis. The purpose of the funding is for local government activities for CHDP care management and conducting CHDP provider oversight, training and enrollment.

Medi-Cal eligible children are entitled to Title XIX EPSDT provisions, including access to case management services. Most children in Medi-Cal receive these care management services through their Medi-Cal managed care plan. CHDP provides care management to children and youth who are uninsured or enrolled in Fee-for-Service Medi-Cal. In addition, eligible children receive care management services through county California Children's Services (CCS) programs, county Health Care Program for Children in Foster Care programs, home and community based service wavier providers and county behavioral health programs.

Per signed Budget Trailer Bill SB 184, the sunset of the CHDP Program and the implementation of the Children's Presumptive Eligibility Program will be effective July 1, 2024. DHCS launched the stakeholder engagement process on September 22, 2022. The process will inform DHCS in the development and implementation of a transition plan and defined milestones to guide the transition of CHDP to other existing Medi-Cal delivery systems or services. DHCS shall strive to ensure the stakeholder engagement process reflects participation from the various regions throughout the state, including large urban and rural jurisdictions.

CHDP COUNTY ALLOCATION
OTHER ADMIN. POLICY CHANGE NUMBER: 16

DHCS will facilitate the transition of the following current CHDP activities and responsibilities into existing Medi-Cal systems:

- Medi-Cal for Kids & Teens formerly known as Early and Periodic Screening, Diagnostic, and Treatment benefits
- Coordination of care, including dental and behavioral health services
- Presumptive eligibility
- Provider oversight and training
- CHDP - HCPCFC and CCS program activities

  DHCS will redirect the entire CHDP budget allocation to fund the administrative and services costs of the Health Care Program for Children in Foster Care (HCPCFC) and the CCS Program to support retention of existing local CHDP positions through the exploration of new partnerships and roles and/or through bolstering existing programs that can leverage CHDP expertise.

Reason for Change:
There is no change from the prior estimate for FY 2023-24.

The change between fiscal years in the current estimate is due to the CHDP Program sunset July 1, 2024. These funds are being redirected to the HCPCFC and CCS Programs.

Methodology:

The allocation amount for FY 2023-24 is $33,962,000 ($10,575,000 GF)

Funding:

FY 2023-24	TF	GF	FF	County Funds
Title XIX (50% FF / 50% GF)	$13,338,000	$6,669,000	$6,669,000	
Title XIX (75% FF / 25% GF)	$15,624,000	$3,906,000	$11,718,000	
Title XIX (100% FF)	$5,000,000	$0	$5,000,000	$5,000,000
Total	**$33,962,000**	**$10,575,000**	**$23,387,000**	**$5,000,000**

ENTERPRISE DATA ENVIRONMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 17
IMPLEMENTATION DATE: 7/2002
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 252

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$33,555,000	$44,232,000
STATE FUNDS	$8,988,300	$11,800,150
FEDERAL FUNDS	$24,566,700	$32,431,850

Purpose:
The policy change was previously named Data Reporting and Analytics Support Systems, but has now been renamed the Enterprise Data Environment (EDE). The policy change estimates the contract costs associated with EDE. EDE includes the Management Information System/Decision Support System (MIS/DSS), Management Administration Reporting Subsystem (MARS), Surveillance Utilization Reporting System (SURS), Enterprise Data Platform (EDP), and MIS/DSS Digital Support Services (MIS/DSS DSS).

Authority:
Contract #14-90129 A04
Centers for Medicaid Services (CMS) Transformed Medicaid Statistical Information System (T-MSIS) Requirements
Contract #21-10284
Contract #23-30004

Interdependent Policy Changes:
COVID-19 Increased FMAP – Other Admin

Background:
EDE manages a variety of Medicaid-related data and incorporate it into an integrated business intelligence system. The MIS/DSS, MARS, SURS, and EDP are critical components of gathering the insight necessary to make recommendations; adjust strategic initiatives; and better capture revenue. Data is a critical component of good decision-making; and good decision-making comes from comprehensive reporting, effective analytics, and subsequent implementation.

These systems are used by more than 20 different areas within the Department (i.e., Audits & Investigations, Managed Care Operations, Pharmacy Benefits, Provider Enrollment, Integrated Systems of Care, Third Party Liability and Recovery, and Accounting), several other State departments, such as the California Department of Public Health and the Department of Justice, and other approved entities. The Department uses these systems in various ways, including:

- CMS Reporting
- The Managed Care Quality and Monitoring Division in its monitoring of health plan performance,
- The Third-Party Liability and Recovery Division in its collection efforts, and
- The Audits and Investigations Division in its anti-fraud efforts.

ENTERPRISE DATA ENVIRONMENT
OTHER ADMIN. POLICY CHANGE NUMBER: 17

Ongoing maintenance and operations (M&O) are accomplished through a multi-year contract. This contract includes M&O of the data warehouse, help desk support, training, and refreshing of hardware and software to maintain peak performance.

The SURS subsystem was implemented on April 3, 2017, and the MARS subsystem was implemented on February 15, 2019. CMS requires implemented projects to be funded at 50%/ 50% Federal Medical Assistance Percentage until certified. Both systems received certification on August 31, 2020. The systems are now receiving enhanced funding of 75%/25%. The Department received CMS approval for the recoupment of $5,010,000 in enhanced funding for MARS and SURS; this was completed in March 2023.

The primary contract with Optum (MIS/DSS, MARS, and SURS) will expire in June 2025. Amendment 4 addresses mandatory mission-critical state and federal requirements that influence the volume and complexity of data to be stored in the warehouse. The increased data will accommodate larger operational data loads, which satisfy T-MSIS requirements now mandated by CMS.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due to hardware and software costs and the volume and complexity of data stored in the warehouse required by Amendment #4 costs. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to the execution of EDP and MIS/DSS DSS contracts and vendor turnover/takeover activities.

Methodology:
1. Optum contract (MIS/DSS, MARS, and SURS) Amendment #4 costs began in September 2022, and will end on June 30, 2025. The contract included a two-year extension from the date of the original contract.

2. The Department is currently working to procure a new EDP 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 MIS/DSS DSS contract to provide product management, technical management, and business management services to EDE in support of the product owners and product managers' responsibilities. There are three one-year optional contract extensions.

4. The estimated breakdown of the SURS, MARS, MIS/DSS, EDP, and MIS/DSS DSS costs are:

ENTERPRISE DATA ENVIRONMENT
OTHER ADMIN. POLICY CHANGE NUMBER: 17

Subsystem	FY 2023-24	FY 2024-25
SURS Operational Costs (75%/25%)	$7,414,000	$6,262,000
MARS Operational Costs (75%/25%)	$2,564,000	$2,048,000
MIS/DSS Operational Costs (75%/25%)	$17,805,000	$14,338,000
MIS/DSS Operational Costs (50%/50%)	$735,000	$755,000
EDP Operational Costs (75%/25%)	$2,254,000	$16,655,000
MIS/DSS DSS Operational Costs (75%/25%)	$2,783,000	$4,174,000
Total	**$33,555,000**	**$44,232,000**

5. The estimated breakdown of the SURS, MARS, MIS/DSS, EDP, and MIS/DSS DSS costs are:

SURS, MARS, MIS/DSS, EDP, and MIS/DSS DSS	TF	GF	FF
Operational Costs (75%/25%)	$29,735,000	$7,433,000	$22,302,000
Operational Costs (65%/35%)	$2,973,000	$1,041,000	$1,932,000
Operational Costs (50%/50%)	$666,000	$333,000	$333,000
100% State Fund	$181,000	$181,000	$0
Total FY 2023-24	**$33,555,000**	**$8,988,000**	**$24,567,000**

SURS, MARS, MIS/DSS, EDP, and MIS/DSS DSS	TF	GF	FF
Operational Costs (75%/25%)	$39,390,000	$9,847,000	$29,543,000
Operational Costs (65%/35%)	$3,919,000	$1,372,000	$2,547,000
Operational Costs (50%/50%)	$684,000	$342,000	$342,000
100% State Fund	$239,000	$239,000	$0
Total 2024-25	**$44,232,000**	**$11,800,000**	**$32,432,000**

Funding:
50% Title XIX / 50% GF (4260-101-0890/0001)
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% GF (4260-101-0001)
COVID-19 funding is identified in the COVID-19 Increased FMAP – Other Admin policy change

POSTAGE & PRINTING

OTHER ADMIN. POLICY CHANGE NUMBER: 18
IMPLEMENTATION DATE: 7/1993
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 231

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$33,425,000	$33,425,000
STATE FUNDS	$16,841,000	$16,841,000
FEDERAL FUNDS	$16,584,000	$16,584,000

Purpose:
This policy change budgets postage and printing costs for items sent to or used by Medi-Cal members.

Authority:
Welfare & Institutions Code 14103.6, 14124.5, and 10725
Title 42, Code of Federal Regulations (CFR), Section 435.905
Title 45, Code of Federal Regulations (CFR), Section 164.520
Title 26, Code of Federal Regulations (CFR), Section 1.6055
California Revenue and Tax Code § 61005

Interdependent Policy Changes:
Not Applicable

Background:
Costs for the mailing of various legal notices and the costs for forms used in determining eligibility and available third party resources are budgeted in the local assistance item since these costs are caseload driven. Under the federal Health Insurance Portability and Accountability Act (HIPAA), it is a legal obligation of the Medi-Cal program to send out a Notice of Privacy Practices (NPP) to each 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

POSTAGE & PRINTING
OTHER ADMIN. POLICY CHANGE NUMBER: 18

and/or be paid for some of these services. The form a provider uses to request authorization is called a Treatment Authorization Request (TAR).

Costs for the printing and postage of notices and letters for the State-funded component of the BCCTP and the printing of EITC notices are 100% general fund (GF). 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 2023-24, is an increase due to an increase in postage costs. There is no change from FY 2023-24 to FY 2024-25 in the current estimate.

Methodology:
1. Based on actuals, the reported population receiving Form 1095-B mailings for FY 2023-24 is assumed to be 14,200,000.

2. Assume that the cost per mailing is $0.85:

   14,200,000 mailings x $0.85 per mailing = $12,070,000 (rounded)

3. Based on FY 2022-23 actuals, assume that 3% of 1095-B forms are resent due to member request for reprints or for corrected 1095-Bs. The cost to send a reprint/correction is $0.85 per unit.

   3% x 14,200,000 mailings = 426,000 returned mailings

   426,000 returned mailings x $0.85 per unit = $362,000 (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 $0.85 per unit and based on FY 2021-22 actuals, assume 133,000 mailers will be sent out to members.

   133,000 mailings x $.85 per mailing = $113,000 (rounded)

5. TAR postage costs for Medi-Cal are assumed to be $80,000 for FY 2023-24 and FY 2024-25.

6. Office of State Publishing costs for printing Family Planning, Access, Care, and Treatment program brochures are assumed to be $150,000 in FY 2023-24 and FY 2024-25.

7. The Department estimates the printing and postage costs for FY 2023-24 and FY 2024-25 are:

POSTAGE & PRINTING

OTHER ADMIN. POLICY CHANGE NUMBER: 18

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
Base Mass Mailing	$18,200	$9,229	$8,971
1095B			
1095 Mailings	$12,070	$6,035	$6,035
Reprinted/Corrected Form 1095-B	$362	$181	$181
Notice for Requested Action	$113	$57	$56
1095 B Subtotal	$12,545	$6,273	$6,272
Emergency Mailings	$2,600	$1,300	$1,300
TAR Postage	$80	$40	$40
Total	**$33,425**	**$16,842**	**$16,583**
FY 2024-25	**TF**	**GF**	**FF**
Base Mass Mailing	$18,200	$9,229	$8,971
1095B			
1095 Mailings	$12,070	$6,035	$6,035
Reprinted/Corrected Form 1095-B	$362	$181	$181
Notice for Requested Action	$113	$57	$56
1095 B Subtotal	$12,545	$6,273	$6,272
Emergency Mailings	$2,600	$1,300	$1,300
TAR Postage	$80	$40	$40
Total	**$33,425**	**$16,842**	**$16,583**

*Totals may differ due to rounding.

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

MEDI-CAL RECOVERY CONTRACTS

OTHER ADMIN. POLICY CHANGE NUMBER: 19
IMPLEMENTATION DATE: 2/2008
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 1551

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$21,175,000	$19,589,000
STATE FUNDS	$5,293,750	$4,897,250
FEDERAL FUNDS	$15,881,250	$14,691,750

Purpose:
This policy change estimates the cost of third party liability contracts to identify and recover Medi-Cal expenditures from responsible third parties. The policy change also includes contracts for disability determinations, online database contracts to access public records, and data matches in support of recovery.

Authority:
Contracts:

Dept. of Industrial Relations – Electronic Adjudication Management System (EAMS)	22-20079
Dept. of Industrial Relations – Workers' Compensation Information System (WCIS)	19-96030
Dept. of Industrial Relations – Workers' Compensation Information System (WCIS)	Pending
Department of Social Services	20-10026
Health Management Systems Inc. (HI)	18-95310 A02
RELX Inc.	17-94636 A03
RELX Inc.	Pending

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
OTHER ADMIN. POLICY CHANGE NUMBER: 19

The Department awarded the Health Insurance contract (18-95310) to Health Management Systems, Inc. (HMS) with an effective date of December 1, 2018, and an expiration date of November 30, 2023.

On April 3, 2023, the Department obtained approval by the Centers for Medicare and Medicaid Services to extend the contract for an additional two years. The amended contract (18-95310 A02) runs through November 20, 2025. The contingency fee remains at 8.5 percent.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to:

- For the HMS – Health Insurance contract, there is an increase in expected recoveries for Managed Care Plans and fee-for-service pharmacy. Additional recoveries are also expected through new initiatives including recoveries on Dental Managed Care as well as the implementation of a pilot project for Provider Type 35. The final Kaiser settlement totaling $17.1 million will occur in FY 2023-24.
- For the Online Database Contracts, there is an increase due to a delay in receiving invoices from the Department of Industrial Relations (DIR)-EAMS and DIR-WCIS contractor from FY 2022-23, which was processed in FY 2023-24.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to:

- For the HMS – Health Insurance contract, recoveries are expected to decrease as Kaiser claims will be fully integrated into the regular recovery process, and Medi-Cal caseloads stabilize. There is a new recovery initiative planned for Home Health Agencies, which is expected to be implemented in FY 2024-25.
- For the Online Database Contracts, the amount will decrease due to the anticipation that the DIR-EAMS and DIR-WCIS contractor will not have future delays with invoicing and the schedule to receive invoices should normalize.

Methodology:

1. The amounts paid to the HMS contractor for HI is contingent upon recoveries. Assume the following recoveries for each fiscal year at the contracted contingency fee percentage. The HI recovery contract was recently amended to extend the timeframe an additional two years. The term of this contract is from December 1, 2018, through November 30, 2025.

   Recoveries x Contingency Fee % = Total Contingency Fee

Contractor	FY 2023-24 Recoveries	FY 2024-25 Recoveries	Contingency Fee %	FY 2023-24 Contingency Fee	FY 2024-25 Contingency Fee
HMS 18A02	$248,600,000	$230,000,000	8.50%	$21,131,000	$19,550,000

MEDI-CAL RECOVERY CONTRACTS
OTHER ADMIN. POLICY CHANGE NUMBER: 19

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 2023-24	FY 2024-25
Department of Industrial Relations - EAMS	$9,000	$5,000
Department of Industrial Relations – WCIS	$3,000	$2,000
Department of Social Services	$4,000	$4,000
RELX Inc.	$28,000	$28,000
Total	**$44,000**	**$39,000**

3. The payments shown below include recent recovery activity.

FY 2023-24	TF	GF	FF
Health Insurance	$21,131,000	$5,283,000	$15,848,000
Online Database Contracts	$44,000	$11,000	$33,000
Total	**$21,175,000**	**$5,294,000**	**$15,881,000**

FY 2024-25	TF	GF	FF
Health Insurance	$19,550,000	$4,887,000	$14,663,000
Online Database Contracts	$39,000	$10,000	$29,000
Total	**$19,589,000**	**$4,897,000**	**$14,692,000**

Funding:
75% Title XIX / 25% GF (4260-101-0001/0890)

HCBA WAIVER ADMINISTRATIVE COST

OTHER ADMIN. POLICY CHANGE NUMBER: 20
IMPLEMENTATION DATE: 7/2019
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2152

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$20,721,000	$23,776,000
STATE FUNDS	$10,360,500	$11,888,000
FEDERAL FUNDS	$10,360,500	$11,888,000

Purpose:
This policy change estimates the administrative cost of the Home and Community-Based Alternatives (HCBA) Waiver.

Authority:
Welfare and Institutions Code, Section 14132.991

Interdependent Policy Changes:
Not Applicable

Background:
The HCBA waiver offers services in the home or community to Medi-Cal members who would otherwise receive care in a skilled nursing facility. Eligibility into the waiver is based on skilled nursing levels of care. The level of care is determined by the Medi-Cal member's medical need. The waiver is held to the principle of federal cost neutrality; thus, services are arranged so that the overall total costs for the waiver and Medi-Cal State Plan services cannot exceed the costs of facilities offering equivalent levels of care.

On September 29, 2021, the Department submitted a waiver renewal application for the HCBA Waiver for a new five-year term, effective January 1, 2023, through December 31, 2027. The waiver was to expire on December 31, 2021; however, the Centers for Medicare & Medicaid Services (CMS) approved a fifth 90-day extension to March 26, 2023. CMS issued a formal approval for the waiver on February 2, 2023, and the new HCBA Waiver term became effective on January 1, 2023. The Department's new HCBA waiver does not add slots until the beginning of January 1, 2025, based on past projected enrollment and attrition trends. However, based on current enrollment and attrition trends, it has been determined that the waiver will reach capacity before the end of 2023. As a result, the Department is submitting a waiver amendment to add additional slots for each waiver year, beginning on January 1, 2024, in order to maintain waiver capacity throughout the new waiver term and align with updated enrollment trends. 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 2023-24, is a decrease due to a lower average cost of administrative claims than previously estimated based on additional actuals data. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a slight increase in costs due to enrollments of members into the HCBA Waiver.

HCBA WAIVER ADMINISTRATIVE COST

OTHER ADMIN. POLICY CHANGE NUMBER: 20

Methodology:

1. Assume there are 8,368 members in the HCBA Waiver in FY 2022-23.

2. Assume 1,176 new members will be enrolled in FY 2023-24 and FY 2024-25.

3. Assume 98% 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 2023-24	$20,721	$10,360	$10,361
FY 2024-25	$23,776	$11,888	$11,888

*Totals may differ due to rounding.

Funding:

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

CAPMAN

OTHER ADMIN. POLICY CHANGE NUMBER: 21
IMPLEMENTATION DATE: 10/2012
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1318

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$20,113,000	$20,599,000
STATE FUNDS	$5,254,000	$5,147,100
FEDERAL FUNDS	$14,859,000	$15,451,900

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 WSE #19-96060
CAPMAN Discovery & Planning #23-30184
CAPMAN Prime Vendor #22-20001
State Controller's Office #22-20159
CAPMAN Support Services #23-30073

Interdependent Policy Changes:
COVID-19 Increased FMAP – Other Admin

Background:
The Health Insurance Portability and Accountability Act (HIPAA) impose transaction requirements, including 5010 and Operating Rules. The CAPMAN system was implemented by the Department in July 2011. The HIPAA-compliant transaction automated and improved the capitation calculation process. CAPMAN allows detailed reporting at the member level while increasing the efficacy of monthly reconciliations and supporting research efforts to perform recoveries. In May 2019, a paperless accounting interface was implemented to interface between the Department's CAPMAN and the State Controller's Office (SCO).

Due to the ACA and the expansion of Medi-Cal Managed Care, the Department implemented additional functionalities in CAPMAN to accommodate the influx of new members. Modifications to the accounting interface were made to enhance the system to incorporate Electronic Funds Transfer (EFT). The paperless accounting interface increases the Department's efficiency. The system will be maintained on an ongoing basis, as new functionality is required.

The Department's administrative activities related to CAPMAN include the following contract and other related costs:

CAPMAN Prime Vendor Contracts
The CAPMAN Prime Vendor Contracts provides services, which include continuing enhancements and maintenance needed to keep up with current technology, new federal and

CAPMAN
OTHER ADMIN. POLICY CHANGE NUMBER: 21

state mandates, and a paperless accounting interface. The Department entered into a new contract effective October 3, 2022, through October 2, 2027.

CAPMAN Support Services:
The Department plans to consolidate the current CPO and other services resulting in a new contract, CAPMAN Support Services. The contract was initially estimated to be effective from February 1, 2023, through January 31, 2027. The contract was delayed until September 1, 2023, and is for a period of four (4) years. The contract provides services in product management, infrastructure performance monitoring, and infrastructure. CAPMAN Support Services support the Department in managing the prime vendor transition and new operational processes, including Service Level Agreements and Work Order Authorizations.

CAPMAN Web Services Engineer (WSE)
The CAPMAN WSE contract ensures performance system monitoring, addresses unresolved issues, and provides infrastructure support. The WSE contract is effective for the period December 3, 2019, through June 30, 2024.

SCO Contract
The Department has an Interagency Agreement (IAA) with SCO to submit electronic claim schedules from the paperless accounting interface to SCO, implement EFT, and issue warrants in response to submitted claim schedules. This contract includes a testing period with SCO and allows for walkthroughs of existing and future systems within the Department. The Department is currently working with SCO to determine budget needs for future system interfaces. The Department IAA will be effective January 2024 through December 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 estimated to be effective January 2024.

Administrative Support
Administrative assistance for the CAPMAN Section includes business process documentation, audit requests, change requests, product support requests, access management, contracts, procurements, and funding management. The contract is estimated to be effective January 2024.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is a decrease due to delays in the CAPMAN Support Services contract and AWS migration. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to adjusted projections for Hardware/Software costs and new contracts for Discovery & Planning, and Administrative Support.

Methodology:
Total costs are estimated to be:

CAPMAN

OTHER ADMIN. POLICY CHANGE NUMBER: 21

FY 2023-24	TF	GF	FF
CAPMAN Prime Vendor	$14,375,000	$3,780,000	$10,595,000
Support Services	$1,908,000	$502,000	$1,406,000
CAPMAN WSE	$271,000	$71,000	$200,000
Discovery & Planning	$252,000	$32,000	$220,000
Hardware/Software	$3,055,000	$803,000	$2,252,000
Administrative Support	$252,000	$66,000	$186,000
Total	**$20,113,000**	**$5,254,000**	**$14,859,000**

FY 2024-25	TF	GF	FF
CAPMAN Prime Vendor	$12,854,000	$3,213,000	$9,641,000
Support Services	$3,146,000	$827,000	$2,319,000
Discovery & Planning	$756,000	$96,000	$660,000
SCO IAA	$2,000	$1,000	$1,000
Hardware/Software	$3,085,000	$811,000	$2,274,000
Administrative Support	$756,000	$199,000	$557,000
Total	**$20,599,000**	**$5,147,000**	**$15,452,000**

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)
COVID-19 funding is identified in the COVID-19 Increased FMAP – Other Admin policy change

PAVE SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 22
IMPLEMENTATION DATE: 4/2016
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1932

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$17,272,000	$18,431,000
STATE FUNDS	$4,712,000	$5,018,050
FEDERAL FUNDS	$12,560,000	$13,412,950

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 A03
Contract # 23-30178

Interdependent Policy Changes:
COVID-19 Increased FMAP – Other Admin

Background:
The Department deployed an enrollment portal and associated business process application to digitize provider management activities to comply with provider integrity mandates under the Affordable Care Act. Some of the requirements are:

- Monthly database checks on enrolled providers and associated entities that manage, own, or have a controlling interest;
- Enroll all ordering, referring, or prescribing providers that bill claims to Medi-Cal;
- Periodic checks of all enrolled providers against various exclusionary databases as well as the Social Security Death Master File; and
- Revalidation of all providers every five years.

PAVE entered the M&O phase in FY 2018-19. Beginning FY 2020-21, the Department requested funding to cover ongoing PAVE M&O costs. PAVE received certification on April 1, 2021, from the Centers for Medicare and Medicaid Services (CMS).

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due to updated actuals and Behavioral Health Modernization Change Request costs. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to Behavioral Health Modernization Change Request costs.

Methodology:
1. The Department continues to add programs and benefits to PAVE on a phase-in basis with costs having begun in FY 2019-20. M&O costs continue to increase due to the inclusion of additional providers, which increases system volume and associated support activities.

PAVE SYSTEM
OTHER ADMIN. POLICY CHANGE NUMBER: 22

2. The Department received CMS certification in April 2021. This allows the M&O Federal Financial Participation (FFP) to be claimed at 75% FF / 25% GF on applicable Provider costs.

3. Funds are based on the monthly service fee associated with using the PAVE system, which is influenced by the number of providers in the system, the number of calls received in the call center, and other key metrics. With these numbers constantly increasing, the monthly rates continuously increase as more providers apply and are enrolled.

4. The FY 2023-24 and FY 2024-25 costs are as follows:

FY 2023-24	TF	GF	FF
Help Desk Cost	$756,000	$370,000	$386,000
Provider Cost	$16,516,000	$4,342,000	$12,174,000
Total	**$17,272,000**	**$4,712,000**	**$12,560,000**

FY 2024-25	TF	GF	FF
Help Desk Cost	$759,000	$371,000	$388,000
Provider Cost	$17,672,000	$4,647,000	$13,025,000
Total	**$18,431,000**	**$5,018,000**	**$13,413,000**

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)
COVID-19 funding is identified in the COVID-19 Increased FMAP – Other Admin policy change

HEALTH ENROLLMENT NAVIGATORS

OTHER ADMIN. POLICY CHANGE NUMBER: 23
IMPLEMENTATION DATE: 7/2021
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2144

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$16,850,000	$21,250,000
STATE FUNDS	$8,425,000	$10,625,000
FEDERAL FUNDS	$8,425,000	$10,625,000

Purpose:
This policy change estimates the funding provided to counties and community-based organizations (CBOs) for Medi-Cal outreach, enrollment, and retention activities.

Authority:
AB 74 (Chapter 23, Statutes of 2019)
SB 154 (Chapter 43, Statutes of 2022)

Interdependent Policy Changes:
Not Applicable

Background:
CBOs play a vital role in assisting counties to reach out to marginalized populations and help eligible individuals apply and successfully complete the health coverage enrollment process, retain coverage, navigate the health care system, and gain timely access to medical care through community-based care management.

Adequate funding for outreach, enrollment, retention, and community-based assistance with utilization and care management is necessary to ensure all Medi-Cal eligible individuals are enrolled in health care coverage and have access to the care they need.

The Department continued the Health Enrollment Navigators Project starting July 2022, through FY 2025-26. Project activities continued with an emphasis on COVID-19 Public Health Emergency-related activities to help beneficiaries retain Medi-Cal coverage by assisting with annual renewals, reporting updated contact information, and engage in outreach, application assistance, enrollment, and retention of difficult-to-reach target populations and support more focused targeted outreach and enrollment for Medi-Cal program and benefit expansions. The project implementation period occurs July 1, 2022, through June 30, 2025, while the close-out period occurs July 1, 2025, through June 30, 2026.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is a decrease due to revised claims processing projections because of actual payment timings. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to anticipating more claims being processed in FY 2024-25.

HEALTH ENROLLMENT NAVIGATORS
OTHER ADMIN. POLICY CHANGE NUMBER: 23

Methodology:

1. Assume selected counties that partner with local CBOs to conduct outreach, enrollment, and retention activities in their applicable area shall receive supplemental funding.

2. The budget agreement for FY 2019-20 (AB 74 with an implementation date of March 1, 2020) provided $60 million TF ($30 million GF) for this item. The FY 2019-20 appropriation has been fully expended. The Budget Act for FY 2022-23 (SB 154 with an implementation date of October 1, 2022) provided an additional $60 million TF ($30 million GF). The table below displays the estimated spending and remaining funds by Appropriation Years:

Appropriation Year 2022-23	TF	GF	FF*
Prior Years	$2,522,000	$1,261,000	$1,261,000
Estimated in FY 2023-24	$16,850,000	$8,425,000	$8,425,000
Estimated in FY 2024-25	$21,250,000	$10,625,000	$10,625,000
Total Estimated Remaining	$19,378,000	$9,689,000	$9,689,000

*Federal funds authority is newly requested for the fiscal year in which funds are anticipated to be expended.

3. Total estimated costs for FY 2023-24 and FY 2024-25 are:

FY 2023-24	TF	GF	FF*
Appropriation Year 2022-23	$16,850,000	$8,425,000	$8,425,000
Total FY 2023-24	**$16,850,000**	**$8,425,000**	**$8,425,000**
FY 2024-25	**TF**	**GF**	**FF***
Appropriation Year 2022-23	$21,250,000	$10,625,000	$10,625,000
Total FY 2024-25	**$21,250,000**	**$10,625,000**	**$10,625,000**

*Federal funds authority is newly requested for the fiscal year in which funds are anticipated to be expended.

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

EMSA - CALIFORNIA POISON CONTROL SYSTEM SVCS.

OTHER ADMIN. POLICY CHANGE NUMBER: 24
IMPLEMENTATION DATE: 2/2023
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 2402

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$15,770,000	$15,905,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$15,770,000	$15,905,000

Purpose:
This policy change estimates the federal match to the Emergency Medical Services Authority (EMSA) via an interagency agreement (IA) for providing services to Medi-Cal members offered by the California Poison Control System (CPCS).

Authority:
Interagency Agreement 19-96235

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 at San Francisco, manages more than 245,000 poison cases each year. CPCS reduces morbidity and mortality associated with harmful exposure and ingestions; it also decreases utilization of Emergency Medical Services (EMS) and emergency department resources. The population served includes everyone with any type of exposure, children and limited-resource populations benefit extensively. CPCS provides poison prevention help and information to the public and health professionals through a toll-free hotline that is accessible 24-hours per day, seven days a week. Calls received by CPCS include ingestion of potentially toxic products, potential allergic reactions to products, and over-the-counter medications.

Uninsured and Medi-Cal population uses constitute 21% and 20%, respectively, of the cases managed by CPCS. The Department and EMSA provides services for Medi-Cal members through utilization of Title XXI Social Security Act reimbursable services offered by the CPCS.

The Department has an existing IA, funded in State Operations, with EMSA to provide the aforementioned services. The funding authority has been moved from State Operations to the Medi-Cal Local Assistance Estimate. The cost for such services may vary year to year. The current IA was executed in May 2021 and is effective from the start of FY 2019-20 through FY 2023-24. SNFD expects either the current IA will be amended, or a new contract will be executed for FY 2024-25 and beyond. The Department draws down and passes through the Medicaid federal funds to EMSA. The non-federal share of the reimbursement is paid for by EMSA.

EMSA - CALIFORNIA POISON CONTROL SYSTEM SVCS.

OTHER ADMIN. POLICY CHANGE NUMBER: 24

Reason for Change:
There is no change in FY 2023-24, from the prior estimate.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to the different annual contract amounts that vary each fiscal year.

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. Assume a contract extension or new contract will be in place for FY 2024-25 and beyond. The annual contract amount is projected at the current FY 2023-24 level.

4. It is assumed the payments to EMSA will be made as follows on a cash basis:

(Dollars in Thousands)

FY 2023-24	TF	FF
FY 2022-23 Q4	$3,841	$3,841
FY 2023-24 Q1-Q3	$11,929	$11,929
Total	**$15,770**	**$15,770**

(Dollars in Thousands)

FY 2024-25	TF	FF
FY 2023-24 Q4	$3,976	$3,976
FY 2024-25 Q1-Q3	$11,929	$11,929
Total	**$15,905**	**$15,905**

Funding:
100% Title XXI FF (4260-101-0890)

CARE ACT - OTHER ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 25
IMPLEMENTATION DATE: 12/2022
ANALYST: Elena Susbilla
FISCAL REFERENCE NUMBER: 2391

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$15,000,000	$0
STATE FUNDS	$15,000,000	$0
FEDERAL FUNDS	$0	$0

Purpose:
This policy change estimates the administrative costs to provide funding to implement the Community Assistance, Recovery, and Empowerment Act (CARE) Act framework.

Authority:
AB 179 (Chapter 319, Statutes of 2022)
Budget Act of 2023 [AB 102 (Chapter 38, Statutes of 2023)]

Interdependent Policy Changes:
Not Applicable

Background:
The CARE Act framework delivers mental health and substance use disorder services for individuals who lack decision-making capacity due to serious mental illness. The framework provides individuals with an individualized, appropriate range of services and supports consisting of behavioral health care, stabilization medications, housing, and enumerated services.

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 Department is responsible for components of the training, technical assistance, data collection, reporting, and the independent evaluation for CARE Act.

Per AB 179, CARE Act funding was appropriated in FY 2022-23 to the Department in the amount of $57,000,000 General Fund (GF). The funding shall be distributed by the Controller pursuant to a county schedule provided by the Department created in consultation with the California State Association of Counties. From the $57,000,000 appropriation:

- $31,000,000 GF is available to support planning and preparation activities, including, but not limited to, hiring, training, and development of policies and procedures, information technology infrastructure costs, including but not limited to, changes to electronic medical record systems, changes to collect needed reporting data, case tracking and

CARE ACT - OTHER ADMIN
OTHER ADMIN. POLICY CHANGE NUMBER: 25

new billing processes to bill commercial plans.

- $26,000,000 GF is available for encumbrance to support Cohort I county planning and preparation to implement CARE.

The Budget Act of 2023 includes an additional $15,000,000 that will be available in FY 2023-24 for Los Angeles County to support planning and preparation activities, including, but not limited to, hiring, training, and development of policies and procedures, information technology infrastructure costs, including but not limited to, changes to electronic medical record systems, changes to collect needed reporting data, case tracking and new billing processes to bill commercial plans.

Reason for Change:
There is no change in FY 2023-24 from the prior estimate.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to no more payments planned after FY 2023-24.

Methodology:
1. Assume $15,000,000 GF in FY 2023-24 to support CARE Act planning and preparation.

(Dollars in Thousands)

Fiscal Year	TF	GF
FY 2023-24	$15,000	$15,000

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

MITA

OTHER ADMIN. POLICY CHANGE NUMBER: 26
IMPLEMENTATION DATE: 1/2011
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1137

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$12,257,000	$20,404,000
STATE FUNDS	$1,556,600	$2,591,400
FEDERAL FUNDS	$10,700,400	$17,812,600

Purpose:
This policy change estimates the costs associated with the Medicaid Information Technology Architecture (MITA) initiative sponsored by Centers for Medicare and 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 #21-00138
Contract# 21-10021
Contract #22-20441
Contract #22-20503
Contract #22-20386

Interdependent Policy Changes:
Not Applicable

Background:
CMS requires the Department to create flexible systems, which support interactions between the federal government and their state partners. Through MITA, the Department develops the ability to streamline the process to access information from various systems, which result in cost-effectiveness. CMS will not approve Advance Planning Documents (APDs) or provide enhanced federal funding to the Department without adherence to MITA.

To operate more effectively and efficiently, the Department takes steps to achieve the maturity goals of the MITA Framework and focus strategic planning, system changes, and modernization around Department-wide business processes rather than focusing on separate program needs. These steps prevent the Department from potentially duplicating efforts regarding hardware, software, and resources across the enterprise.

This Enterprise MITA support services help mature the business processes and position the Department to be more flexible as it serves the growing number of members. Enacting the MITA Framework and associated governance also allows the Department to react to federal and state 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.

MITA
OTHER ADMIN. POLICY CHANGE NUMBER: 26

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 2023-24, is a decrease due to adjusted projections for MITA Governance and delayed contract start and payment dates. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to adjusted projections and a full year of expenditures for new MITA contracts.

Methodology:
1. FY 2023-24 and FY 2024-25 contract amounts are associated with the MITA initiative throughout the Department in order to meet federal regulations and guidelines.

2. FY 2023-24 and FY 2024-25 include the cost of the MITA support services and UCSD IA estimates.

3. The projected FY 2023-24 and FY 2024-25 costs are:

FY 2023-24	APD	TF	GF	FF
Enterprise MITA Support Services	MITA	$7,506,000	$954,000	$6,552,000
UCSD IA	MITA	$466,000	$59,000	$407,000
Provider Management (274)	PROV.	$167,000	$21,000	$146,000
Enterprise Certification Support Services	MITA	$4,118,000	$523,000	$3,595,000
Total		**$12,257,000**	**$1,557,000**	**$10,700,000**

MITA

OTHER ADMIN. POLICY CHANGE NUMBER: 26

FY 2024-25	APD	TF	GF	FF
Enterprise MITA Support Services	MITA	$14,863,000	$1,888,000	$12,975,000
UCSD IA	MITA	$493,000	$63,000	$430,000
Provider Management (274)	PROV.	$263,000	$33,000	$230,000
Enterprise Certification Support Services	MITA	$4,785,000	$607,000	$4,178,000
Total		**$20,404,000**	**$2,591,000**	**$17,813,000**

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)

PASRR

OTHER ADMIN. POLICY CHANGE NUMBER: 27
IMPLEMENTATION DATE: 7/2013
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1720

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$9,643,000	$9,643,000
STATE FUNDS	$2,410,750	$2,410,750
FEDERAL FUNDS	$7,232,250	$7,232,250

Purpose:
This policy change estimates the contractor costs for the Preadmission Screening and Resident Review (PASRR) Level II evaluations.

Authority:
Title 42, Code of Federal Regulations 483.100-483.136, 483.200-483.206

Interdependent Policy Changes:
Not Applicable

Background:
As mandated by federal regulations, the Department contracts with an independent contractor to complete all Level II PASRR evaluations. Per this PASRR service contract, Evaluators travel to facilities and conduct Level II Evaluations. A Level II Evaluation consists of a face-to-face mental status examination and psychosocial assessment of individuals identified with or suspected to have a mental illness upon admission to a nursing facility. The findings of this evaluation result in a determination of need, determination of appropriate setting, and a set of recommendations for services to inform the individual's plan of care. The contractor's licensed clinical evaluators conduct the Level II Evaluations and enter their findings into the PASRR system.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is a decrease due to a lower contractual cost than was previously estimated based on the average monthly cases completed and terminated by contractor for one fiscal year using new contract rates.

There is no change from FY 2023-24 to FY 2024-25, in the current estimate.

Methodology:
1. Expenditures for the PASRR service contract started on July 1, 2023 and is effective until June 30, 2026.

2. The PASRR payments on a cash basis are estimated at:

FY 2023-24	TF	GF	FF
Evaluations	**$9,643,000**	**$2,411,000**	**$7,232,000**

PASRR

OTHER ADMIN. POLICY CHANGE NUMBER: 27

FY 2024-25	TF	GF	FF
Evaluations	**$9,643,000**	**$2,411,000**	**$7,232,000**

Funding:
75% Title XIX / 25% GF (4260-101-0001/0890)

OUTREACH & ENROLLMENT ASSIST. FOR DUAL BENES

OTHER ADMIN. POLICY CHANGE NUMBER: 28
IMPLEMENTATION DATE: 6/2022
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 2405

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$8,600,000	$2,000,000
STATE FUNDS	$4,300,000	$1,000,000
FEDERAL FUNDS	$4,300,000	$1,000,000

Purpose:
This policy change estimates the costs for Medi-Cal eligibility outreach and enrollment for beneficiaries dually eligible for Medicare and Medi-Cal.

Authority:
SB 129 (Chapter 69, Statute of 2021)
Contract: 21-10405

Interdependent Policy Changes:
Not Applicable

Background:
Per SB 129 (Chapter 69, Statutes of 2021), the Department is contracting with a nonprofit agency for Medi-Cal eligibility outreach and enrollment of $24 million total funds ($12 million general funds from multi-year authority and $12 million federal funds requested as needed in each Budget Act) for encumbrance or expenditure until June 30, 2024. The population of focus for this contract is low-income older adults. The outreach and enrollment is conducted in coordination with the California Department of Aging and the Health Insurance Counseling and Advocacy Program.

Reason for Change:
There is no change from the prior estimate for FY 2023-24. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to anticipating four payments being made in FY 2023-24 and one payment in FY 2024-25.

Methodology:
1. This policy change budgets for a Department contract for Medi-Cal outreach and enrollment assistance for dually eligible individuals.

OUTREACH & ENROLLMENT ASSIST. FOR DUAL BENES

OTHER ADMIN. POLICY CHANGE NUMBER: 28

2. The table below displays the estimated spending and remaining funds by Appropriation Years:

(Dollars in Thousands)

Appropriation Year 2021-22	**TF**	**GF**	**FF***
Prior Years	$13,400	$6,700	$6,700
Estimated in FY 2023-24	$8,600	$4,300	$4,300
Estimated in FY 2024-25	$2,000	$1,000	$1,000
Total Estimated Remaining	$0	$0	$0

*Federal funds authority is newly requested for the fiscal year in which funds are anticipated to be expended.

3. The estimated costs in FY 2023-24 and FY 2024-25 are as follows:

(Dollars in Thousands)

FY 2023-24	**TF**	**GF**	**FF***
Appropriation Year 2021-22	$8,600	$4,300	$4,300
Total FY 2023-24	**$8,600**	**$4,300**	**$4,300**

FY 2024-25	**TF**	**GF**	**FF***
Appropriation Year 2021-22	$2,000	$1,000	$1,000
Total FY 2024-25	**$2,000**	**$1,000**	**$1,000**

*Federal funds authority is newly requested for the fiscal year in which funds are anticipated to be expended.

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

LA COUNTY PUBLIC HEALTH NURSING PILOT

OTHER ADMIN. POLICY CHANGE NUMBER: 29
IMPLEMENTATION DATE: 1/2024
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 2271

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$8,250,000	$8,250,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$8,250,000	$8,250,000

Purpose:
This policy change estimates the Federal Financial Participation (FFP) for administrative costs related to the Los Angeles County Child Welfare Public Health Nursing (PHN) Early Intervention Pilot Program.

Authority:
Welfare & Institutions Code, Section 16521.8

Interdependent Policy Changes:
Not Applicable

Background:
In FY 2023-24, the Department expects to start FFP reimbursements for the Child Welfare PHN Early Intervention Pilot Program conducted in the County of Los Angeles to improve outcomes for the expanded population of youth at risk of entering the foster care system by maximizing access to health care and health education, and connecting youth and families to safety net services. It is the intent of the Legislature for the program to maximize the use of county public health nurses in the field in order to provide families with children who are at risk of being placed in the child welfare system with preventative services to meet their medical, mental, and behavioral health needs.

Los Angeles County has begun administrative work on the pilot program. The Department plans to secure Centers for Medicare and Medicaid Services (CMS) approval to cover any cost that falls outside the scope of Medicaid administrative activities directly related to the implementation of California's State Plan.

The Department plans to enter into an Interagency Agreement (IA) contract with Los Angeles County to enable the Department to receive FFP for administrative costs for the pilot program.

Reason for Change:
There is no change in FY 2023-24, from the prior estimate.

There is no change from FY 2023-24 to FY 2024-25, in the current estimate.

LA COUNTY PUBLIC HEALTH NURSING PILOT

OTHER ADMIN. POLICY CHANGE NUMBER: 29

Methodology:

1. Assume payments for administrative costs under a State Plan Amendment will begin January 2024.

2. The estimated administrative cost reimbursements for FY 2023-24 and FY 2024-25, on a cash basis are:

(Dollars in Thousands)

LA County Public Health Nursing Pilot	TF	FF
FY 2023-24	$8,250	$8,250
FY 2024-25	$8,250	$8,250

Funding:

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

CALAIM MLTSS & D-SNP INTEGRATION ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 30
IMPLEMENTATION DATE: 7/2012
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 1677

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$7,100,000	$0
STATE FUNDS	$3,550,000	$0
FEDERAL FUNDS	$3,550,000	$0

Purpose:
This policy change estimates the contractor costs for technical assistance and outreach to support the California Advancing and Innovating Medi-Cal (CalAIM) Managed Long-Term Services and Supports (MLTSS) and Dual Eligible Special Needs Plan (D-SNP) integrated care initiatives.

