

**MEDI-CAL
MAY 2006
LOCAL ASSISTANCE ESTIMATE
for
FISCAL YEARS
2005-06 and 2006-07**

Fiscal Forecasting and Data Management Branch
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**REGULAR
POLICY CHANGES**

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Director
Department of Health Services

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FAMILY PLANNING INITIATIVE

REGULAR POLICY CHANGE NUMBER: 1
 IMPLEMENTATION DATE: 1/1997
 ANALYST: Cheri Johnson
 FISCAL REFERENCE NUMBER: 1

| | FY 2005-06 | FY 2006-07 |
|------------------------------|---------------|---------------|
| FULL YEAR COST - TOTAL FUNDS | \$428,287,000 | \$457,301,000 |
| - STATE FUNDS | \$126,019,300 | \$148,956,600 |
| | | |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| | | |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$428,287,000 | \$457,301,000 |
| STATE FUNDS | \$126,019,300 | \$148,956,600 |
| FEDERAL FUNDS | \$302,267,700 | \$308,344,400 |

DESCRIPTION

Effective January 1, 1997, family planning services were expanded under the Family PACT program to provide contraceptive services to more persons in need of such services who have incomes under 200% of poverty.

A Section 1115 demonstration project waiver was approved by CMS effective December 1, 1999. Family planning services and testing for sexually transmitted infections (STIs) (about 87% of FPACT costs) are eligible for 90% FFP; treatment of STIs and other family planning companion services (about 11% of costs) are eligible for the Title XIX FMAP; and treatment of other medical conditions, including inpatient care for complications from family planning services and sterilizations* (about 2% of costs) are not eligible for FFP. Within these categories, costs for undocumented persons (assumed to be the following percentages of the Family PACT population: 13.95% in FY 2005-06 and 17.79% in FY 2006-07) are budgeted at 100% GF.

The original waiver expired on November 30, 2004. On May 27, 2004, the Department submitted an application for a three-year renewal. The renewal request is being evaluated by CMS. An extension through May 31, 2006, has been granted by CMS. Subsequent extensions will be in one-month increments.

Drug rebates for Family PACT drugs are included in the Family PACT Drug Rebate Program policy change.

FAMILY PLANNING INITIATIVE

REGULAR POLICY CHANGE NUMBER: 1

May 2006 Estimate by Service Category:

| Service Category | FY 2005-06 | | FY 2006-07 | |
|-------------------------|----------------------|----------------------|----------------------|----------------------|
| | TF | GF | TF | GF |
| Physicians | \$50,240,723 | \$14,782,830 | \$48,746,729 | \$15,878,272 |
| Other Medical | \$249,458,216 | \$73,400,585 | \$264,397,790 | \$86,122,292 |
| County Outpatient | \$3,802,386 | \$1,118,814 | \$3,918,622 | \$1,276,413 |
| Community Outpatient | \$4,409,094 | \$1,297,332 | \$4,291,309 | \$1,397,808 |
| Pharmacy | \$120,376,603 | \$35,419,612 | \$135,946,776 | \$44,281,943 |
| TOTAL | \$428,287,022 | \$126,019,173 | \$457,301,226 | \$148,956,728 |

*See Policy Change 102, Family Pact Sterilization Policy, for revision of sterilization policy.

BREAST AND CERVICAL CANCER TREATMENT

REGULAR POLICY CHANGE NUMBER: 2
 IMPLEMENTATION DATE: 1/2002
 ANALYST: Cheri Johnson
 FISCAL REFERENCE NUMBER: 3

| | FY 2005-06 | FY 2006-07 |
|------------------------------|--------------|--------------|
| FULL YEAR COST - TOTAL FUNDS | \$79,403,000 | \$83,895,000 |
| - STATE FUNDS | \$32,201,300 | \$35,003,950 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$79,403,000 | \$83,895,000 |
| STATE FUNDS | \$32,201,300 | \$35,003,950 |
| FEDERAL FUNDS | \$47,201,700 | \$48,891,050 |

DESCRIPTION

The Budget Act of 2001 (Ch. 106/2001) authorized the Breast and Cervical Cancer Treatment Program (BCCTP) effective January 1, 2002, for women under 200% of the FPL.

Title XIX Medicaid funds (65%FFP/35%GF) may be claimed under the federal Medicaid Breast and Cervical Cancer Treatment Act of 2000 (P.L. 106-354) for cancer treatment and full scope Medi-Cal benefits for women under age 65 who are citizens or legal immigrants with no other health coverage.

