AGENDA
ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 ON HEALTH AND HUMAN SERVICES

Part II

Assemblymember Hector De La Torre, Chair

THURSDAY, MAY 19, 2005
STATE CAPITOL, ROOM 127

ITEMS TO BE HEARD

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ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

ISSUE 1: MEDICARE MODERNIZATION ACT

The Medicare Prescription Drug, Improvement and Modernization Act (MMA) became law on December 8, 2003. The MMA makes significant changes to the federal Medicare Program. The scope of the Act is broad and it will be years before all of its provisions are implemented and its effects understood. The implications of the Federal Medicare Part D drug program will be significant for the dual eligibles – beneficiaries who are eligible for both Medicare and Medi-Cal benefits. In addition to the Medicare Part D prescription drug benefit, the MMA also includes a number of other benefit changes.

The dual eligibles are individuals who are entitled to Medicare and who are eligible for some form of Medi-Cal benefits. There are approximately 1.1 million dual eligibles in the Medi-Cal Program. Dual eligibles tend to be in fair or poor health due to chronic illnesses and conditions. Because dual eligibles are eligible for Medicare, they are the Medi-Cal recipients most significantly affected by Part D.

The Governor's budget plan would reduce General Fund expenditures for the Medi-Cal Program by about $747 million ($1.5 billion all funds) in the budget year in recognition of the savings to the state from no longer providing a drug benefit to the dual eligibles under Medi-Cal. These savings would be partially offset by a new payment that the state will have to make to the federal government known as a "phased-down state contribution" or, more commonly, as a "clawback". This clawback payment is estimated to be $646 million General Fund in the budget year. As a result, the General Fund effect upon the Medi-Cal Program from the new Part D drug benefit is projected to result in net savings of about $100 million General Fund in 2005-06. The estimate of net savings is misleading when other factors relating to implementation of Part D have been taken into account.

The new Part D drug benefit will result in savings of about $100 million General Fund in 2005-06, but will probably be a losing proposition for the Medi-Cal Program beyond the budget year. This is partly due to the so-called clawback provision written into the new federal law, and the specific way this provision is being interpreted and implemented by CMS. The clawback provision and other important changes resulting from MMA probably mean that, after a short-lived one- to two-year gain, the Medi-Cal Program will end up experiencing large net financial losses for at least several years afterward.

The LAO estimates that the combined effect of the reduction in drug expenditures, the clawback payments, and the loss of drug rebates associated with the dual eligibles will result in cumulative additional General Fund costs to the state through 2008-09 of about $758 million. The following table provides the LAO estimates of the fiscal effect that the MMA will have on Medi-Cal Program finances over the next four years.

Figure 10
Fiscal Impact of New Medicare Drug Benefit
As Reflected in the Governor's Budget Plan[a]

(In Millions)

	2005-06 (Half-year)	2006-07	2007-08	2008-09
Reduced Drug Costs	-$747	-$1,617	-$1,818	-$2,043
Clawback	646	1,428	1,574	1,737
Reduced drug rebates	—	273	620	705
Annual Impact	**-$101**	**$84**	**$376**	**$399**
Cumulative Impact		**-$17**	**$359**	**$758**

A 2006-07, 2007-08, and 2008-09 figures are LAO estimates.

Legislative Analyst Office

As pointed out above, dual eligibles are the Medi-Cal beneficiaries that are most directly affected by the implementation of Medicare Part D. The LAO notes that the new program has some potential pitfalls for dual eligibles whose drug coverage would be shifted from Medi-Cal to Medicare. In some cases, these individuals may not be able to get the same drugs under Medicare that they now get under Medi-Cal, with unknown medical consequences. As a result, the state faces the difficult choice of whether to continue their state-supported drug benefits without any further financial support from the federal government

Factors related to Medicare Part D implementation that could increase cost pressures on the state are summarized in Figure 11.

Figure 11

How the Medicare Part D Benefit Could Be Costly to Medi-Cal

	Annual Cost
Wrap-Around Under existing state law, the state provides wrap-around coverage.	Unknown, potentially low hundreds of millions of dollars.
Clawback Effect Provision requires the state to pay the federal government back most of the state's savings from no longer providing drug coverage to dual eligibles.	$646 million in 2005-06.
Reduced Drug Rebates The state's drug rebates will be reduced because fewer drugs will be purchased.	$273 million beginning in 2006-07, and larger amounts thereafter.
Supplemental State Rebates The state's ability to negotiate supplemental drug rebates with pharmaceutical manufacturers may be negatively affected when the volume of drugs that the state purchases decreases.	Unknown, potentially up to tens of millions of dollars.
County Administration Creates additional workload in county welfare offices by requiring them to do eligibility determinations for Medicare Part D low-income assistance.	Unknown.
Woodwork Effect May result in increased Medi-Cal caseloads because county welfare offices will have to screen people applying for low-income Medicare Part D assistance for some Medi-Cal low-income assistance programs.	Unknown, probably relatively small.

Legislative Analyst Office

However, MMA does not allow California or other states to keep all of these savings. The measure includes a clawback provision that requires states to pay back most of their estimated savings to the Medicare program to help pay for the Part D benefit. States are required to pay the federal government 90 percent of their estimated savings in calendar year 2006. During the following nine years the clawback percentage is reduced by 1.66 percent per year until it reaches 75 percent, then remains set at that level.

Beginning in January 2006, California is required to make a monthly clawback payment that is to be deposited into a federal government account. The amount of each state's monthly payment is determined by a complex formula with several components, including the amount the state spent on drugs covered by Part D for dual eligibles in calendar year 2003 on a per-person basis and the rebates received by a state from drug manufacturers.

The CMS has issued final regulations that will determine how the clawback formula will be applied to each state. The DHS concluded that the regulation adopted by CMS unduly disadvantages California by overstating the true net costs it had incurred in the past for providing prescription drugs to dual eligibles—a key component of the federal clawback formula. The DHS found that the proposed clawback formula inaccurately calculates the rebates collected from drug suppliers for 2003 by using the dollar amount of rebates collected in 2003. The department indicates a more appropriate calculation, which would have taken into account rebates collected in 2004 that would reduce the state's clawback payments by $91 million a year. Although the regulations have been finalized, the CMS has not yet determined the amount of the state clawback payment. The deadline for the CMS to announce state clawback payments is October 15, 2005.

A point noted earlier is that DHS' budget proposal assumes that the rebates the state receives from drug manufacturers will decrease by about $273 million in 2006-07 as a result of the implementation of the Part D benefit and dual eligibles receiving their drugs under Medicare instead of Medi-Cal. That $273 million decline in rebates represents only the partial-year effect of Part D implementation. The estimate for the full annualized loss of Medi-Cal rebate revenues could be more than $620 million in 2007-08.

In addition to the direct reduction in rebates, the implementation of Part D could reduce the state's bargaining power with drug manufacturers for drug rebates under the Medi-Cal Program. The anticipated decrease of more than 50 percent in the amount of drug purchases being made under the fee-for-service component of Medi-Cal as a result of dual eligibles shifting from Medi-Cal drug coverage to Medicare drug coverage could weaken DHS' ability to successfully negotiate supplemental rebates with drug manufacturers, potentially increasing program costs by tens of millions of dollars annually.

Certain state agencies and groups of medical providers who provide services to Medicare beneficiaries have historically built the costs of drug coverage into their operations. For example, the cost of providing prescription drugs is embedded in the rates that the state now pays to certain Medi-Cal managed care providers, and in funding for developmental centers operated by the Department of Developmental Services (DDS) and state hospitals operated by the Department of Mental Health (DMH).

The implementation of Medicare Part D means that the drug costs in these programs will decrease as drug costs for Medicare patients' shifts to the new Part D program. The LAO notes the budgets for these other programs have not been adjusted in the Governor's budget plan to

reflect these potential savings. Their rates and funding levels could be adjusted to reflect this anticipated decrease in their drug costs. The LAO estimates that fully recognizing these adjustments for the startup of Medicare Part D drug coverage could collectively result in significant General Fund savings as much as $100 million in 2005-06, and as much as $200 million annually by 2006-07.

ISSUE 2: MEDI-CAL MANAGED CARE

The Administration, in its 2005-2006 fiscal year budget proposal, is proposing to redesign the Medi-Cal program in order to maintain health care coverage to eligible Californians while containing costs and maximizing operating efficiencies.

Medi-Cal provides medical services for 6.6 million low-income individuals. In addition to providing services to these individuals, Medi-Cal is a critical funding source for hospitals and clinics serving Medi-Cal beneficiaries and the uninsured. Program expenditures for 2005-06 will exceed $34 billion ($12.9 billion in State General Fund). Medi-Cal is the second largest expenditure in the State budget behind K-12 education.

While Medi-Cal is one of the most cost-effective Medicaid programs in the nation, continuing and increasing fiscal demands threaten the program's long-term financial viability and will jeopardize the State's ability to fund other programs.

Since 1998-99, General Fund expenditures in Medi-Cal have grown by 60 percent ($4.5 billion). These costs are the result of several factors, including:

- Program expansions and reforms have added 1.2 of the 1.6 million new beneficiaries since 1998-99, a 32 percent increase in the number of people receiving health care services through the Medi-Cal program.
- Demographic trends have increased the number of people eligible for Medi-Cal.
- Health care costs have risen at rates above the general inflation rate.
- Medical advances have improved outcomes and increased the cost of treatment.
- Medi-Cal provides beneficiaries with a comprehensive range of benefits, exceeding the scope of benefits of other states and employer-based programs.