Authority:
Contract # 22-20501
CalAIM Initiative
Welfare & Institutions Code 14184.102(e)

Interdependent Policy Changes:
Not Applicable

Background:
CalAIM includes initiatives that modify and expand Coordinated Care Initiative (CCI) policies for the statewide Medi-Cal managed care Long Term Care (LTC) carve-in, mandatory enrollment of dual eligibles into Medi-Cal managed care, and integrated D-SNP in all counties. In coordination with the Centers for Medicare & Medicaid Services (CMS), CalAIM included the transition of Cal MediConnect (CMC) plan members to a Medicare Advantage Exclusively Aligned Enrollment D-SNP structure beginning CY 2023 in the seven CCI counties, and the expansion of the D-SNP model to other counties in future years. The seven CCI counties were Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

The LTC carve-in and duals integration technical assistance and outreach contractor activities funded through this policy change were provided under the CCI from FY 2012-13 through FY 2021-22, and the same contractor activities were transitioned to CalAIM beginning FY 2022-23. The contractor activities include project management, policy development support, stakeholder engagement, and individual/local provider, member, and health plan outreach for the LTC carve-in and the transition to the D-SNP structure in CCI and non-CCI counties.

Effective July 1, 2024, funding authority will transition from the Medi-Cal Local Assistance Estimate to State Operations.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due to updated contract costs for outreach and technical assistance activities. The change from FY 2023-24 to FY 2024-

CALAIM MLTSS & D-SNP INTEGRATION ACTIVITIES
OTHER ADMIN. POLICY CHANGE NUMBER: 30

25, in the current estimate, is a decrease due to ongoing costs transitioning to state operations starting July 1, 2024.

Methodology:
1. The CCI development, implementation, operation, and transition costs began July 2012 and continued through June 2022. Contractor activities transitioned from the CCI to CalAIM starting FY 2022-23.

2. Effective July 1, 2024, ongoing costs will be budgeted through state operations.

3. Local assistance costs are estimated to be:

Fiscal Year	TF	GF	FF
FY 2023-24	$7,100,000	$3,550,000	$3,550,000

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

NEWBORN HEARING SCREENING PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 31
IMPLEMENTATION DATE: 7/2014
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1824

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$6,303,000	$6,392,000
STATE FUNDS	$3,151,500	$3,196,000
FEDERAL FUNDS	$3,151,500	$3,196,000

Purpose:
This policy change estimates the Newborn Hearing Screening Program's (NHSP) contract service costs.

Authority:
AB 2780 (Chapter 310, Statutes of 1998)
Health & Safety Code Section 123975 and Sections 124115 - 124120.5
Contract 19-96295
Contract 18-95011

Interdependent Policy Changes:
Not Applicable

Background:
The NHSP contracts with Hearing Coordination Centers (HCC) to provide technical assistance and consultation to hospitals in the implementation and ongoing execution of facility hearing screening programs. The HCCs also track and monitor every infant who refers on their initial hearing screening to assure they receive necessary follow-up services.

The NHSP has had a data management contract that supported the reporting activities of the program. The data management contract provided a database that assisted the NHSP in the collection and reporting of infant hearing screening data. The information collected included screening and diagnostic services provided to newborns and infants who are deaf or hard-of-hearing.

The data management and HCC contract breakdowns are as follows:

- Data management contract
    - Contract # 18-95011 expires June 30, 2024. The Department is in process of developing a new Request for Proposal (RFP) for the new data management contract. The same terms and conditions in the current contract are expected to be requested in the new RFP.

- HCC contract #19-96295 began June 1, 2020, and expires June 30, 2024.

NEWBORN HEARING SCREENING PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 31

Reason for Change:
The change from the prior estimate, for FY 2023-24, is a decrease due to incorporating actuals. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an estimated increase due to the anticipation of awarding a new RFP to replace the expiring contract.

Methodology:
1. The HCC contract for tracking and monitoring services costs for FY 2023-24 is $5,223,000 and $5,312,000 for FY 2024-25.

2. The Data Management Contract for the use of a vendor's data management system cost for FY 2023-24 is $1,080,000. Costs for FY 2024-25 are estimated to be $1,080,000, which is pending award of the new contract through an RFP.

3. The estimated costs for FY 2023-24 and FY 2024-25 are as follows:

FY 2023-24	TF	GF	FF
HCC Contract	$5,223,000	$2,611,000	$2,612,000
Data Management Contract	$1,080,000	$540,000	$540,000
Total	**$6,303,000**	**$3,151,000**	**$3,152,000**

FY 2024-25	TF	GF	FF
HCC Contract	$5,312,000	$2,656,000	$2,656,000
Data Management Contract	$1,080,000	$540,000	$540,000
Total	**$6,392,000**	**$3,196,000**	**$3,196,000**

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

STATEWIDE VERIFICATION HUB

OTHER ADMIN. POLICY CHANGE NUMBER: 32
IMPLEMENTATION DATE: 6/2022
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 2358

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$4,467,000	$2,315,000
STATE FUNDS	$446,700	$231,500
FEDERAL FUNDS	$4,020,300	$2,083,500

Purpose:
This policy change estimates the Statewide Verification Hub (SVH) funding for the multi-departmental effort that will see the planning, design, development, and implementation of a data repository service hub to facilitate better data matches and enhance the efficiency of programmatic administration.

Authority:
Welfare & Institutions Code 14005.37 and 14013.3
42 Code of Federal Regulations 435.945, 435.948, 435.949 and 435.952
22 California Code of Regulations 50167, 50167.2 and 50168
Contract #22-20592
Contract #21-10312
DHCS/CDSS SVH IAA: DHCS 21-10376

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. Initial efforts will focus 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 will develop a modernized and leverageable Hub that will connect 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 CalHHS Office of the Agency Information Officer is the executive project sponsor for SVH, with formal project sponsorship from the Department and the California Department of Social Services.

Over the next federal fiscal years, the project will work to create a holistic view of the current business process across CalFresh, CalWORKs, childcare programs, and Medi-Cal program areas. This includes creating detailed process maps, county and customer worker journey maps, detailed data maps, and existing technical architecture. At the end of the planning phase, the project will be able to identify:

STATEWIDE VERIFICATION HUB
OTHER ADMIN. POLICY CHANGE NUMBER: 32

- Documents to create and guide the need for the future SVH by identifying the to-be functional and service architectures, while developing a robust alternative analysis of proposed solutions for the SVH.
- A recommended solution approach that aligns the needs of county users while prioritizing customer experience.
- Features and functionality that will substantially enhance transparency around eligibility verification and/or determination and benefit and/or aiding-level determinations, while improving the capacity of the State to report upon utilization rates, measures, and outcomes of eligibility verifications for means-tested human services programs.

Reason for Change:
The change from the prior estimate, is an increase for FY 2023-24, due to additional funding being requested for Implementation Advanced Planning Document renewal for October 1, 2023, through September 30, 2025. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to reduced contract resources being available in FY 2024-25.

Methodology:
1. Assume the interagency agreement became effective in August 2022.

2. Assume the project management contract began in June 2022 and was extended through December 2023. A new contract was procured and became effective in January 2024.

3. Assume the technical services contract began in June 2023.

4. The Department estimates SVH costs for FY 2023-24 and FY 2024-25 to be:

Fiscal Years	TF	GF	FF
FY 2023-24	$4,467,000	$447,000	$4,020,000
FY 2024-25	$2,315,000	$231,000	$2,084,000

Funding:
90% FF/10% GF (4260-101-0001/0890) (Design, Development, and Implementation of Medicaid Management Information System)

DRUG MEDI-CAL PARITY RULE ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER: 33
IMPLEMENTATION DATE: 11/2023
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2206

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$4,407,000	$5,875,000
STATE FUNDS	$1,469,000	$1,958,000
FEDERAL FUNDS	$2,938,000	$3,917,000

Purpose:
This policy change estimates the administration cost related to Parity Rule activities for Drug Medi-Cal (DMC) counties.

Authority:
42 Code of Federal Regulations (CFR) Part 438
Welfare & Institutions (W&I) Code, Section 14197.1

Interdependent Policy Changes:
Not Applicable

Background:
The federal Parity Rule prescribes requirements states must address to ensure Medicaid beneficiaries are able to access mental health and substance use disorder (SUD) services in the same way they are able to access physical health services.

Specifically, according to Title 42 of the CFR, Part 438.910 and 438.920, parity applies to DMC counties because parity protects the enrollees of medical/surgical Medi-Cal Managed Care Plan, and those Managed Care Plan enrollees could be receiving their substance use disorder services in either a DMC-ODS or DMC county. Furthermore, the W&I Code, Section 14197.1 gives the Department the authority to ensure that all SUD benefits are provided in compliance with the Parity Rule.

Through continued assessment of the Parity Rule, the Department has identified additional requirements that are necessary to align standards for beneficiary 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:
The change in FY 2023-24, from the prior estimate, is due to the following:

- The payment start date was delayed from May 2023 to November 2023.
- Removal of the inter-governmental transfers (IGTs) which were previously budgeted to fund for costs incurred beginning July 1, 2023.

DRUG MEDI-CAL PARITY RULE ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER: 33

The change in the current estimate, from FY 2023-24 to FY 2024-25, is an increase due to FY 2024-25 including an additional quarters cost.

Methodology:

1. Payments for the Parity Rule activities began in November 2023.

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 2023-24 and FY 2024-25 are:

FY 2023-24	TF	GF	FF	CF
DMC Administration - Regular	$5,655,000	$1,414,000	$2,827,000	$1,414,000
DMC Administration - UR & QA	$221,000	$55,000	$111,000	$55,000
Total	$5,876,000	**$1,469,000**	**$2,938,000**	$1,469,000

FY 2024-25	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)

ELECTRONIC ASSET VERIFICATION PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 34
IMPLEMENTATION DATE: 7/2023
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 2002

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$4,068,000	$227,000
STATE FUNDS	$2,034,000	$113,500
FEDERAL FUNDS	$2,034,000	$113,500

Purpose:
This policy change estimates the administrative costs associated with implementing an electronic asset verification program (AVP) with LexisNexis Risk Solutions (LNRS). The current contract for AVP services with LNRS is required under federal law, which includes a 60-month lookback period or until the remaining Period of Ineligibility (POI) requirements expire.

Authority:
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
State Plan Amendment (SPA) 09-003
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 beneficiaries through requests to financial institutions. The law further stipulates that the program be consistent with the approach taken by the Social Security Administration (SSA) under 42 U.S. Code Section 1383(e)(1); this includes the requirement that the program be administered electronically. The 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.

Financial institutions provide data that could indicate assets and property not reported by the applicant or beneficiary. If information is obtained indicating unreported assets, the applicant or beneficiary must provide additional supporting documentation before an eligibility determination or redetermination is made.

The Department reimburses financial institutions when obtaining asset information for ABD beneficiaries. 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 beneficiary.

ELECTRONIC ASSET VERIFICATION PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 34

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 Death, Residency Verification Program (RVP), and Commercial Mail Receiving Agency (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 eligible beneficiaries who are deceased, residing out-of-state, or have a residential address that is identified as a CMRA.

A third contract amendment will be executed to remove Appriss, Death*, RVP and CMRA matching activities and significantly reduce 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 POI requirements for individuals seeking Long-Term Care (LTC)/Nursing Facility Level of Care (NFLOC) necessitating a 60-month lookback period, the Department will continue to purchase AVP inputs for the LTC applicant population after January 1, 2024. The Department anticipates this contract will continue until December 31, 2028, or until the remaining POIs expire. Appriss, Death*, RVP, and CMRA inputs/matches from the 20-10158** scope of work will be separated from the contract and shift to a new contract unaffiliated with this policy change.

*Includes the ten Accurint licenses provided by LNRS.
**Appriss inputs for incarceration verification were added in A01.
**Death, RVP and CMRA matches were added in A02.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due to paying an additional six months of payments to LNRS for LTC AVP application inputs for the remaining six months of FY 2023-24, from January through June 2024.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to the removal of Appriss, Death, RVP, and CMRA data matching activities from this PC.

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 a determination of eligibility.

ELECTRONIC ASSET VERIFICATION PROGRAM
OTHER ADMIN. POLICY CHANGE NUMBER: 34

2. The Department is required to verify assets for the Non-MAGI ABD population at application, annual renewal, or whenever the Department determines an asset record is necessary. It is anticipated that the Department will continue sending AVP requests for the LTC applicant population even after asset elimination on January 1, 2024, due to federal asset transfer and POI requirements for individuals seeking LTC/NFLOC.

3. Based on ABD enrollment data, assume the estimated number of asset verifications performed will be 1,380,000 in FY 2021-22 and FY 2022-23. The volume of verifications for death and out of state residency is 1,400 and 68,000 per FY 2021-22.

4. The reimbursement rate, based on estimated query volume, is estimated to be $653,400 per month for FY 2022-23. The increased rate from FY 2021-22 to FY 2022-23 is due to the addition of death, out-of-state, and CMRA matching services to the vendor agreement.

5. The reimbursement rate for the first half of FY 2023-24, from July to December 2023, is expected to be $659,150/month due to the death and residency matches added in FY 2022-23 and an extended 6-month term period. The reimbursement rate for the second half of FY 2023-24, from January to June 2024, is estimated to be $18,900/month due to the significant reduction in scope of AVP and the removal of Appriss, Death, RVP and CMRA data matching activities from this PC.

Time Period	Monthly Rate	Months	Cost
July – December	$659,150	6	$3,954,900
January – June	$18,900	6	$113,400
FY 2023-24		12	$4,068,300

6. The $18,900/month cost estimation is based on the monthly average of LTC renewal requests over a 15-month period from November 2018 to January 2020. An average of 4,500 is estimated, which factors in growth in the LTC ABD population. This average is multiplied by an estimated cost per AVP input of $4.20. The cost per month amount will be updated once the modified cost per input is finalized.

4,500 inputs/month x $4.20/input = $18,900/month.

7. The reimbursement rate for FY 2024-25 is estimated to be $18,900/month due to the cost of running an electronic AVP for LTC applicants.

Time Period	Monthly Rate	Months	Cost
FY 2024-25	$18,900	12	$226,800

8. The estimated vendor costs are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2023-24	**$4,068**	**$2,034**	**$2,034**
FY 2024-25	**$227**	**$113**	**$114**

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

SDMC SYSTEM M&O SUPPORT

OTHER ADMIN. POLICY CHANGE NUMBER: 35
IMPLEMENTATION DATE: 7/2013
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1732

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$3,898,000	$2,492,000
STATE FUNDS	$1,949,000	$1,246,000
FEDERAL FUNDS	$1,949,000	$1,246,000

Purpose:
This policy change estimates the infrastructure and contractor's costs to perform the ongoing maintenance and operations (M&O) support for the Short-Doyle/Medi-Cal (SDMC) system.

Authority:
Contract #22-20171

Interdependent Policy Changes:
Not Applicable

Background:
The SDMC system adjudicates Medi-Cal claims for Specialty Mental Health Services (SMHS) and Substance Use Disorder Services (SUDS). Due to the Affordable Care Act, Medi-Cal has experienced an increase in the volume of claims which has created a need for system upgrades, including application servers, reporting servers, middleware, database, and storage.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due to more contracted resources to enhance the existing SDMC application. The enhancements will support the California Advancing and Innovating Medi-Cal (CalAIM) and Justice-Involved initiatives. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to the completion of SDMC application enhancements.

Methodology:
1. The contractor cost for the five (5) years that began on July 1, 2022, is $11,954,800.

2. Projections include the contractor cost related to processing SMHS and SUDS claims payments.

FY 2023-24	TF	GF	FF
M&O	$3,898,000	$1,949,000	$1,949,000
Total	**$3,898,000**	**$1,949,000**	**$1,949,000**

FY 2024-25	TF	GF	FF
M&O	$2,492,000	$1,246,000	$1,246,000
Total	**$2,492,000**	**$1,246,000**	**$1,246,000**

SDMC SYSTEM M&O SUPPORT

OTHER ADMIN. POLICY CHANGE NUMBER: 35

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

PACES

OTHER ADMIN. POLICY CHANGE NUMBER: 36
IMPLEMENTATION DATE: 9/2016
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1972

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$3,732,000	$3,745,000
STATE FUNDS	$981,100	$984,450
FEDERAL FUNDS	$2,750,900	$2,760,550

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:
COVID-19 Increased FMAP – Other Admin

Background:
Federal law mandates the Department to collect and report on Medi-Cal claims and encounters, whether they be submitted as part of a Fee-for-Services or a contracted managed care arrangement. PACES plays a vital role in the collection of encounter and provider network data from Medi-Cal's numerous managed care plans. PACES accepts encounter transactions from both medical and dental managed care plans as well as encounter-related pharmacy transactions. PACES also accepts medical and dental provider network data from Medi-Cal's managed care plans. This data is used to ensure that managed care plans are meeting the department's network adequacy requirements.

PACES Interfaces and New Data Sources
42 CFR 438.10(e) (2) (vi) requires the Department to provide Medi-Cal enrollees with provider directory information for contracted managed care entities on a regular basis. Furthermore, 42 CFR 438.68 requires the Department to enforce network adequacy standards for contracted managed care entities. In order to fulfill these federal regulations, the Department must collect provider network information from participating managed care organizations as well as managed models, such as county behavioral health systems, that are considered managed care for the purpose of regulation.

The Department is in the process of extending the use of the 274 transactions to cover behavioral health. The Department has completed the analysis to expand the use of the 274 transactions to the county mental health plans and the Drug Medi-Cal Organized Delivery System counties. Extending the 274 processes to behavioral health will allow the Department to monitor the networks within those models.

PACES

OTHER ADMIN. POLICY CHANGE NUMBER: 36

State projects seeking Medicaid enhanced 75/25 federal funding for maintenance & operations (M&O) after development must meet the Centers for Medicare & Medicaid Service (CMS) System Certification requirements. PACES completed the CMS Final Certification Review on July 12, 2021, and received the Certification Approval Letter dated October 25, 2021.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due to more usage of cloud hosting services. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to adjusted projections for cloud hosting services.

Methodology:
1. A new 5-year contract for a vendor to provide M&O services 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 2023-24	TF	GF	FF
M&O	$3,230,000	$849,000	$2,381,000
Cloud Services	$502,000	$132,000	$370,000
Total	**$3,732,000**	**$981,000**	**$2,751,000**

FY 2024-25	TF	GF	FF
M&O	$3,245,000	$853,000	$2,392,000
Cloud Services	$500,000	$131,000	$369,000
Total	**$3,745,000**	**$984,000**	**$2,761,000**

Funding:
75% Title XIX / 25% GF (4260-117-0001/0890)
65% Title XXI / 35% GF (4260-101-0001/0890)
50% Title XIX / 50% GF (4260-101-0001/0890)
100% State GF (4260-101-0001)
COVID-19 funding is identified in the COVID-19 Increased FMAP –Other Admin policy change

HCBS SP - CONTINGENCY MANAGEMENT ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 37
IMPLEMENTATION DATE: 5/2023
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2362

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$2,768,000	$6,119,000
STATE FUNDS	$1,186,000	$0
FEDERAL FUNDS	$1,582,000	$6,119,000

Purpose:
This policy change estimates the administrative costs of adding Contingency Management (CM) in select Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver counties as an optional evidence-based Medi-Cal benefit under the federally approved CalAIM Section 1115(a) Waiver Program using enhanced federal funding from the American Rescue Plan Act of 2021 (ARP).

Authority:
American Rescue Plan (ARP) Act (2021)
Budget Act of 2021 [SB 129 (Chapter 69, Statutes of 2021)]
CalAIM 1115 Demonstration Waiver

Interdependent Policy Changes:
Not Applicable

Background:
The ARP Act of 2021 provides additional Coronavirus Disease 2019 (COVID-19) relief to states. Section 9817 of the ARP provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS). Increased FMAP is available from April 1, 2021, through March 31, 2022. States must use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021, and states must use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. State funds equivalent to the amount of federal funds attributable to the increased FMAP are deposited in the Home and Community-Based Services American Rescue Plan (HCBS ARP) Fund pursuant to Section 11.95 of the 2021 Budget Act. Section 11.95 appropriates this funding to eligible HCBS activities identified in the HCBS Spending Plan.

The Centers for Medicare and Medicaid Services (CMS) approved the addition of CM as an optional benefit in DMC-ODS counties as part of the 1115 Demonstration Waiver renewal, as a pilot, beginning July 1, 2022 through March 2024. CM uses small motivational incentives combined with behavioral health treatment and has been shown in repeated meta-analyses to be the most effective treatment for stimulant use disorder. CM was approved in the 2021 Budget Act, funded from the HCBS ARP Fund.

This policy change budgets administrative costs for CM services under the CalAIM 1115 Demonstration Waiver. Effective April 1, 2024, the Department will extend the recovery

HCBS SP - CONTINGENCY MANAGEMENT ADMIN
OTHER ADMIN. POLICY CHANGE NUMBER: 37

incentives program as an optional CM benefit for all DMC-ODS counties who opt-in to cover CM as a DMC-ODS service in alignment with the timeline of the CalAIM 1115 Demonstration waiver (through December 31, 2026). Funding for the non-federal share of administrative costs for CM services will be with county funds beginning April 1, 2024. Counties would voluntarily opt-in to provision of this benefit and use of county funds for the non-federal share of payments.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is a decrease due to the following:
- Updated roll-out and payment lag adjustments.
- Removal of the inter-governmental transfers (IGTs) which were previously budgeted for costs incurred beginning July 1, 2023.

The change in the current estimate, from 2023-24 to FY 2024-25, is an increase due to a higher projected ramp up of benefit.

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. Total estimated administrative costs for CM, on a cash basis, is as follows:

Contingency Management Admin	TF	HCBS ARP Fund	FF	CF
FY 2023-24	$3,163,000	**$1,186,000**	**$1,582,000**	$395,000
FY 2024-25	$12,238,000	**$0**	**$6,119,000**	$6,119,000

Funding:
100% Title XIX (4260-101-0890)
Home and Community-Based Services American Rescue Plan Fund (4260-101-8507)

CALAIM - INMATE PRE-RELEASE PROGRAM ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 38
IMPLEMENTATION DATE: 1/2023
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2413

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$2,746,000	$2,746,000
STATE FUNDS	$1,373,000	$1,373,000
FEDERAL FUNDS	$1,373,000	$1,373,000

Purpose:
This policy change estimates the cost for county social services agencies to process Medi-Cal applications in support of the Mandatory County Pre-Release mandate, effective January 1, 2023.

Authority:
Penal Code Section 4011.11
Welfare & Institutions Code Sections 14011.10, 14132.275, 14184.800, and 14186
AB 133 (Chapter 143, Statutes of 2021)

Interdependent Policy Change:
Not Applicable

Background:
California is requesting federal authority necessary to implement California Advancing & Innovating Medi-Cal (CalAIM), a framework that encompasses broad-based delivery system, program and payment reform across the Medi-Cal program. CalAIM recognizes the opportunity to move California's whole-person care approach – first authorized by the Medi-Cal 2020 Section 1115 demonstration – to a statewide level, with a clear focus on improving health and reducing health disparities and inequities. Collectively, the Section 1115 CalAIM demonstration and Section 1915(b) waiver, along with related contractual and Medi-Cal State Plan changes, will enable California to fully execute the CalAIM initiative, providing benefits to certain high needs, hard-to-reach populations, with the objective of improving health outcomes for Medi-Cal beneficiaries 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 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
OTHER ADMIN. POLICY CHANGE NUMBER: 38

- 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 2023-24. The is no change from FY 2023-24 to FY 2024-25 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. Assume County/Jail probation and State Prison administrative costs will begin in FY 2025-26.

4. Total estimated costs for FY 2023-24 and FY 2024-25 are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2023-24	$2,746	$1,373	$1,373
FY 2024-25	$2,746	$1,373	$1,373

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

PUBLIC HEALTH REGISTRIES SUPPORT

OTHER ADMIN. POLICY CHANGE NUMBER: 39
IMPLEMENTATION DATE: 7/2021
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1370

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$2,737,000	$5,475,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$2,737,000	$5,475,000

Purpose:
This policy change estimates the administrative costs for California Department of Public Health (CDPH) programs that the Department is supporting under Medicaid Enterprise Systems (MES) funding.

Authority:
Code of Federal Regulations, Title 42, Part 433
Interagency Agreement CAIR (Pending)
Interagency Agreement CalREDIE (Pending)
Advance Planning Document (CA-2021-01-16-MMIS-IAPD-Public Health Registries APD update forthcoming)

Interdependent Policy Changes:
Not Applicable

Background:
The Department works with the CDPH in support of the California Immunization Registry (CAIR) and California Reportable Disease Information Exchange (CalREDIE) projects. The Centers for Medicare & Medicaid Services (CMS) originally approved federal funding for these projects in the 2021 Public Health Registries Advance Planning Document (APD), which covered the fiscal year (FY) 2021-22. For FY 2022-23, CDPH was able to utilize emergency COVID funding and did not submit an APD. However, CDPH will be submitting an APD for FY 2023-24 and FY 2024-25.

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 is 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.

CMS requires implemented projects to be funded at 50% / 50% Federal Medical Assistance Percentage until certified. CMS certification is projected to be received in July 2024. The

PUBLIC HEALTH REGISTRIES SUPPORT
OTHER ADMIN. POLICY CHANGE NUMBER: 39

programs will receive enhanced funding of 75% / 25% after certification. The Department expects CMS approval for the recoupment of $5,475,000 in enhanced funding; this will be completed in July 2024.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is a decrease due to changes in costs related to the CAIR and CalREDIE projects.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to the funding split for the CAIR and CalREDIE projects likely obtaining CMS certification by FY 2024-25, resulting in an increased federal share in FY 2024-25 and a retroactive payment amount for FY 2023-24.

Methodology:
1. For the CAIR and CalREDIE, the non-federal share is budgeted by CDPH. This policy change budgets the Title XIX FF that will be provided to CDPH per the contracts through an interagency agreement.

2. Until CAIR and CalREDIE are certified by CMS, they can only receive 50% Title XIX funding. Since they intend to achieve certification late in the FY 2023-24, it is assumed 50% Title XIX funding for FY 2023-24 (before certification) and 75% Title XIX funding for FY 2024-25 (after certification).

FY 2023-24	**TF**	**CDPH GF**	**FF**
CalREDIE (50% FF/50% GF)	$1,417,000	$709,000	$708,000
CAIR (50% FF/50% GF)	$4,058,000	$2,029,000	$2,029,000
Total FY 2023-24	$5,475,000	$2,738,000	**$2,737,000**
FY 2024-25	**TF**	**CDPH GF**	**FF**
CalREDIE (75% FF/25% GF)	$1,417,000	$354,000	$1,063,000
CAIR (75% FF/25% GF)	$4,058,000	$1,015,000	$3,043,000
Pre-Certification funding for FY 2023-24 (50% FF/50% GF)*	($5,475,000)	($2,738,000)	($2,737,000)
Post-Certification funding for FY 2023-24 (75% FF/25% GF)*	$5,475,000	$1,369,000	$4,106,000
Total FY 2024-25	$5,475,000	$0	**$5,475,000**

*Retroactive payment for enhanced funding related to the APD Certification

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

T-MSIS

OTHER ADMIN. POLICY CHANGE NUMBER: 40
IMPLEMENTATION DATE: 9/2013
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1768

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$2,708,000	$1,851,000
STATE FUNDS	$383,450	$288,200
FEDERAL FUNDS	$2,324,550	$1,562,800

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
#22-20364
#22-20507

Interdependent Policy Changes:
COVID-19 Increased FMAP – Other Admin

Background:
The CMS requires data in a standardized format from the states to review system projects related to the ACA. The Department implemented an enterprise-wide ETL data solution to modernize and streamline the data transmission processes from the Department to the CMS T-MSIS. The project provides modern capabilities to improve business processes by collecting comprehensive data regarding the cost, quantity, and quality of health care provided for Medi-Cal members. Data transferred to the T-MSIS includes claims, eligibility, third-party liability, managed care, and provider information.

In November 2017, CMS approved an Implementation Advance Planning Document Update (IAPDU), providing enhanced funding for software support as well as ETL system and training costs through Federal Fiscal Year (FFY) 2021. On August 10, 2018, CMS issued a State Health Official (SHO) letter (#18-008) providing guidance to states regarding expectations for Medicaid and Children's Health Insurance Program data and ongoing T-MSIS implementation, and access to enhanced funding for future costs to California's Medicaid Enterprise System (MES). Enhanced funding for additional system enhancement and operational costs associated with MES is contingent upon the Department's continued ability to meet T-MSIS requirements of complete, accurate, and timely data reporting. Specifically, CMS expects that:

T-MSIS
OTHER ADMIN. POLICY CHANGE NUMBER: 40

- T-MSIS data quality should be a permanent and ongoing process of state operations;
- States commit the necessary resources to make steady progress in improving their data quality;
- States resolve data quality issues for the 12 Top Priority Items no later than six months after the release of SHO letter #18-008.

CMS approved the T-MSIS IAPD for FFY 2023-24 on October 26, 2022.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is a decrease due to updated actuals. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to the end of the 35C Migration Planning Contract in January 2024.

Methodology:
1. The approved FFY 2022-23 IAPD includes funding for ongoing M&O (75% Title XIX / 25% GF) activities, which include the annual renewal of software licenses for T-MSIS ETL data solutions and staff training costs.

2. The 35C contract began on January 9, 2023, for one (1) year. This is for DDI (90% Title XIX/10% GF) activities and will end on January 8, 2024.

3. The T-MSIS Standard Operation Procedures (SOP) testing contract began on April 3, 2023, for two (2) years. This is for DDI (90% Title XIX/10% GF) activities, and will end on April 2, 2025.

FY 2023-24	TF	GF	FF
M&O	$289,000	$76,000	$213,000
DD&I	$2,419,000	$307,000	$2,112,000
Total	**$2,708,000**	**$383,000**	**$2,325,000**

FY 2024-25	TF	GF	FF
M&O	$391,000	$103,000	$288,000
DD&I	$1,460,000	$185,000	$1,275,000
Total	**$1,851,000**	**$288,000**	**$1,563,000**

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)
COVID-19 funding is identified in the COVID-19 Increased FMAP – Other Admin policy change

HEALTH INFORMATION EXCHANGE INTEROPERABILITY

OTHER ADMIN. POLICY CHANGE NUMBER: 41
IMPLEMENTATION DATE: 6/2020
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2159

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$2,017,000	$250,000
STATE FUNDS	$1,967,000	$125,000
FEDERAL FUNDS	$50,000	$125,000

Purpose:
This policy change estimates the cost to administer data exchange activities to support care for Medi-Cal beneficiaries. 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
HIE Roadmap Contract 22-20401
ASCMI Contracts 22-20546, 22-20547, 22-20548
HIE Subject Matter Expert Contract 20-10394

Interdependent Policy Changes:
Not Applicable

Background:
The California Health Information Exchanges (HIE) Onboarding Program (Cal-HOP), approved by Centers for Medicare and Medicaid Services (CMS) in February 2020, was constructed based on the CMS guidance and supported Health Information Organizations (HIO) onboarding and technical assistance as well as establish interfaces between HIOs and Controlled Substance Utilization Review and Evaluation System (CURES).

The Cal-HOP, which used state and federal funds, ended in September 2021. The state funds were originally appropriated as part of a stakeholder proposal to support data exchange in Medi-Cal. The Department received budget authority to spend the unused general funds share of the Cal-HOP funding to support other interoperability and data exchange efforts during FY 2021-22, which was extended in the May 2022 Appropriations Budget until the end of FY 2022-23.

In FY 2022-23, the Department utilized the unused Cal-HOP funding for three initiatives. One of these, the Authorization to Share Confidential Medi-Cal Information (ASCMI) Form and consent management service pilot, ended June 30, 2023, though invoices will be paid in FY 2023-24. The second initiative was a contract to build an HIE Roadmap focused on CalAIM, make recommendations how HIE should be utilized to achieve Departmental goals, and develop a communications plan to reach key stakeholders about fulfilling the goals identified for the Department and partner HIEs. Invoices for the HIE Roadmap will also be paid in FY 2023-24.

HEALTH INFORMATION EXCHANGE INTEROPERABILITY
OTHER ADMIN. POLICY CHANGE NUMBER: 41

Lastly, the remaining resources were planned to be used to assess provider directory data sources within and outside the Department that would support data exchange with providers. These planning efforts commenced late in FY 2022-23 but will continue in FY 2023-24.

The HIE subject matter expert (SME) supports and guides the Department's efforts to comply with interoperability mandates, which includes providing expertise in the following, but not limited to, work efforts with consent management, identity and access management, advanced and complex data exchange methodologies and structures, and Fast Healthcare Interoperability Resources (FHIR) Implementation Guides (IG). Additionally, the HIE SME serves as a liaison between the Department and California Health and Human Services Agency to facilitate and provide expertise in implementing components of the Agency's Data Exchange Framework (DxF).

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due to Data Exchange Planning and ASCMI Pilot invoices moving from FY 2022-23 to FY 2023-24. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to all costs related to Data Exchange Planning, ASCMI Pilot, and HIE Roadmap being expended in FY 2023-24.

Methodology:
1. Estimated expenditures for planning for data exchange components managed by the Department infrastructure uses the remaining Cal-HOP funds are $1,000,000 TF ($1,000,000 GF) in FY 2023-24.

2. The ASCMI and HIE Roadmap contracts are funded utilizing the remaining Cal-HOP funding.

3. Estimated expenditures for the HIE SME contract are $100,000 TF ($50,000 GF) in FY 2023-24 and $250,000 in TF ($125,000 GF) in FY 2024-25.

FY 2023-24	TF	GF	FF
HIE SME	$100,000	$50,000	$50,000
Data Exchange Planning	$1,000,000	$1,000,000	$0
ASCMI Pilot	$750,000	$750,000	$0
HIE Roadmap	$167,000	$167,000	$0
Total	**$2,017,000**	**$1,967,000**	**$50,000**

FY 2024-25	TF	GF	FF
HIE SME	$250,000	$125,000	$125,000
Total	**$250,000**	**$125,000**	**$125,000**

*Note: some slight variations due to rounding

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

MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 42
IMPLEMENTATION DATE: 6/2023
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 2321

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$2,000,000	$2,000,000
STATE FUNDS	$1,000,000	$1,000,000
FEDERAL FUNDS	$1,000,000	$1,000,000

Purpose:
This policy change estimates the cost of the Department's contract with public or private entities for the purpose of assisting dual eligible beneficiaries 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 beneficiaries 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 beneficiaries statewide in 2023. This contract is intended to enable the contribution and expansion of the CalMediConnect (CMC) Independent Ombudsman, which offered ombudsperson services to CMC beneficiaries.

Reason for Change:
There is no change from the prior estimate for FY 2023-24. There is no change from FY 2023-24 to FY 2024-25 in the current estimate.

Methodology:
1. Annual contract costs are $2,000,000.

2. The contract began in January 2023. The initial invoice was paid in June 2023.

MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 42

3. The anticipated costs for FY 2023-24 and FY 2024-25 of this contract are:

Fiscal Year	TF	GF	FF
FY 2023-24	$2,000,000	$1,000,000	$1,000,000
FY 2024-25	$2,000,000	$1,000,000	$1,000,000

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

FIELD TESTING OF MEDI-CAL MATERIALS

OTHER ADMIN. POLICY CHANGE NUMBER: 43
IMPLEMENTATION DATE: 8/2023
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2357

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$2,000,000	$200,000
STATE FUNDS	$1,000,000	$100,000
FEDERAL FUNDS	$1,000,000	$100,000

Purpose:
This policy change estimates the cost to provide funding for the California Pan-ethnic Health Network to manage a community-based process to review and evaluate Medi-Cal materials for correctness of foreign language translations and cultural appropriateness.

Authority:
AB 128 (Chapter 21, Statutes of 2021)

Interdependent Policy Changes:
Not Applicable

Background:
The stakeholder community has expressed concerns about the accuracy and cultural appropriateness of the translations of many of the most common and most often used notices, letters, and forms utilized by Medi-Cal beneficiaries and county eligibility workers.

The purpose is to provide funding for the California Pan-ethnic Health Network to manage a community-based process, allowing a group of community-based translators and institutions, to:

- Review and evaluate Medi-Cal notices, letters, forms, and publications for correctness of foreign language translations and cultural appropriateness;
- Help the Department determine if changes need to be made; and
- Assist with making necessary changes.

The funding includes costs for services and time of those individuals engaged in this effort.

Reason for Change:
There is no change from the prior estimate for FY 2023-24. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease as FY 2023-24 has upfront, implementation costs while FY 2024-25 only contains ongoing program costs.

Methodology:
1. Assume the policy implemented August 2023.

2. The Department estimates Field Testing costs for FY 2023-24 and FY 2024-25 to be:

FIELD TESTING OF MEDI-CAL MATERIALS

OTHER ADMIN. POLICY CHANGE NUMBER: 43

Fiscal Years	TF	GF	FF
FY 2023-24	$2,000,000	$1,000,000	$1,000,000
FY 2024-25	$200,000	$100,000	$100,000

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

MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)

OTHER ADMIN. POLICY CHANGE NUMBER: 44
IMPLEMENTATION DATE: 7/2009
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1441

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$1,984,000	$1,984,000
STATE FUNDS	$804,000	$804,000
FEDERAL FUNDS	$1,180,000	$1,180,000

Purpose:
This policy change estimates the maintenance and operations (M&O) expenses resulting from legislative mandates, federal and/or state directives, and Medi-Cal program policy changes, which impact the Medi-Cal Eligibility Data System (MEDS).

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
The MEDS is a statewide database containing eligibility information for public assistance programs administered by the Department and other departments. MEDS provides users with the ability to perform multi-program application searches, verify program eligibility status, enroll members in multiple programs, and validate information on application status. Funding is required for the following M&O functions:

- MEDS Master Client Index maintenance;
- Data matches from various federal and state agencies;
- Supplemental Security Income termination process support;
- Medi-Cal application alerts;
- Medicare Modernization Act Part D buy-in process improvements;
- Eligibility renewal process;
- Reconciling county eligibility data used to support the counties in Medi-Cal eligibility determination;
- Supporting eligibility and enrollment functions; and
- Enabling counties to perform online statistical analysis and MEDS-alert reporting as well as allowing them to track and report county workers' MEDS transactions.

MEDS generates Client Index Numbers (CIN) to uniquely identify Medi-Cal members. CINs can be used to identify members for public assistance programs, including Temporary Assistance for Needy Families, In-Home Support Services, and other Health and Human Services programs such as Covered California's Advance Premium Tax Credit.

The Department implements MEDS functionality to support the Medi-Cal program related to member eligibility and interfacing with the county consortia and state and county business

MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)
OTHER ADMIN. POLICY CHANGE NUMBER: 44

partners. The California Department of Technology (CDT) houses MEDS and charges the Department for all associated data storage, processing, networking, data archiving, and backup costs. CDT invoices the Department on a monthly basis for the services provided. CDT data center charges change based on the volume of members enrolled within the MEDS system.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due to the generation of more mainframe jobs. There is no change from FY 2023-24 to FY 2024-25 in the current estimate.

Methodology:
1. Reporting and tracking costs include non-production support costs consisting of CDT data center charges for development, testing, quality assurance, and not all system-related charges related to essential M&O functions.

2. M&O costs include, but are not limited to, the MEDS Reconciliation Process for both the counties and the State, Third Party Liability file matches related to recipients that may have other health coverage, and Medicaid-related system and production support costs to cover the M&O functions described in the background section.

3. M&O and Reporting and Tracking costs include quarterly reconciliation for OTECH services incorrectly billed, resulting in retro-corrections of expenses.

4. The projected costs for FY 2023-24 and FY 2024-25 are:

FY 2023-24	TF	GF	FF
Reporting and Tracking (50% FF / 50% GF)	$1,232,000	$616,000	$616,000
Maintenance & Operations (75% FF / 25% GF)	$752,000	$188,000	$564,000
Total	**$1,984,000**	**$804,000**	**$1,180,000**

FY 2024-25	TF	GF	FF
Reporting and Tracking (50% FF / 50% GF)	$1,232,000	$616,000	$616,000
Maintenance & Operations (75% FF / 25% GF)	$752,000	$188,000	$564,000
Total	**$1,984,000**	**$804,000**	**$1,180,000**

Funding:
50% Title XIX / 50% GF (4260-101-0890/0001)
75% Title XIX / 25% GF (4260-101-0890/0001)

MFP/CCT SUPPLEMENTAL FUNDING

OTHER ADMIN. POLICY CHANGE NUMBER: 45
IMPLEMENTATION DATE: 10/2022
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2392

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$1,950,000	$1,950,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,950,000	$1,950,000

Purpose:
This policy change budgets supplemental funding in Money Follows the Person (MFP) that the Centers for Medicare and Medicaid Services (CMS) made available to state MFP grantees to support planning and capacity building activities.

Authority:
Federal Deficit Reduction Act (DRA) of 2005 (P.L. 109-171), Section 6071
Affordable Care Act (ACA) (P.L. 111-148), Section 2403
Medicaid Extenders Act of 2019 (P.L. 116-3), Section 2
Medicaid Services Investment and Accountability Act of 2019 (P.L. 116-16), Section 5
Sustaining Excellence in Medicaid Act of 2019 (P.L. 116-39), Section 4
Further Consolidated Appropriations Act, 2020 (P.L. 116-94), Section 205
Coronavirus Aid, Relief, and Economic Security (CARES) Act, 2020 (P.L. 116-136) Section 3811
Consolidated Appropriations Act, 2021 (P.L. 108-361) Section 204
Contract #22-20091

Interdependent Policy Changes:
Not Applicable

Background:
On September 23, 2020, CMS notified MFP state grantees of a supplemental funding opportunity for those that operate MFP Demonstration programs. The Department developed a proposal to submit to CMS to receive up to $5 million in supplemental funding for planning and capacity building activities to accelerate long-term care system transformation design and implementation, and to expand home and community-based services capacity. The Department submitted their proposal for supplemental funding to CMS on June 30, 2021.

On July 27, 2021, CMS approved the Department's MFP Supplemental Funding application. CMS approved the Department's request for $5 million in supplemental funding to conduct a statewide Gap Analysis and Multiyear Roadmap of its Home and Community-Based Services (HCBS) and Managed Medi-Cal Long-Term Supports and Services programs and networks. The Department's project narrative identified how the funding will be utilized for planning and capacity building activities to accelerate long-term care system transformation design and implementation, and to expand HCBS capacity.

In July 2022, the Department selected Mathematica to conduct the MFP Supplemental Funding – Gap Analysis and Multiyear Roadmap. The contract between Mathematica and the

MFP/CCT SUPPLEMENTAL FUNDING
OTHER ADMIN. POLICY CHANGE NUMBER: 45

Department was fully executed on October 6, 2022, retroactive to September 1, 2022, through June 30, 2025. The Department intends to roll over unspent funds from the first year of the contract to the outyears through a contract amendment.

Reason for Change:
The change from the prior estimate, is an increase for FY 2023-24, due to shifting funds from FY 2022-23 into FY 2023-24 for payment as a result of contract activities being initiated later than expected. There is no change from FY 2023-24 to FY 2024-25 in the current estimate.

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 will receive a one-time MFP supplemental funding up to $5,000,000 TF through FY 2024-25.

3. Assume the Department spent $1,014,000 TF in FY 2022-23 and will spend **$1,950,000 TF** in **FY 2023-24** and in **FY 2024-25**.

Funding:
MFP Federal Grant (4260-106-0890)

CALIFORNIA HEALTH INTERVIEW SURVEY

OTHER ADMIN. POLICY CHANGE NUMBER: 46
IMPLEMENTATION DATE: 7/2015
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1902

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$1,757,000	$1,785,000
STATE FUNDS	$178,500	$192,500
FEDERAL FUNDS	$1,578,500	$1,592,500

Purpose:
This policy change estimates the California Health Interview Survey (CHIS) contract services costs.