A State-Only program covers women aged 65 or older, women with inadequate health coverage, undocumented women, and males for cancer treatment only. The coverage term is 18 months for breast cancer and 2 years for cervical cancer. Estimated State-Only costs include undocumented persons' nonemergency services during cancer treatment.

Beneficiaries are screened through Centers for Disease Control (CDC) and Family PACT providers.

Assumptions:

1. There were 9,471 fee-for-service (FFS) eligibles and 1,369 managed care eligibles as of March 2006 (total of 10,840). 2,393 of the FFS eligibles were eligible for State-Only services (Aid Codes 0R, 0T, 0U and 0V).
2. 3,387 of the FFS eligibles were in Accelerated Enrollment Aid Code 0N as of March 2006.
3. 245 of the FFS eligibles were in State-Only Other Health Coverage Aid Code 0R as of March 2006. Assume the State will pay Medicare and other health coverage premiums for an average of 240 0R beneficiaries monthly in FY 2005-06 and 275 0R beneficiaries monthly in FY 2006-07. Assume an average monthly premium cost per beneficiary of \$200.

FY 2005-06: 240 x \$200 x 12 months = \$576,000 (\$576,000 GF)

FY 2006-07: 275 x \$200 x 12 months = \$660,000 (\$660,000 GF)

BREAST AND CERVICAL CANCER TREATMENT

REGULAR POLICY CHANGE NUMBER: 2

4. FFS costs are estimated as follows:

| | FY 2005-06 | | FY 2006-07 | |
|------------------|---------------------|---------------------|---------------------|---------------------|
| | TF | GF | TF | GF |
| Full-Scope Costs | \$72,618,000 | \$25,416,000 | \$75,217,000 | \$26,326,000 |
| State-Only Costs | \$6,785,000 | \$6,785,000 | \$8,678,000 | \$8,678,000 |
| Services | \$6,209,000 | \$6,209,000 | \$8,018,000 | \$8,018,000 |
| Premiums | \$576,000 | \$576,000 | \$660,000 | \$660,000 |
| Total | \$79,403,000 | \$32,201,000 | \$83,895,000 | \$35,004,000 |

5. All BCCTP costs are budgeted in policy changes. BCCTP managed care costs are budgeted in managed care policy changes.
6. Federal reimbursement for State-Only BCCTP based on the certification of public expenditures is budgeted in Policy Change 101, Hosp. Financing - BCCTP, in the Policy Changes section of the estimate.

CHDP GATEWAY - PREENROLLMENT

REGULAR POLICY CHANGE NUMBER: 3
 IMPLEMENTATION DATE: 7/2003
 ANALYST: Cheri Johnson
 FISCAL REFERENCE NUMBER: 8

| | FY 2005-06 | FY 2006-07 |
|------------------------------|--------------|--------------|
| FULL YEAR COST - TOTAL FUNDS | \$17,303,000 | \$17,303,000 |
| - STATE FUNDS | \$6,056,050 | \$6,056,050 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$17,303,000 | \$17,303,000 |
| STATE FUNDS | \$6,056,050 | \$6,056,050 |
| FEDERAL FUNDS | \$11,246,950 | \$11,246,950 |

DESCRIPTION

The CHDP Gateway program was implemented July 1, 2003. Children who receive a CHDP screen are preenrolled (PE) in Medi-Cal or the Healthy Families Program (HFP). PE provides a minimum of 2 months of full-scope coverage, during which the family may apply for ongoing Medi-Cal or HFP coverage. The state-funded CHDP program continues to provide screens to children eligible for limited-scope Medi-Cal.

Assumptions:

- In 2005, 668,996 children were screened through the Gateway, Medi-Cal: 543,308 (81%), HFP: 78,447 (12%), CHDP state-only 47,241 (7%).
- 2005 average monthly PE eligibles and annual costs were:

| | | | |
|----------|--------|---------------|---------|
| Medi-Cal | 90,862 | \$114,268,000 | (50/50) |
| HFP | 13,106 | \$17,303,000 | (65/35) |

- Based on the actual recent eligibles and claims data, assume the following annual average monthly eligibles/annual costs:

| | | | |
|----------|---------|---------------|----------------------|
| * M-C PE | 90,862 | \$114,268,000 | (\$57,134,000 SF) ** |
| * HFP | 13,106 | \$17,303,000 | (\$6,056,000 GF) |
| Total | 103,968 | \$131,571,000 | (\$63,190,000 SF) |

CHDP GATEWAY - PREENROLLMENT**REGULAR POLICY CHANGE NUMBER: 3**

4. All costs for Medi-Cal Gateway PE are 100% in the base. Costs for HFP Gateway PE eligibles will never be included in the base, and are shown here:

FY 2005-06: HFP: \$17,303,000 (\$6,056,000 GF)

FY 2006-07: HFP: \$17,303,000 (\$6,056,000 GF)

5. Based on information provided by the Children's Medical Services Branch, assume that \$130,000 SF in FY 2005-06 will be Childhood Lead Poisoning Prevention (CLPP) funding.