California provides Medi-Cal benefits via managed care in 22 counties to 3.2 million beneficiaries including families, children, seniors and people with disabilities. Managed care delivers better quality care and greater beneficiary access at a lower cost than the Medi-Cal fee-for-service program. Redesign seeks to build upon this success by:

- Enrolling 262,000 parents and children in managed care in 13 additional counties. The expansion will involve beneficiaries in El Dorado, Imperial, Kings, Lake, Madera, Marin, Mendocino, Merced, San Benito, San Luis Obispo, Sonoma, Placer and Ventura counties.
- Enrolling 554,000 seniors and disabled individuals into managed care in all counties in which managed care is available (these population groups are already enrolled in managed care in the 8 counties with an existing County Organized Health System).
- Implementing Acute and Long Term Care Integration projects in Contra Costa, Orange and San Diego counties to test innovative approaches for enabling more individuals to receive care in settings that maximize community integration.

The managed care expansion will be achieved through a phased-in process over a twelve- to eighteen-month period commencing in January 2007.

Other elements of the Medi-Cal Redesign proposal include:

- Hospital financing to strengthen the state's health care safety net, a new five-year hospital financing waiver is being negotiated with the federal government. This new waiver will allow California to continue contracts with selected hospitals serving low-income and vulnerable populations and will replace current funding methods with new systems that create opportunities to draw down additional federal dollars.

- Modify the Medi-Cal Benefit Package and the Medi-Cal dental benefit package provided to approximately 3 million adults will be aligned with private employer-based and public sector health coverage programs by placing an annual limit of $1,000 on dental services provided to adults. The majority of the dental needs of the approximately 3 million Medi-Cal adult beneficiaries, including the cost of dentures, are expected to be covered by the $1,000 benefit limit. The limit will not apply to federally mandated dental services provided by a physician, emergency dental services, and hospital costs associated with dental treatment.

- Beneficiary Cost Sharing Medi-Cal beneficiaries with incomes above the federal poverty level will pay a small premium to maintain their Medi-Cal coverage. These beneficiaries include 460,000 families and children in households with incomes above 100 percent of the Federal Poverty Level and 90,000 seniors and persons with disabilities with incomes above the Supplemental Security Income/State Supplemental Payment level. Premiums will be $4 per month for each child under the age of 21 and $10 per month for adults, with a maximum of $27 per month per family. The required premium payments represent approximately 1-2 percent of the total annual income for affected individuals.

Realization:

Experience with Medi-Cal's shifting people to Managed Care in the mid 1990s underscores the importance of a deliberate and gradual implementation so that systems and providers are ready and beneficiaries fully informed to understand the changes that will occur. For these reasons the Department proposed a multi-year timeline to realize its Medi-Cal Redesign goals.

When fully implemented, Medi-Cal Redesign is expected to maintain and improve Medi-Cal coverage for eligible individuals and will reduce annual Medi-Cal expenditures by $287,180,000 ($144,902,000 GF). Savings over the first 5 years are expected to total $332,000,000 ($171,000,000 GF).

The rationale for expanding managed care in the Medi-Cal Program has been founded on the expectation that when implemented in a careful, deliberate manner, can increase access to services, improve patient outcomes, increase accountability for health care dollars, and be more cost effective than an unmanaged fee-for-service program. The Program has recently been challenged by research published by the Robert Woods Johnson Foundation In an article published in March 2005 that focused on how mandatory enrollment in managed care has affected both spending and health outcomes for California Medicaid recipients. The author found that despite a dramatic increase in Medicaid managed care enrollment – from less than 12 percent in 1993 to 51 percent in 1999- there was neither a significant reduction in spending nor improved health outcomes. Specifically the author found "In fact, Medicaid spending appeared to increase by almost 20 percent following a shift to managed care and persisted long after the mandates first took effect."

Questions for Department of Health Services:

1. It would be helpful if the department could provide HEDIS results of HMOs that operate in the Geographic Managed Care and Two Plan counties. How do the results compare to the County Organized Health Systems which provide care to the ABDs and the national averages?

2. What are the profit margins of HMOs that contract with the State for MediCal? How does this compare with the commercial sector?

3. Does the State have any requirements on how much profit a plan can make? (Maryland and other states have limits) Is there a minimum threshold for medical/loss ratio?

4. Historically HMO's have resisted taking the Aged, Blind and Disabled (ABD) population. Why is there interest now? What has changed? And, since the HMOs haven't historically treated the ABDs, are they prepared to do so? Do they have the networks and programs in place; networks/programs designed for ABD rather than TANF?

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ISSUE 3: MANAGED CARE EXPANSION STAFF

The Legislative Analyst Office developed the following table to summarize its recommendation on the staffing for the Managed Care Expansion. The LAO recommends approval 42.0 of the 47.5 requested positions and recommends a corresponding reduction of $469,819. The LAO also recommends 4.0 positions proposed as permanent to be approved on a two-year limited-term basis until the ongoing workload associated with the Acute and Long Term are Integration section of the proposal justifies establishing these positions on a permanent basis.

LAO Analysis of DHS Managed Care Expansion Proposal - Summary			
Unit	*Requested*	*LAO position adjustments to Managed Care Expansion BCP**	*Fiscal effect of adjustment proposed by LAO*
Managed Care			
Medical Consultant II	1.0		
Actuary	2.0		
Staff Services Manager II	1.0		
Research Program Specialist II	1.0		
Nurse Consultant III	1.0		
Staff Services Manager I	2.0		
Research Program Specialist I	1.0		
Associate Management Auditor	2.0		
Associate Governmental Program Analyst	8.0	-2.0	-$180,455
Nurse Evaluator II	2.0		
Office Technician - Typing	1.0		
Payment Systems, Health Care Options			
Associate Governmental Program Analyst	2.0		
Office Technician	1.0		
Research Program Specialist I	1.0		
Staff Information Systems Analyst	2.0		
Payment Systems Division, FI-OMB			
Associate Governmental Program Analyst	2.0		
Word Processing Technician	0.5		
Long Term Care			
Staff Services Manager II	1.0		
Staff Services Manager I	1.0	limit term	
Associate Governmental Program Analyst	4.0	limit term of 2.0	
Office Technician	1.0	limit term	
Nurse Evaluator II	1.0		
Administration			

Personnel Specialist	0.5		
Associate Governmental Program Analyst	1.0		
Research Program Specialist II	1.5	-0.5	-$49,562
Account Technical	1.0		
Office Assistant	1.0	-1.0	-$44,836
Legal Services			
Staff Counsel III	1.0		
Staff Counsel I	1.0		
Office of Regulations			
Staff Services Manager	1.0	-1.0	-$103,739
Associate Governmental Program Analyst	1.0	-1.0	-$90,227
Total	**47.5**	**-5.5**	**-$468,819**
* Limited term positions are for two years unless otherwise noted.			

ISSUE 4: LONG TERM CARE INTEGRATION

A cornerstone of the Administration's Medi-Cal Redesign effort is the expanded use of managed care delivery systems. The Administration is proposing to increase access to care and improve health outcomes through expansion of Medi-Cal managed care plan options. This would be accomplished by expanding the geographic areas in which managed care is available and the population groups within Medi-Cal who are enrolled in managed care.

The Administration is proposing the following uncodified language to provide some definition as to whom and for what 05-06 LTCI/ALTCI grant funds would be provided.

Any and all monies available in the general fund for 2005-2006 fiscal year that were originally allocated to the long term care integration pilot project set forth in Article 4.3 (commencing with Section 14139), of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, shall be made available to the director for use by local entities implementing Acute and Long Term Care Integration and shall be available only for reimbursable start-up costs approved by the director.

ACUTE AND LONG TERM CARE INTEGRATION PROJECTS

Add Article 9, Section 14499.80, to Chapter 8 of Part 3 of Division 9 of the Welfare and Institutions Code to read:

14499.80. *(a) It is the intent of the Legislature to authorize the implementation of Acute and Long Term Care Integration (ALTCI) projects in three counties to enable individuals to receive the full continuum of services that maximizes community integration. Through the development of these ALTCI projects, the viability of a cost-effective statewide program offering a comprehensive scope of services can be evaluated.*

(b) For purposes of this article, the following definitions shall apply:

"Contracting entity" means an entity responsible for providing, or arranging and paying for the provision of, integrated medical, social and supportive benefits to eligible persons pursuant to the project authorized under this section.

"Department" means the State Department of Health Services.

"Eligible population" means seniors and adult persons with disabilities who are Medi-Cal eligible or are dually eligible for Medi-Cal and Medicare.

"Dual eligible" means any person who is simultaneously qualified for full benefits under Title XIX of the Social Security Act (42 U.S.C. Sec. 1396 et seq.) and Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395 et seq.).

"Seniors and adult persons with disabilities" means individuals, age 21 or older, who otherwise meet the definition of aged, blind or disabled under the federal Supplemental Security Income Program as set forth in Title 42, United States Code, and Section 1382c.

"Person-centered care planning" means a care management model that considers an individual's needs across medical, social and supportive services.

"Personal care services" means assistance with activities of daily living.

(8) "Long Term Care Diversion Assessment Protocol" means a protocol adopted by the state that would augment medical assessment information in order to determine an individual's home and community-based service needs and service preferences across the continuum of long term care services, based on his/her unique abilities, functions and preferences.

(c) Consistent with the provisions of this article, the Director of the Department may establish, in consultation with the federal Centers for Medicare and Medicaid Services, and administer a federally approved project that integrates Medicare and Medi-Cal funding streams, and integrates medical, social and supportive benefits. The project established under this section shall be known as the Acute and Long Term Care Integration (ALTCI) program for the purposes of providing services to seniors and adult persons with disabilities who are Medi-Cal only and/or Medicare and Medi-Cal eligible. ALTCI shall promote a cost-effective program offering a comprehensive and integrated scope of benefits that will provide individuals improved options for the decisions made regarding the needed services, providers and the types of supports that

meet their identified health and social service needs. The project shall be implemented only if, and to the extent, permitted under federal law.