Authority:
Interagency Agreement (IA) 21-10053
IA 22-20502 (Pending)

Interdependent Policy Changes:
Not Applicable

Background:
CHIS is a random-dial telephone survey that asks questions on a wide range of health topics. CHIS is conducted on a continuous basis allowing it to provide a detailed picture of the health and health care needs of California's large and diverse population. The survey provides statewide information on the overall population including many racial and ethnic groups, as well as county-level information for most counties to aid with health planning, priority setting, and to compare health outcomes in numerous ways.

The University of California, Los Angeles (UCLA) Center for Health Policy Research conducts CHIS in collaboration with the California Department of Public Health (CDPH) and the Department. The Department contracts directly with UCLA to utilize the CHIS for program needs and performance. The current contract is funded by federal funds; the non-federal share is paid through certified public expenditures (CPEs). The Department's current contract with UCLA is effective from July 1, 2021, through June 30, 2024, plus one three-year extension.

Beginning January 2023, the Department will contract with UCLA to fund the addition of a Caregiving Module to the CHIS. The Department is currently working with UCLA to draft the Interagency Agreement for the Caregiving Module. The contract will be funded with 50% federal funds and 50% general fund; the non-federal share will not be paid through CPEs.

Reason for Change:
The change from the previous estimate, for FY 2023-24, is an increase due to additional costs for FY 2022-23 invoices being paid in FY 2023-24. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to increased contract costs for the Caregiving Module in the CHIS.

CALIFORNIA HEALTH INTERVIEW SURVEY

OTHER ADMIN. POLICY CHANGE NUMBER: 46

Methodology:

1. On an accrual basis, beginning FY 2023-24, the maximum reimbursable amount for CHIS is $1,400,000 FF annually.

2. Beginning January 2023, funding from the Department for the Caregiving Module will be added to the CHIS. This portion of CHIS funding will not be eligible for CPEs.

3. The estimated administrative costs reimbursements for FY 2023-24 and FY 2024-25, on a cash basis, are:

FY 2023-24	TF	GF	FF
FY 2022-23 Claims	$117,000	$0	$117,000
FY 2023-24 Claims	$1,283,000	$0	$1,283,000
FY 2022-23 Caregiving Module Invoices	$127,000	$63,000	$64,000
FY 2023-24 Caregiving Module Invoices	$230,000	$115,000	$115,000
Total	**$1,757,000**	**$178,000**	**$1,579,000**

FY 2024-25	TF	GF	FF
FY 2023-24 Claims	$117,000	$0	$117,000
FY 2024-25 Claims	$1,283,000	$0	$1,283,000
FY 2023-24 Caregiving Module Invoices	$21,000	$10,000	$11,000
FY 2024-25 Caregiving Module Invoices	$364,000	$182,000	$182,000
Total	**$1,785,000**	**$192,000**	**$1,593,000**

*Totals may differ due to rounding.

Funding:

100% Title XIX FF (4260-101-0890)
50% Title XIX FF / 50% GF (4260-101-0890/0001)

PROTECTION OF PHI DATA

OTHER ADMIN. POLICY CHANGE NUMBER: 47
IMPLEMENTATION DATE: 5/2010
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1452

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$1,656,000	$1,408,000
STATE FUNDS	$828,000	$704,000
FEDERAL FUNDS	$828,000	$704,000

Purpose:
This policy change estimates the upgrades to the infrastructure and ongoing costs of maintaining and securing electronic Protected Health Information (PHI).

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
The Department has implemented security processes, technologies, and backup systems to protect, monitor, and secure electronic PHI data to minimize the amount of encrypted data flowing across the Wide Area Network. These systems contain Medi-Cal member information that is considered confidential and/or PHI by federal and state mandates.

The current protection of these systems will:

- Secure and protect the Department’s electronic data from unauthorized disclosure;
- Protect the privacy of Medi-Cal members;
- Avoid costs to notify millions of people if a large breach does occur; and
- Maintain the Department’s public image and integrity by protecting the confidentiality and privacy of the information that it maintains on its customers.

The Department is continuing its effort in protecting PHI data and will continue to implement and improve security processes and technologies to ensure the Confidentiality, Integrity, and Availability of PHI data and establish accountability for the Department’s administrators and employees with access to PHI data. These ongoing efforts ensure that new and current systems adhere to the Principles of Confidentially, Integrity, and Availability in the most secure manner available. Privileged Access Management (PAM) looks into the entire privileged account lifecycle, starting from granting and revoking permissions of these accounts to having a fail-proof password change cycle.

The Department is also continuing to enhance current security tools and services to reduce its inherent risk pertaining to account compromise, privilege escalation, and lateral movement. These ongoing efforts also will have the residual effect of deterring breaches and cutting off the spread of ransomware before it is allowed to propagate across the organization. In addition, the Department continues to migrate data from on-premises servers to the Department's Amazon Web Services (AWS) cloud in an immutable format that ransomware cannot infect.

PROTECTION OF PHI DATA
OTHER ADMIN. POLICY CHANGE NUMBER: 47

Reason for Change:
The change from the prior estimate, for FY 2023-24, is a net increase due to adjusted projections. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to delayed payment for Imperva Secure Sphere in FY 2023-24 and not in FY 2024-25.

Methodology:
1. The costs include annual hardware and software maintenance and support for:
    a. Data Domain is a solution that stores data and includes a software suite that protects data by limiting and monitoring staff access and encrypting data at rest.
    b. Backup and Recovery System is a solution that protects data and prevents data loss by delivering data archival, monitoring, access control, encryption at rest, backup, and point-in-time recovery.
    c. Database Activity Monitoring (DAM) system is a database firewall that has data security profiles designed to protect databases, monitor activities, provide staff access control, and capture security events. The department is looking to upgrade the software to provide better safeguards and security.

2. The annual costs include licensing, software maintenance, implementation, and contracted personnel to perform the administrative functions of the solution.
    a. 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.

3. The following amounts are based upon the latest projections of cost:

Fiscal Year	TF	GF	FF
FY 2023-24	$1,656,000	$828,000	$828,000
FY 2024-25	$1,408,000	$704,000	$704,000

* Totals may differ due to rounding

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

GENDER-AFFIRMING CARE

OTHER ADMIN. POLICY CHANGE NUMBER: 48
IMPLEMENTATION DATE: 7/2023
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 2404

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$1,500,000	$1,500,000
STATE FUNDS	$750,000	$750,000
FEDERAL FUNDS	$750,000	$750,000

Purpose:
This policy change estimates expenditures related to developing a quality standard to measure cultural competency and a training for evidence-based cultural competency for Medi-Cal managed care plans (MCP) and Program of All-Inclusive Care for the Elderly (PACE) organizations.

Authority:
SB 923 of Budget Act of 2022

Interdependent Policy Changes:
Not Applicable

Background:
SB 923 ensures that California prioritizes the delivery of inclusive healthcare by requiring that health plans ensure their contracted providers and staff who interact with transgender, gender diverse, or intersex (TGI) people undergo cultural competency training. By requiring that a health plan's online directories include a search feature that shows providers who offer gender affirming services, SB 923 will help TGI individuals to make informed decisions regarding their primary care and health needs.

The Department is participating in a work group to develop a quality standard to measure cultural competency and training to provide trans-inclusive health care for individuals who identify as TGI. If a complaint has been filed and a decision has been made in favor of the complainant, Medi-Cal MCPs and PACE organization subcontractors, downstream subcontractors, and staff in direct contact with members will need to complete a refresher course for not providing trans-inclusive health care. The Department is also helping to develop and implement procedures and impose sanctions to ensure compliance with the above-described provisions. The Department will track and monitor complaints received related to trans-inclusive health care and publicly report this data with other complaint data on its website. Medi-Cal MCPs and PACE organizations will include information within or accessible from their provider directories and accessible from their call centers that identify which of their in-network providers have affirmed that they offer and have provided gender-affirming services. The Department will adopt regulations by July 1, 2027, and implement these provisions by means of guidance letters or similar instructions without taking any regulatory action before that date. The Department is required to provide semiannual status reports to the Legislature until regulations are adopted.

GENDER-AFFIRMING CARE

OTHER ADMIN. POLICY CHANGE NUMBER: 48

Reason for Change:
There is no change from the prior estimate for FY 2023-24. There is no change from FY 2023-24 to FY 2024-25 in the current estimate.

Methodology:

1. The estimated costs, including planning and development for gender-affirming care, are $1,500,000 TF ($750,000 GF) in FY 2023-24 and $1,500,000 TF ($750,000 GF) in FY 2024-25.

2. Assume any associated managed care costs are sufficiently captured in the managed care base rates. Any adjustments necessary will be updated accordingly in future rate updates.

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

MEDCOMPASS SOLUTION

OTHER ADMIN. POLICY CHANGE NUMBER: 49
IMPLEMENTATION DATE: 7/2017
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1982

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$1,365,000	$5,320,000
STATE FUNDS	$358,600	$1,398,850
FEDERAL FUNDS	$1,006,400	$3,921,150

Purpose:
This policy change estimates contractor costs to implement the MedCompass system changes and ongoing licensing and operations costs.

Authority:
Title XIX of the Federal Social Security Act 1903(a) (3)
Contract # 16-93448 A03
Contract # 24-40001

Interdependent Policy Changes:
COVID-19 Increased FMAP – Other Admin

Background:
The MedCompass is a Software-as-a-Service solution that was implemented for the Integrated Systems of Care Division (ISCD) with a solution provider, AssureCare. MedCompass replaced the Case Management Information System and Microsoft Access Databases that ISCD used to manage cases under the Home and Community-Based Alternatives Waiver, Early Periodic Screening, Diagnostics and Treatment, and Assisted Living Waiver Programs.

MedCompass entered Maintenance and Operations (M&O) on December 18, 2017. The Department obtained Centers for Medicare and Medicaid Services (CMS) certification approval for the MedCompass system on May 14, 2021. The Department submitted a cost recoupment change in MedCompass M&O federal financial participation (FFP) from 50% FF / 50% GF to 75% FF / 25% GF in August 2022. The recoupment request included eligible costs from October 1, 2019, to May 14, 2021. The Department received CMS approval for the cost recoupment change of $626,000 in September 2022; the recoupment was completed in December 2022.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is a decrease due to having paid licensing cost expenditures early. Licensing costs were paid in June 2023 rather than the previously budgeted September 2023.The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to licensing costs and procurement of a Non-Competitively Bid (NCB) contract with AssureCare, LLC, which includes higher hosting and M&O costs.

Methodology:
1. The estimated costs are based upon the MedCompass solution provider contract provisions, as amended in July 2021, to exercise the contract's provision for three optional years ending on June 30, 2024.

MEDCOMPASS SOLUTION
OTHER ADMIN. POLICY CHANGE NUMBER: 49

2. From October 1, 2019, to May 14, 2021, all costs reflect payment at 50% FF/ 50% GF. The MedCompass system was certified in May 2021 and currently claims applicable costs at 75% FF/ 25% GF.

3. The Department is currently pursuing an NCB eight-year term contract with AssureCare, LLC, to continue delivering the MedCompass Software as a Service (SaaS) solution M&O support services. The new contract is anticipated to begin on July 1, 2024, and end on June 30, 2032, and includes two optional two-year terms.

FY 2023-24	TF	GF	FF
M&O	$1,365,000	$359,000	$1,006,000
Total	**$1,365,000**	**$359,000**	**$1,006,000**

FY 2024-25	TF	GF	FF
M&O	$5,320,000	$1,399,000	$3,921,000
Total	**$5,320,000**	**$1,399,000**	**$3,921,000**

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)
COVID-19 funding is identified in the COVID-19 Increased FMAP – Other Admin policy change

SSA COSTS FOR HEALTH COVERAGE INFO.

OTHER ADMIN. POLICY CHANGE NUMBER: 50
IMPLEMENTATION DATE: 1/1989
ANALYST: Javier Guzman
FISCAL REFERENCE NUMBER: 237

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$1,266,000	$1,321,000
STATE FUNDS	$633,000	$660,500
FEDERAL FUNDS	$633,000	$660,500

Purpose:
This policy change estimates the cost of obtaining Supplemental Security Income/State Supplementary Payment (SSI/SSP) recipient information from the Social Security Administration (SSA).

Authority:
Social Security Act 1634(a)

Interdependent Policy Changes:
Not Applicable

Background:
The Department uses SSI/SSP information from the SSA to defer medical costs to other payers. The SSA administers the SSI/SSP programs. The SSI program is a federally funded program, which provides income support for persons aged 65 or older and qualified blind or disabled individuals. The SSP is a state program which augments SSI. The Department receives SSI/SSP information about health coverage and assignment of rights to medical coverage from SSA. The SSA bills the Department quarterly for this activity.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is an increase based on an average projection using the actual billed amount from SSA in FY 2020-21, FY 2021-22, and FY 2022-23.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase based upon the most current actual billed amounts from SSA for FY 2021-22, FY 2022-23, and the projected billing for FY 2023-24.

Methodology:
1. The following projections are averaged based upon the most current actual billings from SSA.

Fiscal Year	TF	GF	FF
FY 2023-24	**$1,266,000**	**$633,000**	**$633,000**
FY 2024-25	**$1,321,000**	**$660,000**	**$661,000**

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

FAMILY PACT PROGRAM ADMIN.

OTHER ADMIN. POLICY CHANGE NUMBER: 51
IMPLEMENTATION DATE: 7/2012
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 1675

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$965,000	$915,000
STATE FUNDS	$96,500	$91,500
FEDERAL FUNDS	$868,500	$823,500

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
AB 1464 (Chapter 21, Statutes of 2012)

Interdependent Policy Changes:
Not Applicable

Background:
The Family PACT program has two main objectives, to increase (1) access to services for low-income women and men, including adolescents; and (2) the number of providers who serve these clients. Education and support services are provided to the Family PACT providers and potential providers, as well as clients and potential clients. Services include, but are not limited to:

- Public education, awareness, and direct client outreach;
- Provider enrollment, recruitment, and training;
- Training and technical assistance for medical and non-medical staff;
- Education and counseling services;
- Preventive clinical services;
- Sexually transmitted infection/human immunodeficiency virus training and technical assistance services; and
- Toll-free referral number.

Reason for Change:
The change from the prior estimate for FY 2023-24, and the change from FY 2023-24 to FY 2024-25 in the current estimate, is a decrease due to projections that utilize the lower expenditure trends from FY 2021-22 and FY 2022-23.

FAMILY PACT PROGRAM ADMIN.

OTHER ADMIN. POLICY CHANGE NUMBER: 51

Methodology:

1. The administrative costs for the Family PACT program are estimated in the table below:

Fiscal Years	TF	GF	FF
FY 2023-24	$965,000	$96,500	$868,500
FY 2024-25	$915,000	$91,500	$823,500

Funding:

90% Family Planning / 10% GF (4260-101-0890/0001)

MMA - DSH ANNUAL INDEPENDENT AUDIT

OTHER ADMIN. POLICY CHANGE NUMBER: 52
IMPLEMENTATION DATE: 7/2009
ANALYST: Calvin Low
FISCAL REFERENCE NUMBER: 266

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$747,000	$800,000
STATE FUNDS	$373,500	$400,000
FEDERAL FUNDS	$373,500	$400,000

Purpose:
This policy change estimates the administrative costs of contracting for the annual independent audit of the Disproportionate Share Hospital (DSH) program.

Authority:
Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)
Title 42, Code of Federal Regulations, section 455.300 et. seq.

Interdependent Policy Changes:
Not Applicable

Background:
The MMA requires an annual independent certified audit that primarily certifies:

1. The extent to which DSH hospitals have reduced their uncompensated care costs to reflect the total amount of claimed expenditures made under section 1923 of the MMA.

2. That DSH payment calculations of hospital-specific limits include all payments to DSH hospitals, including supplemental payments.

DSH-eligible Designated Public Hospitals participating in the Global Payment Program are not subject to the DSH audit.

The audits are funded with 50% Federal Financial Participation and 50% General Fund (GF). The Centers for Medicare and Medicaid Services (CMS) released the final regulation and criteria for the annual certified audit in 2008. Each fiscal year's annual audit and report is due to CMS by December 31st.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to lower actual invoice amounts for May and June 2023 than previously estimated.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to higher estimated payments in FY 2024-25, which is based on an estimated monthly average of the full contracted amount.

MMA - DSH ANNUAL INDEPENDENT AUDIT

OTHER ADMIN. POLICY CHANGE NUMBER: 52

Methodology:

1. The initial contract period began on January 1, 2020, and was valid through June 30, 2022, for a total amount of $2,000,000. The Department has exercised an extension through December 31, 2024 for an additional $2,000,000.

2. Prior to the conclusion of the current DSH Audit contract, the Department plans to initiate a new contract, similar to the prior contract, to allow for continued DSH audits through an independent auditing firm beginning in January 2025.

3. In FY 2023-24, the Department will make payments for the FY 2019-20 and FY 2020-21 audit invoices.

4. In FY 2024-25, the Department will make payments for the FY 2020-21 and FY 2021-22 audit invoices.

Fiscal Year	TF	GF	FF
FY 2023-24	$747,000	$373,000	$374,000
FY 2024-25	$800,000	$400,000	$400,000

Funding:

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

CCT OUTREACH - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 53
IMPLEMENTATION DATE: 4/2011
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 1556

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$340,000	$340,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$340,000	$340,000

Purpose:
This policy change budgets the federal funding to cover California Community Transitions (CCT) administrative costs to increase the community-based network of service providers that serve the CCT-eligible population.

Authority:
Federal Deficit Reduction Act (DRA) of 2005 (P.L. 109-171), Section 6071
Affordable Care Act (ACA) (P.L. 111-148), Section 2403
Medicaid Extenders Act of 2019 (P.L. 116-3), Section 2
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
Consolidated Appropriations Act, 2023 (P.L. 117-328), Section 5114
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 & Medicaid Services (CMS) authorized the Department to draw down $750,000 in MFP Rebalancing Demonstration supplemental grant funding. The Department allocated the supplemental grant funding to implement an assessment tool to improve the ability of Skilled Nursing Facilities/Nursing Facilities, states, and other qualified entities to identify members who are interested in returning to the community. The Department is collaborating with the Aging and Disability Resources Connection (ADRC) programs, CCT lead organizations, and other community-based providers to increase the community-based network of service providers that serve the CCT-eligible population. This supplemental grant funding does not require matching funds. The costs were 100% federally funded.

Beginning January 1, 2016, the Department will allocate MFP grant funding to continue efforts that were initiated under the supplemental grant to increase community-based network of service providers that serve the CCT-eligible population. These activities qualify as administrative marketing and outreach activities, which are 100% federally funded through the MFP grant.

On January 24, 2019, the federal Medicaid Extenders Act of 2019 was passed into law and authorized MFP state grantees to continue to transition members to through December 31,

CCT OUTREACH - ADMINISTRATIVE COSTS
OTHER ADMIN. POLICY CHANGE NUMBER: 53

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.

On December 27, 2020, the President signed the Consolidated Appropriations Act, 2021 into law, which includes an extension of the MFP grant through FFY 2023 and appropriates funding through 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 December 29, 2022, the President signed the Consolidated Appropriations Act of 2023 into law, which appropriates additional funding for each fiscal year 2024 through 2027. Unexpended grant funds awarded for any fiscal year can continue to be spent for up to four additional years, through September 30, 2031.

Reason for Change:
There is no change from the prior estimate, for FY 2023-24. There is no change, in the current estimate, from FY 2023-24 to FY 2024-25.

Methodology:
1. Assume $340,000 from the MFP grant administrative funding is expected to be paid in FY 2023-24 and FY 2024-25.

2. A new contract was executed in January 2024.

3. Estimated costs are based on the approved contract budget which includes proposed expenditures for the following activities:

    - ADRC planning and implementation,
    - ADRC/MFP collaborative strategic planning,
    - MDS 3.0 Section Q referrals policy development,
    - MDS/Options counseling training sessions, and
    - ARDC Workgroup.

CCT OUTREACH - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 53

FY 2023-24	TF	GF	FF
CCT Costs PC:			
GF costs and Total FFP	$27,259,000	$5,480,000	$21,779,000
State-Funded CCT Population	$3,000	$2,000	$1,000
ALW Transition Costs	$21,546,000	$5,576,000	$15,970,000
COVID-19 Title XIX Increased FFP	$0	($205,000)	$205,000
Total Costs	$48,808,000	$10,853,000	$37,955,000
CCT Savings:			
Total GF savings and Total FFP	($103,791,000)	($51,895,000)	($51,896,000)
CCT Fund Transfer to CDSS PC:			
CCT Fund Transfer Costs	$287,000	$0	$287,000
COVID-19 Title XIX Increased FFP	$8,000	$0	$8,000
Total Costs	$295,000	$0	$295,000
CCT Outreach - Admin costs PC:	**$340,000**	**$0**	**$340,000**
Total of CCT PCs including savings	($54,348,000)	($41,042,000)	($13,306,000)

*The savings are included in the total, however, they are fully reflected in the base estimates.

CCT OUTREACH - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 53

FY 2024-25	TF	GF	FF
CCT Costs PC:			
GF costs and Total FFP	$40,541,000	$8,151,000	$32,390,000
State-Funded CCT Population	$3,000	$2,000	$1,000
ALW Transition Costs	$21,546,000	$9,533,000	$12,013,000
Total Cost	$62,090,000	$17,686,000	$44,404,000
CCT Savings:			
Total GF savings and Total FFP	($133,348,000)	($66,674,000)	($66,674,000)
CCT Fund Transfer to CDSS PC:	$391,000	$0	$391,000
CCT Outreach - Admin costs PC:	**$340,000**	**$0**	**$340,000**
Total of CCT PCs including savings	($70,918,000)	($48,988,000)	($21,930,000)

*The savings are included in the total, however, they are fully reflected in the base estimates.

Funding:
MFP Federal Grant (4260-106-0890)

HEALTH PLAN OF SAN MATEO DENTAL INTEGRATION EVAL

OTHER ADMIN. POLICY CHANGE NUMBER: 54
IMPLEMENTATION DATE: 7/2023
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 2438

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$68,000	$164,000
STATE FUNDS	$34,000	$82,000
FEDERAL FUNDS	$34,000	$82,000

Purpose:
This policy change estimates costs for the statutorily mandated external program evaluation of the Health Plan of San Mateo (HPSM) Dental Integration.

Authority:
SB 849 (Chapter 47, Statutes of 2018)

Interdependent Policy Changes:
Not Applicable

Background:
Chapter 47, Statues 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 contract is anticipated to begin in FY 2023-24 and extend through FY 2026-27, with the evaluation produced during the final year.

Reason for Change:
This is a new policy change.

Methodology:
1. On a cash basis, costs for the procurement of this service and initial implementation cost assumed for the vendor are estimated to be:

Fiscal Years	TF	GF Reimb.	FF
FY 2023-24	$68,000	$34,000	$34,000
FY 2024-25	$164,000	$82,000	$82,000

HEALTH PLAN OF SAN MATEO DENTAL INTEGRATION EVAL

OTHER ADMIN. POLICY CHANGE NUMBER: 54

Funding:

FY 2023-24	TF	GF Reimb.	FF
100% Title XIX FF (4260-101-0890)	$34,000	$0	$34,000
Reimbursement GF (4260-601-0995)	$34,000	$34,000	$0
Total	**$68,000**	**$34,000**	**$34,000**

FY 2024-25	TF	GF Reimb.	FF
100% Title XIX FF (4260-101-0890)	$82,000	$0	$82,000
Reimbursement GF (4260-601-0995)	$82,000	$82,000	$0
Total	**$164,000**	**$82,000**	**$82,000**

CALAIM - JUSTICE INVOLVED MAA

OTHER ADMIN. POLICY CHANGE NUMBER: 56
IMPLEMENTATION DATE: 4/2025
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2447

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$0	$12,000,000
STATE FUNDS	$0	$6,000,000
FEDERAL FUNDS	$0	$6,000,000

Purpose:
This policy change estimates the costs for reimbursing counties and state partners for Medi-Cal Administrative Activities (MAA) claims for MAA provided to the justice-involved population 90 days prior to release.

Authority:
Penal Code Section 4011.11
Welfare & Institutions Code Sections 14011.10, 14132.275, 14184.800, and 14186
AB 133 (Chapter 143, Statutes of 2021)

Interdependent Policy Change:
Not Applicable

Background:
California is requesting federal authority necessary to implement California Advancing & Innovating Medi-Cal (CalAIM), a framework that encompasses broad-based delivery system, program and payment reform across the Medi-Cal program. CalAIM recognizes the opportunity to move California's whole-person care approach – first authorized by the Medi-Cal 2020 Section 1115 demonstration – to a statewide level, with a clear focus on improving health and reducing health disparities and inequities. Collectively, the Section 1115 CalAIM demonstration and Section 1915(b) waiver, along with related contractual and Medi-Cal State Plan changes, will enable California to fully execute the CalAIM initiative, providing benefits to certain high needs, hard-to-reach populations, with the objective of improving health outcomes for Medi-Cal members and other low-income people in the state.

Inmates leaving correctional facilities are at extremely high risk of poor health outcomes due to high rates of mental illness, substance use disorders, complex medical conditions, and unmet social needs such as housing insecurity, unemployment, and inadequate social connections. CalAIM proposes to improve outcomes for this population by mandating county inmate pre-release application processes, allowing Medi-Cal reimbursement for services in the 90-day time period prior to release, and to ensure a facilitated referral and linkage ("warm hand-off") to behavioral health services, both to providers in managed care networks and to county behavioral health departments.

The federal Medicaid 1115 demonstration waiver authorizes one-time funding opportunities to correctional agencies through Providing Access and Transforming Health (PATH) 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

CALAIM - JUSTICE INVOLVED MAA
OTHER ADMIN. POLICY CHANGE NUMBER: 56

Department will establish a Justice Involved MAA to ensure county and state participants may have access to an ongoing revenue stream for these activities no later than July 1, 2025, pending the approval of the Centers for Medicare & Medicaid Services (CMS).

CalAIM's justice-involved initiative helps California address poor health outcomes and disproportionate risk of illness and accidental death among justice-involved Medi-Cal eligible adults and youth as they re-enter their communities. To facilitate these activities on an ongoing basis, the Department is proposing to seek federal authority to expand MAA performed by state and county partners for this population. MAA includes activities such as:

- Medi-Cal outreach,
- Facilitating Medi-Cal applications,
- Referrals of Medi-Cal services, and
- Coordination of Medi-Cal services.

Reason for Change:
This is a new policy change.

Methodology:
1. Assume the MAA program for the justice-involved population will be established by FY 2024-25 Quarter 3, given that the necessary approvals are received from CMS, resources requested through the Budget Change Proposal are approved as of July 1, 2024, and following the staff hiring and training process, policy development, and stakeholder engagement.

2. Assume MAA claiming will begin in FY 2024-25 Quarter 3 by at least 50% of the county jails, state prisons, and youth correctional facilities, with the first MAA payments anticipated for payment in Quarter 4 due to a 3-month lag in claims processing.

3. Assume the General Fund will be use for the non-federal share of the MAA claims.

4. Total estimated costs for FY 2024-25 are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2024-25	$12,000	$6,000	$6,000

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

CALAIM - BH - CONNECT DEMONSTRATION ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 57
IMPLEMENTATION DATE: 1/2025
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2398

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$0	$1,554,000
STATE FUNDS	$0	$777,000
FEDERAL FUNDS	$0	$777,000

Purpose:
This policy change estimates the administrative costs of the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration, previously referred to as the California Behavioral Health Community-Based Continuum (CalBH-CBC) 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 are reporting 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 already making many investments in expanding behavioral health services. The BH-CONNECT Demonstration was designed to expand on these investments, complement existing major behavioral health initiatives, and strengthen the continuum of care for Medi-Cal members.

The Department will apply for a new Medicaid Section 1115 demonstration, titled the BH-CONNECT Demonstration, to expand access to and strengthen the continuum of mental health services for Medi-Cal members living with significant behavioral health needs. 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.

CALAIM - BH - CONNECT DEMONSTRATION ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 57

The proposed BH-CONNECT Demonstration approach includes five key components:

- Strengthening the statewide continuum of community-based services and evidence-based practices available through Medi-Cal for individuals living with significant behavioral health needs.
- Supporting statewide practice transformations and improvements in the county-administered behavioral health system.
- Improving statewide county accountability for meeting service improvement requirements and implementing new benefits through incentives, robust technical assistance, and oversight.
- Establishing a county option to provide enhanced community-based services.
- Establishing a county option to receive Federal Funds Participation (FFP) for services provided during short-term stays in IMDs, contingent on counties meeting robust accountability requirements.

This policy change budgets administrative costs for the BH-CONNECT Demonstration.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is due to a delay of the implementation from January 1, 2024 to January 1, 2025.

The change in the current estimate, from FY 2023-24 to FY 2024-25, is due to no administrative costs in FY 2023-24.

Methodology:

1. Assume the BH-CONNECT demonstration will be implemented through a staged approach over multiple years, beginning January 1, 2025.

2. Total estimated administrative costs for the BH-CONNECT Demonstration, on a cash basis, is as follows:

FY 2024-25	TF	GF	FFP	IGT*
SMHS - Statewide	$1,466,000	$107,000	$733,000	$626,000
SMHS -Opt-in	$88,000	$0	$44,000	$44,000
Total	**$1,554,000**	**$107,000**	**$777,000**	**$670,000**

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

CMS DEFERRED CLAIMS - OTHER ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 58
IMPLEMENTATION DATE: 7/2021
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 2123

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$0	$0
STATE FUNDS	-$3,932,000	$0
FEDERAL FUNDS	$3,932,000	$0

Purpose:
This policy change estimates the repayment of administrative deferred claims to the Centers for Medicare and Medicaid Services (CMS).

Authority:
California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)
Title 42, Code of Federal Regulations (CFR), 430.40

Interdependent Policy Changes:
Not Applicable

Background:
CMS reviews claims submitted by state Medicaid agencies to ensure federal financial participation (FFP) eligibility. Claims for which CMS questions the FFP eligibility are deferred and the state Medicaid agency is issued a deferral notice. Upon receipt of the deferral notice, the state Medicaid agency has 120 days to resolve the deferred claim.

When CMS issues a deferral to the state Medicaid agency, in accordance with the timelines set forth in 42 CFR 430.40, the state Medicaid agency must immediately return the deferred FFP to the applicable Payment Management System (PMS) subaccount while the deferral is being resolved. As part of the resolution process, the state Medicaid agency submits documentation in support of the deferred claim to CMS for review. If CMS determines the deferred claim is allowed, then the deferral is released, the funds are returned to the appropriate PMS subaccount, and the state Medicaid agency is notified that the funds are available to be redrawn.

Pursuant to Special Terms and Conditions paragraph 164 of the California Medi-Cal 2020 Demonstration Waiver, Medi-Cal is required to bring all deferrals current. The Department is working with CMS to resolve specific items. All deferred claims and negative PMS subaccount balances must be repaid by the end of the demonstration waiver, December 31, 2020, or within three years from CMS' approval of California's repayment schedule, whichever is longer.

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.

CMS DEFERRED CLAIMS - OTHER ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 58

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to including reclaimed FFP that has been transferred to the GF in FY 2023-24.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to no administrative CMS deferrals or resolved deferrals are estimated in FY 2024-25.

Methodology:
1. In FY 2023-24, the Department has reclaimed $3.93 million FFP in resolved deferrals.

FY 2023-24	Total Estimated Resolved Deferrals
Estimated Resolved Deferrals	($3,932,000)
Total FY 2023-24	**($3,932,000)**

Funding:

FY 2023-24	TF	GF	FF
100% Title XIX FFP (4260-101-0890)	$3,932,000	$0	$3,932,000
100% Title XIX GF (4260-101-0001)	($3,932,000)	($3,932,000)	$0
Total Funds	**$0**	**($3,932,000)**	**$3,932,000**

COVID-19 INCREASED FMAP - OTHER ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 59
IMPLEMENTATION DATE: 7/2023
ANALYST: Kalanie Coleman
FISCAL REFERENCE NUMBER: 2216

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$0	$0
STATE FUNDS	-$223,000	$0
FEDERAL FUNDS	$223,000	$0

Purpose:
This policy change estimates the impact on administrative expenditures of assuming the availability of increased federal medical assistance percentage (FMAP) from January 2020 through December 2023. For the estimated impact of assuming increased FMAP from January 2020 through December 2023 on benefits expenditures, see the COVID-19 Increased FMAP – DHCS policy change.

Authority:
Families First Coronavirus Response Act (FFCRA)
Coronavirus Aid, Relief, and Economic Security (CARES) Act
Consolidated Appropriations Act of 2023

Interdependent Policy Changes:
Not Applicable

Background:
On March 4, 2020, Governor Newsom declared a state of emergency in response to the developing pandemic of COVID-19. A statewide stay at home order was introduced on March 19, 2020. The federal government declared a national public health emergency on January 31, 2020, and a national emergency on March 13, 2020. These actions triggered the availability of Medicaid and Children's Health Insurance Program flexibilities, including under Section 1135 of the Social Security Act. Additionally, the President signed major federal legislation—including the FFCRA and the CARES Act—that provides increased federal funding in Medicaid and creates new options for states to address the COVID-19 pandemic.

Medicare Part D is the prescription drug benefit provided to all dual eligible beneficiaries and other Medicare eligible beneficiaries that enroll in Part D. The federal government requires the states to contribute part of their savings for no longer providing the drug benefit to dual eligible beneficiaries. This is referred to as the Medicare Part D phased-down contribution and is funded 100% by State General Funds.

The effects of the COVID-19 pandemic are unprecedented in modern times from a public health emergency and economic perspective. This will have fiscal impacts across policy areas and beneficiary populations within the Medi-Cal program.

The increased FMAP is effective January 1, 2020, and extends through the last day of the calendar quarter of the Health and Human Services COVID-19 national public health emergency.

COVID-19 INCREASED FMAP - OTHER ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 59

The Consolidated Appropriations Act of 2023, was passed on December 29, 2022 and established a fixed phase-out schedule for the increased FMAP that is no longer dependent on the PHE timeline. The phase-out will occur over Calendar Year 2023, and increased FMAP is available as follows:

- 6.2% increased FMAP for Title XIX and 4.34% for Title XXI from Jan 2020 to March 2023;
- 5% increased FMAP for Title XIX and 3.50% for Title XXI from April 2023 to June 2023;
- 2.5% increased FMAP for Title XIX and 1.75% for Title XXI from July 2023 to Sept 2023;
- 1.5% increased FMAP for Title XIX and 1.05% for Title XXI from Oct 2023 to Dec 2023;
- No increased FMAP beginning January 2024.

Reason for Change:
For dollars budgeted in this policy change, there is a decrease in general fund savings from the prior estimate for FY 2023-24 due to policy change updates. There is a decrease in general fund savings from FY 2023-24 to FY 2024-25, in the current estimate, due to the phase-out schedule for increased FMAP.

Methodology:

1. The increased FMAP of 6.2% is applicable on regular Medicaid 50% FMAP expenditures through March 2023, with a phase-out schedule to apply thereafter through December 2023.

2. A CHIP FMAP increase of 4.34% is applicable on CHIP expenditures through March 2023, with a phase-out schedule to apply thereafter through December 2023.

3. A Breast and Cervical Cancer Treatment Program (BCCTP) FMAP increase of 4.34% is applicable on BCCTP expenditures through March 2023, with a phase-out schedule to apply thereafter through December 2023.

4. The Medicare Part D increase in FMAP from the FFCRA affected the calculation of the phased-down State contribution per capita rates retroactive to January 1, 2020, producing a General Fund saving for the State. The Consolidated Appropriations Act of 2023 established a fixed phase-out schedule through December 2023 for the increased FMAP that is no longer dependent on the PHE timeline. A full year of General Fund savings are assumed for CY and eight months in BY because phased-down payments have a two-month lag. The first nine months of CY savings are reflected in actual expenditures as reported in the Medicare Payments – Part D Phased-Down policy change.

5. The FFCRA is assumed to continue through December 2023 with a phase-out schedule to apply from April 2023 through December 2023.

6. The following estimates reflect a cash basis:

COVID-19 INCREASED FMAP - OTHER ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 59

(Dollars in Thousands)

FY 2023-24	TF	GF	SF	FF
COVID-19 Increased FMAP - DHCS:				
FFCRA T19 Increased FFP	$840	($580,463)	$0	$581,303
FFCRA T21 Increased FFP	$64	($32,219)	$0	$32,283
Medicare Part D FFCRA T19 Incr. FFP	($50,922)	($50,922)	$0	$0
Total COVID-19 Incr. FMAP - DHCS:	($50,018)	($663,604)	$0	$613,587
COVID-19 Increased FMAP - Other Admin:				
FFCRA T21 Increased FFP	$0	($223)	$0	$223
Total COVID-19 Incr. FMAP - Other Admin:	**$0**	**($223)**	**$0**	**$223**
COVID-19 Increased FMAP In other PCs:				
FFCRA T19 Increased FFP	$672,110	($115,673)	($277,369)	$1,065,151
FFCRA T21 Increased FFP	$1,394	($13,873)	($15,351)	$30,617
BCCTP T19 Increased FFP	$0	$26	$0	($26)
Medicare Part D FFCRA T19 Incr. FFP	($66,536)	($66,536)	$0	$0
Total COVID-19 Incr. FMAP In other PCs:	$606,967	($196,056)	($292,719)	$1,095,743
Total of PCs including COVID-19 Increased FMAP	$556,950	($859,883)	($292,719)	$1,709,552

*Totals may differ due to rounding.

COVID-19 INCREASED FMAP - OTHER ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 59

(Dollars in Thousands)

FY 2024-25	TF	GF	SF	FF
COVID-19 Increased FMAP - DHCS:				
FFCRA T19 Increased FFP	$0	$820	$0	($820)
FFCRA T21 Increased FFP	$0	$0	$0	$0
Medicare Part D FFCRA T19 Increased FFP	$0	$0	$0	$0
Total COVID-19 Incr. FMAP - DHCS:	$0	$820	$0	($820)
COVID-19 Increased FMAP - Other Admin:				
FFCRA T21 Increased FFP	$0	$0	$0	$0
Total COVID-19 Incr. FMAP - Other Admin:	**$0**	**$0**	**$0**	**$0**
COVID-19 Increased FMAP In other PCs:				
FFCRA T19 Increased FFP	($1,701)	($103,728)	($132,650)	$234,676
FFCRA T21 Increased FFP	$0	($6,872)	($10,651)	$17,523
BCCTP 4.34% Increased FFP	$0	$0	$0	$0
Medicare Part D FFCRA T19 Incr. FFP	$0	$0	$0	$0
Total COVID-19 Incr. FMAP In other PCs:	($1,701)	($110,600)	($143,301)	$252,199
Total of PCs including COVID-19 Increased FMAP	($1,701)	($109,780)	($143,301)	$251,379

*Totals may differ due to rounding.

Funding:
COVID-19 Title XXI Increased FFP (4260-101-0890)
COVID-19 Title XXI GF (4260-101-0001)

MEDICAL FI BO & IT COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 60
IMPLEMENTATION DATE: 11/2019
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2115

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$53,316,000	$73,096,000
STATE FUNDS	$14,845,550	$19,783,100
FEDERAL FUNDS	$38,470,450	$53,312,900

Purpose:
This policy change estimates the total cost reimbursement of the Gainwell Medical Fiscal Intermediary (FI) contracts.

Authority:
Gainwell Contract # 18-95357
IBM Contract # 18-95302

Interdependent Policy Changes:
COVID-19 Increased FMAP – Other Admin

Background:
The FI contracts require the FIs to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal members. The Assumption of Operations for the Business Operations and Information Technology Maintenance and Operations (IT M&O) contracts started in October 2019. The FI Business Operations contract term is five years with two one-year optional extensions. The IT M&O contract term is five years with two one-year optional extensions.

Various costs incurred by the contractor while performing responsibilities under the contract are reimbursed by the Department using a cost reimbursement, or direct cost, pricing methodology. These costs are not a part of the bid price of the contract and are paid dollar for dollar, with no overhead or profit included. Any of the following costs may be cost reimbursed under the contract:

- Postage
  - Postal rates utilized to mail documents to providers, members, the State, the federal government, or any other Medi-Cal or State program-related business. Return envelope postage is also reimbursable.

- Parcel Services and Common Carriers
  - The actual charges paid for parcel services and common carriers for the delivery of: Medi-Cal and other health program claim and Treatment Authorization Request (TAR) forms to providers; and documents, materials, and equipment to providers, members, and state or federal offices.

MEDICAL FI BO & IT COST REIMBURSEMENT
OTHER ADMIN. POLICY CHANGE NUMBER: 60

- Equipment and Services (personal computers, monitors, printers, related equipment, and software)
    - Installation and monthly charges for data lines;
    - Purchase, lease, installation, and maintenance of desktops for State staff at Field Offices and Contractor facilities; and
    - Point-of-Sale (POS) devices.

- Facilities Lease, Improvement, Modifications
    - The direct costs for the Medi-Cal Operations Center (MOC) as well as any required modifications and improvements.

- Consultant Contracts
    - Consultant contracts utilized for operational project oversight that are paid through Cost Reimbursement.

- Telecommunications and Data Center
    - Telephone Toll Charges – Actual telecommunication charges paid for by the contractor for maintaining toll-free lines available to providers and members, telephone lines for audio text equipment, computer media claims, TAR submissions, the print and distribution center, on-line pharmacy claims processing and on-line eligibility verification, and any other member or provider use lines. Excludes all other direct or indirect costs associated with telephone toll charges.

    - Data Center Access – Actual charges incurred by the contractor for access to records contained in the Medi-Cal Eligibility Data System and the utilization of the telecommunications network, as charged by the Department of Technology Services Data Center.

    - Monthly Cloud Charges

        - MFaaS – Approximately $9 million annual is budgeted for ITM&O hosting of the Mainframe in ITM&O Infrastructure Services policy change (PC) under the current contract. These costs will continue to be paid to the ITM&O vendor until the end of the contract before being transferred to this PC. The Department is exploring MFaaS options for post October 1, 2025 that may change the funding mechanism.

    - Network Management Miscellaneous

        - Non-Mainframe hosting and infrastructure – Approximately $9 million annual is budgeted. Most costs decreasing in the ITM&O contract will come from ITM&O Infrastructure Services PC for non-mainframe hosting. Non-Mainframe will be hosted through Amazon Web Services (AWS) and will be reflected in this PC.

MEDICAL FI BO & IT COST REIMBURSEMENT
OTHER ADMIN. POLICY CHANGE NUMBER: 60

- Software – Approximately $3 million annual. Costs for software are bundled primarily in ITM&O Infrastructure Services PC for ITM&O but may also be reflected in Cost-Reimbursement PC and other PCs related to the ITM&O contract. Some new software will be required as transitions occur, the Department will seek reductions in the ITM&O contract; however, some of these costs are “sunk costs” for vendors as they have already incurred the cost.

- Networking – Network setup will result in smaller costs that may be one-time, ongoing, or both. Future ITM&O contracts will avoid these costs, generating savings estimated at $1 million per year.

- Department support contracts – Approximately $2.25 million annual. Staff augmentation is occurring to support the Department management on the new scope during the transition and ongoing.

- Other Cost Reimbursable Items
  - Equipment and furniture for the Field Office Automation Group (FOAG).

  - The Department has established a rate policy which applies to the contract and defines lodging, mileage, and meal expense reimbursement for travel expenses.

  - Drug Use Review (DUR) work performed on behalf of the Department to provide DUR research, articles for DUR publication, attend conferences, and submit monthly/quarterly reports.

  - Special Training which falls outside the required training scope, as defined by the contract, and directly relates to California Medicaid Management Information System (CA-MMIS) support activities.

  - The demand for the Telehealth Nurse Advice Line (COVID-19 consultations) will continue beyond the planned expiration date of April 30, 2022. There will be $250,000 increase to FY 2023-24, and it will no longer be an anticipated cost beyond FY 2023-24.

- Sales Tax
  - The Department will reimburse the contractor only for the actual sales and/or use tax paid by the Contractor to the California Board of Equalization for the operations of this contract.