* 4260-113 (Title XXI)

** \$130,000 SF CLPP

BRIDGE TO HFP

REGULAR POLICY CHANGE NUMBER: 4
 IMPLEMENTATION DATE: 11/1998
 ANALYST: Cheri Johnson
 FISCAL REFERENCE NUMBER: 5

| | FY 2005-06 | FY 2006-07 |
|------------------------------|-------------|-------------|
| FULL YEAR COST - TOTAL FUNDS | \$4,869,000 | \$5,217,000 |
| - STATE FUNDS | \$1,704,150 | \$1,825,950 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$4,869,000 | \$5,217,000 |
| STATE FUNDS | \$1,704,150 | \$1,825,950 |
| FEDERAL FUNDS | \$3,164,850 | \$3,391,050 |

DESCRIPTION

In order to allow time to apply for Healthy Families, AB 2780 (Chapter 310, Statutes of 1998) provides one month additional Medi-Cal eligibility as a bridge for children who become ineligible for Medi-Cal or begin to have a share-of-cost and have income between 100% and 200% of poverty.

Assumptions:

1. Based on current Medi-Cal data, the average monthly number of eligibles in FY 2005-06 will be 3,872.
2. Continuing the trend, there will be an average of 4,148 eligibles per month in FY 2006-07.
3. Based on cost data from FY 2004-05, assume the cost of benefits is \$73.77 per month for fee-for-service children and \$125.40 for children in managed care plans during FY 2005-06 and FY 2006-07.
4. There are 18,538 fee-for-service eligible-months and 27,924 managed care eligible-months in FY 2005-06.
5. There are 19,861 fee-for-service eligible-months and 29,916 managed care eligible-months in FY 2006-07.

| | | |
|-----------------|-----------------------------|--------------------|
| FY 2005-06: FFS | 18,538 x \$73.77 per mo. = | \$1,367,548 |
| Mgd Care | 27,924 x \$125.40 per mo. = | \$3,501,670 |
| Total | | \$4,869,218 |

| | | |
|-----------------|-----------------------------|--------------------|
| FY 2006-07: FFS | 19,861 x \$73.77 per mo. = | \$1,465,146 |
| Mgd Care | 29,916 x \$125.40 per mo. = | \$3,751,466 |
| Total | | \$5,216,612 |

BRIDGE TO HFP
REGULAR POLICY CHANGE NUMBER: 4

This is a Title XXI program with enhanced FFP of 65.00% in FY 2005-06 and FY 2006-07. These costs are budgeted in 4260-113-0001/0890.

FY 2005-06 \$4,869,000 x 65.00% = \$3,164,850 FFP

FY 2006-07 \$5,217,000 x 65.00% = \$3,391,050 FFP

REDETERMINATION FORM SIMPLIFICATION

REGULAR POLICY CHANGE NUMBER: 5
 IMPLEMENTATION DATE: 5/2006
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 1066

| | FY 2005-06 | FY 2006-07 |
|------------------------------|-------------|--------------|
| FULL YEAR COST - TOTAL FUNDS | \$1,339,000 | \$45,539,000 |
| - STATE FUNDS | \$669,500 | \$22,769,500 |
| PAYMENT LAG | 0.3620 | 0.8210 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$484,700 | \$37,387,500 |
| STATE FUNDS | \$242,360 | \$18,693,760 |
| FEDERAL FUNDS | \$242,360 | \$18,693,760 |

DESCRIPTION

The Medi-Cal annual redetermination form (MC 210 RV) is being revised to make it more user friendly, shorter, and easier for beneficiaries to complete. As a result of the changes, more beneficiaries who would have otherwise not completed the form and, therefore, would no longer be eligible, will now complete the annual redetermination process (RV) and maintain coverage.