(d) Notwithstanding any other provision of law, the director shall have the authority to require the mandatory enrollment of members of the eligible population, into the ALTCI project. The director may initially contract with Contracting entities in three counties designated by the director to implement ALTCI projects. The department shall seek any and all necessary federal waivers for ALTCI project implementation. The director shall not enter into contracts with any ALTCI Contracting entities unless necessary federal approval is obtained.

(e) The department shall perform a program evaluation on a schedule that coincides with federal waiver reporting requirements. The evaluation shall include, but not be limited to, all of the following:

The extent to which each Contracting entity has reduced the use of acute and nursing facility days.

The extent to which each Contracting entity increases the use of home and community-based services.

(3) The extent to which ALTCI is cost-effective.

(4) The extent to which ALTCI consumers report satisfaction with the program.

(f) Contracting entities shall be selected to provide or arrange and pay for comprehensive medical, social and supportive services that integrate all components of care covered pursuant to this article, either directly or through subcontracts. The following shall apply to a Contracting entity:
(1) A Contracting entity pursuant to this article shall either (i) be licensed by the Department of Managed Health Care (DMHC), or (ii) if not licensed by DMHC may contract with the department for a maximum of 24 months. During this 24-month period, such contracting entity shall demonstrate to the department that it is making a good faith effort to obtain DMHC licensure within 24 months of the date of entering into a contract with the department. In their application to the program, those entities that are licensed by DMHC shall provide assurance that they are in good standing with DMHC. Those plans that are not licensed by DMHC at the time of their application to the program shall outline their plans for obtaining licensure from DMHC within 24 months of the time of contracting; and

(2) A Contracting entity shall be either a Medicare Advantage prescription drug plan (MA PD) or a Medicare Special Needs Plan, or any other such designated risk-based Medicare managed care plan established by the Centers for Medicare and Medicaid Services which will offer Medicare benefits and prescription drug coverage that is integrated with the Medi-Cal medical, social and supportive services.

(3) A Contracting entity shall demonstrate an ability to provide, either directly or through subcontracts, Medicare and Medicaid covered services. Contracts under this article shall specify the scope of Medi-Cal medical, social and supportive benefits, standards appropriate for the enrolled population, standards for home and community-based provider networks, and quality standards developed by the department and approved by the federal Centers for Medicare and Medicaid Services.

(4) Integrated services provided pursuant to this article shall include, but not be limited to, the following:

(i) A care management system based on an interdisciplinary team model that includes the consumer. The care management system shall include:
A. Care management services that assist the member to navigate treatment settings; e.g. home, hospital and nursing facility; and
B. Levels of care management services based on the unique needs of each ALTCI member; and
C. Person-centered care and service planning; and
Care-planning that maximizes independence, home and community-based services and diversion from institutional care; and

A comprehensive scope of integrated benefits that includes:
A. Personal care services; including, choice of a qualified personal care provider. Standards for making personal care services available to ALTCI members shall include investigation of qualifications, background checks, and training for both providers and recipients; and
B. Home and community-based services; and
*C. Full scope of Medi-Cal benefits except for services authorized and provided by regional centers, as defined in section **14499.80**(l)and county specialty mental health plans; and .*
D. The full scope of Medicare benefits, including Part A, Part B and Part D drug coverage, for those enrollees who are Medicare-eligible.

Coordination with services not covered under the ALTCI plan, including:
A. Services authorized by regional centers for those who are eligible for regional center services; and
B. County specialty mental health services for those who are eligible for county specialty mental health services; and
C. Independent Living Center services for those who are eligible for Independent Living Center services.

(5) For the purposes of providing personal care services as set forth in subsection (f)(4)(ii)(A), a Contracting entity under this section may enter into a contract with an entity authorized pursuant to W&I 12301.6. An entity authorized pursuant to W&I 12301.6 may enter into contracts with an ALTCI Contracting entity to support the provision of personal care services.

(6) A contracting entity shall meet all external quality review standards, as outlined in Subpart E (commencing with Section 438.320) of Title 42 of the Code of Federal Regulations.

(g) Counties where ALTCI is implemented shall continue their financial maintenance of effort for programs and services integrated under this Article, if any. The amount of a county's maintenance of effort shall be based on the county's share of the non-federal share of annual expenditures for the In-Home Supportive Services (IHHS) program in State Fiscal Year 2003-2004.

(h) In order to achieve maximum cost savings the Legislature determines that an expedited contract process is necessary for ALTCI project contracts. Therefore, all ALTCI project contracts and amendments or change orders thereto, including amendments or change orders to existing Medi-Cal managed care plan contracts, shall be exempt from the provisions of Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contracts

Code. Further, such contracts, including any contract amendment or change order, shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and from the requirements of Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of the Government Code.

(i) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret or make specific this article and any applicable federal waivers by means of all county letters, all plan letters, plan or provider bulletins, or similar instructions to ALTCI projects. Thereafter, the department may adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(j) Prior to implementation of the ALTCI program, the department shall conduct a process in which interested stakeholders will have the opportunity to provide input to the department regarding the quality assurance, safeguards for the eligible population, program integrity, and program consistency efforts required by this article.

(k) The director shall have the authority to, on a bid or nonbid basis, on an exclusive or nonexclusive basis, or on a statewide or more limited geographic basis, develop or procure the development of a uniform diversion assessment protocol and data set for individuals with long term care needs which may be required to be used by some or all ALTCI projects as designated by the director.
(l) Notwithstanding any other provision of law, the Acute and Long Term Care Integration (ALTCI) project shall not include or affect the following services and supports provided by regional centers established pursuant to Welfare and Institutions Code (WIC) Section 4620 et. seq, including, but not limited to:
(1) Targeted Case Management State Plan Amendment – Sections 1905 (a)(19) and 1915(g)(2) of the Social Security Act.
(2) 1915(c) Home and Community-based Services Waiver(s), Section 1915(c) of the Social Security Act.
(3) Individuals with Disabilities Education Act (IDEA) Part C, Early Intervention Services (birth to 3 year olds), Title 14, Section 95000 – 95029 of the Government Code.
(4) Pre-Assessment, Screening-Resident Review, Nursing Home Reform – Section 1919(F) of the Social Security Act.
(5). Any service and support provided by regional centers solely to active recipients of regional center services, but only for services that do not supplant the budget of any agency that has a legal responsibility to serve all members of the general public and are receiving public funds for providing those services (WIC Section 4648) and for services that regional centers are responsible for pursuing funding as defined in WIC 4659 (a).

(m) This article is repealed on January 1, 2012.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

ISSUE 5: MEDI-CAL ESTIMATE (ISSUE 170)

The May Revisions proposes adjustments be made to the following items as noted below:

- Item 4260-101-0001 be decreased by $144,759,000 and increasing reimbursements by $10,900,000;
- Item 4260-102-0001 be reduced by $1,548,000;
- Item 4260-113-0001 be increased by $121,701,000;
- Item 4260-117-0001 be reduced by $887,000;
- Item 4260-101-0080 be decreased by $2,950,000;
- Item 4260-101-0693 be increased by $144,500,000;
- Item 4260-101-0890 be increased by $288,936,000;
- Item 4260-102-0890 be decreased by $1,548,000;
- Item 4260-103-0890 be decreased by $2,027,000;
- Item 4260-113-0890 be decreased by $35,521,000; and
- Item 4260-117-0890 be increased by $7,068,000.

These adjustments represent a variety of caseload and cost changes not highlighted in other Medi-Cal issues in the Finance Letter.

Per the Department of Finance Request - Medi-Cal May Revise Issue 170 was shorted by $200,000 General Fund. The Estimate contains the correct amounts. DOF requests the Assembly include this $200,000 as a technical correction in the action on Issue 170.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

ISSUE 6: MEDI-CAL CLAIMS PROCESSING OPERATIONAL MANAGEMENT - ISSUE (122)

The May Revision proposes that Item 4260-001-0001 be increased by $193,000 and Item 4260-001-0890 be increased by $297,000 to extend the term of five expiring positions for two years to provide adequate oversight of the Medi-Cal claims processing contract.

ISSUE 7: DELINKING MEDI-CAL FROM CALWORKS

The May Revision proposes the following trailer bill language be adopted to delink Medi-Cal and CalWORKs eligibility to hold Medi-Cal harmless from the CalWORKs reduction. Due to the assumption in the 2005-06 Governor's Budget, that transitional Medi-Cal would continue coverage for individuals no longer eligible for CalWORKs; this change does not impact Medi-Cal caseload

ISSUE 8: LONG-TERM CARE RATE INCREASE

The May Revisions requests that Items 4260-101-0001 and 4260-101-0890 each be increased by $29,931,000 to reflect a rate increase for long-term care facilities not impacted by Chapter 875, Statutes of 2004 (AB 1629). This rate increase is dictated by the Medicaid State Plan.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

ISSUE 9: LOS ANGELES COUNTY CLINIC RATE METHODOLOGY

Los Angeles County (LA) clinics are currently reimbursed based upon costs as identified by the LA Waiver. With the expiration of the waiver on June 30, 2005, it is requested that the trailer bill language be adopted to continue reimbursing Los Angeles clinics based upon costs.

ISSUE 10: SPEECH GENERATING DEVICES RATE INCREASE

The May Revision Proposes that Items 4260-101-0001 and 4260-101-0890 each be increased by $50,000 to reflect a rate increase for speech-generating devices. This increase would settle litigation issues by providing adequate access to the product. It is also requested that the related trailer bill language be adopted.