- Audits and Research
  - Annual audits for the Electronic Data Processing Application System shall be cost reimbursed for the direct cost of the audit as paid to the independent auditor by the contractor, excluding procurement costs or effort expended by the contractor.

MEDICAL FI BO & IT COST REIMBURSEMENT
OTHER ADMIN. POLICY CHANGE NUMBER: 60

- Change Order and/or Amendments
    - Certain costs associated with Contract Change Orders/ Amendments can be paid through Cost Reimbursement.

Costs under these categories consist of direct costs, or subsets thereof, which can be specifically identified with the particular cost objective.

Reason for Change:
The change in FY 2023-24 from the prior estimate, is an increase due to the delay in transitioning the infrastructure scope and costs out of the ITM&O contract.

The change from FY 2023 to FY 2024-25, in the current estimate, is an increase due to the transitioning of the infrastructure scope and costs out of the ITM&O contract and Consumer Price Index (CPI) adjustments to the Postage and Parcels costs.

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 and IBM contracts, CPI adjustments are applied annually to the contract cost.

FY 2023-24	TF	GF	FF
Postage (50% FF / 50% GF)	$1,847,000	$904,000	$943,000
Parcel Services & Common Carriers (50% FF / 50% GF)	$378,000	$185,000	$193,000
Equipment & Services (75% FF / 25% GF)	$5,009,000	$1,316,000	$3,693,000
Facilities Improvement & Modification (75% FF / 25% GF)	$10,836,000	$2,848,000	$7,988,000
Consultant Contracts (50% FF / 50% GF, 75% FF / 25% GF, 90% FF / 10% GF)	$27,010,000	$7,045,000	$19,965,000
Telecommunications & Data Center (50% FF / 50% GF, 75% FF / 25% GF)	$5,498,000	$1,471,000	$4,027,000
Other Cost Reimbursable Items (50% FF / 50% GF, 75% FF / 25% GF)	$2,738,000	$1,076,000	$1,662,000
Total	**$53,316,000**	**$14,845,000**	**$38,471,000**

MEDICAL FI BO & IT COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 60

FY 2024-25	TF	GF	FF
Postage (50% FF / 50% GF)	$1,939,000	$949,000	$990,000
Parcel Services & Common Carriers (50% FF / 50% GF)	$404,000	$198,000	$206,000
Equipment & Services (75% FF / 25% GF)	$1,008,000	$265,000	$743,000
Facilities Improvement & Modification (75% FF / 25% GF)	$11,104,000	$2,919,000	$8,185,000
Consultant Contracts (50% FF / 50% GF, 75% FF / 25% GF, 90% FF / 10% GF)	$27,437,000	$7,142,000	$20,295,000
Telecommunications & Data Center (50% FF / 50% GF, 75% FF / 25% GF)	$28,365,000	$7,479,000	$20,886,000
Other Cost Reimbursable Items (50% FF / 50% GF, 75% FF / 25% GF)	$2,839,000	$832,000	$2,007,000
Total	**$73,096,000**	**$19,784,000**	**$53,312,000**

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 75% Title XIX / 25% GF (4260-101-0001/0890)
FI 100% GF (4260-101-0001)
FI 65% Title XXI / 35% GF (4260-101-0001/0890)
FI 50% HIPAA FF / 50% GF (4260-117-0001/0890)
FI 75% HIPAA FF / 25% GF (4260-117-0001/0890)
FI 90% HIPAA FF / 10% GF (4260-117-0001/0890)
COVID-19 funding is identified in the COVID-19 Increased FMAP – Other Admin policy change

MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 61
IMPLEMENTATION DATE: 11/2019
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2119

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$42,039,000	$36,652,000
STATE FUNDS	$11,049,900	$9,634,250
FEDERAL FUNDS	$30,989,100	$27,017,750

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:
COVID-19 Increased FMAP – Other Admin

Background:
The IBM FI contracts require the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal members. The Assumption of Operations for the FI IT Maintenance and Operations (IT M&O) contract started in October 2019. The FI contract term is five years with two one-year optional extensions.

IT Development and Operations Services of the Medical FI IT M&O contract are performed and paid under either an hourly rate or a fixed price where the FI provides a set cost per contract year for the services provided under that portion of the contract. IT Development and Operations Services include the following Application Maintenance and Support Services (AMSS):

- Application Development Services
- Application M&O Services
- Project Management Office

Reason for Change:
The change in FY 2023-24, from the prior estimate, is a decrease due to a reduction in SDN hours from 270,000 to 216,000 in FY 2023-24.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to a reduction in SDN hours from 216,000 to 162,000 in FY 2024-25.

MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 61

Methodology:

1. Costs are paid under an hourly rate or via a fixed price negotiated during the procurement phase of the contract.

2. Beginning contract year 3 and each year thereafter through the end of the IBM contract, CPI adjustments are applied annually to the contract cost.

FY 2023-24	TF	GF	FF
Application Development Services	$23,688,000	$6,226,000	$17,462,000
Application M&O Services	$10,628,000	$2,793,000	$7,835,000
Project Management Office	$7,723,000	$2,030,000	$5,693,000
Total	**$42,039,000**	**$11,049,000**	**$30,990,000**

FY 2024-25	TF	GF	FF
Application Development Services	$18,252,000	$4,798,000	$13,454,000
Application M&O Services	$10,656,000	$2,801,000	$7,855,000
Project Management Office	$7,744,000	$2,036,000	$5,708,000
Total	**$36,652,000**	**$9,635,000**	**$27,017,000**

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)
COVID-19 funding is identified in the COVID-19 Increased FMAP – Other Admin policy change

MEDICAL FI BO & IT CHANGE ORDERS

OTHER ADMIN. POLICY CHANGE NUMBER: 62
IMPLEMENTATION DATE: 11/2019
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2117

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$41,918,000	$41,803,000
STATE FUNDS	$11,017,250	$10,988,500
FEDERAL FUNDS	$30,900,750	$30,814,500

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
Senate Bill (SB) 853 (Chapter 717, Statutes of 2010)
Welfare & Institutions Code Section 14105.05
Budget Act of 2022 [Assembly Bill (AB) 179 (Chapter 249, Statutes of 2022)]

Interdependent Policy Changes:
COVID-19 Increased FMAP – Other Admin

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 two one-year optional extensions. The IT M&O contract term is five years with two one-year optional extensions.

Modifications resulting in changes to contractor responsibilities are initiated by Change Orders (CO) and billed separately from contract operations. A CO is a documentable increase of effort identified as having a direct relation to the administration of the contract that is above the volume of the required work within the scope and above the normal costs of the contract. Either or both of the FI contractors may be required to engage in a CO project and their respective scope is determined at the initiation phase. IT Infrastructure Services estimated in this PC are comprised of work that is outside the scope of work that is estimated in the Medical FI IT Infrastructure Services policy change.

MEDICAL FI BO & IT CHANGE ORDERS
OTHER ADMIN. POLICY CHANGE NUMBER: 62

At the time the contract was procured it is unknown how many COs are needed as it may require increased level of work and effort. The Department has agreed to reimburse the FI for all documentable expenses that are a direct result of CO efforts. The BO FI costs are determined during the analysis phase of a CO. The IT Infrastructure, Development, and Operations costs are estimated based on the preliminary pricing bids that have been submitted by the IT M&O contractor.

While COs are generally not known at the time the contract was executed, in this case, the COs were identified and known but detailed scope and line item costs were not finalized. The items were termed “unanticipated tasks” by the Department of General Services when they approved the contract.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is a minor increase due to the addition in Gainwell Change Orders for Business Operations training and B-Notice Improvement costs.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is a minor decrease due to the reduction in some IBM Change Orders.

Methodology:
1. Certain costs, such as software and travel expenses, can be paid through cost reimbursement. These costs are budgeted in the Medical FI BO & IT Cost Reimbursement policy change.

2. The contract allows for overhead and profit to be included in CO expenses (not to exceed thirty-percent). The FI itemizes the actual costs, overhead, and profit on the invoices submitted to the Department.

3. Contract costs are shared between Federal Funds (FF) and General Funds (GF).

4. Beginning contract year 3 and each year thereafter through the end of the contract, Consumer Price Index (CPI) adjustments are applied annually to the contract cost.

MEDICAL FI BO & IT CHANGE ORDERS

OTHER ADMIN. POLICY CHANGE NUMBER: 62

FY 2023-24	TF	GF	FF
Alternative Format CO-16 (Conlon & Braille)	$657,000	$173,000	$484,000
Bus Ops Training	$800,000	$210,000	$590,000
Contract Innovations	$137,000	$36,000	$101,000
Stabilization	$13,650,000	$3,588,000	$10,062,000
Level 1 Help Desk	$1,003,000	$263,000	$740,000
COGNOS	$279,000	$73,000	$206,000
File Maintenance	$4,195,000	$1,102,000	$3,093,000
State Level Registry Services	$127,000	$34,000	$93,000
Security Services	$4,356,000	$1,145,000	$3,211,000
Testing Services	$9,115,000	$2,396,000	$6,719,000
Formulary Liaison Services	$1,370,000	$360,000	$1,010,000
FOAG	$2,200,000	$578,000	$1,622,000
TPL Liaison	$291,000	$76,000	$215,000
API Connect	$258,000	$68,000	$190,000
SAP BO Licenses	$516,000	$135,000	$381,000
Red Hat	$483,000	$127,000	$356,000
Dallas - Mid-Range Storage Refresh	$327,000	$86,000	$241,000
Remote Connectivity-VPN	$243,000	$64,000	$179,000
RAIS Extension	$1,369,000	$360,000	$1,009,000
MF Rehosting Assessment	$542,000	$143,000	$399,000
Total	**$41,918,000**	**$11,017,000**	**$30,901,000**

FY 2024-25	TF	GF	FF
Alternative Format CO-16 (Conlon & Braille)	$657,000	$173,000	$484,000
CO-16 Alternative Format (Threshold Language)	$500,000	$131,000	$369,000
Bus Ops Training	$800,000	$210,000	$590,000
B-Notice Improvements	$250,000	$66,000	$184,000
Contract Innovations	$137,000	$36,000	$101,000
Stabilization	$14,570,000	$3,830,000	$10,740,000
Level 1 Help Desk	$1,040,000	$273,000	$767,000
COGNOS	$270,000	$71,000	$199,000
File Maintenance	$4,285,000	$1,126,000	$3,159,000
Security Services	$4,422,000	$1,162,000	$3,260,000
Testing Services	$9,321,000	$2,450,000	$6,871,000
Formulary Liaison Services	$1,368,000	$359,000	$1,009,000
FOAG	$2,139,000	$563,000	$1,576,000
TPL Liaison	$293,000	$77,000	$216,000
API Connect	$180,000	$48,000	$132,000
SAP BO Licenses	$158,000	$42,000	$116,000
RAIS Extension	$1,413,000	$372,000	$1,041,000
Total	**$41,803,000**	**$10,989,000**	**$30,814,000**

MEDICAL FI BO & IT CHANGE ORDERS

OTHER ADMIN. POLICY CHANGE NUMBER: 62

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)
COVID-19 funding is identified in the COVID-19 Increased FMAP –Other Admin policy change

MEDICAL FI IT INFRASTRUCTURE SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 63
IMPLEMENTATION DATE: 11/2019
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2118

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$32,412,000	$22,096,000
STATE FUNDS	$8,521,450	$5,807,550
FEDERAL FUNDS	$23,890,550	$16,288,450

Purpose:
This policy change estimates the cost of the IBM Medical Fiscal Intermediary (FI) contract Information Technology (IT) Infrastructure Services.

Authority:
IBM Contract # 18-95302

Interdependent Policy Changes:
COVID-19 Increased FMAP – Other Admin

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 Maintenance and Operations (IT M&O) IBM contract started in October 2019. The FI contract term is five years with two one-year optional extensions.

IT Infrastructure Services of the IBM Medical FI IT M&O contract are performed and paid under a fixed price where the FI provides a set cost per contract year for the services provided under that portion of the contract. 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

MEDICAL FI IT INFRASTRUCTURE SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 63

Reason for Change:
The change in FY 2023-24, from the prior estimate, is an increase due to the delay of IBM descoping. Funding is added back to Mainframe Data Center, Disaster Recovery, Service Delivery, Hardware and Software.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to IBM descoping with $10 million shifting to the Medical FI BO IT Cost Reimbursement policy change.

Methodology:
1. 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. Beginning contract year 3 and each year thereafter through the end of the IBM contract, CPI adjustments are applied annually to the contract cost.

FY 2023-24	TF	GF	FF
Mainframe Data Center Operations Services	$5,584,000	$1,468,000	$4,116,000
Midrange Data Center Operations Services	$3,227,000	$848,000	$2,379,000
Midrange Storage Operations Services	$268,000	$71,000	$197,000
Managed Network Services	$4,168,000	$1,096,000	$3,072,000
Disaster Recovery	$1,845,000	$485,000	$1,360,000
Service Delivery Mgmt, Asset Mgmt, and Facilities	$6,588,000	$1,731,000	$4,857,000
Fixed Security Services	$2,552,000	$671,000	$1,881,000
Hardware and Refresh	$593,000	$156,000	$437,000
Software	$7,587,000	$1,995,000	$5,592,000
Total	**$32,412,000**	**$8,521,000**	**$23,891,000**

FY 2024-25	TF	GF	FF
Midrange Data Center Operations Services	$3,493,000	$919,000	$2,574,000
Midrange Storage Operations Services	$259,000	$68,000	$191,000
Managed Network Services	$4,168,000	$1,096,000	$3,072,000
Disaster Recovery	$1,248,000	$328,000	$920,000
Service Delivery Mgmt, Asset Mgmt, and Facilities	$5,084,000	$1,336,000	$3,748,000
Fixed Security Services	$2,488,000	$654,000	$1,834,000
Hardware and Refresh	$472,000	$124,000	$348,000
Software	$4,884,000	$1,283,000	$3,601,000
Total	**$22,096,000**	**$5,808,000**	**$16,288,000**

MEDICAL FI IT INFRASTRUCTURE SERVICES
OTHER ADMIN. POLICY CHANGE NUMBER: 63

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)
COVID-19 funding is identified in the COVID-19 Increased FMAP – Other Admin policy change

MEDICAL FI BO OTHER ESTIMATED COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 64
IMPLEMENTATION DATE: 11/2019
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2112

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$24,859,000	$26,228,000
STATE FUNDS	$7,468,650	$7,877,950
FEDERAL FUNDS	$17,390,350	$18,350,050

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:
COVID-19 Increased FMAP – Other Admin

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 two one-year optional extensions.

Some functions and services of the Gainwell Medical FI contract are performed and paid using a fixed price payment methodology. For fixed price categories, the Contractor is paid a fixed rate for certain annual services.

Costs under this category consist of payment to the contractor for contract services, such as:

- Process Appeals - The Contractor reviews the appeal documents and the claim history, and either rejects the appeal or approves and resubmits the claim for processing. The Contractor regularly provides information to the providers regarding claim appeal status, denial reasons, and estimated payment dates, as appropriate. All appeal information is recorded in the California Medicaid Management Information System (CA-MMIS) Appeals subsystem.

- Support Audits - The Contractor is required to plan, track, and coordinate audit support tasks, gather data or other information requested for the audit, and obtain all information necessary to present a complete and accurate audit response to the Department for review and approval.

- Process Drug Rebates – The Contractor processes drug rebates in order to create invoices submitted to manufacturers which generate revenue received by the Department in excess of $4 billion annually.

MEDICAL FI BO OTHER ESTIMATED COSTS
OTHER ADMIN. POLICY CHANGE NUMBER: 64

- Provide Litigation Support - The Contractor's litigation support includes, but is not limited to, planning, tracking, and coordinating litigation support tasks, developing responses to subpoenas and other legal requests, and providing written and oral testimony on behalf of the Department.

- Service Delivery Support – The Contractor performs broad management, administrative, and supporting services that apply to the delivery of all business, information technology, and facilities services while conforming to standardized process, protocols, templates, and tools as prescribed by the Department.

- Publish Provider Communications – The Contractor assists with the development and distribution of provider communications related to provider billing as well as related processes and procedures. Provider communications take many forms, such as bulletins targeted to the different provider types, forms, public content forums, Provider Manual changes, Medi-Cal website content, provider letters, news articles, system alerts, user guides, technical documents, and education and training opportunities.

- Conduct Provider Outreach and Education – The Contractor conducts centralized and regional provider outreach and education activities, and provides on-site support resources and specialists focused on small providers, and out-of-state providers to address specific provider issues.

- Print and Mail Medi-Cal Information - The Department requires the Contractor to print and mail information of any type, as approved by the Department, to audiences, identified by the Department, on a scheduled and ad hoc basis. The Contractor is also required to create, update, and manage forms, including developing and maintaining a Master Index of Forms. The Contractor prints 1099s, Departmental standard forms, ad hoc forms as requested, and reports monthly regarding these activities.

- Perform Proactive Provider Research - The Contractor conducts research and reviews provider customer services data from multiple sources to identify trends, systemic issues, needs, and concerns. The findings lead to recommendations for development of provider communication materials, provider educational materials, policy changes, and process and procedural improvements for review by the Department. The Contractor prepares position papers, problem statements, and reports for review and approval by the Department prior to taking any action. The Contractor also develops and submits content changes directly to outreach and training teams for inclusion in ongoing services.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to a minor decrease in the Consumer Price Index (CPI) adjustment.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to an increase in the CPI adjustment to FY 2024-25.

MEDICAL FI BO OTHER ESTIMATED COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 64

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 2023-24	TF	GF	FF
Process Appeals (75% FF/25% GF, 100% GF)	$880,000	$232,000	$648,000
Support Audits (75% FF/25% GF)	$188,000	$50,000	$138,000
Process Drug Rebates (75% FF/25% GF)	$1,332,000	$350,000	$982,000
Provide Litigation Support (75% FF/25% GF)	$192,000	$51,000	$141,000
Service Delivery Support (75% FF/25% GF)	$11,042,000	$2,903,000	$8,139,000
Publish Provider Communication Materials (75% FF/25% GF, 50% FF/50% GF)	$3,581,000	$1,509,000	$2,072,000
Conduct Provider Outreach and Education (75% FF/25% GF)	$5,143,000	$1,352,000	$3,791,000
Print and Mail Medi-Cal Information (75% FF/25% GF, 50% FF/50% GF)	$2,301,000	$969,000	$1,332,000
Perform Proactive Provider Research (75% FF/25% GF)	$200,000	$52,000	$148,000
Total	**$24,859,000**	**$7,468,000**	**$17,391,000**

MEDICAL FI BO OTHER ESTIMATED COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 64

FY 2024-25	TF	GF	FF
Process Appeals (75% FF/25% GF, 100% GF)	$928,000	$243,000	$685,000
Support Audits (75% FF/25% GF)	$198,000	$52,000	$146,000
Process Drug Rebates (75% FF/25% GF)	$1,406,000	$370,000	$1,036,000
Provide Litigation Support (75% FF/25% GF)	$203,000	$53,000	$150,000
Service Delivery Support (75% FF/25% GF)	$11,650,000	$3,062,000	$8,588,000
Publish Provider Communication Materials (75% FF/25% GF, 50% FF/50% GF)	$3,779,000	$1,593,000	$2,186,000
Conduct Provider Outreach and Education (75% FF/25% GF)	$5,425,000	$1,426,000	$3,999,000
Print and Mail Medi-Cal Information (75% FF/25% GF, 50% FF/50% GF)	$2,428,000	$1,023,000	$1,405,000
Perform Proactive Provider Research (75% FF/25% GF)	$211,000	$56,000	$155,000
Total	**$26,228,000**	**$7,878,000**	**$18,350,000**

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)
COVID-19 funding is identified in the COVID-19 Increased FMAP – Other Admin policy change

MEDICAL FI BO TELEPHONE SERVICE CENTER

OTHER ADMIN. POLICY CHANGE NUMBER: 65
IMPLEMENTATION DATE: 11/2019
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2116

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$18,185,000	$19,186,000
STATE FUNDS	$5,443,300	$5,741,950
FEDERAL FUNDS	$12,741,700	$13,444,050

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:
COVID-19 Increased FMAP – Other Admin

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 two one-year optional extensions.

The TSC functions and services of the Gainwell Medical FI contract are paid using a fixed price and a variable pricing methodology. For fixed price categories, the Contractor is paid a fixed rate for certain annual services. Variable pricing methodology is based on estimated volume-driven metrics and account for increases in actual volumes. The costs are calculated using a fixed annual rate for transactions up to a State-specified volume and a per-transaction rate for transactions which exceed that volume. Variable pricing is also known as “Fixed Plus.”

The TSC provides telephone and chat services to providers and members in three areas. Each TSC service area utilizes telecommunications infrastructure, Customer Relationship Management application(s), and the records repository which are implemented and maintained by the contractor.

- Provider Customer Services (variable pricing)
- Member Customer Services (variable pricing)
- Financial Services (fixed price)

MEDICAL FI BO TELEPHONE SERVICE CENTER

OTHER ADMIN. POLICY CHANGE NUMBER: 65

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to a minor Consumer Price Index (CPI) adjustment.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to a CPI adjustment in FY 2024-25.

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 2023-24	TF	GF	FF
TSC – Conduct Provider Customer Services (75% FF/25% GF, 50% FF/50% GF)	$9,864,000	$2,953,000	$6,911,000
TSC – Conduct Member Customer Services (75% FF/25% GF, 50% FF/50% GF)	$6,460,000	$1,934,000	$4,526,000
TSC – Provide Financial Services (75% FF/25% GF, 50% FF/50% GF)	$1,861,000	$557,000	$1,304,000
Total	**$18,185,000**	**$5,444,000**	**$12,741,000**

FY 2024-25	TF	GF	FF
TSC – Conduct Provider Customer Services (75% FF/25% GF, 50% FF/50% GF)	$10,407,000	$3,115,000	$7,292,000
TSC – Conduct Member Customer Services (75% FF/25% GF, 50% FF/50% GF)	$6,815,000	$2,040,000	$4,775,000
TSC – Provide Financial Services (75% FF/25% GF, 50% FF/50% GF)	$1,964,000	$587,000	$1,377,000
Total	**$19,186,000**	**$5,742,000**	**$13,444,000**

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)
COVID-19 is identified in the COVID-19 Increased FMAP – Other Admin policy change

MEDICAL FI BUSINESS OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER: 66
IMPLEMENTATION DATE: 11/2019
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2111

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$16,603,000	$17,492,000
STATE FUNDS	$4,388,500	$4,606,000
FEDERAL FUNDS	$12,214,500	$12,886,000

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:
COVID-19 Increased FMAP – Other Admin

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 two one-year optional extensions.

The Operations functions and services of the Gainwell Medical FI contract are paid using a Variable Pricing methodology. The Variable Pricing methodology is based on estimated volume-driven metrics and account for increases in actual volumes. The costs are calculated using a fixed annual rate for transactions up to a State-specified volume and a per-transaction rate for transactions which exceed that volume. Variable Pricing is also known as “Fixed Plus.”

Operations constitute contractual responsibilities required for the contractor to administer and operate the California Medicaid Management Information System (CA-MMIS). These cost categories consist of:

- Process Paper Claims – The Contractor is responsible for the manual entry of claim data into the CA-MMIS Claims system for adjudication, when those claims are received on paper (mail or fax), rather than electronically.

- Process Suspended Claims - The Contractor uses CA-MMIS subsystems and applications to manually adjudicate suspended claims and address suspended claims issues, in accordance with program policy, system validations, established rates, and State and Federal statutes and regulations.

MEDICAL FI BUSINESS OPERATIONS
OTHER ADMIN. POLICY CHANGE NUMBER: 66

- 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 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 2023-24, from the prior estimate, is a net decrease due to the Consumer Price Index (CPI) adjustment and county payments for General Fund (GF) reimbursements to the FI.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is a net increase due to a CPI adjustment increase in FY 2023-24 and county payments for GF reimbursements to the FI.

Methodology:
1. Operation costs are paid using Fixed Plus pricing methodology with a rate for an annual volume threshold and a rate for each transaction which exceeds that threshold.

2. Projected volumes are established by the Department using trends and counts from previous years and the FI rate established by the contract is applied to the respective volume.

3. Costs are shared between Federal Funds (FF), GF, and GF Reimbursements.

MEDICAL FI BUSINESS OPERATIONS
OTHER ADMIN. POLICY CHANGE NUMBER: 66

4. Beginning contract year 3 and each year thereafter through the end of the Gainwell contract, CPI adjustments are applied annually to the cost.

5. County Medi-Cal Services Program (CMSP) is billed annually for services agreed upon in the Incoming Funds Request (IFR) agreement #22-20044.

   - FY 2023-24 cost estimate includes services for FY 2021-22, FY 2022-23, and FY 2023-24.

   - FY 2024-25 includes services for FY 2024-25.

FY 2023-24	TF	GF	FF	Reimbursement
Process Paper Claims	$9,130,000	$2,400,000	$6,730,000	$0
Process Suspended Claims	$3,630,000	$954,000	$2,676,000	$0
Manage Records	$1,428,000	$375,000	$1,053,000	$0
Process Member Card Requests	$1,968,000	$517,000	$1,451,000	$0
Process Paper TAR	$414,000	$109,000	$305,000	$0
Contract #22-20044				
FY 2021-22	$11,000	$0	$0	$11,000
FY 2022-23	$11,000	$0	$0	$11,000
FY 2023-24	$11,000	$0	$0	$11,000
Total	**$16,603,000**	**$4,355,000**	**$12,215,000**	**$33,000**

FY 2024-25	TF	GF	FF	Reimbursement
Process Paper Claims	$9,633,000	$2,532,000	$7,101,000	$0
Process Suspended Claims	$3,829,000	$1,006,000	$2,823,000	$0
Manage Records	$1,507,000	$396,000	$1,111,000	$0
Process Member Card Requests	$2,076,000	$546,000	$1,530,000	$0
Process Paper TAR	$436,000	$115,000	$321,000	$0
Contract #22-20044				
FY 2024-25	$11,000	$0	$0	$11,000
Total	**$17,492,000**	**$4,595,000**	**$12,886,000**	**$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)
COVID-19 funding is identified in the COVID-19 Increased FMAP – Other Admin policy change

MEDICAL FI BO HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 67
IMPLEMENTATION DATE: 11/2019
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2113

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$11,989,000	$12,648,000
STATE FUNDS	$3,152,200	$3,324,450
FEDERAL FUNDS	$8,836,800	$9,323,550

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:
COVID-19 Increased FMAP – Other Admin

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 two one-year optional extensions.

Under the Gainwell Medical FI contract, certain activities are reimbursed on an hourly basis by the Department. The rate paid to the contractor consists of all direct and indirect costs required to support these activities, plus profit. Hourly reimbursed items under the contract consist of Medical Review Services and Service Changes.

- Medical Review Services - The Contractor provides drug utilization review, Formulary File analysis, medical review consultation, and Treatment Authorization Request (TAR) adjudication. An outcome of the Contractor's Medical Review Services is a reduction in excessive treatment and expense while remaining fully compliant with State and Federal requirements and Medi-Cal policy.

- Service Changes - The collection of activities performed by the Contractor's Business Services staff to ensure any changes to the California Medicaid Management Information System (CA-MMIS) Business Services either improve the efficiency of, and/or minimize the disruption to, related services.

MEDICAL FI BO HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 67

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to a minor decrease in a Consumer Price Index (CPI) adjustment.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to a CPI adjustment in FY 2024-25.

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 2023-24	TF	GF	FF
Perform Medical Review Services	$6,804,000	$1,789,000	$5,015,000
Service Changes (formerly Systems Group)	$5,185,000	$1,363,000	$3,822,000
Total	**$11,989,000**	**$3,152,000**	**$8,837,000**

FY 2024-25	TF	GF	FF
Perform Medical Review Services	$7,178,000	$1,887,000	$5,291,000
Service Changes (formerly Systems Group)	$5,470,000	$1,438,000	$4,032,000
Total	**$12,648,000**	**$3,325,000**	**$9,323,000**

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)
COVID-19 funding is identified in the COVID-19 Increased FMAP – Other Admin policy change

MEDICAL FI BO MISCELLANEOUS EXPENSES

OTHER ADMIN. POLICY CHANGE NUMBER: 68
IMPLEMENTATION DATE: 11/2019
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2114

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$2,446,000	$2,161,000
STATE FUNDS	$707,350	$567,600
FEDERAL FUNDS	$1,738,650	$1,593,400

Purpose:
This policy change estimates the cost of miscellaneous expenses of the Gainwell Medical Fiscal Intermediary (FI) contract.

Authority:
Gainwell Contract # 18-95357
Interagency Agreement (IA) # 20-10163, 21-10145 A01, 21-10005 A02, and 22-20086

Interdependent Policy Changes:
COVID-19 Increased FMAP – Other Admin

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 two one-year optional extensions.

Under the Medi-Cal FI contract, services classified as miscellaneous expenses are paid using a fixed pricing methodology and include IAs, Optional Contract Services (OCS), and Facilities provisioning.

Pursuant to an IA with the Department, the California State Controller's Office (SCO) issues warrants to Medi-Cal providers and the California State Treasurer's Office (STO) provides funds for warrant redemption.

Pursuant to an IA with the California Department of Consumer Affairs (CDCA), Medical Board of California, the Department purchases licensure data. This data gives the Department the ability to verify prospective providers are currently licensed prior to enrollment in the Medi-Cal program. It also enables the Department to verify the validity of the referring provider license number on Medi-Cal claims.

OCS are contractor-proposed methods of providing services, functions, and procedures above contract requirements to improve the California Medicaid Management Information System (CA-MMIS) performance. Unlike regular operations activities, OCS are not always part of the FI budget. Costs in this category are due to the contractor proposing an OCS and the Department approving the OCS.

MEDICAL FI BO MISCELLANEOUS EXPENSES

OTHER ADMIN. POLICY CHANGE NUMBER: 68

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 2023-24, from the prior estimate, and from FY 2023-24 to FY 2024-25, in the current estimate is a minor decrease due to declining postage costs attributed to the transition to paperless instead of bulk mail.

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 2023-24	TF	GF	FF
Interagency Agreements (75% FF/25% GF, 50% FF/50% GF)	$2,446,000	$708,000	$1,738,000
Total	**$2,446,000**	**$708,000**	**$1,738,000**

FY 2024-25	TF	GF	FF
Interagency Agreements (75% FF/25% GF)	$2,161,000	$568,000	$1,593,000
Total	**$2,161,000**	**$568,000**	**$1,593,000**

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)
COVID-19 funding is identified in the COVID-19 Increased FMAP – Other Admin policy change

HCO COST REIMBURSEMENT 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 69
IMPLEMENTATION DATE: 11/2018
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 2052

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$31,939,000	$32,740,000
STATE FUNDS	$15,729,950	$16,124,450
FEDERAL FUNDS	$16,209,050	$16,615,550

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 2023-24, is a decrease due updated actuals and adjusted projection calculations. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to adjusted projection calculations.

Methodology:
1. Contract costs are shared between GF and FF.

HCO COST REIMBURSEMENT 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 69

FY 2023-24	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced Title XXI	Enhanced Title XXI
Postage	$16,222,000	$7,705,000	$7,705,000	$284,000	$528,000
Printing	$4,773,000	$2,267,000	$2,267,000	$84,000	$155,000
Materials Maintenance and Development	$3,964,000	$1,883,000	$1,883,000	$69,000	$129,000
Mass Mailings	$1,257,000	$597,000	$597,000	$22,000	$41,000
Other Cost Reimb.	$1,586,000	$753,000	$753,000	$28,000	$52,000
Additional Systems Group Staff	$3,415,000	$1,622,000	$1,622,000	$60,000	$112,000
Miscellaneous	$722,000	$343,000	$343,000	$13,000	$23,000
Total	**$31,939,000**	**$15,170,000**	**$15,170,000**	**$560,000**	**$1,039,000**

FY 2024-25	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced Title XXI	Enhanced Title XXI
Postage	$16,627,000	$7,898,000	$7,898,000	$291,000	$540,000
Printing	$4,894,000	$2,324,000	$2,324,000	$86,000	$160,000
Materials Maintenance and Development	$4,063,000	$1,930,000	$1,930,000	$71,000	$132,000
Mass Mailings	$1,289,000	$612,000	$612,000	$23,000	$42,000
Other Cost Reimb.	$1,625,000	$772,000	$772,000	$28,000	$53,000
Additional Systems Group Staff	$3,501,000	$1,663,000	$1,663,000	$61,000	$114,000
Miscellaneous	$741,000	$352,000	$352,000	$13,000	$24,000
Total	**$32,740,000**	**$15,551,000**	**$15,551,000**	**$573,000**	**$1,065,000**

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 65% Title XXI / 35% GF (4260-101-0001/0890)

HCO OPERATIONS 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 70
IMPLEMENTATION DATE: 11/2018
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 2051

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$31,427,000	$31,940,000
STATE FUNDS	$15,477,700	$15,730,450
FEDERAL FUNDS	$15,949,300	$16,209,550

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 2023-24, is a decrease due to updated actuals and adjusted projection calculations. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to adjusted projection calculations.

Methodology:
1. Operations costs are fixed price rates based on volumes within the minimum and maximum ranges under the HCO contract. These are based on agreed-upon contracted bid rates in the contract.

HCO OPERATIONS 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 70

FY 2023-24	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced Title XXI	Enhanced Title XXI
Transactions	$5,971,000	$2,836,000	$2,836,000	$105,000	$194,000
Packet Mailings	$5,971,000	$2,836,000	$2,836,000	$105,000	$194,000
BDA/Call Center	$19,485,000	$9,255,000	$9,255,000	$341,000	$634,000
Total	**$31,427,000**	**$14,927,000**	**$14,927,000**	**$551,000**	**$1,022,000**

FY 2024-25	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced Title XXI	Enhanced Title XXI
Transactions	$6,069,000	$2,883,000	$2,883,000	$106,000	$197,000
Packet Mailings	$6,069,000	$2,883,000	$2,883,000	$106,000	$197,000
BDA/Call Center	$19,802,000	$9,406,000	$9,406,000	$346,000	$644,000
Total	**$31,940,000**	**$15,172,000**	**$15,172,000**	**$558,000**	**$1,038,000**

Funding:
FI 50%Title XIX / 50% GF (4260-101-0001/0890)
FI 65% Title XXI / 35% GF (4260-101-0001/0890)

HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 71
IMPLEMENTATION DATE: 11/2018
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 2053

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$14,474,000	$13,153,000
STATE FUNDS	$7,128,400	$6,477,650
FEDERAL FUNDS	$7,345,600	$6,675,350

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 2023-24, is an increase due to updated actuals and adjusted projection calculations that include updated contract bid prices and the temporary addition of seventeen (17) ESRs for the resumption of re-determinations after Federal Public Health Emergency. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to the reduction of seventeen (17) ESRs.

Methodology:
1. The hourly reimbursement costs are fixed price hourly rates for full-time equivalent ESR staff at county offices statewide.

HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 71

2. The estimated costs for FY 2023-24 and FY 2024-25 are based on 234.50 ESRs until June 30, 2024, and 217.5 ESRs after June 30, 2024.

FY 2023-24	TF	GF	FF
Title XXI (65% FF / 35% GF)	$13,750,000	$6,875,000	$6,875,000
Title XIX (50% FF / 50% GF)	$724,000	$253,000	$471,000
Total	**$14,474,000**	**$7,128,000**	**$7,346,000**

FY 2024-25	TF	GF	FF
Title XXI (65% FF / 35% GF)	$12,494,000	$6,247,000	$6,247,000
Title XIX (50% FF / 50% GF)	$659,000	$231,000	$428,000
Total	**$13,153,000**	**$6,478,000**	**$6,675,000**

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 65% Title XXI / 35% GF (4260-101-0001/0890)

DENTAL FI-DBO ADMIN 2022 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 72
IMPLEMENTATION DATE: 10/2022
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2380

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$61,652,000	$84,920,000
STATE FUNDS	$12,816,800	$21,856,500
FEDERAL FUNDS	$48,835,200	$63,063,500

Purpose:
This policy change estimates the total administrative cost for operations, cost reimbursable items, and billable labor for the Fiscal Intermediary-Dental Business Operations (FI-DBO) contract. This policy change includes the total cost of Fiscal Intermediary-Dental Business Operations (FI-DBO) contract Takeover, which facilitates the orderly transition of required business services from the incumbent dental Administrative Services Organization (ASO) contract 16-93287 and dental Fiscal Intermediary (FI) contract 16-93286 to the FI-DBO.

Authority:
RFP 20-10354

Interdependent Policy Changes:
Not Applicable

Background:
The Department selected Gainwell Technologies LLC as the FI-DBO vendor, and the resulting Contract Effective Date (CED) was October 1, 2022. FI-DBO Takeover began on CED and continues until the FI-DBO Contractor assumes operations of all required business services from the ASO and FI Contractors, as approved by the Department, with a maximum Takeover completion date of December 31, 2024.

Takeover constitutes all contractual responsibilities required for the FI-DBO Contractor to assume administrative responsibilities, as defined in Exhibit A, Attachment I – Takeover, as well as any work that occurs during Takeover that is required under Exhibit C – General Terms and Conditions, Exhibit D(F) – Special Terms and Conditions, and Exhibit E – Additional Provisions.

The Department is evaluating Additional Contractual Services (ACS) solicited during the request for proposal, and after CED may direct the FI-DBO to implement one or more ACS items, in accordance with Exhibit A, Attachment V – Additional Contractual Services. ACS are services related to the contract Scope of Work that enhance the support for, or increase the efficiency and effectiveness of, administering the Medi-Cal program.

The FI-DBO is a multi-year contract that provides business operations services for the Medi-Cal Dental Program including, but not limited to, claim and Treatment Authorization Request adjudication, Customer Service Center operations, and member and provider outreach. The administrative cost of the FI-DBO consists of reimbursement for operations, cost reimbursement, and billable labor. The administrative cost will be paid through a combination of payment methods including fixed price, variable price, cost reimbursement, and billable labor.

DENTAL FI-DBO ADMIN 2022 CONTRACT
OTHER ADMIN. POLICY CHANGE NUMBER: 72

Operations, which began on December 1, 2023, constitutes all contractual responsibilities required for the contractor to administer and operate the FI-DBO. Operations costs are reimbursed through a combination of fixed price and fixed plus variable price payment methods, across payment categories as defined in Exhibit B, Attachment I, Provision 3.

A two percent (2%) withhold will be administered on Member Outreach and Provider Outreach invoices, to account for performance standards evaluating year-over-year increases in volume, in accordance with Exhibit B, Attachment I, Provision 7.A. The 2% withhold will be held from each monthly invoice until the end of each Contract Year, pending contractor substantiation that annual performance outcomes are met. If the FI-DBO does not meet required performance standards, the 2% withhold will not be released.

The Department will reimburse various cost, in arrears, incurred by the FI-DBO in fulfilling its requirements under the contract, referred to as cost reimbursement. These items are in addition to operations and are not part of the contract bid price. The cost reimbursement payment method is limited to direct cost within the following categories, as defined in Exhibit B, Attachment I, Provision 4:

- Postage
- Parcel Services and Common Carriers
- Office Automation
- Printing
- Travel and Special Training Sessions
- Facilities Improvements
- Audits and Research
- Sales/Use Tax
- Change Orders and/or Contract Amendments
- Consultant Contracts
- Services and Subscriptions
- Annual Risk Assessments
- Conventions, Provider Enrollment Workshops, and Health Fairs
- Telephone Toll Charges
- Language Line
- Clinical Screening
- Translation and Alternative Format Services
- Other Cost Reimbursable Items

In addition, certain activities are reimbursed as billable labor by the Department, subject to written pre-approval from the Department. The rate paid to the contractor consists of all direct and indirect costs required to support these activities.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is a decrease due to the delayed assumption of operations and delay in takeover payments. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to a full year of operational costs.

DENTAL FI-DBO ADMIN 2022 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 72

Methodology:

1. Takeover will be paid on a fixed price basis up to a maximum of thirty million dollars ($30,000,000), and subject to validation of submitted documentation by the Department.

2. Eighty percent (80%) of the Takeover bid will be paid in equal monthly installments, as defined by the Department approved Contractor's project schedule. Twenty percent (20%) of the Takeover bid will be paid upon completion of Takeover as approved by the Department Contracting Officer.

3. ACS items approved for implementation by the Department will be paid on a fixed price basis, in addition to the Takeover maximum, and subject to validation of submitted documentation by the Department.

4. Eighty percent (80%) of each ACS bid will be paid in equal monthly installments, as defined by the Department approved Contractor's project schedule. Twenty percent (20%) of each ACS bid will be paid upon completion of the ACS as approved by the Department Contracting Officer.

5. Takeover Costs:

Fiscal Year	TF	GF	FF
FY 2023-24	$20,000,000	$2,000,000	$18,000,000
FY 2024-25	$0	$0	$0

6. Operations cost are a combination of fixed price and fixed plus variable price for defined payment categories under the FI-DBO contract.

7. A two percent (2%) withhold will be held from monthly Perform Member Outreach and Conduct Provider Outreach invoices, until the end of each Contract Year pending Contractor substantiation that annual performance outcomes are met. The withhold is based on actual invoices received. If performance requirements are met for Contract Year 1, the funds will be released in FY 2024-25.

8. Operations Costs:

Fiscal Year	TF	GF	FF
FY 2023-24	$37,847,000	$9,462,000	$28,385,000
FY 2024-25	$76,101,000	$19,025,000	$57,076,000

9. Cost Reimbursements:

Fiscal Year	TF	GF	FF
FY 2023-24	$2,008,000	$966,000	$1,042,000
FY 2024-25	$4,016,000	$1,933,000	$2,083,000

DENTAL FI-DBO ADMIN 2022 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 72

10. Billable Labor Costs:

Fiscal Year	TF	GF	FF
FY 2023-24	$1,394,000	$349,000	$1,045,000
FY 2024-25	$2,788,000	$697,000	$2,091,000

11. Total Administration Costs:

Fiscal Year	TF	GF	FF
FY 2023-24	$61,652,000	$12,817,000	$48,835,000
FY 2024-25	$84,920,000	$21,857,000	$63,064,000

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 75% Title XIX / 25% GF (4260-101-0001/0890)
FI 90% Title XIX / 10% GF (4260-101-0001/0890)
***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

DENTAL ASO ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 73
IMPLEMENTATION DATE: 3/2018
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2007

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$60,683,000	$11,352,000
STATE FUNDS	$21,742,750	$2,838,000
FEDERAL FUNDS	$38,940,250	$8,514,000

Purpose:
This policy change estimates the total cost for reimbursable items, operations, turnover, and runout for the 2016 Dental Administrative Services Organization (ASO).

Authority:
Contract 16-93287

Interdependent Policy Changes:
Not Applicable

Background:
Delta Dental of California (Delta) was awarded a multi-year ASO contract in 2016. ASO assumption of operations began in February 2018. Delta is responsible for ASO services for the Medi-Cal Dental Program. The administrative costs consist of reimbursement for cost reimbursables, operations, turnover, and runout.

Operations constitute all contractual obligations required for the contractor to administer and operate the ASO. Only direct costs of certain operations are eligible for cost reimbursement. All other costs are to be included in fixed price components. These cost categories consist of:

- Adjudicated Claim Service Lines (ACSL), paid on a per claim line basis and includes claims related to the Dental Transformation Initiative from Federally Qualified Health Centers;
- Treatment Authorization Requests (TAR), paid on a per document basis; and
- Telephone Service Center (TSC), paid on a per minute basis.

A 2% withhold is being administered on operation invoices which are calculated using ACSL and TAR. The 2% withhold will be released if the ASO meets performance requirements set in the ASO contract; if the ASO does not meet performance measures, the 2% withhold will not be released.