Assumptions:

- Using data input from 7 CWDs, with a combined 62.6% of the statewide Medi-Cal caseload, assume that the percentage of RV approved per month is 3% of the number of eligibles.
- Based on point-in-time data for May 2005, the average Medi-Cal only monthly eligibles statewide is 3,827,826. The monthly number subject to RVs is:

$$3,827,826 \times 3\% = 115,289$$

- Assume that 2% more of the eligibles will complete the RV.

$$115,289 \times 2\% = 2,306$$

- Assume that the cost of benefits is the November 2005 Estimate current year average cost per eligible for each aid category. This results in a weighted average of benefits and dental costs per eligible in the impacted aid categories of \$193.61.
- The monthly cost of benefits for the additional eligibles who complete the redetermination process will be:

$$2,306 \times \$193.61 = \$446,465$$

REDETERMINATION FORM SIMPLIFICATION**REGULAR POLICY CHANGE NUMBER: 5**

6. Assume that the use of the revised form will have its first impact on the number of eligibles in the month of May 2006. Two months of impact in FY 2005-06 is:

FY 2005-06: $\$446,465 \times 3 (2+1) = \mathbf{\$1,339,000}$ (\$669,500 GF)

7. Assume that the monthly rate of increase due to the use of the form will continue through FY 2006-07. The FY 2006-07 cost is:

| | | |
|---|---------------------|-------------------|
| $\$446,465 \times 2$ months from FY 2005-06 x 12 months = | \$10,715,000 | |
| $\$446,465 \times 78$ (12,11,10...) = | \$34,824,000 | |
| FY 2006-07 cost of benefits | \$45,539,000 | (\$22,769,500 GF) |

BCCTP RETROACTIVE COVERAGE

REGULAR POLICY CHANGE NUMBER: 6
 IMPLEMENTATION DATE: 3/2006
 ANALYST: Cheri Johnson
 FISCAL REFERENCE NUMBER: 1030

| | FY 2005-06 | FY 2006-07 |
|------------------------------|------------|------------|
| FULL YEAR COST - TOTAL FUNDS | \$401,000 | \$802,000 |
| - STATE FUNDS | \$140,350 | \$280,700 |
| PAYMENT LAG | 0.4020 | 0.9280 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$161,200 | \$744,300 |
| STATE FUNDS | \$56,420 | \$260,490 |
| FEDERAL FUNDS | \$104,780 | \$483,770 |

DESCRIPTION

The Budget Act of 2001 (Ch. 106/2001) authorized the Breast and Cervical Cancer Treatment Program (BCCTP) effective January 1, 2002, for women under 200% of the FPL.

Title XIX Medicaid funds (65%FFP/35%GF) may be claimed under the federal Medicaid Breast and Cervical Cancer Treatment Act of 2000 (P.L. 106-354) for cancer treatment and full scope Medi-Cal benefits for women under age 65 who are citizens or legal immigrants with no other health coverage.

Due to the receipt of additional staffing, the Department has begun to process requests for the three months of retroactive BCCTP coverage prior to application for BCCTP, available under federal law for persons who met federal eligibility requirements in the months for which retroactive coverage is requested.

Assumptions:

- In FY 2005-06, 250 beneficiaries will qualify for 3 months of retroactive coverage. The breast/cervical cancer ratio is assumed to be 65%/35% (163/87), based on actual historical counts.
- Based on actual early-in-treatment claims in CY 2004, the average cost per beneficiary is estimated to be: \$1,942 for breast cancer; and \$965 for cervical cancer.

FY 2005-06: (163 claims x \$1,942) + (87 claims x \$965) = **\$401,000** (\$140,000 GF)

- In FY 2006-07, notices to all current and past BCCTP enrollees will be sent after the Internet based application is revised to include a question on retroactive coverage. BCCTP statewide retroactive coverage will then commence. Assume that the number of claims for retroactive coverage will at a minimum be twice that of FY 2005-06.

FY 2006-07: 401,000 x 2 = **\$802,000**

MEDI-CAL TO HF ACCELERATED ENROLLMENT

REGULAR POLICY CHANGE NUMBER: 7
 IMPLEMENTATION DATE: 8/2006
 ANALYST: Cheri Johnson
 FISCAL REFERENCE NUMBER: 1031

| | FY 2005-06 | FY 2006-07 |
|------------------------------|------------|-------------|
| FULL YEAR COST - TOTAL FUNDS | \$0 | \$7,370,000 |
| - STATE FUNDS | \$0 | \$2,579,500 |
| PAYMENT LAG | 1.0000 | 0.7690 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$0 | \$5,667,500 |
| STATE FUNDS | \$0 | \$1,983,640 |
| FEDERAL FUNDS | \$0 | \$3,683,900 |

DESCRIPTION

The Budget Act and Health Trailer Bill of 2005 implemented the Medi-Cal (MC) to Healthy Families Program (HFP) Accelerated Enrollment (AE) Program, which provides temporary Title XXI funded fee-for-service benefits to children with family income up to 250% of the federal poverty level who are newly determined eligible for full-scope Medi-Cal with a share of cost, while their applications are forwarded by the counties to the Single Point of Entry (SPE) for HFP eligibility determination.