ISSUE 11: PORTABLE X-RAY TRANSPORTATION RATE INCREASE

The May Revision proposes trailer bill language in Attachment 4 be adopted to increase rates for portable x-ray transportation to 100 percent of Medicare. The cost of providing this benefit would be offset by the savings that would occur in other areas of the program.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

ISSUE 12: THERAPEUTIC DIABETIC SHOES AND INSERTS

The May Revision proposes trailer bill language be adopted to add therapeutic diabetic shoes and inserts as a Medi-Cal benefit. The cost of providing this benefit would be offset by the savings that would occur in other areas of the program.

ISSUE 13: DELTA DENTAL ENROLLMENT STAFF (ISSUE 165)

The May Revision proposes that Item 4260-101-0001 be increased by $281,000 and Item 4260-101-0890 be increased by $716,000 to fund an additional seven Delta Dental provider enrollment positions. According to the Department of Health Services additional contractor, staff are necessary to address a growing backlog in dental provider enrollment that is the result of the need to use a more extensive application form as indicated in a federal audit of the program.

The LAO states the workload does not justify the positions and recommends to the Legislature to reject the proposal

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

ISSUE 14: DRUG REBATE ACCOUNTING AND INFORMATION SYSTEM REFRESH (ISSUE 172)

The May Revision proposes that Item 4260-101-0001 be increased by $457,000 and Item 4260-101-0890 be increased by $1,373,000 to fund a refresh of the Rebate Accounting and Information System (RAIS). A refresh is necessary for the system given its age and the importance the system provides in supporting the invoicing of over $1.0 billion in rebates. Prior to expenditure of funds for the RAIS Refresh, the DHS shall provide a business-based justification of the need as well as a cost analysis for the project; expenditure of these funds will require Department of Finance approval.

The refresh of the RAIS and a new front-end for the Management Information System/Decision Support System (MIS/DSS) are the only new information technology projects that are included in the May 2005 Medi-Cal Estimate. A feasibility study report is being developed for the MIS/DSS project.

ISSUE 15: CALIFORNIA MEDICAID MANAGEMENT INFORMATION SYSTEM ASSESSMENT (ISSUE 173)

The May Revision proposes that Items 4260-101-0001 and 4260-101-0890 each be increased by $250,000 to fund an assessment of the California Medicaid Management Information System (CA-MMIS). The assessment will determine if the CA-MMIS should be replaced or enhanced given the age and complexity of the system.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

ISSUE 16: CALOPTIMA RATE INCREASE (ISSUE 185)

The May Revision proposes that Items 4260-101-0001 and 4260-101-0890 each be increased by $9,218,000 to reflect a three percent rate increase for CalOPTIMA. This rate increase is necessary to address CalOPTIMA's depleting financial reserves.

ISSUE 17: MEDI-CAL MEDICAL THIRD PARTY LIABILITY RECOVERIES

The budget includes an augmentation of state staff, and replacement of the Third Party Liability Branch (TPLB) Recovery program's Automated Collection Management System to significantly increase collections in Estate Recovery and Personal Injury Units. The support staff for the TPLB Health Insurance programs and contracts for other health coverage identification will significantly increase cost avoidance and program savings through increased private health insurance carrier billings, increased enrollment in the Health Insurance Premium Payment Program, and timelier identification of other health coverage.

The federal Social Security Act requires the State Medicaid Agency to seek reimbursement from the estates of certain deceased Medi-Cal beneficiaries and ensuring that Medi-Cal is the payer of last resort for Medi-Cal beneficiaries whose medical expenses were caused by third party torts. The provisions are specified in the Welfare and Institutions Code of California. Federal regulations require the state to utilize liable third party information, within 60 days of receipt, to establish the existence of a liable third party before a claim for payment is filed.

Federal regulations also require the Department to avoid payment of any claim when a liable third party is present and to initiate post-payment recovery processes. The Department has authority under California Statute to recover from liable third private insurance carriers any payments made by Medi-Cal when the private carrier is determined to have primary payment responsibility.

Also, state statute establishes the state mandate to pay private health insurance premiums for eligible Medi-Cal beneficiaries when it is cost effective to do so. In addition the provisions for payment of Medicare premiums on behalf of eligible Medi-Cal beneficiaries are specified in California's Buy-In Agreement with the Centers for Medicare and Medicaid Services. Under the agreement, the state enrolls Medi-Cal eligibles into the Supplemental Medical Insurance Program (Medicare B). The state is statutorily mandated to pay Medicare Part A premiums for certain individuals under the federal Social Security Law.

The Department of Health Services proposes to augment staffing by establishing 34.5 new position, establishing 31 new two-year limited term positions and converting 15 existing limited term positions to permanent full time status in the Third Party Liability Branch, Office of Legal Services and Administration Division. The staffing augmentation costs will be born 25 percent General Fund and 75 percent Federal Funds.

Thru use of existing regulatory power the Department proposes to:

- Recover expenses of Managed Care Beneficiaries through extension of personal injury recoveries to Managed Care Beneficiaries. There is currently no ability to identify Manage Care Personal Injuries cases so this will entail creating a system that generates trauma codes for Managed Care beneficiaries. The Department has legal authority to recover fee-for-services equivalent costs from managed care beneficiaries involved in Personal Injury cases.

- Enhance Estate Recovery and Personal Injury Collections through building upon authority provided to the Department for 15 limited-term positions to address backlogs in the Recovery Section and generate additional revenues. The permanent establishment of the 15 limited positions will maintain the additional $26 million in recoveries generated in the 2003-2004 fiscal year. The activity also proposes to upgrade and replace the Automated Collection Management System which will enable automation of collection activity and enhance tracking and utilization of caseload. The ACMS system replacement is expected to be implemented in the 2007-2008 fiscal year.

- Identify and Deflect Health Care Costs to Other Health Care Insurance – The savings are due to increased recoveries from increased identification of other health care for claims that have already been paid for Medi-Cal beneficiaries. The activity is estimated to save $1.68 million total funds annually.

- Other Coverage Unit Augmentation – This addresses the Health Insurance Questionnaires backlog in the Management Information System. The HIQ information identifies other health, thereby deflecting Medi-Cal expenditure. The information in the HIQ also identifies high-cost medical conditions – which may qualify the individual for the HIPP, Health Insurance Premium Payment, Program, a cost-saving Medi-Cal Program.

- Increase Recoveries from Private Health Insurance Carrier – Recreates the Health Insurance Recovery Group whose function is to recover monies from other health carriers for services paid for by Medi-Cal.

- Increase Other Health Coverage Identification through Electronic Data Matches – Increased recoveries from the electronic data matches for claims that have already been paid to beneficiaries. The recoveries will be collected by the Health Insurance Recovery Group.

- Savings from Data Matches and Buy-In Improvements – Contracted positions will run data matches with Private Health Insurance databases to identify any Medi-Cal beneficiaries who also have private health insurance and address system inadequacies of the Medicare Buy-In System. When other health coverage is identified the Management Information System will updated to reflect Other Health Coverage and will deny claims, thereby deflecting Medi-Cal costs.

The Department has requested 80.5 positions to implement these regulatory changes.

The Legislative Analyst Office recommends approval of 38.0 of the 80.5 positions requested by the Administration. The LAO withholds a recommendation on 15 of the positions as the report on the Estate Recovery Unit was due on December 1, 2004 and is overdue. Under the LAO recommendation the Legislature would approve $2.9 million

Total Funds, $929,000 General Fund which is $3.4 million less than the $6.3 million proposed by the Administration. Also, the LAO recommendation would result in General Fund savings in the budget year of $25.7 million which is $3.7 million less than the $29.4 million projected under the administration's proposal.

ISSUE 18: RESCIND MEDI-CAL THIRD PARTY RECOVERIES LEGISLATION (ISSUES 191 AND 195)

The May Revision proposes that Item 4260-001-0001 be decreased by $166,000, Item 4260-001-0890 be decreased by $288,000, and Items 4260-101-0001 and 4260-101-0890 each be increased by $1,384,000 to reflect the withdrawal of the 2005-06 Governor's Budget proposed legislation for the Estate Recovery and Personal Injury Program. The Administration continues to pursue adoption of the other components of the Third Party Liability Recoveries proposal.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

ISSUE 19: CALRX IMPLEMENTATION COSTS (ISSUE 189)

The May Revision proposes that Item 4260-104-0001 be increased by $7,800,000 to reflect additional program implementation costs not included in the Governor's Budget. The funding will be used to provide $3.4 million to allow pharmacies to be reimbursed before the state receives rebates from drug manufacturers, $4.1 million for additional systems development costs, and $300,000 for additional fiscal intermediary costs.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – PUBLIC HEALTH

ISSUE 1: CALIFORNIA RX

The Governor's 2005–06 budget plan for the Department of Health Services (DHS) proposes to establish a California Rx program aimed at reducing the costs certain California consumers would have to pay for drugs purchased at pharmacies. According to the Legislative Analyst Office, the California Rx plan was initially offered in a modified form as amendments to several legislative measures last year, but was not adopted. Since that time, the Governor has revised his legislative proposal in some significant respects (now contained in SB 19 [Ortiz]), and incorporated a request for 18.5 staff positions and about $3.9 million from the General Fund into the 2005–06 spending plan for DHS. Key features of the proposal are summarized in Figures 1, 2, and 3, and discussed below.

Figure 1

Major Components of California Rx

- ***Who Is Covered?*** Uninsured California residents in families with income up to 300 percent of the federal poverty level would be eligible to enroll.
- ***Voluntary Pharmacist Participation.*** Pharmacists who voluntarily chose to participate would assist individuals in applying for discount cards and must sell prescription drugs at agreed-upon discounts.
- ***Voluntary Drug Company Participation.*** Drug manufacturers could participate in the program if they voluntarily agreed to enable further discounts on prices through payment of rebates to the state.
- ***Federal Designation.*** The state would obtain federal designation as a State Pharmacy Assistance Program, which opens the door to deeper price-cutting by drug makers.
- ***Program Integration.*** The state's California Rx card would be integrated with private consumer discount programs operated by the drug companies themselves. One discount card would access all participating programs.
- ***Related Efforts.*** In a related effort, drug makers have pledged to spend $10 million over two years to publicize and fund toll-free telephone lines and Internet web sites to create a "single point of entry" for discounted drugs for Californians or, in some cases, free medications through existing privately funded assistance programs.