Cost reimbursements are direct costs incurred by the enrollment contractor while performing responsibilities under the contract that are in addition to fixed operations costs. Various costs incurred by the contractor while performing responsibilities under the contract will be reimbursed by the Department. These costs are not a part of the bid price of the contract. Any of the following costs may be cost reimbursed under the contract:

DENTAL ASO ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 73

1. Postage
2. Parcel Services and Common Carriers
3. Printing
4. Telephone Toll Charges
5. Special Training Sessions
6. Conventions, Provider Enrollment Workshops, and Health Fairs
7. Facilities Improvement and Modifications
8. Personal Computers, Monitors, Printers, Related Equipment, and Software
9. Cost Reimbursed Audits and Research
10. Independent Contractor Consideration
11. Annual Risk Assessments
12. Miscellaneous

The ASO has expanded its outreach efforts by securing a subcontractor, RSE, who specializes in marketing and education. RSE began with a beneficiary survey at the end of 2017 followed by focused groups in early 2018. This enabled them to identify any gaps or barriers and create marketing strategies that best captured this population's needs, develop innovative marketing approaches, and improve the content of outreach and education materials while containing costs. Outreach and education will help increase beneficiary awareness about dental benefits and provide assistance in locating a dentist to schedule an appointment.

With the release of the Notice of Intent to Award for the Fiscal Intermediary – Dental Business Operations (FI-DBO) contract, the Department expects to utilize the one-time period of extended operations to extend ASO operations into FY 2024-25 to allow the ASO to remain in operations during the FI-DBO Takeover phase. The addition of the period of extended operations, the Turnover, and Runout phases under the ASO contract will be pushed back as a result.

Turnover constitutes all work activities required of the ASO as defined in the contract documents for with Delta. Turnover ensures the orderly transfer of services from the ASO to the successor Fiscal Intermediary-Dental Business Operations (FI-DBO) contract. The schedule of payments for turnover to the ASO is contractually agreed upon. 55% of the turnover bid price is paid in nine equal installments, with nine percent withheld from each installment. One final installment of 45% and withholds is made upon completion of all turnover requirements. These payments started to be paid in September 2023.

Following turnover of the ASO contract is runout. Runout constitutes all work activities required of the ASO during runout, as defined in the contract documents with Delta. Runout ensures the orderly decommissioning of systems and closeout of the ASO contract. The schedule of payments for runout services to the ASO is contractually agreed upon. 55% of the runout bid price is paid in seven equal installments, with seven percent withheld from each installment. One final installment of 45% and withholds is made upon completion of all runout requirements. These payments are expected to be paid starting in November 2024.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due revised estimates for several categories of services and turnover costs. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due operations transitioning and budgeting only runout costs.

DENTAL ASO ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 73

Methodology:

1. Operations costs are fixed price rates based on volumes within minimum and maximum ranges under the ASO contract.

2. ACSL and TAR volumes are based on actual invoices with a caseload growth factor. Provider Enrollment activities account for 15% of the total ACSL/TAR costs.

    a. Provider Enrollment
        i. 58% of costs are funded at 50% FF and 50% GF
        ii. 42% of costs are funded at 75% FF and 25% GF
    b. Remaining costs are funded at 75% FF and 25% GF

3. The 2% withhold is based on actual invoices received. If performance requirements are met for the calendar year, the funds will be released the following September.

4. TSC minutes are based on actual invoices funded at 50% FF and 50% GF.

FY 2023-24	TF	GF	FF
Administration/Operations (75% FF / 25% GF)	$29,870,000	$7,468,000	$22,402,000
Provider Enrollment (50% FF / 50% GF & 75% FF / 25% GF)	$5,271,000	$1,871,000	$3,400,000
2% Withhold (net of prior year withhold release)	($703,000)	($187,000)	($516,000)
Total ACSL/TAR	$34,438,000	$9,152,000	$25,286,000
TSC – Provider (50% FF / 50% GF)	$8,576,000	$4,288,000	$4,288,000
TSC – Beneficiary (50% FF / 50% GF)	$12,804,000	$6,402,000	$6,402,000
Total TSC	$21,380,000	$10,690,000	$10,690,000
Total Operations Costs	**$55,818,000**	**$19,842,000**	**$35,976,000**

5. Cost reimbursements are based on actual invoices with a caseload growth factor.

Cost Reimbursable	TF	GF	FF
FY 2023-24	**$3,365,000**	**$1,526,000**	**$1,839,000**

6. Turnover and Runout Costs

Fiscal Year	TF	GF	FF
FY 2023-24	**$1,500,000**	**$375,000**	**$1,125,000**
FY 2024-25	**$11,352,000**	**$2,838,000**	**$8,514,000**

DENTAL ASO ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 73

7. Total Administration Cost

Fiscal Year	TF	GF	FF
FY 2023-24	$60,683,000	$21,743,000	$38,940,000
FY 2024-25	$11,352,000	$2,838,000	$8,514,000

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 75% Title XIX / 25% GF (4260-101-0001/0890)
***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

DENTAL FI ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 74
IMPLEMENTATION DATE: 11/2017
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2006

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$22,521,000	$22,329,000
STATE FUNDS	$6,469,750	$6,376,500
FEDERAL FUNDS	$16,051,250	$15,952,500

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. Printing
2. Postage
3. Parcel Services and Common Carriers
4. Data Center Access
5. Special Training Sessions
6. Facilities Improvement and Modifications
7. Personal Computers, Monitors, Printers, Related Equipment, and Software
8. Cost Reimbursed Audits and Research

DENTAL FI ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 74

9. Independent Contractor Consideration
10. Annual Risk Assessments
11. Miscellaneous
12. Cost Reimbursement Invoice

Certain activities are reimbursed on an hourly basis by the Department. The rate paid to the contractor consists of all direct and indirect costs required to support these activities. The hourly reimbursed area consists of the Systems Group (SG).

Reason for Change:
The change from the prior estimate, for FY 2023-24, is an increase due to revised projections for several categories of service. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a net decrease 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. Claim and TAR scanned document volumes are based on FY 2022-23 actual document counts and projected forward.

3. Check write expenditures are associated with the cost of sending payment to providers, based on adjudicated claims from the Dental Administrative Services Organization contractor.

FY 2023-24	TF	GF	FF
Scanned Claims/TAR	$12,489,000	$3,122,000	$9,367,000
Check Write	$267,000	$67,000	$200,000
Change Orders	$278,000	$139,000	$139,000
Total	**$13,034,000**	**$3,328,000**	**$9,706,000**

FY 2024-25	TF	GF	FF
Scanned Claims/TAR	$12,352,000	$3,088,000	$9,264,000
Check Write	$272,000	$68,000	$204,000
Change Orders	$290,000	$145,000	$145,000
Total	**$12,914,000**	**$3,301,000**	**$9,613,000**

4. Cost reimbursements are based on actual invoices.

Fiscal Year	TF	GF	FF
FY 2023-24	**$3,080,000**	**$1,540,000**	**$1,540,000**
FY 2024-25	**$2,886,000**	**$1,443,000**	**$1,443,000**

DENTAL FI ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 74

5. Hourly Reimbursables:

System Group	TF	GF	FF
FY 2023-24	$6,407,000	$1,602,000	$4,805,000
FY 2024-25	$6,529,000	$1,632,000	$4,897,000

6. Total Administration Cost:

Fiscal Year	TF	GF	FF
FY 2023-24	$22,521,000	$6,470,000	$16,051,000
FY 2024-25	$22,329,000	$6,376,000	$15,953,000

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 75% Title XIX / 25% GF (4260-101-0001/0890)
***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

PERSONAL CARE SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 75
IMPLEMENTATION DATE: 4/1993
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 236

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$473,549,000	$488,212,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$473,549,000	$488,212,000

Purpose:
This policy change provides Title XIX federal financial participation (FFP) to the California Department of Social Services (CDSS) for the county cost of administering two In-Home Supportive Services (IHSS) programs: the Personal Care Services Program (PCSP) and the IHSS Plus Option (IPO) program. Title XIX FFP is also provided to CDSS for the IHSS Case Management & Information Payrolling System (CMIPS) Legacy and CMIPS II.

Authority:
Interagency Agreement (IA) 03-75676
IA 09-86307 IPO
IA 18-95714

Interdependent Policy Changes:
Not Applicable

Background:
The IHSS programs, PCSP and IPO, enable eligible individuals to remain safely in their own homes as an alternative to out-of-home care. The PCSP and IPO program provide benefits that include domestic services, non-medical personal care services, and supportive services. The Medi-Cal program includes PCSP in its schedule of benefits.

Both the CMIPS Legacy and CMIPS II are currently used to authorize IHSS payments and provide CDSS and the counties with information such as wages, taxes, hours per case, cost per hour, caseload, and funding ratios.

Reason for Change:
The change from the prior estimate for FY 2023-24 is a decrease, and the change from FY 2023-24 to FY 2024-25 in the current estimate is an increase, due to updated expenditure data provided by CDSS.

PERSONAL CARE SERVICES
OTHER ADMIN. POLICY CHANGE NUMBER: 75

Methodology:
1. On an accrual basis, CDSS estimated FY 2023-24 expenditures at $489,542,000 FF and FY 2024-25 expenditures at $499,502,000 FF.

2. On a cash basis, the estimates below were provided by CDSS.

(Dollars in Thousands)

FY 2023-24	TF	DHCS FFP	CDSS GF/ County Match
EW Time & Health Related	$836,473	$418,237	$418,237
CMIPS II	$66,491	$33,246	$33,246
CMIPS II EVV	$44,133	$22,066	$22,066
Total	$947,097	**$473,549**	$473,549
FY 2024-25	**TF**	**DHCS FFP**	**CDSS GF/ County Match**
EW Time & Health Related	$870,450	$435,225	$435,225
CMIPS II	$61,650	$30,825	$30,825
CMIPS II EVV	$44,325	$22,163	$22,163
Total	$976,425	**$488,212**	$488,212

*Totals may differ due to rounding.

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

HEALTH-RELATED ACTIVITIES - CDSS

OTHER ADMIN. POLICY CHANGE NUMBER: 76
IMPLEMENTATION DATE: 7/1992
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 233

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$358,010,000	$359,692,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$358,010,000	$359,692,000

Purpose:
This policy change provides Title XIX federal financial participation (FFP) to the California Department of Social Services (CDSS) for certain health-related activities provided by county social workers.

Authority:
CWS Interagency Agreement (IA) 01-15931
CWS/CMS IA 06-55834
CSBG/APS IA 01-15931

Interdependent Policy Changes:
Not Applicable

Background:
The health-related services involve helping Medi-Cal eligibles to access covered medical services or maintain current treatment levels in these program areas: 1) Child Welfare Services (CWS); 2) Child Welfare Services/Case Management System (CWS/CMS); 3) County Services Block Grant (CSBG); 4) Adult Protective Services (APS); and 5) Psychotropic Medications Medical Review.

Reason for Change:
There is an increase from the prior estimate for FY 2023-24 due to updated expenditure data provided by CDSS. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a slight increase due to using projections based on updated expenditure data provided by CDSS.

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

HEALTH-RELATED ACTIVITIES - CDSS

OTHER ADMIN. POLICY CHANGE NUMBER: 76

(Dollars in Thousands)

FY 2023-24	TF	DHCS FFP	CDSS GF/ County Match
CWS	$377,210	$188,605	$188,605
CWS/CMS	$9,347	$4,673	$4,673
CSBG/APS	$329,465	$164,732	$164,732
TOTAL	$716,021	**$358,010**	$358,010
FY 2024-25	**TF**	**DHCS FFP**	**CDSS GF/ County Match**
CWS	$368,454	$184,227	$184,227
CWS/CMS	$9,212	$4,606	$4,606
CSBG/APS	$341,718	$170,859	$170,859
TOTAL	$719,384	**$359,692**	$359,692

*Totals may differ due to rounding.

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

CALHEERS DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 77
IMPLEMENTATION DATE: 6/2012
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1679

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$146,038,000	$164,180,000
STATE FUNDS	$37,412,950	$43,008,400
FEDERAL FUNDS	$108,625,050	$121,171,600

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)
Interagency Agreement #19-96234
Contract # 18-95359 A02
Contract # 21-10137
Contract # 21-10171
Contract # 22-20089

Interdependent Policy Changes:
Not Applicable

Background:
California established Covered California to provide competitive health care coverage for individuals and small employers. CalHEERS determines an applicant's eligibility for subsidized coverage. In creating this one-stop-shop experience, states are required to use a single, streamlined application for the applicants to apply for all applicable health subsidy programs. The application may be filed online, in person at a county social services agency, by mail, or by telephone. To meet this requirement, the Department and Covered California formed a partnership to acquire a Systems Integrator to design and implement the CalHEERS as the business solution that allows the required one-stop shopping, making health insurance eligibility purchasing easier and more understandable.

The Department is responsible for the coordination, clarification, and implementation of Medi-Cal regulations, policies, and procedures to ensure 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 DEVELOPMENT
OTHER ADMIN. POLICY CHANGE NUMBER: 77

CalHEERS was programmed to provide Modified Adjusted Gross Income eligibility determinations for individuals seeking coverage through Covered California and Medi-Cal. In order to provide seamless integration with the CalHEERS system, the Department designed and implemented technology solutions for the ongoing maintenance of MEDS and Health Exchange Medi-Cal Interface (HEMI) web services.

The ACA offers additional enhanced federal funding for developing/upgrading Medicaid eligibility systems and for interactions of such systems with the ACA-required health benefit exchanges. The Department receives enhanced federal funding for the requirements validation, design, development, testing, and implementation of MEDS-related system changes needed to interface with CalHEERS. The majority of CalHEERS' costs are shared between Covered California and Medi-Cal. For any design, development, and implementation (DD&I) or maintenance and operations (M&O) activities that are not eligible for federal reimbursement, costs are funded 100% by either the Department or Covered California, as applicable.

The Department requested its own enhanced federal funding from the Centers for Medicare and Medicaid Services (CMS) for HEMI, which CMS approved. In August 2023, the Department submitted an Operational Advanced Planning Document for HEMI to seek approval for increased funding in FFY 2024 and funding for FFY 2025. For CalHEERS, the Department submitted an As Needed Advance Planning Document in July 2023 to seek approval for increased funding in FFY 2024 and through subsequent fiscal years and approval of a new proposed cost share effective October 1, 2023, between the Department (86.54%) and Covered California (13.46%). Approval for enhanced federal funding under both projects will remain in effect until September 30, 2024, and extended to September 30, 2025, once CMS approves both IAPDU submissions.

Reason for Change:
CalHEERS
The change from the prior estimate, for FY 2023-24, is an increase due to Office of Technology and Solution Integration (OTSI) indirect overhead costs, additional contractors, and change requests to accommodate the implementations for Family Planning, Access, Care, and Treatment (Family PACT) Program, and the amendment of the IAA between OTSI and Employment Development Department (EDD) for costs related to SB 644 impacts. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to OTSI indirect overhead costs, consulting service costs for the System Integrator contract, and costs associated with the retrieval of Commercial Source of Income (CSI) from CMS data Service Hub.

HEMI
The change in FY 2023-24, from the prior estimate, is an increase due to the HEMI team having onboarded all available contractors. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to fewer contractors with the end of contracts:18-95359 A02, 21-10171, and 21-10137.

The overall change from the prior estimate, for FY 2023-24, and the change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to OTSI indirect overhead costs, additional contractors, volume of Department change requests and generation of mainframe jobs, EDD IAA related to SB 644 cost impacts, quarterly CDT billing corrections, and costs associated with the retrieval of CSI from CMS data Service Hub.

CALHEERS DEVELOPMENT
OTHER ADMIN. POLICY CHANGE NUMBER: 77

Methodology:

1. CalHEERS' costs are shared between Covered California and Medi-Cal based on the approved Cost Allocation Plan.
   - Effective October 1, 2022, the cost share was 13.323% from Covered California and 86.677% from the Department;
   - Effective FY 2021-22, costs for all Medi-Cal activities that are not eligible for federal reimbursement are identified separately from Title XIX and Title XXI;
   - All costs directly attributable to the Department are the responsibility of the Department;
   - Effective October 1, 2023, the proposed cost share is 13.46% from Covered California and 86.54% from the Department;
   - Effective 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' D&I and M&O activities, which have different FFP reimbursement percentages.
   - The DD&I portion of costs is eligible for:
     i. Title XIX at 90% federal reimbursement;
     ii. Title XXI at 65% federal reimbursement.
   - The M&O portion of costs is eligible for:
     i. Title XIX at 75% federal reimbursement;
     ii. Title XXI at 65% federal reimbursement.

3. The estimates for FY 2023-24 and FY 2024-25 are as follows:

FY 2023-24	TF	GF	FF
Title XIX (90% FF / 10% GF)	$34,590,000	$3,459,000	$31,131,000
Title XIX (75% FF / 25% GF)	$85,485,000	$21,371,000	$64,114,000
Title XXI (65% FF / 35% GF)	$17,553,000	$6,144,000	$11,409,000
100% State GF	$5,735,000	$5,735,000	$0
CalHEERS Subtotal	$143,363,000	$36,709,000	$106,654,000
75% Title XIX FF / 25% GF	$2,321,000	$580,000	$1,741,000
65% Title XXI FF / 35% GF	$354,000	$124,000	$230,000
ETS Subtotal	$2,675,000	$704,000	$1,971,000
Total	**$146,038,000**	**$37,413,000**	**$108,625,000**

CALHEERS DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 77

FY 2024-25	TF	GF	FF
Title XIX (90% FF / 10% GF)	$31,414,000	$3,141,000	$28,273,000
Title XIX (75% FF / 25% GF)	$105,909,000	$26,478,000	$79,431,000
Title XXI (65% FF / 35% GF)	$17,918,000	$6,271,000	$11,647,000
100% State GF	$6,468,000	$6,468,000	$0
CalHEERS Subtotal	$161,709,000	$42,358,000	$119,351,000
75% Title XIX FF / 25% GF	$2,144,000	$536,000	$1,608,000
65% Title XXI FF / 35% GF	$327,000	$114,000	$213,000
ETS Subtotal	$2,471,000	$650,000	$1,821,000
Total	**$164,180,000**	**$43,008,000**	**$121,172,000**

Funding:
90% Title XIX / 10% GF (4260-101-0001/0890)
75% Title XIX / 25% GF (4260-101-0001/0890)
65% Title XXI / 35% GF (4260-101-0001/0890)
100% GF (4260-101-0001)

MATERNAL AND CHILD HEALTH

OTHER ADMIN. POLICY CHANGE NUMBER: 78
IMPLEMENTATION DATE: 7/2022
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 234

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$45,037,000	$69,111,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$45,037,000	$69,111,000

Purpose:
This policy change estimates the federal match provided to the California Department of Public Health (CDPH) for the Maternal, Child, and Adolescent Health (MCAH) programs.

Authority:
Interagency Agreement 07-65592
SB 852 (Chapter 25, Statutes of 2014)

Interdependent Policy Changes:
Not Applicable

Background
The MCAH program administers the following services:

- Conducts outreach to pregnant and parenting adolescents who are potentially eligible for Medi-Cal;
- Assists Medi-Cal enrolled members in accessing covered services.
- Recruits providers for Medi-Cal's Comprehensive Perinatal Services Program (CPSP) and provides technical assistance regarding CPSP enhanced services to Medi-Cal members;
- Administers programs that offer prenatal care guidance for a target population, provides case management services, and conducts follow-up to improve access to early obstetrical care services for Medi-Cal enrolled pregnant women;
- Administers programs for preventive and primary care services for children and youth; and
- Administers programs for family-centered, community-based, comprehensive health services to children with special health care needs;
- MCAH State Operations ensures the provision of statutorily required programs by developing systems to protect and improve the health of women of reproductive age, infants, children, adolescents, and their families.

The MCAH program includes the following services:

- Black Infant Health (BIH): Group intervention and case management services to pregnant and parenting African American Medi-Cal eligible women in an effort to reduce the high death rate for African American infants as well as decrease health and social inequities for African-American women and infants. Effective July 1, 2014, SB 852 restored the General Fund for the BIH Program.

MATERNAL AND CHILD HEALTH
OTHER ADMIN. POLICY CHANGE NUMBER: 78

- Comprehensive Perinatal Services Program (CPSP) and Prenatal Care Guidance (PCG): Provides a wide range of services to Medi-Cal enrolled pregnant women, from conception through 60 days postpartum, case management services, and conduct follow-up to improve access to early obstetrical and post-partum care (60-days following the delivery) for Medi-Cal enrolled pregnant women.
- Adolescent Family Life Program (AFLP): Case management services for Medi-Cal-eligible pregnant adolescents to address the social, health, educational, and economic consequences of adolescent pregnancy by providing comprehensive case management services to pregnant and parenting adolescents and their children. The AFLP emphasizes the promotion of positive youth development, focusing on and building upon the adolescents' strengths and resources to work toward:
    1) Improving the health of the pregnant and parenting adolescent;
    2) Improving graduation rates;
    3) Reducing repeat pregnancies; and
    4) Improving linkages and creating networks for pregnant and parenting adolescents.
- The California Home Visiting Program (CHVP) focuses on young, low-income mothers and provides a wider range of home visiting models based on varying family needs.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is a decrease due to updated actuals and adjusted projections of anticipated payments. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to the addition of CHVP.

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 2023-24 are estimated to be $45,037,000 Federal Funds and FY 2024-25 $69,111,000 Federal Funds.

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

CDDS ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 79
IMPLEMENTATION DATE: 7/1997
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 243

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$113,674,000	$76,198,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$113,674,000	$76,198,000

Purpose:
This policy change estimates the federal match for the California Department of Developmental Services (CDDS) administrative costs.

Authority:
Interagency Agreement (IA)

Interdependent Policy Changes:
Not Applicable

Background:
CDDS administrative costs are comprised of Developmental Centers (DC)/State Operated Facility (SOF) Medi-Cal Administration, DC/SOF Medi-Cal Eligibility, Home and Community Based Services (HCBS) Waiver Administration, Regional Centers (RC) Medicaid Administration, Regional Centers Nursing Home Reform (NHR), and Targeted Case Management (TCM).

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

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to updated expenditure data due to recent expenditure trends that informs the updated estimate and paid expenditures are updated through October 2023. In addition, the DC/SOF HIPAA and TCM HIPAA line items have been removed from this policy change as these items are only included in the CDDS budget.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to updated expenditure trend for FY 2024-25.

CDDS ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 79

Methodology:
CDDS provides the following cash estimates of its administrative cost components:

FY 2023-24		DHCS FFP	CDDS GF	IA #
1	DC/SOF Medi-Cal Admin.	$1,477,000	$1,477,000	03-75282/83
2	DC/SOF Medi-Cal Elig	$789,000	$789,000	01-15378
3	HCBS Waiver Admin.	$56,238,000	$56,238,000	01-15834
4	RC Medicaid Admin.	$41,203,000	$13,734,000	03-75734
5	NHR Admin.	$219,000	$219,000	03-75285
6	TCM Headquarters Admin.	$13,748,000	$13,748,000	03-75284
	Total	**$113,674,000**	$86,205,000	

FY 2024-25		DHCS FFP	CDDS GF	IA #
1	DC/SOF Medi-Cal Admin.	$1,750,000	$1,750,000	03-75282/83
2	DC/SOF Medi-Cal Elig	$829,000	$829,000	01-15378
3	HCBS Waiver Admin.	$42,879,000	$42,879,000	01-15834
4	RC Medicaid Admin.	$21,368,000	$7,123,000	03-75734
5	NHR Admin.	$190,000	$190,000	03-75285
6	TCM Headquarters Admin.	$9,181,000	$9,181,000	03-75284
	Total	**$76,198,000**	$61,952,000	

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

DEPARTMENT OF SOCIAL SERVICES ADMIN COST

OTHER ADMIN. POLICY CHANGE NUMBER: 80
IMPLEMENTATION DATE: 7/2002
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 256

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$55,882,000	$48,265,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$55,882,000	$48,265,000

Purpose:
This policy change provides Title XIX federal financial participation (FFP) to the California Department of Social Services (CDSS) for administering various programs to Medi-Cal beneficiaries.

Authority:
IHSS PCSP Interagency Agreement (IA) 03-75676
IHSS Health Related IA 01-15931
CWS/CMS for Medi-Cal IA 06-55834
IHSS Plus Option Sec. 1915(j) IA 09-86307
SAWS IA 04-35639
Medi-Cal State Hearings IA 16-93214
Public Inquiry and Response IA 16-93213
Medicaid Disability Evaluation Services IA 16-93215
Electronic Visit Verification IA 18-95714
Estate Recovery Claims IA 20-10026
Statewide Verification Hub IA 21-10376
Income and Eligibility Verification IA 22-20039

Interdependent Policy Changes:
Not Applicable

Background:
These costs cover the administration of the Personal Care Services Program (PCSP), the In-Home Supportive Services Plus Option (IPO) Section 1915(j), the Child Welfare Services/Case Management System (CWS/CMS), Statewide Automated Welfare System (SAWS), Community First Choice Option Program (CFCO), Electronic Visit Verification, and the California Community Transitions-Money Follows the Persons (CCT). The Department provides FFP to CDSS for services related to Medi-Cal beneficiaries. CDSS budgets the matching General Fund (GF).

Reason for Change:
The change from the prior estimate for FY 2023-24, as well as the change from FY 2023-24 to FY 2024-25 in the current estimate, is a decrease 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

OTHER ADMIN. POLICY CHANGE NUMBER: 80

FY 2023-24	TF	DHCS FFP	CDSS GF
IHSS PCSP	$18,000,000	$9,000,000	$9,000,000
IHSS Health Related	$128,000	$64,000	$64,000
CWS/CMS for Medi-Cal	$2,000,000	$1,000,000	$1,000,000
IHSS Plus Option Sec. 1915(j)	$6,000,000	$3,000,000	$3,000,000
SAWS	$1,104,000	$552,000	$552,000
Medi-Cal State Hearings	$68,711,000	$34,355,000	$34,355,000
Public Inquiry and Response	$500,000	$250,000	$250,000
Medicaid Disability Evaluation Services	$6,329,000	$3,164,000	$3,164,000
Estate Recovery Claims	$8,000	$4,000	$4,000
Electronic Visit Verification	$6,000,000	$3,000,000	$3,000,000
Statewide Verification Hub	$2,058,000	$1,029,000	$1,029,000
Income and Eligibility Verification	$927,000	$464,000	$464,000
TOTAL	$111,765,000	**$55,882,000**	$55,882,000
FY 2024-25	**TF**	**DHCS FFP**	**CDSS GF**
IHSS PCSP	$18,000,000	$9,000,000	$9,000,000
IHSS Health Related	$128,000	$64,000	$64,000
CWS/CMS for Medi-Cal	$2,000,000	$1,000,000	$1,000,000
IHSS Plus Option Sec. 1915(j)	$6,000,000	$3,000,000	$3,000,000
SAWS	$1,104,000	$552,000	$552,000
Medi-Cal State Hearings	$55,534,000	$27,767,000	$27,767,000
Public Inquiry and Response	$500,000	$250,000	$250,000
Medicaid Disability Evaluation Services	$6,329,000	$3,164,000	$3,164,000
Estate Recovery Claims	$8,000	$4,000	$4,000
Electronic Visit Verification	$6,000,000	$3,000,000	$3,000,000
Statewide Verification Hub	$0	$0	$0
Income and Eligibility Verification	$927,000	$464,000	$464,000
TOTAL	$96,530,000	**$48,265,000**	$48,265,000

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

HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN

OTHER ADMIN. POLICY CHANGE NUMBER: 81
IMPLEMENTATION DATE: 7/1999
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 246

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$54,682,000	$54,682,000
STATE FUNDS	$13,671,000	$13,671,000
FEDERAL FUNDS	$41,011,000	$41,011,000

Purpose:
This policy change budgets the Title XIX federal financial participation (FFP) for the Health Care Program for Children in Foster Care (HCPCFC). The Department of Social Services (CDSS) budgets the amounts for the non-federal share.

Authority:
Welfare & Institutions Code, Section 16501.3
Welfare & Institutions Code, Section 16501.4(d)
Welfare & Institutions Code, Section 5328.04(a), (b), and (f)
Civil Code, Section 56.103
AB 1111 (Chapter 147, Statutes of 1999)
SB 1013 (Chapter 35, Statutes of 2012)
SB 238 (Chapter 534, Statutes of 2015)
SB 319 (Chapter 535, Statutes of 2015)
AB 97 (Chapter 14, Statutes of 2017)
Interagency Agreement (IA) 21-10019
Budget Act of 2017
SB 184 (Chapter 47, Statutes of 2022)

Interdependent Policy Change:
Not Applicable

Background:
On January 1, 2010, the Department, in collaboration with CDSS, implemented the following requirements of the federal Fostering Connections to Success and Increasing Adoptions Act of 2008:

- Connect and support relative caregivers,
- Improve the outcome for children in foster care,
- Provide for tribal foster care and adoption access,
- Improve incentives for adoption, and
- Require Title IV-B state and county agencies to develop a plan for ongoing oversight and coordination of health care services for children in foster care.

CDSS and the Department implemented the HCPCFC through the existing Child Health and Disability Prevention 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.

HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN
OTHER ADMIN. POLICY CHANGE NUMBER: 81

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 sunsets the Child Health and Disability Prevention (CHDP) program on June 30, 2024. Effective July 1, 2024, the Department will redirect portions of the CHDP county budget allocation to fund the administrative and service costs of the Health Oversight and Coordination for Foster Care Children (HCPCFC) program, making HCPCFC a standalone program. Remaining portions of the CHDP county budget allocation will be redirected to the California Children's Services (CCS) to fund new county workload created due to the implementation of CCS County Monitoring and Oversight effective July 1, 2024.

Reason for Change:
There is no change from the prior estimate for FY 2023-24, and there is no change from FY 2023-24 to FY 2024-25 in the current estimate.

Methodology:
1. CDSS provides the annual Local Revenue Fund of $13,671,000 for FY 2023-24.

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
Base Allocation	$32,682	$8,171	$24,512
Psychotropic Medication Monitoring and Oversight	$6,600	$1,650	$4,950
Caseload Relief	$15,400	$3,850	$11,550
Total	**$54,682**	**$13,671**	$41,011
FY 2024-25	**TF**	**GF**	**FF**
Base Allocation	$32,682	$8,171	$24,512
Psychotropic Medication Monitoring and Oversight	$6,600	$1,650	$4,950
Caseload Relief	$15,400	$3,850	$11,550
Total	**$54,682**	**$13,671**	$41,011

*Totals may differ due to rounding.

2. Assume CDSS reimburses the GF to the Department 60 days after the end of each fiscal quarter.

HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN

OTHER ADMIN. POLICY CHANGE NUMBER: 81

(Dollars in Thousands)

Fiscal Year	TF	FF	GF Reimb.	CDSS GF	CF*
FY 2023-24	**$54,682**	**$41,011**	**$13,671**	$13,671	$7,594
FY 2024-25	**$54,682**	**$41,011**	**$13,671**	$13,671	$7,594

*County funds and CDSS GF are not included in the Total Fund.

Funding:
100% Title XIX FFP (4260-101-0890)
GF Reimbursement (4260-610-0995)

FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG

OTHER ADMIN. POLICY CHANGE NUMBER: 82
IMPLEMENTATION DATE: 7/2020
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2244

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$9,297,000	$8,058,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$9,297,000	$8,058,000

Purpose:
This policy change estimates the federal reimbursement process between the Department and the Department of Health Care Access and Information (HCAI) for the Health Care Payments Data Program (HPD).

Authority:
Health & Safety Code
Interagency Agreement (IA) # 20-10306

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 beneficiaries. 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 2023-24. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to a reduction in estimated costs of the contract for the All Payer Claims Database platform vendor.

Methodology:
1. Costs are estimated at $9,297,000 for FY 2023-24 and $8,058,093 for FY 2024-25.

Fiscal Years	TF	GF	FF
FY 2023-24	**$9,297,000**	**$0**	**$9,297,000**
FY 2024-25	**$8,058,000**	**$0**	**$8,058,000**

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

DEPARTMENT OF AGING ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 83
IMPLEMENTATION DATE: 7/1984
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 253

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$6,582,000	$7,673,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$6,582,000	$7,673,000

Purpose:
This policy change estimates the Title XIX federal financial participation (FFP) provided to the California Department of Aging (CDA) for administrative costs related to services provided to Medi-Cal eligibles in Community-Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP), and Medicaid Electronic Visit Verification (EVV).

Authority:
Interagency Agreements:
CBAS 03-76137
MSSP 01-15976
MSSP/CBAS 22-20173

Interdependent Policy Changes:
Not Applicable

Background:
CDA coordinates with the Department to obtain FFP for the administrative costs for services related to Medi-Cal beneficiaries. CDA budgets the matching General Fund (GF). In addition, CDA is implementing the Medicaid EVV in conjunction with the Department and the Office of Systems Integration. The EVV project is anticipated to end on June 30, 2025. CDA will receive an enhanced matching rate for this project.

Reason for Change:
The change from the prior estimate for FY 2023-24 is a decrease, and the change from FY 2023-24 to FY 2024-25 in the current estimate is an increase, due to CDA providing updated invoices, accounting data, and costs related to the Medicaid EVV project.

DEPARTMENT OF AGING ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 83

Methodology:

1. The estimates below were provided by CDA on a cash basis.

Program Support	FY 2023-24		FY 2024-25	
CBAS Support	**CDA GF**	**FFP**	**CDA GF**	**FFP**
FY 2022-23 DOS	$463,000	$718,000	$0	$0
FY 2023-24 DOS	$3,234,000	$4,000,000	$705,000	$885,000
FY 2024-25 DOS	$0	$0	$3,283,000	$4,071,000
Total CBAS	$3,697,000	$4,718,000	$3,988,000	$4,956,000
MSSP Support				
FY 2022-23 DOS	$161,000	$260,000	$0	$0
FY 2023-24 DOS	$1,318,000	$1,496,000	$288,000	$326,000
FY 2024-25 DOS	$0	$0	$1,733,000	$2,278,000
Total MSSP	$1,479,000	$1,756,000	$2,020,000	$2,604,000
MSSP/CBAS EVV Support				
FY 2022-23 DOS	$0	$0	$0	$0
FY 2023-24 DOS	$13,000	$108,000	$2,000	$24,000
FY 2024-25 DOS	$0	$0	$10,000	$90,000
Total EVV Support	$13,000	$108,000	$12,000	$113,000
Grand Total	$5,189,000	**$6,582,000**	$6,020,000	**$7,673,000**

*Totals differ due to rounding.

Funding:

100% Title XIX (4260-101-0890)

FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 84
IMPLEMENTATION DATE: 7/2007
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1192

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$12,502,000	$6,880,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$12,502,000	$6,880,000

Purpose:
This policy change estimates the federal match provided to the California Department of Public Health (CDPH) for State Operations administrative costs related to services provided to Medi-Cal members.

Authority:
Interagency Agreement
IA 07-65693 A01
IA 10-87042 A02
IA 22-20588
IA 07-65642
IA 19-96544
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,

FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 84

- Nurse Aide Training and Competency Evaluation Program,
- Centralized Application Branch – Provider Certification Unit, and
- Intermediate Care Facility for the Developmentally Disabled Continuous Nursing Pilot Project Waiver.

Reason for Change:
The change from the prior estimate for FY 2023-24 is an increase due to updated actuals, delays in CHCQ invoicing, and a new CHCQ interagency agreement. The change from FY 2023-24 to FY 2024-25, in the current estimate, is a decrease due to projections of anticipated payments.

Methodology:
1. CDPH provides the General Fund match.

2. The following estimates have been provided on a cash basis by CDPH.

3. Cash basis expenditures vary from year to year based on when claims are actually paid.

4. The costs for FY 2023-24 are estimated to be $12,502,000 and FY 2024-25 $6,880,000.

FY 2023-24	TF	FF
FY 2021-22 Claims	$1,730,000	$1,730,000
FY 2022-23 Claims	$6,267,000	$6,267,000
FY 2023-24 Claims	$4,505,000	$4,505,000
Total	**$12,502,000**	**$12,502,000**

FY 2024-25	TF	FF
FY 2023-24 Claims	$2,239,000	$2,239,000
FY 2024-25 Claims	$4,642,000	$4,642,000
Total	**$6,880,000**	**$6,880,000**

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

CLPP CASE MANAGEMENT SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 85
IMPLEMENTATION DATE: 7/1997
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 239

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$3,517,000	$3,546,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$3,517,000	$3,546,000

Purpose:
This policy change estimates the federal match provided to the California Department of Public Health (CDPH) for administrative costs associated with Childhood Lead Poisoning Prevention (CLPP) Program case management services.

Authority:
Interagency Agreement 07-65689

Interdependent Policy Changes:
Not Applicable

Background:
The CLPP Program provides services to the community for the purpose of increasing awareness regarding the hazards of lead exposure, reducing lead exposure, and increasing the number of children assessed and appropriately blood tested for lead poisoning as defined by the Medi-Cal State Plan and CDPH. Specifically, the program services include the following:

- Offers home visitation, environmental home inspections, and nutritional assessments to families of children found to be severely lead-poisoned.
- Provides telephone contacts and educational materials to families of lead-poisoned and lead-exposed children.
- Provides information and education to the general public, medical providers, and community-based organizations.
- Provides targeted case management and environmental investigation services with associated administrative activities to lead-burdened children who are Medi-Cal members and meet the case definition of lead poisoning.

Reason for Change:
The change from the prior estimate for FY 2023-24 is a decrease due to updated actuals and adjusted projections. The change from the prior estimate for FY 2023-24 and FY 2024-25 is an increase due to the projection of anticipated payments.

Methodology:
1. Cash basis expenditures vary from year to year based on when claims are actually paid.

2. The estimates are provided by CDPH on a cash basis.

CLPP CASE MANAGEMENT SERVICES
OTHER ADMIN. POLICY CHANGE NUMBER: 85

3. The costs for FY 2023-24 are estimated to be $3,517,000 and FY 2024-25 $3,546,000.

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

CALIFORNIA SMOKERS' HELPLINE

OTHER ADMIN. POLICY CHANGE NUMBER: 86
IMPLEMENTATION DATE: 1/2014
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1680

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$1,518,000	$2,500,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,518,000	$2,500,000

Purpose:
This policy change estimates the federal financial participation (FFP) provided to the California Department of Public Health (CDPH) for administrative costs related to California Smoker's Helpline (Helpline) services provided to Medi-Cal members.

Authority:
Affordable Care Act Section 4107
Interagency Agreement (IA) 13-90417

Interdependent Policy Change:
Not Applicable

Background:
CDPH funds statewide smoker helpline services and counseling to Medi-Cal members through the University of California, San Diego. The Helpline services follow the Centers for Medicare and Medicaid Services guidelines and the Department policies for providing services to Medi-Cal members. CDPH ensures the Helpline services include specially trained counselors to provide free telephone-based counseling, education, and support to Medi-Cal members who currently smoke or have recently quit smoking.

The Department has an existing IA with CDPH to enable the State to receive 50% FFP for Helpline services administrative costs beginning July 1, 2013.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is a decrease due to delays in payment processing and updated actuals. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due projection of anticipated payments.

Methodology:
1. The Helpline services administrative costs are based on expenditure data for services provided to Medi-Cal members. CDPH submits invoices for 50% reimbursement of actual and allowable administrative costs.

2. The estimates are budgeted on a cash basis based on the anticipated payment timing of invoices.

CALIFORNIA SMOKERS' HELPLINE
OTHER ADMIN. POLICY CHANGE NUMBER: 86

3. The estimated administrative cost reimbursements, for FY 2023-24 and FY 2024-25, on a cash basis are:

FY 2023-24	TF	FF
FY 2022-23 Claims	$893,000	$893,000
FY 2023-24 Claims	$625,000	$625,000
Total	**$1,518,000**	**$1,518,000**

FY 2024-25	TF	FF
FY 2023-24 Claims	$2,500,000	$2,500,000
Total	**$2,500,000**	**$2,500,000**

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

HCBS SP CDDS - OTHER ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 87
IMPLEMENTATION DATE: 6/2022
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 2349

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$2,457,000	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$2,457,000	$0

Purpose:
This policy change estimates the federal reimbursements as a one-time payment or ongoing payments for the California Department of Developmental Services (CDDS) home and community-based services (HCBS) spending plan other administrative items.

Authority:
American Rescue Plan (ARP) Act (2021)
Section 11.95, 2021 Budget Act

Interdependent Policy Changes:
Not Applicable

Background:
The American Rescue Plan Act of 2021 (ARP) provides additional Coronavirus Disease 2019 (COVID-19) relief to states. Section 9817 of the ARP provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for HCBS. Increased FMAP is available from April 1, 2021 through March 31, 2022. States must use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021, and states must use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. State funds equivalent to the amount of federal funds attributable to the increased FMAP are deposited in the Home and Community-Based Services American Rescue Plan Fund pursuant to Section 11.95 of the 2021 Budget Act. Section 11.95 appropriates this funding to eligible HCBS activities identified in the HCBS Spending Plan.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to the update of the estimate of the spending plan and billing timing.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to anticipation of complete billing for ARPA within FY 2023-24.

HCBS SP CDDS - OTHER ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 87

Methodology:

1. The cash basis estimate for the HCBS spending plan administrative items for CDDS are:

(Dollars in Thousands)

FY 2023-24	TF	HCBS ARP Fund-CDDS	FF
Developmental Services Rate Model Implementation (Other Admin)	$7,834	$6,346	$1,488
Modernize Regional Center Information Technology Systems	$5,098	$4,129	$969
Enhanced Community Integration for Children and Adolescents	$11,288	$11,288	$0
Total	$24,220	$21,763	**$2,457**

Funding:

100% Title XIX (4260-101-0890)

CALHHS AGENCY HIPAA FUNDING

OTHER ADMIN. POLICY CHANGE NUMBER: 88
IMPLEMENTATION DATE: 7/2001
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 257

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$1,367,000	$1,386,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,367,000	$1,386,000

Purpose:
This policy change estimates and reimburses the California Health and Human Services (CalHHS) Agency the federal funds for qualifying Health Insurance Portability and Accountability Act (HIPAA) activities related to Medi-Cal.

Authority:
Interagency Agreement (IA) 20-10133 A01
IA 23-30066

Interdependent Policy Changes:
Not Applicable

Background:
A HIPAA office has been established at 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. The prior IA expired on June 30, 2023, and the final invoice for the prior IA will be paid in FY 2023-24.

Reason for Change:
There is no change from the prior estimate for FY 2023-24. The change from FY 2023-24 to FY 2024-25, in the current estimate, is due to increased contract costs from the associated IA with CalHHS.

Methodology:
The CalHHS Agency prioritizes HIPAA projects so that the most critical projects are implemented first.

Cash Basis	DHCS FF	CalHHS GF
FY 2023-24	**$1,367,000**	$1,367,000
FY 2024-25	**$1,386,000**	$1,386,000

CALHHS AGENCY HIPAA FUNDING

OTHER ADMIN. POLICY CHANGE NUMBER: 88

Funding:
100% HIPAA (4260-117-0890)

MEDI-CAL INPATIENT SERVICES FOR INMATES

OTHER ADMIN. POLICY CHANGE NUMBER: 89
IMPLEMENTATION DATE: 3/2011
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 1665

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$1,165,000	$1,212,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,165,000	$1,212,000

Purpose:
This policy change estimates the federal match provided to the California Department of Corrections and Rehabilitation (CDCR)/California Correctional Health Care Services (CCHCS) for administrative costs related to the Inmate Eligibility Program.

Authority:
AB 1628 (Chapter 729, Statutes of 2010)
SB 1399 (Chapter 405, Statutes of 2010)
AB 396 (Chapter 394, Statutes of 2011)
AB 80 (Chapter 12, Statutes of 2020)
SB 184 (Chapter 47, Statutes of 2022)
Interagency Agreement #20-10027

Interdependent Policy Changes:
Not Applicable

Background:
AB 1628 (Chapter 729, Statutes of 2010) authorizes the Department and the CDCR/CCHCS to:

- Claim federal reimbursement for inpatient hospital services to Medi-Cal eligible adult inmates in State correctional facilities when these services are provided off the grounds of the facility. As part of these provisions, the CCHCS is claiming federal financial participation (FFP) for their administrative costs to operate the Inmate Eligibility Program. The federal funds provided to the CCHCS are included in the Medi-Cal inpatient hospital costs policy changes.