Assumptions:

- The minimum cost of MC to HFP AE would be 2 months of coverage for each child. The actual months of coverage and costs could be more, depending on the time it takes to complete the application process and the number of children who are terminated due to ineligibility for HFP.
- It is assumed that 87,036 children will be referred to the SPE annually, based on the number currently found eligible for share-of-cost Medi-Cal in aid codes 37 & 83.
- The monthly cost of AE per child is assumed to be \$46.21, based on the average actual cost per child under the current Medi-Cal AE program (aid code 8E).

| | | | |
|----------|----------------------------|-------------|------------------|
| Annually | 87,036 x \$46.21 x 2 mo. = | \$8,044,000 | (\$2,815,000 GF) |
| Monthly | | \$670,000 | (\$235,000 GF) |
- The **2006-07 cost**, assuming August 1, 2006 implementation, would be:

| | | |
|----------------------|--------------------|-------------------------|
| \$670,000 x 11 mo. = | \$7,370,000 | (\$2,579,500 GF) |
|----------------------|--------------------|-------------------------|
- Costs could increase as knowledge of this program increases and families choose to maximize the coverage they can obtain for their children without paying premiums.
- The MC to HFP AE benefits will be funded through the State Children's Health Insurance Program, Title XXI, Item 4260-113-0001/0890.

RESOURCE DISREGARD - % PROGRAM CHILDREN

REGULAR POLICY CHANGE NUMBER: 8
 IMPLEMENTATION DATE: 12/1998
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 13

| | FY 2005-06 | FY 2006-07 |
|------------------------------|---------------|---------------|
| FULL YEAR COST - TOTAL FUNDS | \$0 | \$0 |
| - STATE FUNDS | -\$14,944,500 | -\$15,046,950 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$0 | \$0 |
| STATE FUNDS | -\$14,944,500 | -\$15,046,950 |
| FEDERAL FUNDS | \$14,944,500 | \$15,046,950 |

DESCRIPTION

Based on the provisions of SB 903 (Chapter 624, Statutes of 1997), resources will not be counted in determining the Medi-Cal eligibility of children with family income within Percentage Program limits.

Assumptions:

- Aid codes (8N, 8P, 8R, and 8T) that identify children eligible for Medi-Cal due to disregarding assets were implemented in 12-1998.
- In these aid codes, there were 4,895 eligibles in July 1999, 8,214 in December 1999, 16,979 in December 2000, 36,868 in December 2001, 49,293 in December 2002, 61,741 in December 2003, and 87,779 in December 2004.
- Average monthly eligibles, which are included in the base, are estimated to be 87,311 in FY 2005-06 and 87,882 in FY 2006-07.
- Enhanced federal funding under Title XXI (MCHIP) may be claimed for children eligible under these aid codes. It is 65.00% in FY 2005-06 and will be 65.00% in FY 2006-07.
- Beginning in FY 2000-01, these costs are being budgeted in 4260-113. Only the FFP in excess of the regular Medi-Cal FMAP is budgeted here.
- Costs are estimated to be:

| | FY 2005-06 | FY 2006-07 |
|---------------------|---------------------|---------------------|
| Total | \$99,630,000 | \$100,313,000 |
| FFP | \$67,760,000 | \$65,203,000 |
| General Fund | \$34,870,000 | \$35,110,000 |
| Enhanced FFP | \$14,945,000 | \$15,047,000 |

REFUGEES

REGULAR POLICY CHANGE NUMBER: 9
 IMPLEMENTATION DATE: 7/1980
 ANALYST: Ken Jansma
 FISCAL REFERENCE NUMBER: 14

| | FY 2005-06 | FY 2006-07 |
|------------------------------|--------------|--------------|
| FULL YEAR COST - TOTAL FUNDS | \$0 | \$0 |
| - STATE FUNDS | -\$2,505,000 | -\$2,712,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$0 | \$0 |
| STATE FUNDS | -\$2,505,000 | -\$2,712,000 |
| FEDERAL FUNDS | \$2,505,000 | \$2,712,000 |

DESCRIPTION

Full federal funding is available through the Refugee Resettlement Program (RRP) for refugees receiving Refugee Cash Assistance (Aid Codes 01,08, and 0A) and for Refugee Medical Assistance refugees (Aid Code 02) during their first 8 months in the United States. This funding adjustment shifts the normal state share to federal funds to reflect the full federal funding.

| | Total Refugee Expenditures | Funding Adjustment | |
|------------|----------------------------------|--------------------|--------------|
| | | State Funds | Fed. Funds |
| FY 2005-06 | \$5,010,000 | -\$2,505,000 | +\$2,505,000 |
| FY 2006-07 | \$5,424,000 | -\$2,712,000 | +\$2,712,000 |