Legislative Analyst Office

Eligibility. The Governor proposes to allow low- and moderate-income California residents to enroll in the program by paying a $15 annual fee in order to obtain a prescription drug purchase

discount card. In general, those eligible would be individuals and families with incomes up to 300 percent of the federal poverty level (FPL)—up to roughly $28,000 a year in income for an individual or $56,500 for a family of four. The new discount program would be available on a voluntary basis mainly for persons who do not have other forms of health insurance coverage through either private health insurance or enrollment in the state's Medicaid Program (known as Medi-Cal in California) or in the Healthy Families insurance programs for children. Medicare enrollees could participate in the program in some circumstances.

An applicant would not be required to provide any form of written proof of family income level. The administration estimates that up to 5 million Californians would be eligible to enroll in California Rx.

Pharmacy Discounts. The drug discount card would be generally similar in nature to the discount cards now available from various public and private programs including, most recently, the Medicare Program. Pharmacists who voluntarily chose to participate in the program would assist qualifying individuals in applying to the state for the discount cards, and must also agree to sell prescription drugs to persons possessing such cards at an agreed-upon discount negotiated in advance on a statewide basis with the state.

Beyond not resulting in the lowest prices, the Governor's approach to establishing a pharmacy assistance program has other weaknesses and raises some policy issues. The concerns are summarized in the table below.

Figure 5

Additional LAO Issues and Concerns With California Rx

- ***Some basic accountability*** measures are lacking.
- ***Proposed timing*** for start-up of the program is problematic.
- ***Continuation of outreach*** is not assured after two years.
- ***Integration*** of multiple private and public drug discount programs into one "seamless" system will be difficult to accomplish.
- ***Proposed legislation*** exempts California Rx from competitive bidding requirements that apply to most other state agencies and programs.
- ***Proposed consumer fee*** level is high compared to other states.
- ***Budget request lacks key details*** and does not account for the "float"—the funding gap between when rebate money is paid to the state and when the state must pay pharmacies for rebates paid to consumers.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – PUBLIC HEALTH

ISSUE 2: PROPOSITION 99 FUNDING FOR EMERGENCY ROOM PHYSICIANS

For the last several years the Legislature has been appropriating $24.8 million annually to reimburse emergency and on-call physicians for the costs of providing health care to uninsured patients requiring care in the emergency room.

The following is the proposed trailer bill language.

Item 4260-111-0001 – For local assistance, Department of Health Services

3. (a) Of the funds appropriated in this item, twenty-four million eight hundred three thousand dollars ($24,803,000) shall be allocated in accordance with subdivision (b) for the 2005−06 fiscal year from the following accounts:
(1) Twenty million two hundred twenty-seven thousand dollars ($20,227,000) from the Hospital Services Account.
(2) Four million five hundred seventy-six thousand dollars ($4,576,000) from the Physician Services Account.

(b) The funds specified in subdivision (a) shall be allocated proportionately as follows:
(1) Twenty-two million three hundred twenty-four thousand dollars ($22,324,000) shall be administered and allocated for distribution through the California Healthcare for Indigents Program (CHIP), Chapter 5 (commencing with Section 16940) of Part 4.7 of Division 9 of the Welfare and Institutions Code.
(2) Two million four hundred seventy-nine thousand dollars ($2,479,000) shall be administered and allocated through the rural health services program, Chapter 4 (commencing with Section 16930) of Part 4.7 of Division 9 of the Welfare and Institutions Code.

(c) Funds allocated by this section from the Physician Services Account and the Hospital Services Account in the Cigarette and Tobacco Products Surtax Fund shall be used only for the reimbursement of physicians for losses incurred in providing uncompensated emergency services in general acute care hospitals providing basic, comprehensive, or standby emergency services, as defined in Section 16953 of the Welfare and Institutions Code. Funds shall be transferred to the Physician Services Account in the county Emergency Medical Services Fund established pursuant to Sections 16951 and 16952 of the Welfare and Institutions Code, and shall be paid only to physicians who directly provide emergency medical services to patients, based on claims submitted or a subsequent reconciliation of claims. Payments shall be made as provided in Sections 16951 through 16959 of the Welfare and Institutions Code, and payments shall be made on an equitable basis, without preference to any particular physician or group of physicians.

If a County has an EMS Fund Advisory Committee which includes both emergency physicians and emergency department on-call back-up panel physicians, and if this committee unanimously approves: the administrator of the EMS Fund may create a special fee schedule and claims submission criteria for reimbursement for services rendered to uninsured trauma patients; provided that no more than 15% of the tobacco tax revenues allocated to the County's

EMS Fund be distributed through this special fee schedule, and that all providers who render trauma services are entitled to submit claims for reimbursement under this special fee schedule, and that no provider's claim be initially reimbursed at greater than 50% of losses under this special fee schedule

~~(d) Funds allocated by this section from the Hospital Services Account in the Cigarette and Tobacco Products Surtax Fund shall be used only for reimbursement of uncompensated emergency services, as defined in Section 16953 of the Welfare and Institutions Code, provided in general acute care hospitals providing basic, comprehensive, or standby emergency services. Reimbursement for emergency services shall be consistent with Section 16952 of the Welfare and Institutions Code.~~ [This subdivision is not necessary, as allocations from the Hospital Services Account are already covered in (c) above.]

ISSUE 3: STEVEN M THOMPSON PHYSICIAN CORPS LOAN REPAYMENT PROGRAM

The Steven M. Thompson Physician Corps Loan Repayment Program, operated by the Medical Board of California, is used to repay student loans for physicians and surgeons practicing in medically underserved communities.

Existing law creates the Medically Underserved Account for the purposes of the program. The fund consists of private donations and transfers from the Contingent Fund of the Medical Board which is supported by fees. The total amount of the transfers from the Contingent Fund to the Medically Underserved Account is $3.450 million ($1.150 million annually for three consecutive years which began in 2003). As such, the last transfer occurs in 2005-06.

ITEM 4270 CALIFORNIA MEDICAL ASSISTANCE COMMISSION

ISSUE 1: REIMBURSEMENTS OF CALIFORNIA MEDICAL ASSISTANCE COMMISSIONERS

The May Revision proposes that Item 4270-001-0001 be decreased by $172,000 and be amended by decreasing reimbursements by $171,000 to reflect changing the California Medical Assistance Commissioner's compensation to $50,000 per year, instead of being tied to the compensation paid to state legislators. Trailer bill language is below.

California Medical Assistance Commission Salaries

Welfare and Institutions Code

14165.8. The commission shall be reimbursed at the annual salary of ~~members of the Legislature~~ $50,000. The commission shall set the salary of the executive director and other staff consistent with funds appropriated. The annual compensation provided by this section shall be increased in any fiscal year in which a general salary increase is provided for state employees. The amount of the increase provided by this section shall be comparable to, but shall not exceed, the percentage of general salary increases provided for state employees during that fiscal year.

ITEM 4280 MANAGED RISK MEDICAL INSURANCE BOARD

ISSUE 1: HEALTHY FAMILIES MAY CASELOAD REVISION (ISSUE 170)

The May Revision proposes that Item 4280-101-0001 be increased by $15,346,000, Item 4280-102-0001 be increased by $1,135,000, Item 4280-101-0890 be increased by $29,336,000, Item 4280-102-0890 be increased by $1,959,000 and reimbursements be increased by $77,000. It is also requested that Item 4280-104-0890 be increased by $102,000 and that Item 4280-104-0236 be amended to reflect this change. These adjustments represent changes in anticipated caseload within the Healthy Families Program.

ISSUE 2: HEALTHY FAMILIES PROGRAM HEALTH PLAN RATE INCREASE (ISSUE 144)

The May Revision proposes that Item 4280-101-0001 be increased by $5,106,000 and Item 4280-101-0890 be increased by $9,042,000 to reflect an average 2.9 percent rate increase provided to Healthy Families Program plans.

ISSUE 3: AIM MAY ESTIMATE (ISSUE 171)

The May Revision requests for Proposition 99 funds are included in a consolidated Finance Letter addressing the statewide allocation of Proposition 99 funds.

ITEM 4280 MANAGED RISK MEDICAL INSURANCE BOARD

ISSUE 4: AIM RATE INCREASE (ISSUE 145)

It is requested that Item 4280-101-0001 be increased by $2,233,000 and Item 4280-101-0890 be increased by $4,146,000 to reflect an average 7.2 percent rate increase for pregnant women, an average 1.6 percent rate increase for infants up to one year of age, and an average 3.9 percent rate increase for infants from one year to two years of age.

ISSUE 5: CHIM MAY ESTIMATE (ISSUE 172)

The May Revision proposes that Item 4280-103-3055 be decreased by $350,000 and Item 4280-103-0890 be decreased by $650,000 as a result of adjustments in the estimated funding that counties will provide for the CHIM program.

MEDICARE PART D BENEFIT

As in the 2005-06 Governor's Budget, the May Revision continues to assume that Medicare will be responsible for all drug coverage for dual eligibles effective January 1, 2006, and no

Medi-Cal drug benefit will be available to any Medi-Cal beneficiary enrolled in Medicare (except for limited specific instances. In response to additional information becoming available regarding the new Medicare Part D benefit and its impact on the state, the Department of Finance (Finance) submits the following requests for changes to the 2005-06 Governor's Budget proposal:

ISSUE 1: COVERAGE OF MEDICARE PART D EXCLUDED DRUGS FOR DUAL ELIGIBLES (ISSUE 152)

The May Revision proposes that Items 4260-101-0001 and 4260-101-0890 each be increased by $46,794,000 to cover categories of drugs currently covered by Medi-Cal that will not be covered under Medicare Part D. These categories include weight loss drugs, barbiturates, benzodiazepines, over-the-counter drugs, and various medical supplies.