SB 1399 (Chapter 405, Statutes of 2010) authorizes the Board of Parole Hearings to:

- Grant medical parole to permanently medically incapacitated State inmates. State inmates granted medical parole are potentially eligible for Medi-Cal. When a State inmate is granted medical parole, the CCHCS submits a Medi-Cal application to the Department to determine eligibility. Previously these services were funded through the CDCR with 100% GF.

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

- Claim FFP for inpatient hospital services provided to Medi-Cal eligible juvenile inmates in State and county correctional facilities when these services are provided off the grounds of the facility. Previously, these services were paid 100 percent by the CDCR or

MEDI-CAL INPATIENT SERVICES FOR INMATES
OTHER ADMIN. POLICY CHANGE NUMBER: 89

the county. The County Administration Allocation Policy Change covers the county FFP associated with Medi-Cal eligibility determination activities for county inmates.

AB 80 (Chapter 12, Statutes of 2020) conforms the suspension of benefits for juveniles, as defined under state law, with the existing federal law, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act). The definition of juvenile has changed (both State and County) to include individuals under the age of 21 or individuals enrolled in the former foster youth group under the age of 26. “Eligible Juveniles,” as defined by the SUPPORT Act, only impacts Medi-Cal suspension of benefits policies and does not impact eligibility age restrictions or age requirements for general Medi-Cal programs.

SB 184 (Chapter 47, Statutes of 2022) requires County Welfare Departments to suspend Medi-Cal benefits for all inmates of a public institution for the duration of their incarceration. State law requires the suspension of Medi-Cal benefits for any individual, regardless of age, who is a Medi-Cal beneficiary at the time of their incarceration. This amendment allows counties to activate suspended Medi-Cal benefits upon release from the public institution without requiring a new application, as long as they remain otherwise eligible for Medi-Cal throughout their incarceration.

Reason for Change:
The change from the prior estimate, for FY 2023-24, is a slight decrease due to updated personnel costs. The change from FY 2023-24 to FY 2024-25, in the current estimate, is an increase due to projecting an increase in personnel costs.

Methodology:
1. Implementation of the Inmate Eligibility Program began April 1, 2011.

2. Administrative costs are in accordance with Interagency Agreement #20-10027.

3. Reimbursements for administrative costs began in March 2011.

4. The federal share of ongoing administrative costs is **$1,165,000** in **FY 2023-24** and **$1,212,000** in **FY 2024-25**.

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

VETERANS BENEFITS

OTHER ADMIN. POLICY CHANGE NUMBER: 90
IMPLEMENTATION DATE: 12/1988
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 232

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$1,100,000	$1,100,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,100,000	$1,100,000

Purpose:
This policy change estimates the Title XIX federal funding provided to the California Department of Veterans Affairs (CDVA) for distribution to County Veteran Service Officers (CVSO) for identifying veterans eligible for Veterans Affairs (VA) benefits.

Authority:
AB 1807 (Chapter 1424, Statutes of 1987)
California Military & Veterans Code 972.5
Interagency Agreement (IA) # 20-10053 A1

Interdependent Policy Changes:
Not Applicable

Background:
AB 1807 permits the Department to make available federal Medicaid funds in order to obtain additional VA benefits for Medi-Cal beneficiaries, 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 2023-24. There is no change from FY 2023-24 to FY 2024-25 in the current estimate.

Methodology:
1. The contract amount is estimated to be $1,100,000 for FY 2023-24 and FY 2024-25. The non-federal match is budgeted by CDVA.

FY	FY 2023-24			FY 2024-25		
Cash Basis	**TF**	**CDVA GF**	**DHCS FF**	**TF**	**CDVA GF**	**DHCS FF**
Administrative	$724,000	$362,000	$362,000	$724,000	$362,000	$362,000
Workload Units	$1,476,000	$738,000	$738,000	$1,476,000	$738,000	$738,000
Total	$2,200,000	$1,100,000	**$1,100,000**	$2,200,000	$1,100,000	**$1,100,000**

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

VITAL RECORDS

OTHER ADMIN. POLICY CHANGE NUMBER: 91
IMPLEMENTATION DATE: 5/2016
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1774

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$883,000	$883,000
STATE FUNDS	$4,000	$4,000
FEDERAL FUNDS	$879,000	$879,000

Purpose:
This policy change estimates the federal financial participation (FFP) for the California Department of Public Health (CDPH) to improve delivery of Vital Records data and to provide certified copies of birth and death records, as needed, to the Department.

Authority:
Contract 15-92272
Contract 22-20189

Interdependent Policy Changes:
Not Applicable

Background:
California birth, death, fetal death, still birth, marriage, and divorce records are maintained by the CDPH Vital Records. Information collected in these records is necessary to support core functions of the Department as represented in the Medicaid Information Technology Architecture (MITA) business functions. The MITA, a Centers for Medicare and Medicaid Services (CMS) initiative, fosters an integrated business and information technology transformation across the Medicaid enterprise in an effort to improve the administration and operation of the Medicaid program.

Historically, the Department has received Vital Records data from CDPH in a case-by-case and manual manner. In order to improve efficiency and advance MITA maturity, the Department has received CMS approval for enhanced FFP to establish automated and timely processes to receive Vital Record data from CDPH. CMS approved the contract in June 2016.

Beginning July 2018, the Department entered into a contract with CDPH to provide certified copies of vital records as required for business needs.

Reason for Change:
There is no change from the previous estimate for FY 2023-24. There is no change from FY 2023-24 to FY 2024-25 in the current estimate.

Methodology:
1. On a cash basis, the estimated cost to deliver records data is $1,167,000 TF in FY 2023-24 and $1,167,000 TF in FY 2024-25. The Department receives 75% FFP for ongoing costs to obtain vital records data, with the 25% state share provided by the CDPH Health Statistics Special Fund (HSSF).

VITAL RECORDS
OTHER ADMIN. POLICY CHANGE NUMBER: 91

2. On a cash basis, the annual contract to provide certified copies is $8,000 TF ($4,000 GF).

3. On a cash basis, for both contracts, assume three quarters will be paid in the current fiscal year and the remaining quarter will be paid in the subsequent fiscal year. The estimated reimbursements for FY 2023-24 and FY 2024-25 on a cash basis are:

FY 2023-24	TF	HSSF	GF	FF
FY 2022-23 Records Data	$292,000	$73,000	$0	$219,000
FY 2022-23 Certified Copies	$2,000	$0	$1,000	$1,000
FY 2023-24 Records Data	$875,000	$219,000	$0	$656,000
FY 2023-24 Certified Copies	$6,000	$0	$3,000	$3,000
Total	**$1,175,000**	**$292,000**	**$4,000**	**$879,000**

FY 2024-25	TF	HSSF	GF	FF
FY 2023-24 Records Data	$292,000	$73,000	$0	$219,000
FY 2023-24 Certified Copies	$2,000	$0	$1,000	$1,000
FY 2024-25 Records Data	$875,000	$219,000	$0	$656,000
FY 2024-25 Certified Copies	$6,000	$0	$3,000	$3,000
Total	**$1,175,000**	**$292,000**	**$4,000**	**$879,000**

*Totals may differ due to rounding.

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

KIT FOR NEW PARENTS

OTHER ADMIN. POLICY CHANGE NUMBER: 92
IMPLEMENTATION DATE: 7/2001
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 249

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$604,000	$593,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$604,000	$593,000

Purpose:
This policy change estimates the federal match provided to the California Children and Families Commission (CCFC) for providing the “Kit for New Parents” to parents of Medi-Cal eligible newborns.

Authority:
Interagency Agreement (IA) #23-30146

Interdependent Policy Changes:
Not Applicable

Background:
The Department entered into an IA with the CCFC to allow the Department to claim Title XIX federal funds (FF) for the "Kit for New Parents" distributed to parents of Medi-Cal eligible newborns by the CCFC (Proposition 10).

Reason for Change:
The change in FY 2023-24, from the prior estimate, is due to a spike in distribution during the fourth quarter of FY 2022-23 that is billed in FY 2023-24 due to increased community outreach.

The change from FY 2023-24 to FY 2024-25, in the current estimate, is reduced kit distribution due to no community outreach in FY 2024-25; therefore, distribution is expected to return to normal levels.

Methodology:
1. CCFC distributed 156,174 kits in FY 2022-23, of which 109,130 were paid in FY 2022-23, and 47,044 are paid in FY 2023-24.

2. The annual number of kits estimated at full ramp up is 175,000.

3. An estimated 175,000 kits are estimated to be distributed in FY 2023-24 and FY 2024-25. Of these kits, 43.38% are expected to be distributed to Medi-Cal eligible newborns.

4. Each kit, basic or custom, costs $15.63.

5. 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
OTHER ADMIN. POLICY CHANGE NUMBER: 92

6. On a cash basis for FY 2023-24, the Department will be paying 25% of FY 2022-23 invoices and 75% of FY 2023-24 invoices. On a cash basis for FY 2024-25, the Department will be paying 25% of FY 2023-24 invoices and 75% of FY 2024-25 invoices.

7. 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 2022-23	156,174	43.38%	67,748	$15.63	$1,058,901
FY 2023-24	175,000	43.38%	75,915	$15.63	$1,186,551
FY 2024-25	175,000	43.38%	75,915	$15.63	$1,186,551

8. Assume the Department will pay $604,000 TF in FY 2023-24 and $593,000 TF in FY 2024-25 for kits to new parents of Medi-Cal eligible newborns.

FY 2023-24	TF	FF
FY 2022-23	$319,000	$319,000
FY 2023-24	$890,000	$890,000
Total	$1,209,000	$1,209,000
Total (50%)	**$604,000**	**$604,000**

FY 2024-25	TF	FF
FY 2023-24	$297,000	$297,000
FY 2024-25	$890,000	$890,000
Total	$1,187,000	$1,187,000
Total (50%)	**$593,000**	**$593,000**

Fiscal Year	TF	FF
FY 2023-24	**$604,000**	**$604,000**
FY 2024-25	**$593,000**	**$593,000**

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

MERIT SYSTEM SERVICES FOR COUNTIES

OTHER ADMIN. POLICY CHANGE NUMBER: 93
IMPLEMENTATION DATE: 7/2003
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 263

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$190,000	$190,000
STATE FUNDS	$95,000	$95,000
FEDERAL FUNDS	$95,000	$95,000

Purpose:
This policy change estimates the cost for the interagency agreement (IA) with the California Department of Human Resources (CalHR).

Authority:
IA #12-89476

Interdependent Policy Changes:
Not Applicable

Background:
Federal regulations require that any government agency receiving federal funds have a civil service exam, classification, and pay process. Many counties do not have a civil service system that meets current state regulations. The Merit System Services Program was established under the State Personnel Board and is now administered by CalHR to administer personnel services for the counties that do not have a civil service system. In addition, CalHR reviews the merit systems in the remaining counties to ensure that they meet federal civil service requirements.

The Department reimburses CalHR via an IA for Merit System Services. The agreement continues indefinitely, until terminated, or until there is a change in scope of work affecting the cost.

Reason for Change:
There is no change from the prior estimate for FY 2023-24. There is no change from FY 2023-24 to FY 2024-25 in the current estimate.

Methodology:
1. CalHR provided the estimates on a cash basis.

2. The estimated reimbursement is $190,000 TF ($95,000 GF) in FY 2023-24 and $190,000 TF ($95,000 GF) in FY 2024-25.

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

HEALTH FOR FOSTER CARE CHILDREN ADMIN COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 95
IMPLEMENTATION DATE: 7/2024
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2455

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$0	$13,133,000
STATE FUNDS	$0	$6,566,500
FEDERAL FUNDS	$0	$6,566,500

Purpose:
This policy change estimates the administration and service costs for Health Care Program for Children in Foster Care (HCPCFC).

Authority:
Welfare & Institutions Code, Section 16501.3
Welfare & Institutions Code, Section 16501.4(d)
Welfare & Institutions Code, Section 5328.04(a), (b), and (f)
Civil Code, Section 56.103
AB 1111 (Chapter 147, Statutes of 1999)
SB 1013 (Chapter 35, Statutes of 2012)
SB 238 (Chapter 534, Statutes of 2015)
SB 319 (Chapter 535, Statutes of 2015)
AB 97 (Chapter 14, Statutes of 2017)
Interagency Agreement (IA) 21-10019
Budget Act of 2017
SB 184 (Chapter 47, Statutes of 2022)

Interdependent Policy Change:
Not Applicable

Background:
SB 184 sunsets the Child Health and Disability Prevention (CHDP) program on June 30, 2024. Effective July 1, 2024, the Department will redirect portions of the CHDP county budget allocation to fund the administrative and service costs of the HCPCFC program. The reallocation of the CHDP program funding to the HCPCFC program represents the authorized shift from Foster Care Program operating under the CHDP program to a standalone program.

Where CHDP was the source of funding for Foster Care Program administrative activities, the program will operate autonomously to cover allowable non-clinical expenses and existing non-clinical local positions. Remaining portions of the CHDP county budget allocation will be redirected to the California Children's Services (CCS) to fund new county workload created due to the implementation of CCS County Monitoring and Oversight effective July 1, 2024.

Reason for Change:
This is a new policy change.

HEALTH FOR FOSTER CARE CHILDREN ADMIN COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 95

Methodology:

1. Assume implementation effective on January 1, 2024, with administrative and service costs of the HCPCFC program beginning no sooner than July 1, 2024.

2. The estimate costs are as follows:

Fiscal Years	TF	GF	FF
FY 2024-25	$13,133,000	$6,566,500	$6,566,500

Funding:

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

PIA EYEWEAR COURIER SERVICE

OTHER ADMIN. POLICY CHANGE NUMBER: 96
IMPLEMENTATION DATE: 7/2003
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 1114

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$1,062,000	$1,062,000
STATE FUNDS	$531,000	$531,000
FEDERAL FUNDS	$531,000	$531,000

Purpose:
This policy change estimates courier services costs for Prison Industry Authority (PIA) eyewear.

Authority:
Interagency Agreement (IA) #23-30067

Interdependent Policy Changes:
Not Applicable

Background:
The California PIA fabricates eyeglasses for Medi-Cal beneficiaries. Since July 2003, the Department has had an IA with PIA to reimburse them for one-half of the courier costs for the pick-up and delivery of orders to optical providers. The two-way courier service ensures that beneficiaries have continued access to and no disruption of optical services. 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:
There is no change in FY 2023-24, from the prior estimate, due to anticipated stable utilization and rates per package.

There is no change from FY 2023-24 to FY 2024-25, in the current estimate, due to anticipated stable utilization and rates per package.

Methodology:
1. PIA contracts with a courier service company for the pick-up and delivery of orders to optical providers. The Department is responsible for one-half of the delivery cost per package, with no fuel surcharge. There is a one-quarter lag between services provided and payment of the invoice.

2. The PIA courier contract delivery cost of $2.95 per package is effective from September 1, 2022 to August 31, 2024, with a one-year extension.

PIA EYEWEAR COURIER SERVICE
OTHER ADMIN. POLICY CHANGE NUMBER: 96

3. The estimated packages for FY 2023-24 and FY 2024-25 is assumed below:

Service Quarter	Packages (rounded)
FY 2022-23 Q4	90,000
FY 2023-24 Q1	90,000
FY 2023-24 Q2	90,000
FY 2023-24 Q3	90,000
Total FY 2023-24	**360,000**

Service Quarter	Packages (rounded)
FY 2023-24 Q4	90,000
FY 2024-25 Q1	90,000
FY 2024-25 Q2	90,000
FY 2024-25 Q3	90,000
Total FY 2024-25	**360,000**

Fiscal Year	TF	GF	FF
FY 2023-24	**$1,062,000**	**$531,000**	**$531,000**
FY 2024-25	**$1,062,000**	**$531,000**	**$531,000**

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

REPRODUCTIVE HEALTH ACCESS DEMO 1115 WAIVER

OTHER ADMIN. POLICY CHANGE NUMBER: 97
IMPLEMENTATION DATE: 7/2024
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 2450

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$0	$200,000,000
STATE FUNDS	$0	$100,000,000
FEDERAL FUNDS	$0	$100,000,000

Purpose:
This policy change estimates the funding available for the California's Reproductive Health Access Demonstration (CalRHAD).

Authority:
CalRHAD Section 1115(a)(2) Medicaid Demonstration

Interdependent Policy Change:
Designated State Health Programs

Background:
The Department requested a new three-year demonstration project under Section 11115 of the Social Security Act, titled CalRHAD. CalRHAD will strengthen the State's reproductive health provider safety net, with an emphasis on ensuring access to sexual and reproductive health services as well as the services and supports to access these services by addressing health-related social needs. CalRHAD will provide grants to reproductive health providers for enhancing capacity and access to sexual and reproductive health services and promoting the sustainability of California's reproductive health provider safety net, for the benefit of individuals enrolled in Medi-Cal and other Californians who currently face barriers to such access.

The following objectives will be promoted:

- Support access to whole-person sexual and reproductive health services for Medi-Cal enrollees, as well as other individuals who may face barriers to access;
- Support the capacity and sustainability of California's reproductive-health provider safety net; and
- Promote system transformation for California's sexual and reproductive health safety net.

A Third-Party Administrator (TPA) will administer the grant awards, which includes reviewing grant applications, disbursing funds, and collecting required provider documentation and reports, among other processes. The CalRHAD TPA will facilitate grant implementation and administration, as well as serve as the fiscal intermediary.

As part of the demonstration request, the Department has requested additional funding of $85 million over four years via Designated State Health Programs to offset the cost of this proposal on the state general fund. This offset can be found in the Designated State Health Programs policy change.

REPRODUCTIVE HEALTH ACCESS DEMO 1115 WAIVER

OTHER ADMIN. POLICY CHANGE NUMBER: 97

Reason for Change:
This is a new policy change.

Methodology:
1. Assume CalRHAD became effective on January 1, 2024, and program operations will begin no sooner than July 1, 2024, pending CMS approval.

2. The estimated costs for FY 2024-25 are:

(Dollars in Thousands)

Fiscal Years	TF	GF	FF
FY 2024-25	$200,000	$100,000	$100,000

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

DESIGNATED STATE HEALTH PROGRAMS

OTHER ADMIN. POLICY CHANGE NUMBER: 98
IMPLEMENTATION DATE: 10/2023
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 2459

	FY 2023-24	FY 2024-25
TOTAL FUNDS	$0	$0
STATE FUNDS	-$209,091,000	-$189,939,000
FEDERAL FUNDS	$209,091,000	$189,939,000

Purpose:
This policy change estimates the net impact for additional federal financial participation (FFP) received for Certified Public Expenditures (CPEs) from certain DSHPs (Designated State Health Programs) 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's Reproductive Health Access Demonstration (CalRHAD) Section 1115(a)(2) Demonstration

Interdependent Policy Changes:
CalAIM PATH
Reproductive Health Access Demo 1115 Waiver

Background:
Pursuant to the CalAIM Section 1115 Demonstration renewal request submitted to the Centers for Medicare and Medicaid Services (CMS) on June 30, 2021, the DSHP is effective January 1, 2023, to December 31, 2026. The Department will utilize additional FFP received through DSHP to support the Providing Access and Transforming Health (PATH) Supports. PATH 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.

In 2023, the Department will apply for a new Medicaid Section 1115 Demonstration, CalRHAD, to provide grants to reproductive health providers for enhancing capacity and access to sexual and reproductive health services and promoting the sustainability of California's reproductive health provider safety net, effective January 1, 2024, to December 31, 2026. The Department will also utilize additional FFP received through DSHP to support the CalRHAD program.

DSHPs are funded by state funds (GF). Those expenditures are used to draw FFP, which is then used to credit the GF. The CalAIM waiver authorizes the Department to claim up to a total of $646.425 million in FFP over a four-year period using the CPEs of the approved DSHPs listed below. The CalRHAD waiver will allow the Department to claim up to a total of $85 million FFP over a three-year period using the CPEs of the approved DSHPs listed below:

DESIGNATED STATE HEALTH PROGRAMS

OTHER ADMIN. POLICY CHANGE NUMBER: 98

State Only Medical Programs
California Children Services (CCS)
Genetically Handicapped Persons Program (GHPP)
Medically Indigent Adult Long Term Care (MIA-LTC)
Breast & Cervical Cancer Treatment Program (BCCTP)
Department of Developmental Services (DDS)
Prostate Cancer Treatment Program (PCTP)
Workforce Development Programs
Department of Health Care Access and Information (HCAI) • Song-Brown Health Care Workforce Training • Steven M. Thompson Physician Corp Loan Repayment Program (STLRP)

The DSHP proposal within the CalAIM Section 1115 Demonstration renewal was approved by CMS on January 26, 2023. However, claiming cannot begin until details are finalized in the Demonstration's Standard Terms and Conditions.

Reason for Change:
The change in FY 2023-24, from the prior estimate, is an increase in savings due to:

- Removing this policy change from a Benefits expenditure. This policy change will now be budgeted as an Other Administration expenditure,
- Shifting the Jan 2023- March 2023 DSHP claiming estimated to occur in FY 2022-23 to FY 2023-24,
- Estimating CalRHAD DSHP claiming will begin and one quarter of claiming will occur in FY 2023-24, and
- Shifting the costs for the 2024 Fee-for-Service and managed care provider rate increases to the Medi-Cal Provider Rate Increase policy change.

The change in FY 2023-24 to FY 2024-25 in the current estimate is a net increase in savings due to:

- The DSHP CalAIM claiming includes four quarters in FY 2024-25 compared to five quarters in FY 2023-24,
- Estimating a full year of DSHP CalRHAD claiming in FY 2024-25.

Methodology:

1. DSHP CalAIM claiming is effective January 1, 2023, and claiming will commence in October 2023.

2. DSHP CalRHAD claiming is effective January 1, 2024, and claiming will commence in May 2024.

DESIGNATED STATE HEALTH PROGRAMS
OTHER ADMIN. POLICY CHANGE NUMBER: 98

3. The estimated total net impact on a cash basis is:

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
DSHP CalAIM	$0	($202,008)	$202,008
DSHP CalRHAD	$0	($7,083)	$7,083
Total DSHP	$0	($209,091)	$209,091

(Dollars in Thousands)

FY 2024-25	TF	GF	FF
DSHP CalAIM	$0	($161,606)	$161,606
DSHP CalRHAD	$0	($28,333)	$28,333
Total DSHP	$0	($189,939)	$189,939

Funding:
100% GF (4260-101-0001)
100% Health Care Support Fund (4260-601-7503)

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
November 2023
FISCAL YEARS 2023-24 & 2024-25

INTRODUCTION

The Medi-Cal Benefit Estimate can be segregated into three main components: (1) the Fee-for-Service (FFS) base expenditures, (2) the base policy changes, and (3) regular policy changes. The FFS base estimate is the anticipated level of FFS program expenditures assuming that there will be no changes in program direction and is derived from a 36 month historical trend analysis of actual expenditure patterns. The base policy changes anticipate the Managed Care, Medicare Payments, and non-FFS Medi-Cal program base expenditures. The regular policy changes are the estimated fiscal impacts of any program changes which are either anticipated to occur at some point in the future, or have occurred so recently that they are not yet fully reflected in the base expenditures. The combination of these three estimate components produces the final Medi-Cal Benefit Estimate.

FEE-FOR-SERVICE BASE ESTIMATES

The FFS base expenditure projections for the Medi-Cal estimate are developed using regression equations based upon the most recent 36 months of actual data. Independent regressions are run on user, units/user and dollars/unit for each of 18 aid categories within 11 different service categories. The general functional form of the regression equations is as follows:

	USERS	=	f(TND, S.QV, O.QV, Eligibles)
	CLAIMS/USER	=	f(TND, S.QV, O.QV)
	$/CLAIM	=	f(TND, S.QV, O.QV)
WHERE:	USERS	=	Monthly Unduplicated users by service and aid category.
	CLAIMS/USER	=	Total monthly claims or units divided by total monthly unduplicated users by service and aid category.
	$/CLAIM	=	Total monthly dollars divided by total monthly claims or units by service and aid category.
	TND	=	Linear trend variable.
	S.QV	=	Seasonally adjusting qualitative variable.
	O.QV	=	Other qualitative variable (as appropriate) to reflect exogenous shifts in the expenditure function (e.g. rate increases, price indices, etc.)
	Eligibles	=	Actual and projected monthly eligibles for each respective aid category incorporating various lag calculations for aid category within the service category.

Following the estimation of coefficients for these variables during the period of historical data, the independent variables are extended into the projection period and multiplied by the appropriate coefficients. The monthly values for users, units/user and dollars/unit are then multiplied together to arrive at the monthly dollar estimates and summed to annual totals by service and aid category.

FEE-FOR-SERVICE SERVICE CATEGORIES

Medi-Cal categorizes providers into Provider Types. For estimating purposes, the Medi-Cal Estimate groups these provider types into 11 Service Categories. This information is provided below.

Note: The Fee-For-Service delivery system includes the cost of care for those eligibles in the FFS delivery system, it also includes costs for items excluded in the Managed Care delivery model capitation.

Physicians

- Physicians
- Physician Group

Other Medical

- Audiologist
- Certified Nurse Midwife
- Chiropractor
- Certified Pediatric/Family Nurse Practitioner
- Clinical Laboratory
- Group Pediatric/Family Nurse Practitioner
- Nurse Anesthetist
- Occupational Therapist
- Optometrist
- Optometric Group
- Physical Therapist
- Podiatrist
- Psychologist
- Certified Acupuncturist
- Rural Health Clinic & FQHC
- Employer/Employee Clinic
- Speech Therapist
- Free Clinic
- Community Clinic
- Chronic Dialysis Clinic
- Multispecialty Clinic
- Surgical Clinic
- Exempt From Licensure Clinic
- Rehabilitation Clinics
- County Clinic Not Associate With A Hospital
- Birthing Centers-Primary Care Clinic
- Clinic-Otherwise Undesignated
- Outpatient Heroin Detox Center
- Alternative Birthing Center
- Respiratory Care Practitioner
- Health Access Program (Formerly Family PACT)
- Group Respiratory Care Practitioner
- Indian Health Services (MOU)
- Licensed Midwife

County and Community Outpatient

- County Hospital Outpatient
- Community Hospital Outpatient

Pharmacy
- Pharmacies or Pharmacists

County Inpatient
- County Hospital Inpatient
- Consists of Designated Public Hospitals. The Designated Public Hospitals are paid based on an interim per diem rate utilizing Certified Public Expenditures. DPH payments are 100% federal funds and the DPH pays the State's match. More information is available at the Department's website (www.dhcs.ca.gov).

Community Inpatient
- Community Hospital Inpatient
- Consists of Non-Designated Public Hospitals, Private Hospitals, and some Designated Public Hospitals. The Non-Designated Public Hospitals and Private Hospitals are paid using a Diagnosis Related Group payment methodology. The Designated Public Hospitals are paid based on an interim per diem rate utilizing Certified Public Expenditures. DPH payments are 100% federal funds and the DPH pays the State's match. More information is available at the Department's website (www.dhcs.ca.gov).

Nursing Facilities
- Long Term Care Nursing Facility
- Long Term Care Intermediate Care Facility (NF-A)
- Pediatric Subacute Care – Long Term Care
- These three provider types include Nursing Facility - Level A (NF-A), Nursing Facility – Level B (NF-B), Distinct Part Skilled Nursing Facilities of General Acute Care Hospitals (DP/NF-Bs), Distinct Part Adult Subacute Units for General Acute Care Hospitals (DP/SA), Rural Swing Beds, Institution for Mental Diseases, Acute and Transitional Inpatient Care Administrative Days (Administrative Days Level 1)

ICF-DD
- Long Term Care Intermediate Care Facility/Developmentally Disabled

Medical Transportation
- Ground Medical Transportation
- Air Ambulance Transportation

Other Services

- Adult Day Health Care Center
- Assistive Device & Sick Room Supply Dealers
- Blood Banks
- Fabricating Optical Laboratory
- Optometric Supplies
- Hearing Aid Dispensers
- Home Health Agency -Home & Comm. Based Services
- Optometric Supplies (from Dispensing Opticians, Optometrists, Optometric Group)
- Orthotists
- Portable X-Ray
- Prosthetists
- Genetic Disease Testing
- Medicare Crossover Provider Only
- Certified Hospice Service
- Local Education Agency
- EPSDT Supplemental Services Provider
- HCBS Congregate Living Health Facility
- HCBS Personal Care Agency
- RVN Individual Nurse Provider
- HCBS Professional Corporation
- AIDS Waiver Provider
- Multipurpose Senior Services Program
- CCS/GHPP Non-Institutional
- Independent Diagnostic Center (Medicare Crossover Provider Only)
- ALWPP Residential Care Facility for the Elderly
- ALWPP Care Coordinator
- HCBS Private Non-Profit Proprietary Agency
- Clinical Nurse Specialist (Medicare Crossover Provider Only)

Home Health

- Home Health Agency (except Home & Community Based Services)

Effective January 1, 2014, the Affordable Care Act (ACA) established a new income eligibility standard for Medi-Cal based upon a Modified Adjusted Gross Income (MAGI) of 133% of the federal poverty level (FPL) for pregnant women, children up to age 19, and parent/caretaker relatives. In addition, the former practice of using various income disregards to adjust family income was replaced with a single 5% income disregard. The ACA simplified the enrollment process and eliminated the asset test for MAGI eligible. Existing income eligibility rules for aged, blind, and disabled persons did not change.

The ACA allows current recipients of Medi-Cal to continue to enroll in the program and granted the option for states to expand eligibility under MAGI standards to a new group of individuals: primarily adults, age 19-64, without a disability and who do not have minor children.

AFFORDABLE CARE ACT

The ACA also imposed a tax upon those without health coverage, which will likely encourage many individuals who are currently eligible, but not enrolled in Medi-Cal to enroll in the program. Since January 2014, the Department has experienced significant growth in Medi-Cal enrollment as result of the ACA. The tax upon those without health coverage ceased to be effective, January 1, 2019. Effective January 1, 2020, California established an equivalent penalty on individuals without health coverage.

For those newly eligible adults in the expansion group, the ACA provides California with enhanced Federal Financial Participation (FFP) at the following rates:

- 100% FFP from calendar years 2014 to 2016,
- 95% FFP in 2017,
- 94% FFP in 2018,
- 93% FFP in 2019,
- 90% FFP in 2020 and beyond.

For those who are currently eligible, but not enrolled in Medi-Cal, enhanced FFP will not be available.

Beginning in October 2015, the ACA increased the Children's Health Insurance Program (CHIP) Federal Medical Assistance Percentage provided to California by 23 percent, to 88 percent FFP, up from 65 percent. This increase has now phased out and the state once again receives 65 percent FFP for CHIP, effective October 2020.

In response to the federal ACA mandate and State legislative direction, the Department chose the Health and Human Services Secretary-approved plan option, which allows the Department to seek approval for the same full scope Medi-Cal benefits received by existing beneficiaries. This option requires the selection of a private market reference plan to define the Essential Health Benefits (EHB) offered in the Alternative Benefit Plan (ABP).

The Standard Blue Cross/Blue Shield PPO (FEHB) Plan was selected as the EHB reference plan, as it allows the Department to provide an ABP package that most closely reflects existing State Plan benefits and thereby avoids disparity between the benefits received by new and existing beneficiaries.

HOME AND COMMUNITY BASED SERVICES

Long-Term Care Alternatives

Medi-Cal includes various Long-Term Services and Supports (LTSS) that allow medically needy, frail older adults, and persons with disabilities to avoid unnecessary institutionalization. The Department administers these alternatives either as State Plan benefits or through various types of waivers.

State Plan Benefits

In-Home Supportive Services (IHSS)

IHSS helps eligible individuals pay for services so that they can remain safely in their own homes. To be eligible, individuals must meet at least one of the following:

- 65 years of age or older,
- Disabled,
- Blind, or
- Have a medical certification of a chronic, disabling condition that causes functional impairment expected to last 12 consecutive months or longer or result in death within 12 months and be unable to remain safely at home without the services.

Children with disabilities are also eligible for IHSS. IHSS provides housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments, and protective supervision for individuals with a mental impairment(s).

The four IHSS programs are:

1. Personal Care Services Program (PCSP)
   This program provides personal care services including but not limited to non-medical personal services, paramedical services, domestic services, and protective supervision.
2. IHSS Plus Option (IPO)
   This program provides personal care services but also allows the recipient of services to select a family member as a provider.
3. Community First Choice Option (CFCO)
   This program provides personal care services to those who would otherwise be institutionalized in a nursing facility.
4. Residual (beneficiaries are not full-scope Medi-Cal; State-only program with no FFP)

The Department submitted **the California Disaster Relief State Plan Amendment (**CA DR SPA 21-0042**)** to include payment in the individual provider rate for Coronavirus Disease 2019 (COVID-19) sick leave benefits for IHSS and extend these payments through ~~9/30/21~~ **September 30, 2021**. The DR SPA was approved by Centers for Medicare & Medicaid Services (CMS) on July 28, 2021. Discretionary COVID-19 paid sick leave was allowed until December 31, 2022, and the California Department of Social Services (CDSS) requested that this benefit be extended until that date. As a result of SB 95 and the ARP, these emergency sick leave benefits were extended through December 31, 2022.

HOME AND COMMUNITY BASED SERVICES

The Department submitted CA DR SPA 21-0055 (IHSS Incentive Payments) to create a one-time payment for IHSS providers who provided IHSS care during the COVID-19 Public Health Emergency (PHE). The DR SPA was approved by CMS on December 21, 2021. CDSS processed the one-time payments during the first quarter of calendar year 2022.

Senate Bill 114 was enacted on February 9, 2022, retroactive to January 1, 2022, to provide additional leave benefits related to COVID-19. Supplemental sick leave (SPSL) 2022 applies to all IHSS workers, and provides an IHSS worker with two separate supplemental pay leave banks, each up to 40 hours. The first 40 hour bank is related to COVID-19 in general while the second 40 hour bank is related to a positive test for COVID-19.

Targeted Case Management (TCM)

The TCM Program provides specialized case management services to Medi-Cal eligible individuals who are developmentally disabled. These clients can gain access to needed medical, social, educational, and other services. TCM services include:

- Needs assessment
- Development of an individualized service plan
- Linkage and consultation
- Assistance with accessing services
- Crisis assistance planning
- Periodic review

1915(i) HCBS State Plan Services

The 1915(i) State Plan Services program provides home and community-based services (HCBS) to persons with developmental disabilities (DD) who are Regional Center consumers but do not meet nursing facility level of care criteria required for enrollment in the HCBS Waiver of Persons with DD. As of February 1, 2016, Behavioral Health Treatment (BHT) services for 1915(i) participants under the age of 21 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**X2-**1, was chaptered in October 2015 **(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.

HOME AND COMMUNITY BASED SERVICES

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.

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.

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. ~~The SPA will be effective upon approval.~~ **CMS approved the SPA on April 14, 2023, effective April 14, 2023.**

Waivers

Medi-Cal operates and administers various HCBS waivers that provide medically needy, frail seniors and persons with disabilities with services that allow them to live in their own homes or community-based settings instead of being cared for in facilities. These waivers require the program to meet federal cost-neutrality requirements so that the total cost of providing waiver services plus medically necessary State Plan services are less than the total cost incurred at the otherwise appropriate facility plus State Plan costs. The following waivers require state cost neutrality: Medi-Cal Waiver Program (MCWP), formerly known as the Acquired Immune Deficiency Syndrome (AIDS) Waiver; Assisted Living Waiver (ALW); Home and Community Based Alternatives (HCBA) Waiver; Multipurpose Senior Services Program (MSSP); HCBS Waiver for Persons with DD; and Self-Determination Program (SDP) Waiver for Persons with DD. A beneficiary may be enrolled in only one HCBS waiver at a time. If a beneficiary is eligible for services from more than one waiver, the beneficiary may choose the waiver that is best suited to his or her needs.

Assisted Living Waiver (ALW)

The ALW pays for assisted services and supports, care coordination, and community transition in 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~~ **29**, 2024.

Through California's Home and Community-Based Services (HCBS) Spending Plan, CMS approved the Department's proposal to add 7,000 slots to the ALW in the effort to eliminate the current ALW waitlist. The addition of these slots is enabling the Department to provide sufficient

HOME AND COMMUNITY BASED SERVICES

capacity to enroll all waitlisted beneficiaries and to clear pending enrollments, while still providing a cushion for continued growth.

On October 27, 2021, the Department submitted an ALW technical amendment to increase the maximum number of waiver slots to CMS for approval with a retroactive implementation date of July 1, 2021. On January 7, 2022, CMS approved the amendment with a retroactive implementation date of July 1, 2021. CMS informed the Department that agencies could immediately start enrolling clients on the waitlist. As of ~~December 2022~~ **June 2023**, approximately ~~3,700~~ **5,911** slots have been released for transitioning individuals for placement into the ~~Program~~ **ALW**.

The Department will continue activities for the integration of ALW into the HCBA Waiver. The high-level purpose of integrating the ALW and HCBA Waiver is to expand ALW services statewide, while reducing the internal burden of administering two 1915(c) waivers. To ensure the highest-quality outcome when integrating the ALW and HCBA Waivers, the Department will be implementing a phased-in integration of the ALW and HCBA Waiver by the end of the current ALW term, February ~~28~~ **29**, 2024.

Community-Based Adult Services (CBAS)

AB 97 (Chapter 3, Statutes of 2011) eliminated Adult Day Health Care (ADHC) a Medi-Cal optional benefit. A lawsuit was filed challenging elimination of ADHC (*Darling et al. v. Douglas et al.*), resulting in a settlement agreement between DHCS and the plaintiffs. The settlement agreement eliminated the ADHC program effective March 31, 2012, and replaced it with a new program called CBAS. CBAS is an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, and transportation to approved program participants. CBAS provides necessary medical and social services to individuals with intensive health care needs. CBAS became a managed care benefit effective April 1, 2012, through an amendment to the "Bridge to Reform" 1115 Medicaid waiver. Under the Bridge to Reform Waiver, CBAS was authorized for a temporary extension through December 31, 2015. The Department submitted 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 CalAIM Section 1115 demonstration waiver. This new waiver period is January 1, 2022, through December 31, 2026 and maintains the CBAS benefit.

Due to the COVID-19 pandemic, CBAS centers were not able to provide services in a congregate setting beginning the second half of March 2020. In response, the Department and the California Department of Aging (CDA) developed a new CBAS service delivery model, known as Temporary Alternative Services (TAS). Under this model, CBAS centers ~~provide~~ **provided** limited individual in-center activities, as well as telephonic, telehealth and in-home services to CBAS participants. This temporary model ~~is~~ **was** effective through September 30, 2022, at which point CBAS ~~will return~~ **returned** to full congregate in-person service delivery.

HOME AND COMMUNITY BASED SERVICES

The renewed 1115 Waiver includes an ongoing remote services option for CBAS. Under certain unique circumstances, CBAS Emergency Remote Services (ERS) may be provided in response to the individual's person-centered needs. This is for CBAS members who have unique circumstances and are time limited to facilitate availability for services when beneficiaries are not able to access in person services. CBAS ERS became available on October 1, 2022.

Pursuant to the Budget Act of 2019, the Department implemented the structure of provider supplemental payments for qualified CBAS services funding the state share with revenues from the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56). The supplemental payments structure was subject to suspension on June 30, 2021. The Budget Act of 2021 removed this suspension. The 2022 **Governor's Budget** shifted the state funding source of these supplemental payments to the General Fund.

Home and Community-Based Alternatives (HCBA) Waiver

The HCBA Waiver provides Medi-Cal members with long-term medical conditions, who meet the adult or pediatric acute hospital, subacute, or nursing facility (NF) Level of Care (LOC), with the option of returning to and/or remaining in their home or home-like setting in the community in lieu of institutionalization. The Department contracts with Waiver Agencies for the purpose of performing waiver administration functions and providing the Comprehensive Care Management waiver service. The Waiver Agencies are responsible for functions including: participant 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 ~~will maintain~~ **maintains** an active role in the waiver administration by determining all waiver participant eligibility, setting enrollment goals, and providing continuous, ongoing monitoring and oversight. ~~The~~ **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~~ **The waiver was set to expire on December 31, 2021; however, the** Department received a fifth 90-day temporary extension**,** ~~of the current waiver that is set~~ to ~~expire~~ 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 following changes included in the waiver renewal application will have an impact on the Medi-Cal budget: the addition of new waiver services, a rate increase for Personal Care Agencies in response to the statewide minimum wage increase, and additional waiver slots beginning on January 1, 2024, based on projected enrollment and attrition trends.

Medi-Cal Waiver Program (MCWP) (Previously known as the Acquired Immune Deficiency Syndrome (AIDS) Medi-Cal Waiver)

Local agencies, under contract with the California Department of Public Health (CDPH), Office of AIDS, (CDPH/OA) provide home and community-based services as an alternative to nursing facility care or hospitalization.

Services provided include:

HOME AND COMMUNITY BASED SERVICES

- Administrative Expenses
- Attendant care
- Case management
- Financial supplements for foster care
- Home-delivered meals
- Homemaker services
- In-home skilled nursing care
- Minor physical adaptations to the home
- Non-emergency medical transportation
- Nutritional counseling
- Nutritional supplements
- Psychotherapy

Clients eligible for the program must be Medi-Cal recipients whose health status qualifies them for nursing facility care or hospitalization, in an aid code with full benefits and not enrolled in the Program of All-Inclusive Care for the Elderly (PACE). Waiver participants must also have a written diagnosis of HIV disease or AIDS, certified by the nurse case manager to be at the nursing facility level of care, and score 60 or less using the Cognitive and Functional Ability Scale assessment tool. Children under 13 years of age are eligible if they have been certified by the nurse case manager as HIV/AIDS symptomatic. All waiver participants must have a home setting that is safe for both the client and service providers.

The Department, 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 ~~current~~ waiver that was set to expire December 31, 2021. This temporary extension ~~expires~~ **expired** 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~~. This will extend~~**, extending** the waiver term to December 31, 2027.

Multipurpose Senior Services Program (MSSP) Waiver

The California Department of Aging currently contracts with local agencies statewide to provide social and health care management for frail elderly clients who are at risk of placement in a nursing facility but who wish to remain in the community. The MSSP arranges for and monitors the use of community services to prevent or delay premature institutional placement of these individuals. Clients eligible for the program must be 65 years of age or older, live within an MSSP site service area, be able to be served within MSSP's cost limitations, be appropriate for care management services, be currently eligible for Medi-Cal, and can be certified for placement in a nursing facility. Services provided by MSSP include adult day care center, household and personal care assistance, protective supervision, care management, respite, transportation, meal services, social services, minor home repair/maintenance and communication services.

The program provides services under a federal 1915(c) home and community-based services waiver. The Department submitted a waiver renewal application on March 28, 2019. The MSSP Waiver ended on June 30, 2019, and CMS approved a 90-day ~~Temporary Extension~~ **temporary extention** in order to resolve CMS questions related to the renewal application. The Department

HOME AND COMMUNITY BASED SERVICES

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 benefit was scheduled to be carved out from the Coordinated Care Initiative (CCI), subject to CMS approval, effective January 1, 2021. This proposed carve out was delayed to January 1, 2022, due to the postponement of the California Advancing and Innovating Medi-Cal (CalAIM) initiative and the COVID-19 public health emergency. With the delay of CalAIM, the Department submitted a 12-month extension request to CMS for the Medi-Cal 2020 waiver**,** extending its ~~current~~ term through December 31, 2021.

The Department carved out the MSSP benefit through the MSSP waiver within CCI counties, effective January 1, 2022. **MSSP operates as a waiver benefit in all CCI demonstration counties (except San Mateo County), as it did prior to the implementation of CCI in 2014.**

In 2019, AB 74 (Chapter 23, Statutes of 2019) was approved, which provides a one-time-only supplemental funding for expenditure over a three-year period. The supplemental funding will fund waiver care management and care management support payments. The Budget Act of 2021 extended this supplemental funding and increased the number of program slots, effective January 1, 2022.