NEW QUALIFIED ALIENS

REGULAR POLICY CHANGE NUMBER: 10
 IMPLEMENTATION DATE: 12/1997
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 15

| | FY 2005-06 | FY 2006-07 |
|------------------------------|----------------|----------------|
| FULL YEAR COST - TOTAL FUNDS | \$0 | \$0 |
| - STATE FUNDS | \$156,804,500 | \$170,898,500 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$0 | \$0 |
| STATE FUNDS | \$156,804,500 | \$170,898,500 |
| FEDERAL FUNDS | -\$156,804,500 | -\$170,898,500 |

DESCRIPTION

HR 3734, the Welfare Reform Bill, specified that FFP is not available for full-scope Medi-Cal services for nonexempt qualified aliens who enter the country after August 1996, for the first 5 years they are in the country. They are eligible for FFP for emergency services only. As California law requires that legal immigrants receive the same services as citizens, the nonemergency services are only State funded. Based on actual expenditure reports for the fee-for-service (FFS) nonemergency services costs of New Qualified Aliens from January 2002 through September 2005, the remainder of the current year and the budget year were projected. Using the actual percentage managed care expenditures are of FFS expenditures for nonemergency services in FY 2004-05 (45.71%), the managed care totals were derived.

| | FFS Managed Care | | Total |
|-------------------------------|---------------------|---------------|----------------------|
| FY 2005-06: Jul-Sep 05 | \$58,701,121 | | |
| Oct-Dec 05 | \$50,641,442 | | |
| Jan-Mar 06 | \$51,866,848 | | |
| Apr-Jun 06 | <u>\$54,018,702</u> | | |
| Totals | \$215,228,113 | \$98,380,770 | \$313,609,000 |
| FFP Repayment | | | \$156,804,000 |
| | | | |
| FY 2006-07: Jul-Sep 06 | \$55,973,116 | | |
| Oct-Dec 06 | \$58,097,057 | | |
| Jan-Mar 07 | \$59,153,263 | | |
| Apr-Jun 07 | <u>\$61,349,938</u> | | |
| Totals | \$234,573,374 | \$107,223,489 | \$341,797,000 |
| FFP Repayment | | | \$170,898,000 |

ACCELERATED ENROLLMENT-SCHIP TITLE XXI

REGULAR POLICY CHANGE NUMBER: 11
 IMPLEMENTATION DATE: 10/2003
 ANALYST: Cheri Johnson
 FISCAL REFERENCE NUMBER: 199

| | FY 2005-06 | FY 2006-07 |
|------------------------------|------------|------------|
| FULL YEAR COST - TOTAL FUNDS | \$0 | \$0 |
| - STATE FUNDS | \$0 | \$0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$0 | \$0 |
| STATE FUNDS | \$0 | \$0 |
| FEDERAL FUNDS | \$0 | \$0 |

DESCRIPTION

Applications received by the Single Point of Entry (SPE) are screened for Medi-Cal eligibility based on income. For children who appear Medi-Cal eligible without a share of cost, the SPE establishes accelerated enrollment and inputs eligibility transactions to the MEDS database.

Effective October 1, 2003, the federal share of accelerated enrollment costs is funded from Title XXI under 4260-113. The federal sharing ratio is the regular FMAP for Title XIX.

Assumptions:

- Estimated costs are based on actual claims and dental capitation rates for aid code 8E during July 2003- December 2005.

| | | |
|-------------|--------------|------------------|
| FY 2005-06: | \$16,978,000 | (\$8,489,000 GF) |
| FY 2006-07: | \$16,978,000 | (\$8,489,000 GF) |

The costs of this policy change are fully reflected in the base estimate. This policy change identifies the shift in funding from Title XIX (4260-101) to Title XXI (4260-113).

ADULT DAY HEALTH CARE - CDA

REGULAR POLICY CHANGE NUMBER: 13
 IMPLEMENTATION DATE: 7/1984
 ANALYST: Shelley Stankeivicz
 FISCAL REFERENCE NUMBER: 24

| | FY 2005-06 | FY 2006-07 |
|------------------------------|---------------|---------------|
| FULL YEAR COST - TOTAL FUNDS | \$401,171,000 | \$417,820,000 |
| - STATE FUNDS | \$200,585,500 | \$208,910,000 |
| PAYMENT LAG | 0.9949 | 0.9937 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$399,125,000 | \$415,187,700 |
| STATE FUNDS | \$199,562,510 | \$207,593,870 |
| FEDERAL FUNDS | \$199,562,520 | \$207,593,870 |

DESCRIPTION

Adult Day Health Care (ADHC) is a community-based day program providing health, therapeutic, and social services designed to serve those at risk of being placed in a nursing home. The ADHC Program is funded via DHS' Medi-Cal budget with State General Fund and Title XIX federal funds. DHS performs the licensing of Medi-Cal ADHCs. The Department of Aging (CDA) administers the program and certifies each center for Medi-Cal reimbursement.