ISSUE 2: OUTREACH ACTIVITIES FOR MEDICARE PART D (ISSUE 153)

The May Revision proposes that Item 4260-101-0001 be increased by $1,564,000 and Item 4260-101-0890 be increased by $2,304,000 to fund outreach activities related to the implementation of Medicare Part D. The outreach activities will include mailings to beneficiaries and provider outreach through the Medi-Cal fiscal intermediary.

MEDICARE PART D BENEFIT

ISSUE 3: MANAGED CARE CAPITATION RATE SAVINGS

It is requested that Items 4260-101-0001 and 4260-101-0890 each be reduced by $57,609,000 to reflect savings associated with lower managed care capitation payments for managed care plans since dual eligible enrollees will receive drugs under Medicare Part D.

ISSUE 4: IMPACT OF MEDICARE PART D REFORM – HEADQUARTERS (ISSUE 290)

The May Revision proposes that Item 4440-001-0001 be increased by $69,000 to provide the Department of Mental Health (DMH) headquarters with limited-term resources for implementation of Medicare Part D. Specifically, this reflects resources for 1.0 two-year limited-term Associate Governmental Program Analyst position (0.8 personnel years), effective September 1, 2005.

ISSUE 5: IMPACT OF MEDICARE PART D REFORMS – STATE HOSPITALS (ISSUE 290)

The May Revision proposes that Item 4440-011-0001 be increased by $500,000 and increase Reimbursements by $306,000 to implement Medicare Part D in the state hospitals. This request reflects $371,000 and 9.0 two-year limited-term positions (7.0 personnel years) such as Accounting, Pharmacy, Program, and Health Records Technicians and Staff Services Analysts, effective September 1, 2005; $25,000 one-time for computer workstations and software, $194,000 one-time for consultant services to assist in policy and procedure development and software compatibility issues, $150,000 one-time for billing software, and $66,000 for prescription drug co-payments for low-income eligibles.

MEDICARE PART D BENEFIT

ISSUE 6: IMPACT OF MEDICARE PART D REFORMS TO SAN MATEO PHARMACY AND LABORATORY (ISSUE 292)

The May Revision Proposes that Item 4440-101-0001 be amended by decreasing Reimbursements by $672,000 from the Department of Health Services (DHS) to reflect the estimated Medi-Cal savings in the program due to the Medicare Part D benefit. Of this amount, $335,000 is General Fund in the Department of Health Services budget.

ISSUE 7: IMPACT OF MEDICARE PART D – HEADQUARTERS (ISSUE 110)

The May Revision proposes that Item 4300-001-0001 be increased by $1,199,000 and decrease Reimbursements by $200,000 to provide the Department of Developmental Services (DDS) headquarters with limited-term resources for implementation of Medicare Part D. Specifically, this proposal is for $224,000 and 2.0 two-year limited term positions (1.9 personnel years), 1.0 Pharmacy Services Manager and 1.0 Senior Programmer Analyst (Specialist), effective July 1, 2005; $775,000 one-time for an information technology consultant contract and software purchase, and $200,000 to backfill for lost Medicaid reimbursements for administrative costs.

ISSUE 8: IMPACT OF MEDICARE PART D – DEVELOPMENTAL CENTERS (ISSUE 102)

The May Revision proposes that Item 4300-003-0001 be increased by $1,204,000 to implement Medicare Part D in the developmental centers. This request will provide $586,000 and 11.5 positions, including Accounting, Pharmacy, Program, and Health Records Technicians, effective January 1, 2006; $578,000 one-time for computer workstations, billing software, and consultant services to review existing pharmacy and physician systems, and $40,000 in other operating expenses.

MEDICARE PART D BENEFIT

ISSUE 9: IMPACT OF MEDICARE PART D – REGIONAL CENTERS (ISSUE 201)

It is requested that Item 4300-101-0001 be increased by $9,320,000 to implement Medicare Part D in the regional centers. Specifically, this proposal reflects $4,866,000 one-time for regional centers to contract with enrollment brokers for assistance to consumers in enrollment and appeals and with physicians and clinical pharmacists for enhanced medication review and consultation. This also reflects $4,454,000 one-time for purchase of consumers' medications that may not be initially covered by Medicare.

Budget Bill language in Item 4300-001-0001:

Provision: X. The State Department of Developmental Services shall provide to the Legislature, by May 1, 2006, expenditure data for costs of drugs purchased by regional centers between January 1, 2006 and March 31, 2006, for regional center consumers eligible for the Medicare Part D drug benefit.

ISSUE 10: SECRETARY FOR HEALTH AND HUMAN SERVICES MEDICARE PART D OVERSIGHT (ISSUE 100)

The May Revision proposes that Item 0530-001-0001 be increased by $100,000. This request is to provide the Health and Human Services Agency with 1.0 two-year limited-term Career Executive Assignment (CEA I) to provide oversight and coordination concerning the implementation of Medicare Part D. This position will serve as the central repository for all Medicare Part D information and will assure consistent implementation within the Health and Human Services Agency.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES

ISSUE 1: MEDI-CAL TO HEALTHY FAMILIES ACCELERATED ENROLLMENT

County Welfare Departments encounter children who are either not eligible for Medi-Cal or would have a high share-of-cost in Medi-Cal but would most likely be eligible for enrollment into the HFP. The counties are unable to enroll these children into the Healthy Families Program because they do not have the authority to do so. As a consequence, the children often wait between 4 to 8 weeks for a formal eligibility determination by the Healthy Families Program.

To address the issue, a proposal has been developed to create a Medi-Cal to Healthy Families Program accelerated enrollment program which would authorize counties to temporarily enroll children into a no-cost Medi-Cal Program if a county deems they are eligible for the Healthy Families Program. The temporary enrollment period would be up to 60 days during which the Healthy Families Program is conducting the formal determination of the child's eligibility for that program. During the determination period the state could receive the S-CHIP federal matching rate of 65 percent, versus the Medi-Cal federal matching rate of 50 percent. Temporary enrollment into Medi-Cal would enable the child to receive necessary services immediate. Such a Medi-Cal to Healthy Families Program accelerated enrollment would fill-in a service gap.

The Legislature has adopted several measures over the last few years to create a seamless system of health care coverage for children where they could easily move between the Medi-Cal and Healthy Families Programs.

The following are the assumptions of the proposal:

- ✓ The child or parent or guardian has submitted a Medi-Cal application directly to the county;
- ✓ The child is newly eligible for full-scope Medi-Cal services and has been determined to have a share-of-cost;
- ✓ The child is under 19 years of age and has a family income at or below 250 percent of the federal poverty level; and
- ✓ The child or parent or guardian has given consent for the application to be forwarded to the Healthy Families Program.

The temporary benefits the children would enjoy:

- ✓ Federal S-CHIP Funds (65 percent federal match) would be available for this purpose;
- ✓ Temporary health benefits would be effective on the first of the month in which the county found that a child met the specified criteria. The temporary health benefits would terminate at the end of the month in which the child was discontinued from the Medi-Cal Eligibility Data System (MEDS) due to the full enrollment in or ineligibility for Healthy Families Program; and
- ✓ Temporary health benefits would be identical to the benefits provided to children who received full-scope Medi-Cal benefits without a share-of-cost.

Based on technical assistance provided the Senate by the DHS Fiscal Forecasting Office, it is assumed that 87,456 children would be eligible for 60-days worth of health care coverage in Medi-Cal fee-for-service, pending their application approval at the Healthy Families Program. Assuming a January 1, 2006 implementation date the estimated expenditures for 2005-06 would be:

- ✓ Total for administration and health care benefits =$3.4 million ($1.2 million GF)
- ✓ Health care benefits component =$3.0 million ($1.1 million GF)
- ✓ County administration =$366,000 ($128,000 GF)
- ✓ Annualized expenditures are estimated to be $10.2 million ($3.6 million GF)

Proposal:

- ✓ Increase the Medi-Cal Program by $3.4 million ($1.2 million General Fund) to reflect funding for health care benefits and eligibility administration; and
- ✓ Adopt place holder trailer bill legislation to implement the proposal, including to limit the benefit to 60-days, allowable only with federal S-CHIP funding being available and other related technical aspects to be worked out with the DHS regarding Medi-Cal processing.

ITEM 4300 DEPARTMENT OF DEVELOPMENTAL SERVICES

ISSUE 1: STATEWIDE PURCHASE OF SERVICES STANDARDS

The budget proposal for 2005-2006 provides the Department of Developmental Services the authority for issuing statewide purchase of services standards for all services for which the Regional Centers purchase for clients in the System. Statewide Purchase of Services Standards have been proposed for the last three years. Each year the Legislature has rejected them. If adopted the standards are projected to save $14 million, $10.5 million General Fund, in the 2005-2006 fiscal year.

In addition to denying the imposition of Statewide Purchase of Services Standards the State Operations funding that accompanied the Local Assistance Funding should be rejected. The savings will be $6,229,000 million General Fund

ISSUE 2: COST CONTAINMENT MEASURES (ISSUE 213)

It is requested that Item 4300-101-0001 be decreased by $29,000 and Reimbursements be increased by $115,000. The Governor's Budget included the fiscal impact of implementing cost containment strategies for the purchase of services, including funding for regional centers operations and savings in the purchase of services budget. This technical adjustment updates the estimated net savings from those cost containment strategies due to a projected decline in the regional center caseload.