~~The Department is currently on Formal Request for Additional Information (RAI) from CMS regarding the waiver amendment to transition of MSSP billing codes to be converted to the National HCPCS codes.~~

CMS approved the waiver amendment on May 16, 2023, effective July 1, 2023, to transition of MSSP billing codes to be converted to the National HCPCS codes. The Department is submitting a subsequent amendment to CMS to change the effective date for the code conversion to December 31, 2023, to allow for sufficient time for MSSP sites to implement the code conversion.

Home and Community-Based Waiver for Persons with Developmental Disabilities (HCBS-DD)

The HCBS-DD Waiver provides home and community-based services to persons with developmental disabilities who are Regional Center consumers as an alternative to care provided in a facility that meets the Federal requirement of an intermediate care facility for the developmentally disabled; in California, Intermediate Care Facility/Developmentally Disabled-type facilities, or a State Developmental Center. As of February 1, 2016, BHT services for Waiver participants under the age of 21 is a state plan benefit paid through fee-for-service or the managed care delivery system.

The Department submitted a renewal application to CMS on December 22, 2016**,** and received approval on December 7, 2017. Approved capacity of unduplicated recipients for this waiver is 130,000 in 2018, 135,000 in 2019, 140,000 in 2020, 145,000 in 2021, ~~and~~ 150,000 in 2022**, and 155,000 in 2023**. The waiver is approved from January 1, 2018 through December 31, 2022. **The waiver is approved from January 1, 2023, through December 31, 2027.**

HOME AND COMMUNITY BASED SERVICES

The Department submitted a Waiver Amendment to reflect a rate increase to Home Health Aide and Skilled Nursing Services to align them with increases to Medi-Cal, as authorized by the 2018 Budget Act. The appropriation in the 2018 Budget Act will be applied to increase the payment rates for certified Home Health Aides, Licensed Vocational Nurses, and Registered Nurses. This does not result in a change to the rate methodology. The Amendment was approved with an effective date of July 1, 2018.

The Department submitted a Waiver Amendment to provide time limited rate increases in specific geographic areas for providers of Community-Based Day Services, In-Home Respite Agencies, and providers of Community Living Arrangement Services under the Alternative Residential Model. This amendment also includes Community Crisis Homes as a new provider type under Behavioral Intervention Services, adds Community Based Adult Services as a new waiver service, and adds Adult Day Health Care Center as a provider type under Community Based Adult Services. The approved effective date ~~is~~ **was** May 1, 2019.

The Department submitted an additional Waiver Amendment as a result of SB 81 (Chapter 28, Statutes of 2019), which ~~provides the~~ **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 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 consumers placed at Institutions for Mental Diseases into alternative community settings. The amendment was approved with an effective date of January 19, 2021.

The Department submitted a Waiver Amendment for a time-limited rate increase for Independent Living Program (ILP) providers, pursuant to AB 79, with an effective term of January 1, 2021 through December 31, 2021. The amendment was approved with an effective date of January 1, 2021.

The Department submitted a Waiver Amendment to implement a rate model as described in the 2019 DDS Rate Study. The Waiver Amendment was approved by CMS with an effective date of April 1, 2022.

The Department submitted an Appendix K to implement a rate increase for minimum wage that was approved by CMS with an effective date of January 1, 2022.

The Department submitted an Appendix K to increase incentive payments ~~which will~~ **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.

HOME AND COMMUNITY BASED SERVICES

The Department submitted the HCBS-DD waiver renewal to CMS on September 30, 2022. ~~The~~ **CMS approved the** waiver renewal ~~proposes~~ **for** a new five-year term effective January 1, 2023, through December 31, 2027. The waiver renewal contains ~~proposed~~ 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.

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 may renew the waiver at the end of the initial three-year period by providing evidence and documentation of satisfactory performance and oversight.

As of February 1, 2016, BHT services for Waiver participants under the age of 21 is a state plan benefit and paid through fee-for-service, or the managed care delivery system.
The California Department of Developmental Disabilities engaged in a stakeholder process to obtain stakeholder input regarding recommended changes to include in the waiver renewal application that was submitted to CMS in March 2021. CMS approved the waiver renewal for a new five-year term, effective July 1, 2021**,** through June 30, 2026.

Managed Care Programs

Program of All Inclusive Care for the Elderly (PACE)

PACE is a federally defined, comprehensive, and capitated managed care model program that delivers fully integrated services. PACE covered services include all medical long-term services and supports, dental, vision and other specialty services**,** allowing enrolled beneficiaries who would otherwise be in an intermediate care facility or in a skilled nursing facility to maintain independence in their homes and communities. Participants must be 55 years or older and determined by the Department to meet the Medi-Cal regulatory criteria for nursing facility placement. PACE participants receive their services from a nearby PACE Center where clinical services, therapies, and social interaction take place.

SCAN Health Plan

SCAN is a Medicare Advantage Special Needs Plan that contracts with the Department to provide services for dually eligible Medicare/Medi-Cal beneficiaries residing in Los Angeles, Riverside, San Bernardino, and San Diego counties. SCAN provides all services in the Medi-Cal State Plan, including home and community-based services to SCAN members who are

assessed at the Nursing Facility Level of Care and nursing home custodial care. The eligibility criteria for SCAN specifies that a member be at least 65 years of age, have Medicare A and B, have full scope Medi-Cal with no share of cost and live in SCAN's approved service. SCAN does not enroll individuals with End Stage Renal Disease.

Special Grant

California Community Transitions/Money Follows the Person (CCT/MFP) Rebalancing Demonstration Grant

In January 2007, CMS awarded the Department a grant for the Money Follows the Person Rebalancing Demonstration Grant, called California Community Transitions. This grant is authorized under section 6071 of the federal Deficit Reduction Act of 2005, and was extended by the Patient Protection and Affordable Care Act of 2010.

On April 18, 2018, the federal Medicaid Services Investment and Accountability Act of 2019 was signed into law and appropriated additional federal funding for CMS to allocate state grantees for FY 2019-20.

On January 24, 2019, the Medicaid Extenders Act of 2019 was signed and authorized MFP state grantees to continue to transition eligible beneficiaries through December 31, 2019, using available MFP funding. The Extenders Act provided CMS with the authority to allocate new funding to state grantees for calendar year 2019, to allow funding appropriated through the Extenders Act to be spent through 2023.

On August 6, 2019, the Sustaining Excellence in Medicaid Act of 2019 was signed and appropriated additional federal funds for allocation to MFP state grantees.

On December 20, 2019, the Further Consolidated Appropriations Act, 2020 amended the DRA of 2005 to extend the term of the MFP grant by five months, from January 1, 2020, to May 22, 2020.

On March 18, 2020, the Families First Coronavirus Response Act (FFCRA) was enacted. Section 6008 of the FFCRA provides a temporary 3.1% Federal Medical Assistance Percentage (FMAP) increase to MFP services under Section 1905(b) of the Social Security Act. The increase is being applied retroactively beginning January 1, 2020 and extends through the last day of the calendar quarter in which the COVID-19 public health emergency period, including any extensions, terminates.

On March 27, 2020, the Coronavirus Aid, Relief, and Economic Security Act extended the term of the MFP grant from May 22, 2020, to November 30, 2020. On December 27, 2020, the President signed the Consolidated Appropriations Act of 2021, which includes an extension of the MFP grant through federal fiscal year (FFY) 2023 and appropriates $450 million for FFY 2022, and $450 million for FFY 2023. Under the Act, the CCT Program will receive grant funding

to continue to transition eligible beneficiaries 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 design and implementation, and to expand HCBS capacity. The Department selected Mathematica as its contractor to perform the Gap Analysis and prepare the Multiyear Roadmap. The Department finalized the contract on October 6, 2022, with a retroactive state date of September 1, 2022.

The grant requires the Department to develop and implement strategies for transitioning Medi-Cal members who have resided continuously in health care facilities for 90 days or longer back to a federally-qualified residence. Under the Consolidated Appropriations Act of 2021, effective January 26, 2021, the 90 day minimum stay requirement was reduced to 60 days.

In April 2022, CMS issued a Memorandum to state grantees to announce a change to the FFP available for MFP supplemental services as well as the types of allowable services. Effective January 1, 2022, CMS-approved supplemental services will be fully covered by MFP grant funds at a federal reimbursement rate of 100%. The projected implementation date of CCT supplemental services is ~~in the Spring of~~ 2023.

Beginning January 1, 2021, SB 214 created a temporary program that revises the current requirement for individuals residing in an inpatient facility from 90 days and longer to less than 90 days. The temporary program requires the Department to end enrolling specified individuals by the end of December 31, 2022, and end providing services at the end of December 31, 2023. However, SB 214 was invalidated due to federal legislation that modified criteria for the MFP grant. As a result, the Department proposed amendments to the statute through trailer bill language to align the state-funded CCT population with the new federal requirements.

On July 27, 2021, AB 133 was approved by the Governor and chaptered by the Secretary of State. Approval of AB 133 allowed for the roll out of a state-funded, California Community Transitions (CCT)-like program. AB 133 aligns state statute with the amended federal statute, by reducing the required period of residence in an inpatient facility from 90 days to 60 days. The State-funded, CCT-like program allows CCT Lead Organizations to provide transition services to Medi-Cal beneficiaries who have not yet met the federal, MFP residency eligibility criteria, as

HOME AND COMMUNITY BASED SERVICES

a way to help reduce the amount of time beneficiaries are required to remain in an institution during the COVID-19 PHE.

On December 29, 2022, the President signed the Consolidated Appropriations Act of 2023 into law, which extends the MFP grant indefinitely and appropriates additional funding for each fiscal year through 2024-27. Unexpended grant funds awarded for any fiscal year can continue to be spent for up to four additional years.

The population that is eligible for the state-funded program are residents of inpatient facilities who meet the eligibility criteria to enroll in the federally-funded Money Follows the Person (MFP) Rebalancing Demonstration, with one exception (MFP is known as California Community Transitions (CCT) in our state). To be eligible for the federally-funded program, a beneficiary is required to have been a resident of an inpatient facility for at least 60 days the state-funded program removes the 60-day eligibility criteria to provide transition coordination services to beneficiaries residing in SNF who meet all other MFP/CCT enrollment criteria, including:

- At least one day of their stay in the facility must be funded by Medicaid; and
- The beneficiary would continue to require skilled nursing care in a facility if not for the transition coordination and home and community-based long-term services and supports provided/secured for them through the CCT program.

1115 WAIVER-MH/UCD, BTR, MEDI-CAL 2020, AND CALAIM 1915(b) WAIVER

The Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD) ended on October 31, 2010, and the California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) ended on December 31, 2015. The Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020) was approved effective January 1, 2016, for five years. Due to the COVID-19 pandemic impact on the state's health care delivery systems CMS approved a one-year extension. The Medi-Cal 2020 waiver ended on December 31, 2021.

The CalAIM Section 1115 Demonstration, for the service period of January 1, 2022, through December 31, 2026, has been approved by CMS. In addition, the CalAIM Section 1915(b) Demonstration was also approved for the same January 1, 2022, through December 31, 2026, service period. Together, the CalAIM Section 1115 and the 1915(b) waivers, along with State Plan Amendments approved by CMS, move tested initiatives from prior federal waivers to statewide rollout, benefiting all Medi-Cal enrollees. 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 ~~has been~~ **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. ~~As of~~ **For** rating periods ~~beginning on or after~~ **from** July 2018 **through December 2022**, each plan's final rate is a blend that gives 75% weight to the county-average rate and 25% weight to the plan-specific rate. County Organized Health Systems (COHS) rates are not risk adjusted due to the presence of only one plan in each county.

The risk adjustment policy is examined on an annual basis and adjusted if necessary. As of January 2023, the Department transitioned to the CDPS+Rx risk adjustment model, which combines the diagnostic-based Chronic Illness and Disability Payment System (CDPS) model and the pharmacy-based Medicaid Rx model. For more information on CDPS+Rx, see https://cdps.ucsd.edu/.

For the calendar year (CY) 2023 rating period, subject to federal approval, the Department considers plans' performance on select quality measures to inform adjustments to the 75%/25% blend. In all Two-Plan and Regional Model counties (except San Benito) where a significant difference in quality performance between the two plans is observed, the blend will be adjusted in the direction that is favorable to the higher-performing plan. The weight given to the county-average rate may be reduced to as little as 50% or increased to as much as 100%**. For the CY 2024 rating period, 100% of the rate, except for select services, will be risk adjusted.**

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 Behavioral Health Treatment (BHT) for children. BHT supplemental payments will be

discontinued, and associated costs will be captured within base rates, as of the CY 2023 rating period.

The State implemented a one-time 18-month rating period for the period of July 1, 2019, through December 31, 2020, to aid in future prospective rate development as federally required. Beginning with CY 2021, rates are developed annually on a calendar year basis thereafter.

Managed Care Organization Taxes

SBX2-2 (Chapter 2, Statutes of 2016) implemented a statewide tax on managed care plans based on their enrollment. The tax is tiered based on whether an enrollee is a Medi-Cal enrollee, alternate health care service plan enrollee, or other enrollee. This Managed Care Organization (MCO) Enrollment Tax was effective July 1, 2016, through June 30, 2019. AB 115 (Chapter 348, Statutes of 2019) authorized a modified MCO Enrollment Tax. On April 3, 2020, CMS approved the Department's waiver of the broad-based and uniformity provisions of Sections 1903(w)(3)(B) and (C) of the Social Security Act for the modified MCO Enrollment Tax model. The effective date range from this approval is January 1, 2020, through December 31, 2022. ~~The Department has proposed to renew the~~ **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 ~~proposed to be~~ tiered based on whether an enrollee is a Medi-Cal enrollee or other enrollee.

Prior to the enrollment-based MCO taxes, SB 78 (Chapter 33, Statutes of 2013) introduced a 3.9375% revenue-based MCO tax. The Department is currently in the process of reconciling the MCO tax fund for the July 1, 2013, through June 30, 2016, time period in which the revenue-based tax was applicable. ~~Nearly all of the~~ **The** final reconciliation is expected to be completed in ~~FY 2022-23 with a small portion occurring in~~ FY 2023-24.

~~**Directed and Pass-Through Payments**~~

~~Effective January 1, 2023, the managed care delivery system will include a temporary Distinct Part Nursing Facility (DP-NF) pass-through payment program that will transition supplemental payments for DP-NF days formerly covered in the Medi-Cal FFS delivery system. Due to the need for actual experience from the applicable rating period to complete calculations, payments are anticipated to begin in FY 2024-25.~~

~~The District Hospital Directed Payment (DHDP) program is effective January 1, 2023. The DHDP provides uniform dollar increases for qualifying, contracted inpatient hospital, outpatient hospital, nursing facility and emergency services. The district and municipal hospitals included in the program are nondesignated public hospitals as defined in Welfare and Institutions Code, Section 14166.1(f). Payments are expected to occur beginning in FY 2024-25. The nonfederal share of payments is anticipated to be funded by voluntary intergovernmental transfers from eligible funding entities.~~

Federally Qualified Health Center Alternative Payment Methodology (FQHC APM)

MANAGED CARE

The FQHC APM is a voluntary program aimed towards moving FQHCs from their current volume-based reimbursement model to a capitated value-based model. The program will fund FQHCs through Managed Care Plans with a Per Member Per Month payment for each assigned member to their site. This funding will be equivalent to what they were projected to have received under their Prospective Payment System (PPS) volume-based model. For FQHCs that are suited to participating in the APM, the capitation payment will improve revenue stability and provide additional flexibilities to provide alternative services that are not rendered by a PPS eligible provider. The FQHC APM is currently targeted for implementation date of no sooner than July 1, 2024, subject to CMS approval. The program is currently working toward finalizing program policies as well as preparing a SPA for submission to CMS.

Coordinated Care Initiative (CCI) Program

The 2017 Budget extended the Cal MediConnect (CMC) program and the mandatory enrollment of dual eligible beneficiaries 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 and statewide integration of long-term care into managed care, the CCI pilot program sunset December 31, 2022.

Fee-for-Service (FFS) Expenditures for Managed Care Beneficiaries

Managed care contracts require health plans to provide specific services to Medi-Cal enrolled beneficiaries. Medi-Cal services that are not delegated to contracting health plans remain the responsibility of the Medi-Cal FFS program. When a beneficiary who is enrolled in a Medi-Cal managed care plan is rendered a Medi-Cal service that has been explicitly excluded from their plan's respective managed care contract, providers must seek payment through the Medi-Cal FFS program. The services rendered in the above scenario are commonly referred to as "carved out" services. "Carved-out" services and their associated expenditures are excluded from the capitation payments and are reflected in the Medi-Cal FFS paid claims data.

In addition to managed care carve-outs, the Department is required to provide additional reimbursement through the Medi-Cal FFS program to Federally Qualified Health Center/Rural Health Clinic providers who have rendered care to beneficiaries enrolled in managed care plans. These providers are reimbursed for the difference between their prospective payment system rate and the amount they receive from managed care health plans. These FFS expenditures are referred to as "wrap-around" payments.

Excluding pharmacy costs covered under Medi-Cal Rx, FQHC "wrap-around" payments and California Children's Services "carve-out" expenditures account for the largest share of FFS expenditures generated by Medi-Cal beneficiaries enrolled in managed care plans.

MANAGED CARE

Under CalAIM, long term care (LTC) services that were previously “carved-out” of managed care in non-COHS, non-CCI counties, were integrated into managed care. Under the historical policy, managed care beneficiaries in non-COHS, non-CCI counties were disenrolled from managed care plans one month after the month of admission to an LTC facility, at which point the FFS delivery system would be responsible for providing all State Plan services. With the managed care “carve-in,” both the beneficiary 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

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 that will be 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 will have an operational start date of January 1, 2024, contingent on passing all Plan operational readiness activities.

Quality Withhold and Incentive Program

For the CY 2024 rating period and future periods, subject to CMS approval, the Department is implementing a hybrid Quality Withhold and Incentive program for contracted Medi-Cal managed care plans. This program is expected to be ongoing and withhold 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.

PROVIDER RATES

Provider Rates Reimbursement Methodology and the Quality Assurance Fee for Freestanding Nursing Facility Level Bs & Freestanding Subacute Level B Facilities

The Medi-Cal Long-Term Care Reimbursement Act (Article 3.8 of Chapter 7 of Part 3 of Division 9 of Welfare and Institutions Code, beginning with section 14126) requires the Department to develop a cost-based, facility-specific reimbursement rate methodology for Freestanding Nursing Facility Level-Bs (FS/NF-Bs), and Freestanding Subacute Nursing Facility, Level Bs (FSSA/NF-Bs). Rates are updated annually and are established based on the most recent audited cost report data.

The rate methodology developed by the Department computes facility-specific, cost-based per diem payments for FS/NF-Bs and FSSA/NF-Bs based on five cost categories, which are subject to limits. Limits are set based on expenditures within geographic peer groups. Costs specific to one category may not be shifted to another cost category. Additionally, the budget and authorizing legislation sets maximum annual year-over-year increases.

Labor: This category has two components: direct resident care labor costs and indirect care labor costs.

- Direct resident care labor costs include salaries, wages and benefits related to routine nursing services defined as nursing, social services and personal activities. Costs are limited to the 95th percentile of each facility's peer group.

- Indirect care labor includes costs related to staff support in the delivery of patient care including, but not limited to, housekeeping, laundry and linen, dietary, medical records, in-service education, and plant operations and maintenance. Costs are limited to the 95th percentile of each facility's peer group.

Indirect care non-labor: This category includes costs related to services that support the delivery of resident care including the non-labor portion of nursing, housekeeping, laundry and linen, dietary, in-service education, pharmacy consulting costs and fees, plant operations and maintenance costs. Costs are limited to the 75th percentile of each facility's peer group.

Administrative: This category includes costs related to allowable administrative and general expenses of operating a facility including: administrator, business office, home office costs that are not directly charged and property insurance. This category excludes costs for caregiver training, liability insurance, facility license fees and medical records. Costs are limited to the 50th percentile.

Fair rental value system (FRVS): This category is used to reimburse property costs. The FRVS is used in lieu of actual costs and/or lease payments on land, buildings, fixed equipment and major movable equipment used in providing resident care. The FRVS formula recognizes age and condition of the facility. Facilities receive increased reimbursement when improvements are made.

PROVIDER RATES

Direct pass-through: This category includes the direct pass-through of proportional Medi-Cal costs for property taxes, facility license fees, caregiver training costs, and new state and federal mandates including the facility's portion of the QAF.

Reimbursement Methodology for Other Long-Term Care Facilities

The reimbursement methodology is based on a prospective flat-rate system, with facilities divided into peer groups by licensure, level of care, bed size and geographic area in some cases. Rates for each category are determined based on data obtained from each facility's annual or fiscal period closing cost report. Audits conducted by the Department result in adjustments to the cost reports on an individual or peer-group basis. Adjusted costs are segregated into four categories:

Fixed Costs (Typically 10.5 percent of total costs). Fixed costs are relatively constant from year to year, and therefore are not updated. Fixed costs include interest on loans, depreciation, leasehold improvements and rent.

Property Taxes (Typically 0.5 percent of total costs). Property taxes are updated 2% annually, as allowed under Proposition 13.

Labor Costs (Typically 65 percent of total costs). Labor costs (i.e., wages, salaries, and benefits) are the majority of operating costs in a nursing home. The inflation factor for labor is calculated by DHCS based on reported labor costs.

All Other Costs (Typically 24 percent of total costs). The remaining costs, "all other" costs, are updated by the California Consumer Price Index.

Mandates & Quality Assurance Fee. The Department projects the cost of complying with new state or federal mandates and the Quality Assurance Fee (QAF).

Methodology by Type of LTC Facility

Projected costs for each specific facility are peer grouped by licensure, level of care, and/or geographic area/bed size.

Intermediate Care Facilities (Freestanding Nursing Facilities-Level A, NF-A) are peer-grouped by location. Reimbursements are equal to the median of each peer group.

Distinct Part (Hospital-Based) Nursing Facilities-Level B (DP/NF-B) are grouped in one statewide peer group. DP/NF-Bs are paid their projected costs up to the median of their peer group. When computing the median, facilities with less than 20 percent Medi-Cal utilization are excluded.

Intermediate Care Facilities for the Developmentally Disabled, Developmentally Disabled-Habilitative, and Developmentally Disabled-Nursing (ICF/DD, ICF/DD-H, ICF/DD-N) are peer

grouped by level of care and bed size. Reimbursements are established at the 65th percentile of the group's projected costs.

Adult Subacute Care Facilities are grouped into two statewide peer groups: hospital-based providers and freestanding nursing facility providers. Subacute care providers are reimbursed their projected costs up to the median of their peer group.

Pediatric Subacute Care Units/Facilities are grouped into two peer groups: hospital-based nursing facility providers (Distinct Part Pediatric Subacute (DP/PSA) facilities) and Freestanding Pediatric Subacute (FS/PSA) facilities. There are different rates for ventilator and non-ventilator patients. Reimbursement is based on a model since historical cost data were not previously available. The FS/PSA reimbursement rates equal the lesser of the facility's costs as projected by the Department, or the rate based on the class median rates, broken down by ventilator and non-ventilator.

COVID-19 Impact on Long-Term Care Facilities

In response to the increased cost pressures incurred by the COVID-19 outbreak, the Department with CMS's approval has provided the following long-term care facilities with rate increase equal to 10 percent of their regular 2019-20 total reimbursement amount:

- Freestanding Skilled Nursing Facilities Level-B (FS/SNF-B)
- Nursing Facilities Level-A (NF-A)
- Distinct Part Skilled Nursing Facilities Level-B (DP/SNF-B)
- Freestanding Adult Subacute Facilities (FSSA)
- Distinct Part Adult Subacute Facilities (DP/SA)
- Distinct Part Pediatric Subacute Facilities (DP/PSA)
- Freestanding Pediatric Subacute Facilities (FS/PSA)
- ICF/DD (including ICF/DD-Habilitative, and ICF/DD-Nursing)

This increase does not apply to state-owned Skilled Nursing Facilities or ICFs, including Developmental Centers and Veterans Homes. The increased amounts are inclusive of add-ons, and the FS/PSA and the ICF/DD Proposition 56 supplemental payments.

The COVID-19 rate increases are effective March 1, 2020. For FS/SNF-Bs and FSSAs, the COVID-19 rate increase will continue through December 31, 2023. For ICF-DDs, rates after the end of the public health emergency (PHE) will be the greater of the annually updated regular rate or the total reimbursement on the last day of the PHE, inclusive of the COVID-19 rate increase. ~~Under current law, the COVID-19 rate increase will continue until the expiration of the PHE and thereafter will revert back to their regular levels.~~

PROVIDER RATES

In accordance with the 2023 Budget Act, and pending federal approval, for dates of service July 1, 2023, through December 31, 2023, FS/PSA reimbursement rates will be set at the total per diem rate in effect on August 1, 2022, inclusive of an amount equivalent to the COVID-19 PHE rate increase then in effect. For dates of service on or after January 1, 2024, FS/PSA rates shall be the greater of:

(1) the reimbursement rate established by the applicable State Plan reimbursement methodology, or
(2) the reimbursement rate in effect for the facility on December 31, 2023, inclusive
of the amount equivalent to the COVID-19 PHE rate increase.

For all other facilities, the COVID-19 rate increase continued until the expiration of the PHE on May 11, 2023. Following expiration of the PHE, rates will revert back to their regular levels.

CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM)

CalAIM is a comprehensive set of proposals that collectively are intended to: (1) identify and manage member risk and need through whole person care approaches and addressing the social determinants of health, (2) move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility, and (3) improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform. See https://www.dhcs.ca.gov/calaim for more information.

Initial components of CalAIM launched in the beginning of 2022 and the remaining components will go live over the next several years. Where fiscal impacts have been identified, policy changes have been included in the Medi-Cal Estimate to budget needed funding. Other components of the CalAIM proposal do not have estimated fiscal impacts in the Medi-Cal Estimate at this time, but are described hereafter:

1. Managed Care Specialty Mental Health Services Carve-Out

   Under CalAIM, the Department is standardizing benefits provided through Medi-Cal managed care plans statewide. With some exceptions, regardless of a beneficiary's 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 will result in a reduction in capitation paid to managed care plans, accounted for in the appropriate managed care base policy changes in the Estimate.

2. Updated Criteria for Specialty Mental Health Services

   The Department is modifying the criteria for specialty mental health services to align with state/federal requirements and more clearly delineate and standardize the benefit statewide, effective January 1, 2022. As part of this effort, the Department is also seeking to identify and implement screening and transition of care tools that shall be used to determine the appropriate level of care for mental health services, effective January 1, 2023.

3. BH Administrative Integration

   Research indicates that approximately 50% of individuals who have a serious mental illness have a co-occurring substance use disorder and that those individuals benefit from integrated treatment. The State provides Medi-Cal covered SUD and SMHS through two separate county-operated delivery systems, which makes it difficult for counties to provide integrated treatment to individuals who have co-occurring disorders. For example, counties participating in mental health and substance use disorder managed care are subject to two separate annual quality assessments, two separate post payment chart audits, and two separate reimbursement and cost reporting methods. In order to comply with these separate processes, counties providing integrated treatment to a Medi-Cal beneficiary must document

the SUD service separately from the specialty mental health service. The purpose of this proposal is to make necessary state and county changes that would provide SUD and SMHS through one delivery system. Efforts to begin working on integration are targeted for January 1, 2022, aiming for a single county contract for SUD and mental health treatment starting January 1, 2027.

4. BH Regional Contracting

The Department recognizes that some counties have resource limitations often due simply to their size and the number of beneficiaries residing in their county. Therefore, the Department is encouraging counties to develop regional approaches to administer and deliver SMHS and SUD services to Medi-Cal beneficiaries. There are a variety of options available to counties, including a Joint Powers Authority to operate such services for a multi-county region (e.g., Sutter/Yuba). Counties could also pool resources to contract with an administrative services organization/third-party administrator or other entity, such as the County Medical Services Program, to create administrative efficiencies across multiple counties. Small counties, rural/frontier counties, and counties with shared population centers or complementary resources should consider opportunities for regional partnership. Furthermore, the Department is interested in discussing how counties not currently seeking DMC-ODS participation may be more interested in doing so through a regional approach and/or how services provided under SUD fee-for-service might also be provided through a regional approach. The Department is committed to working with counties to offer technical assistance and support to help develop regional contracts and establish innovative partnerships.

5. Enhancing CCS Oversight and Monitoring

The California Children's Services (CCS) program provides case management, diagnostic, treatment, and physical and occupational therapy services to children and youth with special health care needs.

CCS beneficiaries are best served when their care is delivered in a standardized and consistent manner across the State. Through the CalAIM initiative, the State shall ensure consistent high quality standard of care, compliant with federal and State guidelines, is provided to all qualified beneficiaries. As part of this initiative, the Department will implement new processes and procedures to provide enhanced monitoring and oversight of all 58 counties to ensure optimal care is provided for this medically fragile population. To implement this enhanced monitoring and oversight, the Department will develop a robust strategic compliance program that includes, but is not limited to review of all current standards and guidelines for the CCS program; development and implementation of auditing tools to assess county operations and compliance; analysis and evaluation of the findings gathered during audits (desk, on-site and/or virtual) to identify gaps and vulnerabilities across counties within these programs; implementation of corrective action plans as necessary; tracking trends; and, along with input from our county partners and other stakeholders, establishing goals, metrics, performance measures, and milestones to ensure counties are conducting provider oversight and providing the necessary medical and dental

care for beneficiaries. The Department will also enter into a Memorandum of Understanding with each county that will outline the State and county responsibilities to hold both entities accountable for action/in-action.

After initial deployment of the enhanced monitoring and oversight, the Department will continue to conduct ongoing audits~~/surveys~~, be proactive with emerging developments, and monitor trends to ensure high-quality consistent care. The Department will allow sufficient time for counties to implement and adjust to this new structure prior to engaging in any sort of progressive action. The Department will continue this robust strategic compliance oversight in order to preserve and improve the overall health and well-being of these vulnerable populations.

6. Enhancing Eligibility Oversight & Monitoring

The Enhancing County Eligibility Oversight and Monitoring initiative within the CalAIM proposal was precipitated by recent audits performed by federal and state oversight agencies which found weaknesses in the Department's oversight practices, and suggest that both increased monitoring and the development and implementation of additional oversight activities are needed to reduce erroneous eligibility determinations and facilitate increased accuracy in the administration of the Medi-Cal and CHIP programs. Due to the continuous coverage requirement in the federal Families First Coronavirus Response Act (FFCRA) signed into law on March 18, 2020, and instruction to counties to halt all Medi-Cal renewal processes and negative actions through the duration of the Public Health Emergency (PHE), this CalAIM initiative will be delayed accordingly. The implementation dates selected will be based on resumption of normal county business processes as we continue to navigate the PHE, with a measure of time built in afterward for counties to process and clean-up the resulting backlog. By December 31, 2023, DHCS will have implemented enhanced county oversight and monitoring activities to include lifting the current hold-harmless policy and reinstating county performance standards, publishing a public facing county performance dashboard, and taking steps toward fiscal sanctions for counties which do not demonstrate sufficient improvement in meeting performance expectations or are unresponsive.

7. Regional Managed Care Capitation Rates

As part of the CalAIM initiative, the Department proposes to transition 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 proposal to 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 will simplify the presentation of rates to CMS with a goal of allowing the Department to pursue/implement financing advancements and innovations utilizing a more flexible rate model. The second benefit of regional rates is that it will allow 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 will produce 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. Enhanced Care Management (ECM) Risk Corridor~~

~~Effective January 1, 2022, the Department implemented a new ECM benefit in the Medi-Cal managed care delivery system. Medi-Cal managed care plans in counties without Whole Person Care pilots and/or Health Homes Programs will implement the new ECM benefit on July 1, 2022, for certain mandated populations of focus.~~

~~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 rating period, with calculations starting no sooner than January 1, 2025.~~

9. **CalAIM Major Organ Transplant Risk Corridor**

Effective January 1, 2022, all organ transplant benefits were standardized and carved into MCP covered benefits statewide for all Medi-Cal managed care members. This will continue to reduce complexity and ensure continuity of care without burdening beneficiaries 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.

CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM)

Calculations are anticipated to begin no sooner than January 1, 2024. A risk corridor will also be in place for the CY 2023 rating period, with calculations starting no sooner than January 1, 2025.

AMERICAN RESCUE PLAN ACT

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.

Behavioral Health Funding in ARPA

The ARPA provides various funding streams related to behavioral health. Some of these funding streams, such as that provided through Section 9813 (described immediately below) would come through the Medicaid program. Others would come in the form of additional grant funding outside of Medicaid.

Section 9813 provides 85 percent Medicaid match for qualifying community-based mobile crisis intervention services for twelve quarters during the five-year period starting April 1, 2022. Crisis response is a key gap in the state's system of behavioral health (BH) care. The Estimate includes a policy change to use the 85 percent Medicaid match in the Mobile Crisis Services policy change.

Sections 2701 and 2702 provide additional funding that would be made available to California counties using existing processes with additional workload to amend allocations and contracts. The funding is administered by Substance Abuse and Mental Health Services Administration and must be spent by September 23, 2025.

Section 2703 provides grant funding to support mental and behavioral health training for health care professionals, para-professions, and public safety offers. In order to spend the additional unanticipated funding made available through ARPA, the Department will need to develop policy and administration protocols. At this time, additional amounts allocated to California is still unknown.

Sections 2706 and 2707 provide funding to award grants to support states, local, tribal, and territorial governments; tribal organizations, nonprofit community-based organizations; and primary behavioral health organizations. Section 2706 grant awards will go toward supporting community-based overdose prevention programs, syringe services programs, and other harm reduction services, with a focus on drug misuse. Section 2707 grant awards will go towards addressing increased community behavioral health needs exacerbated by the COVID-19 pandemic (e.g., training the mental and behavioral health workforce using telehealth to deliver services).

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

AMERICAN RESCUE PLAN ACT

used for specific purposes including addressing public health impacts, negative economic impacts, and water, sewer, and broadband. State and local governments have until December 31, 2024 to expend the ARPA funds. Specified ARPA funds to California are deposited into the Coronavirus Fiscal Recovery Fund of 2021.

INFORMATION ONLY

REVENUES

1. Revenues

The State is expected to receive the following revenues from quality assurance fees and other collections (accrual basis):

FY 2023-24:	~~$33,683,000~~ **$27,453,000**	ICF-DD Quality Assurance Fee
	~~$550,554,000~~ **$576,544,000**	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	~~$9,053,000~~ **$9,514,000**	ICF-DD Transportation/Day Care Quality Assurance Fee
	~~$8,269,212,000~~ **$8,269,303,000**	MCO Enrollment Tax (Item 4260-601-3428)
	~~$5,553,768,000~~**$6,140,931,000**	Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)
	~~$8,642,000~~ **$2,308,000**	Emergency Medical Air Transportation (EMATA) Fund (Item 4260-101-3168)
	~~$66,163,000~~ **$60,278,000**	Medi-Cal Emergency Medical Transport (MEMTF) (Item 4260-601-3323)
	~~$2,448,508,000~~ **$2,485,237,000**	Medi-Cal Drug Rebates Fund (Item 4260-601-3331)
	~~$16,939,583,000~~ **$17,571,568,000**	Total

FY 2024-25:	**$26,817,000**	ICF-DD Quality Assurance Fee
	$576,544,000	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	$9,514,000	ICF-DD Transportation/Day Care Quality Assurance Fee
	$8,526,774,000	MCO Enrollment Tax (Item 4260-601-3428)
	$4,226,815,000	Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)
	$0	Emergency Medical Air Transportation (EMATA) Fund (Item 4260-101-3168)
	$61,323,000	Medi-Cal Emergency Medical Transport (MEMTF) (Item 4260-601-3323)
	$2,483,312,000	Medi-Cal Drug Rebates Fund (Item 4260-601-3331)
	$15,911,099,000	Total

Effective August 1, 2009, the Department expanded the amount of revenue upon which the quality assurance (QA) fee for AB 1629 facilities is assessed, to include Medicare.

INFORMATION ONLY

Effective January 1, 2012, pursuant to ABX1 19 (Chapter 4, Statutes of 2011), the Department will implement a QA fee from Freestanding Pediatric Subacute Care facilities, pending Centers for Medicare and Medicaid Services approval.

SBx2-2 (Chapter 2, Statutes of 2016) provides that the new tax will apply to the Medi-Cal revenue of most managed care plans in the state, with some exemptions. The new tax structure will meet federal requirements while achieving the same GF savings as the previous tax and also providing sufficient funding to restore the 7% reduction in the In-Home Supportive Services Program.

AB 1383 (Chapter 627, Statutes of 2009) authorized the implementation of a quality assurance fee on applicable general acute care hospitals. The fee is deposited into the Hospital Quality Assurance Revenue Fund (Item 4260-601-3158). This fund is used to provide supplemental payments to private and non-designated public hospitals, grants to designated public hospitals, and enhanced payments to managed health care and mental health plans. The fund is also used to pay for health care coverage for children, staff and related administrative expenses required to implement the Quality Assurance Fee (QAF) program. SB 90 (Chapter 19, Statutes of 2011) extended the hospital QAF through June 30, 2011. SB 90 also ties changes in hospital seismic safety standards to the enactment of a new hospital QAF that results in revenue for FY 2011-12 children's services of at least $320 million.

SB 335 (Chapter 286, Statues of 2011) authorized the implementation of a new Hospital QAF program for the period of July 1, 2011 to December 31, 2013. This new program authorizes the collection of a quality assurance fee from non-exempt hospitals. The fee is deposited into the Hospital Quality Assurance Revenue and is used to provide supplemental payments to private hospitals, grants to designated public hospitals and non-designated public hospitals, increased capitation payments to managed health care plans, and increased payments to mental health plans. The fund is also used to pay for health care coverage for children and for staff and related administrative expenses required to implement the QAF program.

SB 239 (Chapter 657, Statutes of 2013) extended the Hospital QAF program from January 1, 2014, through December 31, 2016. This extension authorizes the collection of a quality assurance fee from non-exempt hospitals. The fee is deposited into the Hospital Quality Assurance Revenue and is used to provide supplemental payments to private hospitals, grants to designated public hospitals and non-designated public hospitals, and increased capitation payments to managed health care plans. The fund is also used to pay for health care coverage for children and for staff and related administrative expenses required to implement the QAF program.

AB 1607 (Chapter 27, Statutes of 2016) extended the inoperative date of the Hospital QAF program to January 1, 2018, creating a one-year extension of the program.

Proposition 52, approved by California voters on November 8, 2016, permanently extends the Hospital QAF program.

INFORMATION ONLY

The California Department of Public Health (CDPH) lowered Licensing and Certification (L&C) fees for long-term care providers for FY 2010-11. The aggregate amount of the reductions allowed the QA fee amounts collected from the freestanding NF-Bs and ICF/DDs (including Habilitative and Nursing) to increase by an equal amount. Currently, the QA fee amounts are calculated to be net of the L&C fees in order to be within the federally designated cap, which provides for the maximum amount of QA fees that can be collected. For FY 2011-12, CDPH increased L&C fees which resulted in a reduction in the collection of the QA fee by an equal amount to the L&C fee increase for free-standing NF-Bs, Freestanding Pediatric Subacute Facilities and ICF/DDs (including Habilitative and Nursing).

Effective January 1, 2011, AB 2173 (Chapter 547, Statutes of 2010) imposes an additional penalty of $4 for convictions involving vehicle violations.

AB 119 (Chapter 17, Statutes of 2015) extends the AB 1629 facility-specific rate methodology, QAF, and QASP program through July 31, 2020. Further, beginning rate year 2015-16, the annual weighted average rate increase is 3.62%, and the QASP will continue at FY 2014-15 levels, rather than setting aside a portion of the annual rate increase. Additionally, beginning FY 2015-16, the legislation requires the Department to incorporate direct care staff retention as a performance measure into the QASP Program.

SB 523 (Chapter 773, Statutes of 2017) implements a Ground Emergency Medical Transportation (GEMT) Quality Assurance Fee (QAF) on all ground emergency medical transports, effective July 1, 2018. The QAF will be assessed on each GEMT transport for base ground emergency medical services. The revenue generated by the QAF collections will be deposited directly into the Medi-Cal Emergency Medical Transportation Fund (MEMTF).

ELIGIBILITY

1. Impact of SB 708 on Long-Term Care for Individuals with Unsatisfactory Immigration Status

   Section 4 of SB 708 (Chapter 148, Statutes of 1999) reauthorizes state-only funded long-term care for individuals with unsatisfactory immigration status currently receiving the benefit (including aliens who are not lawfully present). Further, it places a limit on the provision of state-only long-term care services to individuals with unsatisfactory immigration status who are not entitled to full-scope benefits and who are not legally present. This limit is at 110% of the FY 1999-00 estimate of eligibles, unless the legislature authorizes additional funds. SB 708 does not eliminate the uncodified language that the *Crespin* decision relied upon to make the current program available to eligible new applicants. Because the number of undocumented immigrants receiving State-only long-term care has not increased above the number in the 1999-00 base year, no fiscal impact is expected due to the spending limit.

INFORMATION ONLY

2. Refugee Resettlement Program

   The federal Refugee Resettlement Program provides medical services to refugees during their first eight months in the United States. In California, these medical services are provided through the Medi-Cal delivery system and funded with 100% federal funds through a federal grant. The California Department of Public Health administers the Refugee Resettlement Program federal grant. With the Affordable Care Act, a majority of refugees are expected to be eligible for Medi-Cal and will no longer receive their medical services through the Refugee Resettlement Program. The Department expects the number of eligibles receiving their medical services under the Refugee Resettlement Program to be negligible. All medical costs associated with the Refugee Resettlement Program will be funded 100% through the federal grant.

3. FFP Claiming Methodology Update for Lawfully Present Pregnant Women and Children

   Under an approved State Plan Amendment, the Department may claim Federal Financial Participation (FFP) for full scope Medi-Cal services provided to eligible documented immigrants who are lawfully present in the United States if they are under 21 years of age or pregnant. This includes New Qualified Immigrants and other lawfully present immigrants as defined by the federal government. The Department has determined that some of these immigrants who are currently claimed at a 50/50 federal/state matching rate are eligible for a higher FFP matching rate (currently 65/35). The Department is reviewing current claiming methodology for this population. When that analysis is completed, the Department will take the steps necessary to claim any additional FFP available.

4. Senate Bill 260 (Chapter 845, Statutes of 2019) – Covered California Automatic Enrollment

   Senate Bill 260 (Chapter 845, Statutes of 2019) originally required beginning no later than July 1, 2021, that Covered California automatically enroll individuals who transition from Medi-Cal and the State Children's Health Insurance Program into the lowest cost silver plan or their previous managed care plan before their current coverage ends. The system implementation of the SB 260 auto enrollment ~~was moved to~~ **occurred** July 1, 2022, **and the functionality was "turned on" May 19, 2023, to align with the continuous coverage unwinding.** ~~due to the pandemic and other initiatives.~~ **The first Medi-Cal members to transition to Covered California with auto-plan selection occurred on June 1, 2023.**

5. Conform Inmate Eligibility to Federal Law

   The federal "Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act" requires the Department to implement indefinite Medi-Cal suspension for eligible incarcerated juveniles. Current federal law requires eligible juvenile inmates to no longer have time-limited suspensions of Medi-Cal benefits; therefore, California's current state law limit of one year for Medi-Cal suspensions must be changed for this population to conform to federal law. This policy was implemented, effective October 1, 2020.

INFORMATION ONLY

6. Postpartum Care Extension

Medi-Cal provides coverage for pregnancy and pregnancy-related services, including postpartum care for individuals who are pregnant. Prior to SB 104 (Chapter 67, Statutes of 2019), postpartum care was terminated 60 days after the last day of pregnancy. SB 104 extended postpartum care for up to 12 months after the last day of pregnancy specifically for beneficiaries who receive pregnancy-related services and are diagnosed with a mental health condition. The passage of ARP allows a Medicaid eligible individual who is receiving pregnancy-related services to remain eligible for Medi-Cal postpartum care for an additional 12 months after the last day of their pregnancy. Implementation of this new policy was effective April 1, 2022. However, costs for this policy are captured after the assumed PHE end period, through May 11, 2023.