In Dec. 2003 CMS notified DHS that the ADHC program must be approved under a waiver or SPA with specified changes to the program in order to continue receiving federal funding. DHS is obtaining legislative authority in FY 05-06 & working with CDA in development of the SPA or waiver. Estimated implementation is Spring 2008.

This policy change includes the impact of the Budget Act and Health Trailer Bill of 2004, which implemented a twelve-month moratorium on the certification of new Adult Day Health Care centers effective August 16, 2004, including in-house applications, with specified exceptions. The Budget Act and Health Trailer Bill of 2005 included language to allow specific additional exemptions to the moratorium. The moratorium will be extended until the SPA or waiver is ready for implementation.

The Budget Act of 2005 included funding for the LTC rate increase. ADHC rates, which are set at 90% of the NF-A weighted average rate, was increased by 5.72% effective Aug. 1, 2005.

1. The average cost per participant is \$749.60 and \$792.48 with a 5.72% rate increase. This is based on participant data from CDA and 12 month average paid claims data for the 2005 calendar year.
2. Total actual participants as of June 2005 are 41,626.
3. Total projected participants as of June 2006 are 43,001.
4. Total projected participants as of June 2007 are 44,727.

ADULT DAY HEALTH CARE - CDA

REGULAR POLICY CHANGE NUMBER: 13

FY 2005-06 cost: **\$401,171,000**
41,748 Participant Months (PM) x \$749.60 = \$31,289,054
466,741 PM x \$792.48 = \$369,881,563

FY 2006-07 cost: **\$417,820,000**
527,231 PM x \$792.48 = \$417,820,023

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

REGULAR POLICY CHANGE NUMBER: 14
 IMPLEMENTATION DATE: 7/2000
 ANALYST: Jenn Brooks
 FISCAL REFERENCE NUMBER: 25

| | FY 2005-06 | FY 2006-07 |
|------------------------------|---------------|---------------|
| FULL YEAR COST - TOTAL FUNDS | \$100,000,000 | \$153,000,000 |
| - STATE FUNDS | \$0 | \$0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$100,000,000 | \$153,000,000 |
| STATE FUNDS | \$0 | \$0 |
| FEDERAL FUNDS | \$100,000,000 | \$153,000,000 |

DESCRIPTION

Through an interagency agreement with the California Department of Education, Local Educational Agencies (LEAs) can become Medi-Cal providers and submit claims to be reimbursed for health services provided to Medi-Cal eligible students in schools within their jurisdictions. The Medi-Cal program provides federal matching funds.

State Plan Amendment 03-024, approved in March 2005, will implement a new methodology for reimbursement in June 2006, retroactive to April 2003. Interim rates based on a rate study will be used for covered LEA services, and costs will be reconciled against reimbursements. System changes are expected to be implemented on June 26, 2006, with reimbursements beginning in July 2006.

The CDHS Interagency Agreement with the California Department of Education is CDHS 99-86325.

This policy change reflects FMAP changes.

MEDI-CAL CONTINUATION OF PART D EXCLUDED

REGULAR POLICY CHANGE NUMBER: 15
 IMPLEMENTATION DATE: 1/2006
 ANALYST: Karen Fairgrievies
 FISCAL REFERENCE NUMBER: 1047

| | FY 2005-06 | FY 2006-07 |
|------------------------------|--------------|---------------|
| FULL YEAR COST - TOTAL FUNDS | \$89,181,000 | \$194,472,000 |
| - STATE FUNDS | \$44,590,500 | \$97,236,000 |
| PAYMENT LAG | 0.8864 | 0.9970 |
| % REFLECTED IN BASE | 23.25 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$60,670,900 | \$193,888,600 |
| STATE FUNDS | \$30,335,450 | \$96,944,290 |
| FEDERAL FUNDS | \$30,335,450 | \$96,944,290 |

DESCRIPTION

On January 1, 2006, Medicare's Part D benefit began. All eligibles dually enrolled in Medi-Cal and Medicare will become enrolled in Part D. Medicare Part D will provide drug coverage for most prescription drugs along with insulin and insulin-related medical supplies. The details of the coverage under Part D plans were released in October 2005.