ISSUE 3: EMPLOYMENT SERVICES FUNDING

The California Rehabilitation Association states that the only programs that suffered rate reductions in the past two budgets were employment programs. The affected programs are those that enable people with disabilities to work, earn wages, pay taxes and become more independent. The Association requests the five percent Work Activity Program rate reduction and the two-one-half percent Supported Employment Program rate reduction be restored. The Department estimates the restorations for a full year would increase expenditures $4.664 million Total Funds, $3.592 million General Fund.

The Department of Finance is checking with the Department of Rehabilitation for the budgetary effects.

ISSUE 4: REGIONAL CENTERS ESTIMATE (ISSUE 200)

It is requested that Item 4300-101-0001 be reduced by $89,223,000 and Reimbursements be increased by $35,033,000. It is further requested that Item 4300-101-0890 be increased by $654,000. These changes are comprised of the following adjustments:

- Regional centers operations will increase by a net $189,000 due to updated caseload data.
- Regional centers purchase of services will decrease by a net $53,725,000 based on updated base, caseload, utilization, and expenditure data.

ISSUE 5: COMPLIANCE WITH THE HOME AND COMMUNITY-BASED SERVICES WAIVER (ISSUE 209)

It is requested that Item 4300-101-0001 be decreased by $1,755,000 and Reimbursements be increased by $11,424,000. The Governor's Budget proposed to augment regional centers operations by $10,559,000 General Fund to improve case management ratios for compliance with the HCBSW. That request is being updated due to the recognition that the proposed regional center positions would be eligible for increased FFP from HCBSW Administration, Medicaid Administration, and Targeted Case Management. Due to the increased FFP, General Fund need is reduced by $1.8 million, and the total proposed augmentation increases by $9.7 million to $20.2 million.

ITEM 4440 DEPARTMENT OF MENTAL HEALTH

ISSUE 1: PROPOSITION 63 IMPLEMENTATION

The Department of Finance submitted a letter requesting the implementation of Proposition 63, the Mental Health Services Act which became effective on January 1, 2005. The initiative established a state personal income tax surcharge on the one percent of taxpayers with an annual taxable income of more than $1.0 million. The funds from the surcharge are deposited into the new state Mental Health Services Fund and will be used for state and county planning and implementation consistent with the Act's provisions. The Act provides for the expansion of mental health services and includes specific provisions related to education and training of the mental health workforce, development of innovative programs and integrated plans for prevention, intervention, and system of care services, investment in capital facilities and technology needs and enhanced oversight and accountability.

The estimated revenues in the Fund in the current fiscal year will total $254 million and $683 million in the budget year. While most of the revenues will be available to county mental health programs, the Act authorizes up to five percent of the revenues in the Fund annually for state administration. Funding available for state administration is projected to $12.7 million in the current fiscal year and $34.2 million in the budget year.

The Act provides a continuous appropriation from the Fund for state and county expenditures; the Administration proposes to establish in-lieu appropriations for state administrative costs during the first several years of implementation.

The Finance Letter request the position authority be increased by 109.0 positions, including 20.0 positions effective January 2006. The positions include 55.0 permanent positions and 54.0 three-year limited term positions. The proposed resources will enable the Department of Mental Health to provide leadership and oversight to county mental health departments in the development of education and training programs, capital facilities and technology, prevention and early intervention programs and Children's System of Care and Adult and Older Adult System of Care Programs, consistent with the Act's provisions. The request includes $6.151 million for contracts in variety of areas, including but not limited to, the stakeholder input process, policy design, outreach and training, data support and information technology support.

The Finance Letter also proposes budget bill language be added to provide and in-lieu appropriation for the Department of Mental Health's administrative cost. Also, the Finance Letter proposes provisional language is requested to allow the Director of Finance to increase the funding no sooner than 30 days after providing the specified legislative notification. The flexibility is to accommodate additional Department of Mental Health needs that may be identified as the department progresses in its planning efforts.

For the current year the Department of Mental Health spend $4.991 million from the continuous appropriation for immediate planning and implementation efforts. This includes $3.271 million for various contracts. The Administration has also approved administrative establishment of 20.0 positions effective February 1, 2005 and an additional 31.0 positions effective April 1, 2005.

The Legislative Analyst Office has proposed an alternative to the plan proposed by the Administration. The proposal is as follows:

1) Approve the proposed reduction in DMH positions and dollars identified on the attached spreadsheet.

2) Approve an increase in oversight commission positions and dollars, modified to include minor technical adjustments on the dollar amounts calculated by DMH, and as shown on the attached spreadsheet.

3) Limit all limited term positions to two years, instead of the proposal for three years, for all departments with Prop. 63 requests. DADP, DHS and DOE would also be affected by this recommendation.

4) Recognize $1 million in General Fund revenues in 2005-06 to reflect the initial results of the expansion of audit activity made possible with some of the new positions.

5) Adopt Budget Bill language, modified for the appropriation level, as proposed by the administration.

6) Adopt placeholder trailer bill language to provide information to the Legislature in the future about local assistance expenditures of Prop. 63 funding.

In addition the Department proposes in a Finance Letter the following Budget Bill Language:

4440-001-3085—For Support of Department of Mental Health, for payment to Item 4440-001-0001, payable from the Mental Health Services Fund

Provisions:

1. *Funds appropriate in this item are in lieu of the amounts that otherwise would have been appropriate for administration pursuant to Section 5892(d) of the Welfare and Institutions Code.*

2. *Notwithstanding any other provision of law, the Director of Finance may increase the funding provided in this item to further the implementation of Mental Health Services Act. Any increase would occur no sooner than 30 days after written notification has been provided to the chairperson of the committee in each house of the Legislature that considers appropriations, the chairpersons of the committees, and the appropriate subcommittees, in each house that considers the State Budget, and the Chairperson of the Joint Legislative Budget Committee identifying the need for such increase and the expenditure plan for the additional funds.*

LAO analysis of DMH Proposition 63 budget request — Summary - *Including DMH Proposed Adjustments*

Version: 4/21/05 Revised 5/04/05 Revised 5/5/05

UNIT Classification	*Prop 63 BCP (positions)*	*LAO position adjustments to Prop 63 BCP*	*Fiscal effect of adjustment proposed by LAO*	*LAO rationale (see footnotes below)*	*DMH position adjustment to Prop 63 BCP*	*Fiscal effect of adjustment proposed by DMH*
Directors Office						
350 Mental Health Planning Council:						
Assoc Mental Hlth Spec	2	0	$0	(a)	0	$0
550 Mental Health Services Oversight & Acct. Comm						
Staff Mental Hlth Spec	2	1	$94,369	(b)	1	$93,340
Assoc Mental Hlth Spec	1	2	$171,794	(b)	2	$169,921
Program Compliance (Prop 63 pos eff 1/1/06)						
610 Licensing and Certification:						
Staff Mental Health Spec (1 Prop 63 pos eff 7/05)	3	-2	-$94,369	(e)	-2	-$93,340
Assoc Mental Health Spec	3	-3	-$128,845	(c) (e)	-3	-$127,441
Office Techn-Typing	1	-1	-$26,222	(e)	-1	-$25,936
632 Medi-Cal Oversight - South:						
Staff Mental Health Spec	1	-1	-$47,185	(c) (d)	-1	-$46,670
Assoc Mental Health Spec	1	-1	-$42,948	(c) (d)	-1	-$42,480
640 Audits:						
Supvng Govtl Auditor II						
Gen Auditor III	4	0	$0	(c) (f)	0	
Gen Auditor II	2	0	$0	(c) (f)	0	
Systems of Care						
734 County Operations-North/Bay:						
Assoc Mental Health Spec	2	-1	-$85,897	(c)	0	
735 County Operations-South/Central:						
Assoc Mental Health Spec	2	-1	-$85,897	(c) (g)	0	
737 Children and Family Program Policy:						
Staff Mental Health Spec	3	0			-1	-$93,340
Assoc Mental Health Spec	3	-1	-$85,897	(c) (d) (g)	-1	-$84,961
751 Statistics and Data Analysis:						
Research Analyst II-Soc/Behavioral	3	-1	-$90,180	(c)	0	
755 Epidemiology, Allocation & Support:						
Research Manager II	1	0			-1	-$107,700
Research Program Spec II	2	0			-1	-$102,508
Research Analyst II-Soc/Behavioral	3	-1	-$90,180	(e)	-3	-$267,592
752 Perf Outcomes & Quality Improve:						
Research Prog Spec I-Soc/Behavioral	2	-1	-$94,369	(c)	0	
Administrative Services						
912 Personnel:						
Pers Svcs Spec I	1	-1	-$50,795	(c)	0	
Office Techn-Typing	1	-1	-$52,444	(c)	-1	-$51,872
913 Business Services:						
Business Services Assistant	1	0			-1	-$98,083

933 Accounting:						
Acctg Techn	1	-1	-$51,515	(c)	-1	-$50,954
950 Information Technology:						
Staff Programmer Analyst - Spec	2	-2	-$197,760	(c)	-1	-$97,802
Total proposed adjustments		-16	-$958,342		-16	-$1,027,419

Footnotes:

(a) Position was vacant 4/7 but has since been filled.

(b) Insufficient staff resources available for independent review of county plans.

(c) Workload could be handled by filling existing vacancies.

(d) AB 3632 workload largely unrelated to Prop 63. Also, the administration is proposing to suspend AB 3632.

(e) Request premature; workload increase not yet demonstrated.

(f) Productivity of existing auditing staff not yet documented.

(g) Position reduction adjusted to reflect vacancies caused by recent shift of staff into new administratively established Prop 63 positions.

(h) Vacancy count excludes 20 additional positions established administratively for Prop. 63 implementation, nine of which had been filled as of 4/7.