7. Medi-Cal Eligibility for New Afghan Arrivals

As a result of the U.S. withdrawal from Afghanistan, there is a significant influx of Afghan arrivals who will need Medi-Cal coverage. These individuals and future arrivals may have a variety of different immigration statuses upon entry to the United States. Many of these arrivals will be eligible for federally funded full scope Medi-Cal to the same extent as refugees, and may be eligible for other federal and state benefits and services if they qualify. For example, individuals with “Special Immigrant” (SI) parole, or SI Visa status, are eligible for the same federal benefits as refugees if they meet all eligibility requirements. Some of the new Afghan arrivals will enter the United States with other immigration statuses, or circumstances under which they may qualify for state-funded full scope Medi-Cal if otherwise eligible. The influx of new Afghan arrivals will potentially increase costs across state-funded and federally-funded full scope Medi-Cal programs, and Refugee Medical Assistance.

INFORMATION ONLY

AFFORDABLE CARE ACT

1. Realignment

Under the Affordable Care Act, county costs and responsibilities for indigent care are expected to decrease as uninsured individuals obtain health coverage. The State, in turn will bear increased responsibility for providing care to these newly eligible individuals through the Medi-Cal expansion. The budget sets forth two mechanisms for determining county health care savings that, once determined, will be redirected to fund local human services programs. The 12 public hospital counties and the 12 non-public/non-County Medical Services Program counties have selected one of two mechanisms. Option 1 is a formula that measures health care costs and revenues for the public hospital county Medi-Cal and uninsured population and non-public/non-CMSP county indigent population. Option 2 is redirection of 60% of a county's health realignment allocation plus 60% of the maintenance of effort. Assembly Bill (AB) 85 (Chapter 24, Statutes of 2013) as amended by Senate Bill 98 (Chapter 358, Statutes of 2013) lays out the methodology for the formula in Option 1, and requires the department to perform the calculation. AB 85 also sets targets, and a process to meet the targets, for the number of newly eligible Medi-Cal enrollees who will be default assigned to County Public Hospital health systems as their managed care plan primary care provider. Public hospital health systems will be paid at least cost for their new Medi-Cal population.

BENEFITS

1. Child Health and Disability Prevention (CHDP)

The CHDP program administered by the state and implemented by the counties provides Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) preventive health screening examinations (i.e., well child health assessments) and immunizations to Medi-Cal eligible children under 21 years of age and to the former non-Medi-Cal eligible children under 19 years of age whose family income was at or below 200% of the Federal Poverty Level (FPL).

In May 2016, the passage of SB 75 expanded Medi-Cal for all income eligible children, including the former CHDP non-Medi-Cal population. All persons under 19 years of age who were eligible for state-only CHDP service (the former CHDP non-Medi-Cal population) were shifted to full-scope Medi-Cal and budgeted in the EPSDT Screens policy change. EPSDT costs now are captured in the Fee-For-Service base expenditures and the policy change was retired in the May 2020 Medi-Cal Local Assistance Estimate.

The Department will be sunsetting CHDP effective July 1, 2024. A transition planning process, including key stakeholders, commenced on September 22, 2022. Transition planning will ensure the successful continuity of current CHDP activities beyond July 1, 2024, as well as identify necessary supplemental administrative and fiscal resources necessary to replace the services CHDP currently performs for other programs. The Department's proposal preserves presumptive eligibility enrollment activities currently offered through the CHDP Gateway. Further, this proposal ensures the continuation of the Health Care Program for Children in Foster Care (HCPCFC) as a standalone program. On

INFORMATION ONLY

July 1, 2024, the Department will launch the Children's Presumptive Eligibility Program to replace the CHDP Gateway. The Children's Presumptive Eligibility Program will expand provider access to include all applicable Medi-Cal providers. The majority of children and youth under the age of 21 will be enrolled into a MCP, through which they will receive all medically necessary services. This aligns with the Department's goal under CalAIM to reduce administrative complexities. The proposal will also enhance coordination of care and increase standardization of care across Medi-Cal by consolidating care responsibilities for children/youth under the Medi-Cal managed care plans.

2. Palliative Care Services Implementation

   SB 1004 (Chapter 574, Statutes of 2014) requires the Department to:

   - Establish standards and provide technical assistance for Medi-Cal managed care plans to ensure delivery of palliative care services;
   - Establish guidance on the medical conditions and prognoses that render a beneficiary eligible for the palliative care services;
   - Develop a palliative care policy that, to the extent practicable, is cost neutral to the General Fund on an ongoing basis;
   - Define palliative care services; and
   - Provide access to curative care for beneficiaries eligible for palliative care.

   Services are available concurrently with curative care and care is provided through a coordinated interdisciplinary team.

HOME & COMMUNITY BASED-SERVICES

1. No additional information.

BREAST AND CERVICAL CANCER TREATMENT

1. No additional information.

PHARMACY

1. No additional information.

DRUG MEDI-CAL

1. Early Intervention for Beneficiaries Under 21 Years Old
   This item has been deleted as this has been implemented with Behavioral Health Information Notice 22-003.

INFORMATION ONLY

2. Traditional Healers and Natural Helpers

The Department proposes to add Traditional Healers and Natural Helpers as allowable provider types of DMC-ODS services when delivered by DMC-certified Indian Health Care Providers (IHCPs). IHCPs are limited to a health care program operated by the Indian Health Service (IHS), or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603). The purpose of this request is to support the Department's focus on advancing health equity and provide culturally appropriate options and improve access to SUD treatment for American Indians and Alaska Natives with SUD. In the CalAIM Section 1115 demonstration renewal request submitted June 30, 2021, DHCS requested that CMS grant expenditure authority as necessary for federal reimbursement for covered DMC-ODS services delivered to DMC-ODS beneficiaries by Natural Helpers and Traditional Healers at DMC-certified IHCPs. CMS did not approve this request as part of their December 29, 2021 CalAIM Section 1115 demonstration approval. This proposal to add Traditional Healers and Natural Helpers is still contingent on CMS approval.

MENTAL HEALTH

1. Short-Term Residential Therapeutic Program/Qualified Residential Treatment Programs

Congress enacted the Family First Prevention Services Act (FFPSA) on February 9, 2018. One of the intents of the FFPSA is to restrict the use of congregate care, unless absolutely necessary, by limiting Title IV-E maintenance payments to specific congregate care settings meeting defined requirements. The FFPSA added Qualified Residential Treatment Programs (QRTP) as one of those congregated care settings that may be used when specific criteria are met. In California, STRTPs are equivalent to QRTPs. QRTPs may be determined to meet criteria as an Institution for Mental Disease (IMD) in Title XIX, which prohibits federal reimbursement for covered services provided to beneficiaries who are residents of an IMD. The Department wrote CMS and asked for STRTPs not to be considered as IMDs; CMS responded that it could not give this blanket approval, and would require the Department to individually assess each STRTP to determine if it is an IMD. The Department completed its assessments and determined that three facilities are IMDs. Pending approval and implementation of the SMI/SED Demonstration Waiver, the state anticipates receiving federal reimbursement for services provided to beneficiaries in those STRTP facilities that are assessed to be IMDs, exempting STRTPs from the standard length of stay limitations for a two-year period.

2. 9-8-8 Crisis Line

The National Suicide Hotline Designation Act of 2020 launched a national 9-8-8 suicide prevention and mental health crisis line on July 16, 2022, and gives authority for states to issue a fee to support state operations. Vibrant Health funded California to do implementation planning in this fiscal year; funding was granted to the Department, and the Department in turn contracted with the Lifeline Call Centers, with Didi Hirsch as lead, to lead a stakeholder process that started on February 1, 2021 and ended on January 31, 2022,

with a final report by February 15, 2022. The Department will fund crisis call centers with $20 million to support building capacity during the current fiscal year. In addition, the American Rescue Plan Act allows states to implement a new Medicaid benefit, Mobile Crisis Response Services, with an 85% federal match for the first three years of services for 12 quarters during the five year period starting April 2022. The interplay between this mobile crisis benefit and the 9-8-8 implementation is still to be determined.

1115 WAIVER—MH/UCD & BTR/WAIVER 2020

1. Waiver 2020 Negative Balance and Deferral Repayment

The Special Terms and Conditions (STC) of the California Medi-Cal 2020 Demonstration Waiver (Medi-Cal 2020) requires California's resolution of all existing negative Payment Management System (PMS) subaccount balances and deferred claims.

- Negative PMS subaccount balances: Pursuant to STC 164 of the Medi-Cal 2020 waiver, negative PMS subaccount balances for federal fiscal year (FFY) 2013 and prior must be resolved by the end of the Medi-Cal 2020 waiver period (December 31, 2021). California and the Centers for Medicare and Medicaid Services (CMS) continue to actively work toward the resolution of these negative PMS subaccount balances. In June of 2017, due to the progress made to date, the CMS waiver team verbally declared that the STC 164 requirements had been met and that they would be sending written confirmation. Written confirmation from CMS is still pending. STC 164 requires that, for any negative PMS subaccount balances remaining after June 30, 2017, CMS will issue a demand letter and require California to return sufficient funding to bring the PMS subaccount balances to $0. California has submitted adjustments to resolve a significant portion of the negative PMS subaccount balances via Quarters 1 and 2 of the 2016 grant year. If CMS disallows adjustments or claims, California will have the right to appeal them. STC 164 further requires that, for negative PMS subaccount balances identified in CMS' demand letter, California will need to repay CMS, in regular quarterly installments, with interest, by the end of the Medi-Cal 2020 waiver (December 31, 2021) or in three years from CMS' approval of California's repayment schedule, whichever is longer. Interest begins on the date of CMS' demand letter.

Repayment of deferred claims: Claims for which California has drawn down federal funding but CMS has deferred on or before June 30, 2017, CMS will issue a disallowance, triggering the appeal process. However, if the appeal is unsuccessful, California will be required to reimburse the federal funding. The deferred claims reimbursement will not be subject to interest. Some deferred claims contribute to the negative PMS subaccount balances, mentioned above, and may be liquidated through the negative PMS subaccount balance resolution. California is actively working to resolve these deferrals and the total federal funding reimbursement is unknown at this time. California will begin the FFY quarterly payments when the amounts are finalized.

INFORMATION ONLY

Ongoing deferred claims repayment: In the past, California has not returned federal funding on CMS deferred claims until after the deferred claim was officially disallowed. Pursuant to the STCs of the Medi-Cal 2020 waiver, California must begin complying with 42 Code of Federal Regulations 430.40, which requires the immediate repayment of federal funding for deferred claims while the deferral is being resolved. Upon its determination that the claim is allowable, CMS will release the funding and allow California to utilize the federal funding. CMS disallowances fluctuate quarter to quarter, resulting in an unpredictable federal fund repayment amount.

The County Administration CMS Deferred Claims policy change will be deactivated until funds are available in the ADM-16 account to be reclaimed, of which $8.21 million remains.

MANAGED CARE

1. CalAIM – Managed Care SMHS Carve-Out

Specialty Mental Health Services (SMHS) benefits are currently within the scope of certain Medi-Cal managed care plans in two counties (Partnership in Solano, for certain enrollees, and Kaiser in Sacramento). Effective no sooner than July 1, 2023, the SMHS benefits will be carved out from these managed care plans' responsibility and be provided through the Behavioral Health delivery system.

PROVIDER RATES

1. Newborn Screening Program Fee Increase

This assumption has been deleted as this is now included in the GDSP Newborn Screening Program Fee Increase policy change.

SUPPLEMENTAL PAYMENTS

1. Capital Project Debt Reimbursement

In February 2014, Los Angeles County requested reimbursement of a $322 million bond project for the Construction, Renovation and Reimbursement Program (CRRP). The project was completed in April 2014.

The Department determined Los Angeles County's Harbor UCLA Surgery Emergency Replacement project was eligible under the CRRP and proceeded to provide CRRP supplemental reimbursement of $176M in allowable principal, with an effective date of April 1, 2018.

2. Local Educational Agency Medi-Cal Billing Option Program (LEA BOP) Expansion

SPA 19-0009: The Department submitted SPA 19-0009 in March 2019, with a proposed effective date of January 1, 2019. The proposed SPA seeks to improve the health of low-

income children by increasing their access to needed vision services by providing comprehensive eye exams, corrective lenses, and frames at school sites. In addition, CMS has indicated that the Department has the option to restructure how school-based services are written into the State Plan, and remove any duplicative or unnecessary State Plan language. This new approach also includes removing references to all licensing, credentialing and supervision practitioner requirements for the LEA Program in SPA 19-0009. SPA-19-0009 is currently under Department review.

COVID-19

1. Managed Care Bridge Period (July 1, 2019 – December 31, 2020) Risk Corridor

   To protect the managed care health plans, the State, and the Federal Government against excessive gains/losses due to unexpected cost/utilization changes as a result of the COVID-19 public health emergency, the Department will be implementing a two-sided risk corridor pursuant to AB 80 (Chapter 12, Statutes of 2020). The two-sided risk corridor will be symmetrical as it pertains to risk and profit. Calculations are anticipated to begin in FY 2022-23.

OTHER: AUDITS AND LAWSUITS

1. Managed Care Potential Legal Damages

   Three health plans filed lawsuits against the Department challenging the Medi-Cal managed care rate-setting methodology for rate years 2002 through 2005. The cases are referred to as:

   - *Health Net of California, Inc. v. DHCS*
   - *Blue Cross of California, Inc., dba Anthem Blue Cross v. DHCS*
   - *Molina Healthcare of California, Inc., v. DHCS*

   On June 13, 2011, judgment was issued in favor of Plaintiffs in the Health Net, Blue Cross, and Molina Healthcare cases. In all of the cases, the trial court determined that the Department had breached its contract with the managed care plans for the years in question. On November 2, 2012, the Department and Health Net entered into a settlement agreement resolving the Health Net lawsuit. Similarly, the Department has entered into settlement agreements with Blue Cross and Molina in mid/late 2013. The amount of payment due is contingent on each plan's profits, and the settlement accounting is scheduled to occur as follows, subject to applicable run-out and reconciliation periods provided in the settlement terms, and contractual risk corridor calculations: *Molina* (January 1, 2018); *Blue Cross* (January 1, 2019); *Health Net* (January 1, 2020).

2. MALDEF, et al. Title VI Administrative Complaints; Analina Jimenez Perea, et al., v. et al., *Deuschel v. CHHS et. al.*

   On December 15, 2015, the Mexican American Legal Defense and Educational Fund (MALDEF), the National Health Law Program (NHeLP), and several other advocacy groups

INFORMATION ONLY

filed an administrative complaint with the U.S. Department of Health & Human Services' Office for Civil Rights (DHHS OCR) pursuant to Title VI of the 1964 Civil Rights Act. The groups allege, on behalf of several Medi-Cal beneficiaries, that inadequate Medi-Cal reimbursement rates, coupled with the Department's failure to ensure timely access to services, constitute discrimination against the Latino population. They seek a finding from DHHS OCR that the Department's reimbursement rates violate Title VI and an order requiring the Department to raise the rates. On December 22, 2015, MALDEF sent a copy of the administrative complaint to the attention of CHHS Secretary Diana Dooley and Department Director Jennifer Kent, along with a cover letter citing the Department's regulations governing Title VI complaint investigations. The letter demands immediate action from the Department to raise reimbursement rates and improve monitoring of access. There has been no DHHS OCR activity known to the Department since the administrative complaint was filed.

On July 12, 2017, five individuals and three organization filed a class action suit (Perea, et al.) against CHHS and DHCS in Alameda County Superior Court seeking injunctive relief against the same Medi-Cal reimbursement and access policies identified in the above described Title VI Administrative Complaints. Plaintiffs allege that the Department's failure to provide adequate access to providers disparately impacts Latinos. Plaintiffs allege that Medi-Cal is "disproportionately and majority Latino," and that while all beneficiaries receive poorer treatment than whites covered by other insurance plans (such as Medicare and employer-provided insurance), Latinos are impacted more than other non-Latino Medi-Cal beneficiaries. They also allege that administrative burdens in the Medi-Cal program hinder access to "meaningful" health care. Plaintiffs also contend that the Department fails to monitor Medi-Cal beneficiaries' access to health care services, and fails to ensure managed care plans have adequate networks of providers. Finally, plaintiffs contend that as the percentage of Latino Medi-Cal beneficiaries has increased, the Department has "disinvested" in the Medi-Cal program by reducing Medi-Cal rates relative to Medicare. All of these acts, plaintiffs contend, have disparately impacted Latinos, and constitute purposeful discrimination.

Plaintiffs allege violations of Government Code section 11135 (prohibiting discrimination in state programs), and the California Constitution, Articles I and IV (equal protection, substantive due process). Plaintiffs seek injunctive relief as taxpayers, under California Code of Civil Procedure section 526a, and seek a writ of mandate under Code of Civil Procedure section 1085. Plaintiffs contend that the Department's actions also violate federal Medicaid statutes, including 42 U.S.C. section 1396b (m)(1)(a)(i), and 42 U.S.C. section 1396a(a)(30)(A). Plaintiffs do not seek monetary relief for any of the individual plaintiffs. Rather, they are seeking an order requiring the Department to increase the rates it pays to Medi-Cal providers. On April 12, 2018, the court sustained the Department's demurrer but granted Plaintiffs leave to amend their complaint. Plaintiffs filed their first amended complaint on May 18, 2018, and the Department demurred on June 20, 2018. On September 21, 2018, the court sustained the Department's demurrer to the first amended complaint but granted Plaintiffs leave to amend. Plaintiffs filed their second amended complaint on October 29, 2018, and the Department demurred on November 30, 2018. On January 31, 2019, the court again sustained the Department's demurrer with leave to amend. On June 21, 2019, the court overruled the Department's demurrer allowing the case to continue to discovery. The Department filed its answer to the third amended complaint on

INFORMATION ONLY

August 30, 2019. Discovery had commenced, but was later stayed under multiple stipulations due to the COVID-19 public health emergency. The stay was lifted on April 9, 2021, and discovery is continuing. The Department filed a Motion for Judgment on the Pleadings (MJOP) which was heard on December 17, 2021. The parties stipulated to continue the class certification motion deadline until after the MJOP is decided. On March 9, 2022, the court granted the Departments' MJOP with respect to plaintiffs' disparate impact claim, but allowed plaintiffs' other claims to advance. On June 8, 2022, the court of appeal denied plaintiffs' writ petition seeking review of the court's dismissals of the disparate impact claim. On June 29, 2022, plaintiffs filed a request for dismissal of their disparate treatment, substantive due process, and derivative claims, and the court entered judgment dismissing those claims without prejudice on the same day. Plaintiffs sought dismissal as they now intend to seek appellate review of the court's rulings as to their disparate impact theories.

On December 11, 2017, another lawsuit (Deuschel) was filed by an individual plaintiff against the Department, CHHS, and the Department of Social Services making similar discrimination allegations as the class action suit, though the allegations are based on disability status. Plaintiff seeks injunctive relief and writ of mandate requiring the Department to increase Medi-Cal rates and to monitor and enforce network adequacy and timely access, as well as compensatory damages. The Department filed a demurrer on February 9, 2018. Plaintiff filed an amended complaint on September 18, 2018. The Department filed its demurrer to the amended complaint on November 9, 2018.The court has since issued multiple continuances, and the entire case was stayed until January 24, 2021. On October 14, 2021, the court ruled in favor of the Department, granting the demurrer and dismissing the plaintiff's complaint without leave to amend.

3. Blue Cross of California v. DHCS, et. al.; *California Physicians' Service DBA Blue Shield of California v. DHCS, et. al.; Health Net of California, Inc. v. DHCS, et al.*

Blue Cross of California Blue Shield of California, and Health Net of California (Plaintiffs) are real parties in interest in a pending California taxpayer action filed in Los Angeles Superior Court captioned Myers v. State Board of Equalization, et al. (Myers), which seeks a writ of mandate directing the appropriate taxing agencies to collect the annual gross premiums tax (GPT) from Plaintiffs as "insurers" under the California Constitution. The Plaintiffs seek reimbursement from the Department for managed care organization (MCO) taxes paid or that will be paid pursuant to SBx2 2 (Chapter 2, Statutes of 2016, 2nd Ex. Sess.) and AB 115 (Chapter 348, Statutes of 2019) in the event that Myers action results in the Plaintiffs being subject to the GPT and exempt from assessment of the MCO taxes. The Blue Cross Blue Shield, and Health Net actions have all been formally stayed after being designated related cases to Myers.

INFORMATION ONLY

4. California Pharmacists Association, et al. v. Kent, et al.

   The lawsuit was filed in U.S. District Court for the Northern District on June 5, 2019, against the Department and the federal Secretary of the U.S. Department of Health and Human Services. Plaintiff pharmacies seek injunctive and declaratory relief to prevent the Department from implementing reimbursement changes approved in State Plan Amendment no. 17-002 relating to covered outpatient drug benefits in Medi-Cal, including the Department's retroactive implementation of those reimbursement changes effective for dates of service on or after April 1, 2017. Plaintiffs allege that the Department's revised outpatient pharmacy reimbursement methodologies violate the Medicaid Act and other state and federal laws, and that the Federal defendants improperly approved such changes in the Medi-Cal State Plan. On February 21, 2020, the court denied Plaintiffs' motion for a preliminary injunction, and requested additional briefing on the issue of retroactive implementation of the reimbursement changes. Briefing was completed in December 2020. On February 4, 2021, the Department announced it will pause retroactive recoupments for past pharmacy claims until further notice. On March 10, 2021, the court ordered the parties to participate in mediation, staying all deadlines until that process is complete. The latest mediation session occurred on December 9, 2021. On March 15, 2022, plaintiffs filed to dismiss their remaining claims in this lawsuit without prejudice, subject to the Department providing at least thirty days' notice before it resumes retroactive recoupments at any point through the end of the 2021-22 regular legislative session. The 2022 Budget Act authorized the Department to forego recoupment against certain independent pharmacies for overpayments associated with the April 1, 2017 through February 22, 2019 service period.

5. ~~Independent Living Center of Southern California, et al. v. Kent, et al.~~

   ~~In 2009, Plaintiffs sued the Department challenging legislatively-mandated Medi-Cal payment reductions (AB 5 and AB 1183) in the U.S. District Court for the Central District. On February 27, 2009, the district court issued a preliminary injunction against the payment reductions. On February 22, 2012, the U.S. Supreme Court issued a ruling vacating the Ninth Circuit decision affirming the district court's injunction. In May 2014, the parties in this case and three other federal lawsuits involving AB 5 and AB 1183 reductions executed a settlement in which the Department agreed not to recoup amounts from providers for certain time periods in exchange for Plaintiffs dismissing several state court lawsuits. On April 23, 2015, the district court issued an order dismissing with prejudice Plaintiffs' suit and retaining jurisdiction, until January 1, 2016, for purposes of attorney fees and settlement enforcement. On July 6, 2015, the Department agreed to pay $180,000 to Plaintiffs' counsel Lynn Carman and the Medicaid Defense Fund to settle their claims for attorney fees. On that same date, the Court denied all other claims against the State for attorney fees, including those filed by attorney Stanley Friedman and the law firm Hooper, Lundy, and Bookman (HLB). On July 24, 2015, both attorney Friedman and HLB filed a notice of appeal of the order denying fees. On November 21, 2018, the Ninth Circuit reversed and ruled that attorney fees may in fact be available under State law since plaintiffs initially filed a State law claim. The case was remanded to the district court to determine whether plaintiffs are eligible for fees, and if so, to calculate the award amount. Discovery and briefing in the district court is ongoing. A hearing was held on June 24, 2019, and on August 7, 2019, the district court granted Plaintiffs' and intervenors' motions for attorneys' fees. Following discovery and subsequent briefing, the district court on January 24, 2020, issued its decision awarding approximately~~

INFORMATION ONLY

~~$7 million in aggregate fees, with approximately $2.7 million awarded to attorney Friedman and approximately $4.3 million awarded to intervenors HLB. The $4.3 million payment to intervenors HLB was displayed in the Lawsuits/Claims policy change in the 2020 May Revise Local Assistance Medi-Cal Estimate. On February 21, 2020, attorney Friedman filed a notice of appeal with the Ninth Circuit. On April 5, 2021, the Ninth Circuit increased the award to attorney Friedman to approximately $8.2 million. On April 19, 2021, attorney Friedman filed a request for attorneys' fees and costs related to the fee appeal, totaling approximately $3.2 million. On April 27, 2021, the Ninth Circuit issued a clerk's mandate, awarding $1,217 in costs to attorney Friedman, and assigned an appellate commissioner to determine the appropriate fee amount. On December 15, 2021, the appellate commissioner awarded an additional $2.37 million related to the fee appeal. On December 28, 2021, attorney Friedman filed a request for additional appellate fees and pre- and post-judgment interest. On May 17, 2022, the Ninth Circuit denied the request for additional fees and interest as untimely. The final judgment relating to attorney Friedman's awarded fees was entered on June 7, 2022. The total amount of fees and costs awarded to attorney Friedman (approximately $10.563 million) was displayed in the Lawsuits/Claims policy change in the 2022 May Revise Local Assistance Medi-Cal Estimate. After receiving payment in June 2022, attorney Friedman filed a motion with the district court requesting approximately $20,000 in additional costs, which remains pending. The Department filed its objection to this motion for additional costs on July 29, 2022.~~

6. Hinkle, et al. v. Kent, et al.

Plaintiffs (individual Medi-Cal beneficiaries 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 beneficiaries to Plaintiffs and similarly situated individuals in their requested alternative format; and 2) in consultation with Plaintiffs, develop a plan that includes any policy changes necessary for a durable remedy.

Plaintiffs filed their Complaint on October 22, 2018. Initial disclosures and an answer to the Complaint were filed on February 1, 2019. Settlement discussions and mediation are ongoing.

INFORMATION ONLY

7. Kent v. Phillip

The Department filed an estate recovery complaint to recover capitation payments made on behalf of a Medi-Cal beneficiary, consistent with state and federal policy. In response, the beneficiary's heirs filed a 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 beneficiaries enrolled in Medi-Cal managed care. The cross-complaint was subsequently amended to include similarly situated individuals. On January 16, 2019, the court denied the Department's motion for judgement on the pleadings. On October 27, 2021, the court denied the Department's Motion for Summary Judgement, and the Department appealed. The class certification hearing date ~~is~~ **was** scheduled for ~~April 28, 2023~~ **August 2, 2023**. No trial date has been set, and discovery is ongoing.

8. Community Health Center Alliance, et al. v. Will Lightbourne, et al.

On October 29, 2020, the Community Health Center Alliance for Patient Access (CHCAPA) and its constituent Federally Qualified Health Center (FQHC) members sued the Department and Director Lightbourne in the Eastern District Court of California. Plaintiffs' Complaint alleges that the Department's transition of the pharmacy benefit from Medi-Cal managed care to the Medi-Cal Rx fee-for-service delivery system will prevent FQHCs from receiving the full extent of the cost-based Prospective Payment System (PPS) reimbursement for pharmacy services mandated under federal law. Plaintiffs seek to enjoin the implementation of the Medi-Cal Rx transition, along with the State's extension of the Medi-Cal 2020 demonstration project (which authorizes managed care generally) on procedural grounds.

Plaintiffs contend that the primary impact of the transition of the pharmacy benefit from Medi-Cal managed care to Medi-Cal Rx on FQHCs will be to deprive California FQHCs of the opportunity to profit on their drug sales to Medi-Cal managed care plans, which FQHCs purchase at discounted 340B rates. Furthermore, Plaintiffs claim that other aspects of the State's PPS reimbursement to FQHCs violate federal law, particularly for FQHCs who decide to "carve-in" the costs of pharmacy services to their PPS rate. In this regard, Plaintiffs allege that the inflation-based growth rate for PPS rates will prevent FQHCs from receiving adjustments to their PPS rate to account for increases in pharmaceutical costs that exceed inflation, and that California's process for adjusting PPS rates violates federal law by limiting those adjustments to 80 percent of the per visit increase in costs.

On November 9, 2020, Plaintiffs filed a Motion for Temporary Restraining Order (TRO), seeking to enjoin the implementation of Medi-Cal Rx on January 1, 2021. Then, on November 16, 2020, the Department announced that it was deferring implementation of Medi-Cal Rx transition until April 1, 2021. On November 24, 2020, the Court denied Plaintiffs' TRO Motion without a hearing. Thereafter, on December 15, 2020, the Court ordered the Department to file its Motion to Dismiss and Plaintiffs to file its Motion for Preliminary Injunction on December 24, 2020.

INFORMATION ONLY

On February 17, 2021, the Department announced it was postponing the prior April 1, 2021, effective date for the Medi-Cal Rx transition (to a later effective date to be subsequently determined).

On March 9, 2021, the court held a hearing on the Department's Motion to Dismiss and Plaintiffs' Motion for Preliminary Injunction. In a ruling from the bench, the court granted the Department's Motion to Dismiss, without prejudice, in light of the postponed effective date and the still pending federal administrative process associated with the transition, and denied the Plaintiffs' motion on mootness grounds.

On December 29, 2021, the federal Centers for Medicare and Medicaid Services (CMS) announced its approval of the State's CalAIM Section 1915(b) waiver, including the transition of pharmacy coverage from managed care to the fee-for-service delivery system. As a result, on December 30, 2021, plaintiffs filed an amended complaint against both the Department and CMS seeking to enjoin the Medi-Cal Rx transition. On January 10, 2022, the court denied Plaintiffs' motion for a temporary restraining order. The Department filed a motion to dismiss on February 8, 2022. ~~No hearing on the Department's motion was held and the parties await the court's ruling.~~ **On July 17, 2023, the District Court granted defendants' Motions to Dismiss. The court found that CMS's determinations and approvals were not arbitrary and capricious. With the dismissal of the underlying claims, the court also granted dismissal of the purported claim for declaratory relief. The defendants' Motions to Dismiss were granted without leave to amend.**

9. 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 September 29, 2023, the court partially granted the Department's demurrer, with leave to amend, as to five of plaintiff's six claims. On October 22, 2022, petitioners filed an Amended Petition and served discovery shortly thereafter. Because the Amended Petition failed to cure the defects alleged in the first demurrer, the Department filed a second demurrer and motion to stay discovery until the second demurrer is decided. The Department's second demurrer was heard on February 15, 2023. The court granted the Department's Motion to Stay Discovery and Motion for Relief from Waiver, it then took the demurrer under advisement ~~explaining a decision would likely issue in 90 days~~. **On May 1, 2023, the court**

INFORMATION ONLY

overruled the Department's demurrer and lifted the stay on discovery. A hearing is scheduled for February 9, 2024.

10. Audit of California Department of Health Care System's Substance Abuse Prevention and Treatment Block Grant (SABG) Expenditures (A-09-21-01001)

    The Office of Inspector General (OIG) is conducted an audit to determine whether California's SABG expenditures for Los Angeles County, including expenditures for contracted transitional housing providers, complied with Federal and State requirements. The audit period covered FY 2019-20, in which it was determined the county reported total transitional housing expenditures of $3,967,038 on the Quarterly Federal Financial Management Reports (QFFMR) and general ledgers. However, the county did not have support for $1,688,913 in transitional housing expenditures reported on the ledgers. According to the county, it erroneously included previously claimed transitional housing expenditures of $1,688,913 on the QFFMR and general ledger for the fourth quarter of FY 2019-20.

    OIG held an exit conference with the Department on October 21, 2022, in which OIG recommended the Department work with the county to recover the $1,688,913 for transitional housing expenditures when closing out the SABG award for the audit period. OIG has not yet issued the draft audit report but expects to do so by the ~~first~~ **third** quarter of 2023. Further, the Department will review whether counties claimed expenditures previously claimed as part of the cost report review. Internal Audits will revisit the potential payment once the draft report is issued. The Department cannot confirm at this stage whether the amount is agreed to or whether it is accurate; as such, the amount has not been included in the budget for Audit Settlements.

INFORMATION ONLY

OTHER: REIMBURSEMENTS

1. Federal Upper Payment Limit

   The Upper Payment Limit (UPL) is computed in the aggregate by hospital category, as defined in federal regulations. The federal UPL limits the total amount paid to each category of facilities to not exceed a reasonable estimate of the amount that would be paid for the services furnished by the category of facilities under Medicare payment principles. Payments cannot exceed the UPL for each of the three hospital categories.

2. Accrual Costs Under Generally Accepted Accounting Principles

   Medi-Cal has been on a cash basis for budgeting and accounting since FY 2004-05. On a cash basis, expenditures are budgeted and accounted for based on the fiscal year in which payments are made, regardless of when the services were provided. On an accrual basis, expenditures are budgeted and accounted for based on the fiscal year in which the services are rendered, regardless of when the payments are made. Under Generally Accepted Accounting Principles (GAAP), the state's fiscal year-end financial statements must include an estimate of the amount the state is obligated to pay for services provided but not yet paid. This can be thought of as the additional amount that would have to be budgeted in the next fiscal year if the Medi-Cal program were to be switched to an accrual basis.

3. Refund of Recovery

   CMS requested the Department prepare reconciliations of grant awards vs. federal draws for all fiscal years. The Department determined FFP was overpaid on some recovery activities. As a result of this determination, the Department is correcting the reporting of overpayments on the CMS 64 report. The Department expects a one-time refund of $240 million FFP for federal FY 2007 through 2011 and $34 million FFP ongoing each month.

4. Payment Deferrals

   The Department issues weekly payments for Fee-For-Service providers. This process is referred to as the checkwrite. Starting in FY 2004-05, the Department implemented (1) an additional week of claim review prior to the release of provider payments starting in July 2004, this shifts the payment s of the Fee-For-Service checkwrite by one week, and (2) the last checkwrite in June of each fiscal year has been delayed until the start of the next fiscal year.

OTHER: RECOVERIES

1. Recovery Audit Contractor (RAC)

   Title 42 Code of Federal Regulations Section 455.500 through 455.518 requires that States enter into contract with one or more RACs for the purpose of identifying underpayments and overpayments and recouping overpayments. The RAC Program's mission is to reduce improper Medi-Cal payments through the efficient detection and collection of overpayments,

the identification of underpayments, the reporting of fraudulent and/or criminal activities, and the implementation of actions that will prevent future improper payments.

State Plan Amendment (SPA) 20 – 0017 provides the Department exemption from contracting with a RAC through February 1, 2022. A request for proposal for the Department to enter into contract with a RAC was awarded in June 2021. The RAC will be paid on a contingency basis determined by the amounts recovered from overpayments identified, and the refunded amounts of identified underpayments. The Department does not anticipate any contract costs in FY 2021-22 or FY 2022-23.

OTHER: MISCELLANEOUS

1. Vital Records

The Department has two contracts with CDPH to obtain vital records data. One contract allows the Department to obtain electronic data files of birth, death, and fetal death records from CDPH. The second contract allows the Third Party Liability Recovery Division, the Audits & Investigations Division, and the Medi-Cal Eligibility Division to request certified copies of birth, death, marriage, divorce, and fetal death records of Medi-Cal beneficiaries from CDPH. The Department may amend the contract for certified copies to include other divisions as appropriate.

2. Electronic Visit Verification

Electronic Visit Verification (EVV) is a telephone and computer-based method that electronically verifies in-home service visits. EVV systems must verify type of service performed; individual receiving the service; date of the service; location of service delivery; individual providing the services; and time the service begins and ends. Section 1903 of the SSA [42 U.S.C. 1396b(l)] requires all states to implement EVV for Medicaid-funded Personal Care Services (PCS) and Home Health Care Services (HHCS) that require an in-home visit by a provider. In California, EVV impacts all PCS and HHCS provided under the Medi-Cal state plan and under several Medicaid waiver programs, including those Medicaid programs administered by the Department, CDSS, the California Department of Developmental Services (CDDS), the California Department of Aging (CDA), and the California Department of Public Health (CDPH).

States must require EVV use for all Medicaid-funded PCS by January 1, 2020, and HHCS by January 1, 2023. Otherwise, a state is subject to incremental Federal Medical Assistance Percentage (FMAP) reductions from 0.25% and up to 1%. The Centers for Medicare and Medicaid Services (CMS) approved California's request for a one-year good faith exemption for PCS on October 22, 2019. As a result of the exemption, California will not be subject to FMAP reductions in 2020 for PCS, however they will be subject to incremental FMAP reductions beginning with 0.5% starting January 1, 2021. Federal penalties for not complying with EVV requirements increase each calendar year by 0.25 percentage points to a maximum of one percent in 2023 for PCS **and 2027 for HHCS**. ~~There is a similar penalty for HHCS if EVV for HHCS is not implemented by January 1, 2023.~~ **The Department submitted a GFE for HHCS to exclude penalties for calendar year 2023.**

INFORMATION ONLY

~~The State is currently in the process to successfully implement the EVV mandates outlined in the CURES Act which will require extensive multi-agency planning, collaboration, and coordination. The Department is collaborating with CDSS, DDS, CDPH, and CDA to develop, implement, and manage a cross-department EVV solution that meets federal requirements.~~

The State ~~is implementing~~ **implemented** two EVV systems, known as EVV Phase I **(Case Management Information and Payrolling System** (CMIPS)**)** and EVV Phase II (CalEVV). EVV Phase I ~~is being implemented via the existing Case Management Information Payrolling System~~ **was implemented on July 1, 2023 via the existing CMIPS** for PCS with a self-directed model and primarily impacts self-directed In-Home Supportive Services and Waiver Personal Care Services. ~~The projected date for EVV Phase I implementation is July 1, 2023.~~ EVV Phase II for PCS was implemented on January 1, 2022**, and January 1, 2023 for HHCS,** via a new California Electronic Visit Verification (CalEVV) solution for PCS **and HHCS** with an agency model. This model includes **all PCS and HHCS provided under all** Medicaid **authorities, including the State Plan, and** ~~waiver~~ programs administered by the Department, DDS, CDA, **CDSS,** and CDPH.

~~The EVV Phase II project is now focused on implementing the EVV requirements for Home Health Care Services (HHCS) by January 1, 2023. EVV Phase II for HHCS was successfully implemented for most services on January 1, 2023. The remaining services are projected to be implemented by or before July 1, 2023.~~

FISCAL INTERMEDIARY: MEDICAL

1. No additional information.

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

2. No additional information.

FISCAL INTERMEDIARY: DENTAL

1. State Controller's Office Interagency Agreement

   The Department initiated an interagency agreement with the State Controller's Office (SCO) in FY 2016-17 to transition checkwrite services away from the Fiscal Intermediary (FI). Due to competing priorities, the Department put this project on hold. The Department initially planned to restart this work in FY 2017-18. However, due to lack of resources to fully support the project, a pending enterprise solution to the Federal Drawdown Reporting (FDR) system, as well as no legal mandate to transition the services at the time, the Department halted the project until the FDR could be properly implemented.

   The Department does intend to work in the future with the SCO to alter the current check write function, which the FI is currently responsible for. The FI will continue to fulfill duties related to checkwrite until a new process has been implemented between the SCO and the

INFORMATION ONLY

Department. This complex effort will require multiple phases in order to alter the current system to allow for SCO takeover of the check write function. Costs to consider in the future pertain to analyzing business processes, system testing, updating the CD-MMIS and enabling the SCO systems the ability to perform the check write function.

DISCONTINUED POLICY CHANGES

Fully Incorporated into Base Data/Ongoing

ELIGIBILITY
PC 8 Minimum Wage Increase – Caseload Savings
PC 88 CalAIM – Transitioning Populations

AFFORDABLE CARE ACT
Not applicable.

BENEFITS
PC 31 Community Health Worker
PC 32 CalAIM – Organ Transplant
PC 40 Routine Costs for Clinical Trials
PC 43 Annual Cognitive Assessments

HOME & COMMUNITY-BASED SERVICES
Not applicable.

BREAST AND CERVICAL CANCER
Not applicable.

PHARMACY
PC 44 Continuous Glucose Monitoring Systems Benefit
PC 164 COVID-19 Vaccine Administration

DRUG MEDI-CAL
Not applicable.

MENTAL HEALTH
Not applicable.

1115 WAIVER—MH/UCD & BTR
Not applicable.

MANAGED CARE
Not applicable.

PROVIDER RATES
PC 124 10% Provider Payment Reduction

SUPPLEMENTAL PAYMENTS
Not applicable.

COVID-19
PC 166 COVID-19 LTC Reimbursement Rates

DISCONTINUED POLICY CHANGES

Fully Incorporated into Base Data/Ongoing

OTHER: AUDITS AND LAWSUITS
Not applicable.

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

DISCONTINUED POLICY CHANGES

Time Limited/No Longer Available

ELIGIBILITY
PC 6 Accelerated Enrollment for Adults
PC 14 Medicare Optional Expansion Adjustment

AFFORDABLE CARE ACT
Not applicable.

BENEFITS
Not applicable.

HOME & COMMUNITY-BASED SERVICES
PC 162 COVID-19 Sick Leave Benefits
PC 172 IHSS HCBS Care Economy Payments

BREAST AND CERVICAL CANCER
Not applicable.

PHARMACY
Not applicable.

DRUG MEDI-CAL
Not applicable.

MENTAL HEALTH
PC 65 MHP STRTP Grants

1115 WAIVER—MH/UCD & BTR
Not applicable.

MANAGED CARE
PC 21 ACA Optional Expansion MLR Risk Corridor
PC 26 Litigation Related Services
PC 79 CCI Managed Care Payments
PC 83 2020 MCO Enrollment Tax Mgd. Care Plans-Incr. Cap.
PC 92 Reconciliation of MCO Tax Fund 3156
PC 103 2020 MCO Enrollment Tax Managed Care Plans
PC 104 2020 MCO Enrollment Tax Mgd Care Plans-Funding Adj
PC 146 Prop 56 – Value-Based Payment Program
PC 215 Alameda County Supportive Housing

PROVIDER RATES
PC 121 Durable Medical Equipment Rate Adjustment

SUPPLEMENTAL PAYMENTS
Not applicable.

DISCONTINUED POLICY CHANGES

Time Limited/No Longer Available

COVID-19
Not applicable.

STATE ONLY CLAIMING
Not applicable.

OTHER: AUDITS AND LAWSUITS
Not applicable.

OTHER: REIMBURSEMENTS
PC 258 Repayment of Federal Funds for Non-Compliant PASRR

OTHER: RECOVERIES
Not applicable.

OTHER: MISCELLANEOUS
PC 36 Medically Tailored Meal Pilot Program
PC 173 Electronic Visit Verification Fed Penalties
PC 214 PACE Infrastructure Funding
PC 210 Los Angeles County Reproductive Health Pilot
PC 216 Backfill Lost Title X Family Planning Funding
PC 98 Health Plan of San Mateo Dental Integration Evaluation
PC 261 State-Only Claiming - Prosp. Adj.

FISCAL INTERMEDIARY: MEDICAL
Not applicable.

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS
Not applicable.

FISCAL INTERMEDIARY: DENTAL
Not applicable.

DISCONTINUED POLICY CHANGES

Withdrawn

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
PC 63 Designated State Health Programs

MANAGED CARE
Not applicable.

PROVIDER RATES
PC 264 Freestanding Pediatric Subacute Rates

SUPPLEMENTAL PAYMENTS
Not applicable.

COVID-19
OA 10 COVID-19 Vaccination Incentive Program Admin
PC 157 COVID-19 Caseload Impact
PC 160 COVID-19 Vaccination Incentive Program
PC 168 COVID-19 Caseload Impact Base Adjustment

OTHER: AUDITS AND LAWSUITS
Not applicable.

DISCONTINUED POLICY CHANGES

Withdrawn

OTHER: REIMBURSEMENTS
Not applicable.

OTHER: RECOVERIES
Not applicable.

OTHER: MISCELLANEOUS
PC 206 Watsonville Community Hospital Acquisition
PC 230 American Rescue Plan Increased FMAP for HCBS
OA 94 CDPH I&E Program Evaluation

FISCAL INTERMEDIARY: MEDICAL
Not applicable.

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS
Not applicable.

FISCAL INTERMEDIARY: DENTAL
Not applicable.