ITEM 4440 DEPARTMENT OF MENTAL HEALTH

ISSUE 2: CHRONIC HOMELESSNESS INITIATIVE (ISSUE 502)

It is requested that Item 4440-001-0001 be increased by $2.3 million and amended by increasing Item 4440-001-3085 by $2.3 million. This funding, when combined with $100,000 in Proposition 63 funds previously requested in the April Finance letter for this purpose, will provide $2.4 million on a one-time basis for the Governor's Chronic Homelessness Initiative. These funds would be available for expenditure for two years and would be used for rent subsidies ($2.0 million) and to establish collaboratives ($400,000) at the local level to assist counties in developing projects to promote stable housing for homeless persons. It is also requested that provisional language be added to Item 4440-001-3085 consistent with this request (Attachment IV).

Proposed Provisional Language for Item 4440-001-3085

Related to:

Implementation of Proposition 63, Mental Health Services Act—Issue 600 &
Proposition 63 Contribution to Governor's Initiative to End Chronic Homelessness—Issue 502

X. Notwithstanding Government Code Section 19080.3, 54 positions are established for a three-year limited term expiring June 30, 2008 for the purpose of implementing the Mental Health Services Act.

*X. Of the funds appropriated in this item, $2,400,000 is one-time funding for rent subsidies and collaborative efforts to promote stable housing for homeless persons. These funds will be used for the Governor's Initiative to End Chronic Homelessness. These funds are available for expenditure in 2005-06 and 2006-*07.

ISSUE 3: EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT PROGRAM - FUNDING ADJUSTMENTS

The budget proposes a decrease of $29.164 million in local assistance reimbursements from the Department of Health Services in the current year to reflect adjustments from updated paid claims information to the funding level for the Early and Periodic Screening, Diagnosis and Treatment Program. In addition, the budget proposes an increase in the budget year of $47.487 million to reflect additional program costs. This includes a State General Fund (SGF) increase of $27,232,000 and an increase of $20,255,000 in Federal Financial Participation (FFP). The increase also reflects a slowdown in the rate of growth of the program, which reflects for a total savings for the General Fund of $15.8 million, and a reduction in Federal Funds of $13.35 million.

ISSUE 4: EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT PROGRAM CASELOAD – ISSUE 240

It is requested that Item 4440-101-0001 be amended by decreasing reimbursements by $117,913,000 ($55,671,000 General Fund and $62,242,000 federal funds in the DHS budget) to reflect a lower projection of claimed costs for the Early and Periodic Screening Diagnosis and Treatment program (EPSDT).

ISSUE 5: FINAL SETTLEMENT OF FISCAL YEAR 2002-2003 EPSDT COUNTY COST REPORTS – ISSUE 241

It is requested that Item 4440-101-0001 be amended by increasing reimbursements by $139,357,000 ($67,672,000 General Fund and $71,685,000 federal funds in the DHS budget) to pay counties for final settlement of fiscal year 2002-03 EPSDT cost reports.

ITEM PROPOSITION 99

As compared to the 2005-06 Governor's Budget expenditure plan, the amendments noted above and displayed in Attachment B would result in a net reduction of $1,000 General Fund and a net increase of $38,187,000 Proposition 99 funds for the budget year, as follows:

- +$3,000,000 Health Education Account
- +$17,432,000 Hospital Services Account
- +$11,835,000 Physician Services Account
- +$5,920,000 Unallocated Account

ISSUE 1: AMEND PROPOSITION 99 – MAXIMIZE FEDERAL FINANCIAL PARTICIPATION

It is requested that the Legislature adopt policy legislation to amend Proposition 99 to authorize the state to use Proposition 99 funds to draw down federal financial participation (FFP). Similar to Proposition 99 amendments enacted by the Legislature in the past, this legislation requires approval by a 4/5 vote. The Governor's Budget proposed shifting Access for Infants and Mothers Program (AIM) from Proposition 99 to General Fund to achieve this FFP. However, this policy legislation would allow the state to draw down additional FFP while funding the AIM program using Proposition 99 funds, rather than General Fund

ISSUE 2: MANAGED RISK MEDICAL INSURANCE FUND PROPOSITION 99 FUNDING (ISSUE 149)

Historically, $40.0 million Proposition 99 funds have been transferred to the MRMIB to support the Major Risk Medical Insurance Program. As a result of the program recovering prior-year overpayments to participating health insurance plans, the fund has built up a sizeable reserve of $20.0 million. On a one-time basis, the May Revision proposes to transfer only $20.0 million to the MRMIF for fiscal year 2005-06 and redirect $20.0 million of Proposition 99 funds to fund other one-time expenditures. As a result, it is requested that Item 4280-112-0232 be reduced by $6,393,000 transfer authority and Item 4280-112-0233 be reduced by $3,607,000 transfer authority. Trailer Bill language included in Attachment A would to reduce the amount of transfer required by Section 12739 of the Insurance Code by $10.0 million.

ISSUE 3: AIM AND MOTHERS MAY ESTIMATE (ISSUE 171)

It is requested that Item 4280-101-0001 be decreased by $29,649,000, Item 4280-101-0890 be increased by $6,818,000, Item 4280-111-0232 be increased by $23,603,000 transfer authority, and Item 4280-111-0233 be increased by $7,185,000 transfer authority, as a result of the caseload increases and the decision to fund AIM with Proposition 99 funds.

ISSUE 4: HEALTHY FAMILIES PROGRAM CONSUMER (ISSUE 175)

It is requested that Item 4280-101-0236 be increased by $175,000, Item 4280-101-0890 be increased by $325,000, and Item 4280-101-0001 be amended to fund a Healthy Families Program (HFP) Consumer Assessment, which will examine access to hospital and physician services for low-income children served through the HFP. This assessment would assist California in complying with federal monitoring requirements.

ISSUE 5: DEPARTMENT OF MENTAL HEALTH STATE HOSPITAL POPULATION GROWTH

It is requested that Item 4440-011-0232 be reduced by $20,491,000 and Item 4440-001-0001 be increased by that amount to shift costs of state hospital population growth to the General Fund in the budget year.

The shift from Proposition 99 funding to the General Fund is also proposed in the current year. Specifically, the proposal is to shift $16,724,000 in state hospital cost to the General Fund. This shift will increase the Department of Mental Health's deficiency request. This issue is further discussed in a separate May Revision letter revising the Administration's request for a supplemental appropriation for state hospital population costs in the current year.

ISSUE 6: DEPARTMENT OF HEALTH SERVICES EVERY WOMAN COUNTS PROGRAM CASELOAD INCREASE

It is requested that Item 4260-111-0236 be increased by $1,139,000 and Item 4260-111-0001 be amended to reflect this change. This augmentation is necessary to support increased caseload in the Every Woman Counts Program.

ISSUE 7: NEWLY QUALIFIED ALIENS

It is requested that Item 4260-101-0232 be reduced by $5,206,000, Item 4260-101-0233 be reduced by $7,185,000, Item 4260-101-0236 be reduced by $20,402,000, and Item 4260-101-0001 be increased by $32,793,000. This action would shift funding for the Newly Qualified Aliens Program from Proposition 99 to the General Fund. The Newly Qualified Aliens Program is an on-going program. As such, funding this program with General Fund, rather than Proposition 99 funds, is consistent with the Administration's proposal to use the increased Proposition 99 resources for one-time expenditures.

ISSUE 8: ORTHOPAEDIC HOSPITAL

It is requested that Item 4260-101-0232 be increased by $5,823,000, Item 4260-101-0233 be increased by $20,008,000, and Item 4260-101-0001 be reduced by $25,831,000. This shift would result in General Fund savings and would maintain payments for the Orthopaedic Hospital Settlement.

ISSUE 9: COMPETITIVE ACTION GRANTS (ISSUE 472)

It is requested that Item 4260-111-0231 be increased by $2,600,000, Item 4260-111-0236 be increased by $1,000,000, and Item 4260-111-0001 be amended to reflect this change. This augmentation would provide additional funding for the Tobacco Control Section's Competitive Grant Program. This program funds a variety of local, regional, statewide and pilot projects that seek to educate Californians about the dangers of tobacco use.

It is requested that Item 4260-001-0231 be increased by $400,000 and Item 4260-001-0001 be amended to reflect this change. This augmentation would allow the Department of Health Services to evaluate the competitive grant programs and projects and to provide funds to upgrade the online tobacco information system. Expenditure of the funding for the information system will require the approval of a feasibility study report.

ISSUE 10: CALIFORNIA HEALTHCARE FOR INDIGENTS PROGRAM (ISSUE 482)

It is requested that Item 4260-111-0232 be increased by $12,332,000, Item 4260-111-0233 be increased by $10,652,000, and Item 4260-111-0001 be amended to reflect this change. This augmentation would provide additional funding for the California Healthcare for Indigents Program, which provides funds to large counties to reimburse private physicians, emergency physicians, and hospitals for uncompensated care.

ISSUE 11: RURAL HEALTH SERVICES PROGRAM (ISSUE 483)

t is requested that Item 4260-111-0232 be increased by $1,371,000, Item 4260-111-0233 be increased by $1,183,000, and Item 4260-111-0001 be amended to reflect this change. This augmentation would provide additional funding for the Rural Health Services program, which provides funds to small counties to reimburse private physicians, emergency physicians, and hospitals for uncompensated care.

ISSUE12: ASTHMA PUBLIC HEALTH INITIATIVE

It is requested that Item 4260-001-0236 be increased by $4,000,000 and Item 4260-001-0001 be amended to reflect this change. This augmentation would provide additional funding for the Asthma Public Health Initiative, which seeks to improve the quality of life for all children and adults with asthma through implementation of effective programs and policies in asthma education, management, and prevention.