Medi-Cal will continue coverage for those drug categories excluded from Part D. These categories include weight loss drugs, barbiturates, benzodiazepines, over-the-counter drugs, cough and cold drugs, and various medical supplies.

Assumptions:

1. January - June 2006 estimated average monthly dual eligibles are 1,006,000. 865,660 (86.05%) are in Medi-Cal FFS.
2. The estimated excluded pharmacy cost for these dual eligibles for January - June 2006 is \$103.02 per person (\$8.60 per month.)
3. FY 2006-07 estimated average monthly dual eligibles are 1,043,000. 897,500 are in Medi-Cal FFS.
4. The estimated pharmacy cost for these dual eligibles for FY 2006-07 is \$216.68 per person (\$18.10 per month.)

| FY 2005-06 | | Savings (Rounded) |
|----------------|------------------------------|---------------------|
| Dual's Rx | \$1,791.24 x 865,660 duals = | (\$1,550,609,000) |
| Excluded Drugs | \$103.02 x 865,660 duals = | \$89,181,000 |
| Part D Savings | \$1,688.22 x 865,660 duals = | (\$1,461,428,000) |

MEDI-CAL CONTINUATION OF PART D EXCLUDED

REGULAR POLICY CHANGE NUMBER: 15

FY 2006-07

| | | |
|----------------|------------------------------|----------------------|
| Dual's Rx | \$3,767.49 x 897,500 duals = | (\$3,381,325,000) |
| Excluded Drugs | \$216.68 x 897,500 duals = | \$194,472,000 |
| Part D Savings | \$3,550.81 x 897,500 duals = | (\$3,186,853,000) |

MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA

REGULAR POLICY CHANGE NUMBER: 16
 IMPLEMENTATION DATE: 7/1984
 ANALYST: Shelley Stankeivicz
 FISCAL REFERENCE NUMBER: 28

| | FY 2005-06 | FY 2006-07 |
|------------------------------|--------------|--------------|
| FULL YEAR COST - TOTAL FUNDS | \$44,515,000 | \$44,515,000 |
| - STATE FUNDS | \$22,257,500 | \$22,257,500 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$44,515,000 | \$44,515,000 |
| STATE FUNDS | \$22,257,500 | \$22,257,500 |
| FEDERAL FUNDS | \$22,257,500 | \$22,257,500 |

DESCRIPTION

The Multipurpose Senior Services Program is designed to evaluate the effects of providing a comprehensive array of social and health services to persons 65 or older who are "at risk" of long-term care. The program provides services under a federal home and community-based services waiver to an average of 16,335 clients in 11,789 client slots, at \$3,776 per year per client slot.

(Dollars in Thousands)

| | FY 2005-06 | | FY 2006-07 | |
|------|------------|----------|------------|----------|
| | TF | DHS-GF | TF | DHS-GF |
| MSSP | \$44,515 | \$22,258 | \$44,515 | \$22,258 |

MSSP cash cost estimates are provided by the Department of Aging.

This policy change reflects FMAP changes.

MEDICARE PART B DEDUCTIBLE INCREASE

REGULAR POLICY CHANGE NUMBER: 17
 IMPLEMENTATION DATE: 1/2006
 ANALYST: Richard Hargraves
 FISCAL REFERENCE NUMBER: 194

| | <u>FY 2005-06</u> | <u>FY 2006-07</u> |
|------------------------------|-------------------|-------------------|
| FULL YEAR COST - TOTAL FUNDS | \$14,573,000 | \$30,626,000 |
| - STATE FUNDS | \$7,286,500 | \$15,313,000 |
| PAYMENT LAG | 0.9477 | 0.9738 |
| % REFLECTED IN BASE | 16.81 % | 4.52 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$11,489,200 | \$28,475,600 |
| STATE FUNDS | \$5,744,620 | \$14,237,790 |
| FEDERAL FUNDS | \$5,744,620 | \$14,237,790 |

DESCRIPTION

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 included yearly increases to the Part B Deductible. On January 1, 2005, the Part B deductible increased by \$10 to \$110 per beneficiary. On January 1, 2006, the deductible increased by an additional \$14 to \$124 per beneficiary. Each year, the deductible will increase according to an inflation factor determined by the federal government.

Medi-Cal pays for the Part B deductible for eligible beneficiaries. The deductible is met for 100% of the beneficiaries and is typically paid at the beginning of the calendar year.

Assumptions:

1. Assume the average annual FY 2005-06 Part B dual eligible population is 1,040,896 and 1,093,780 for FY 2006-07.
2. Assume the Part B deductible costs will be incurred in January and February of each year.
3. Assume the Part B deductible will increase \$14 on January 1, 2007 to \$138.

FY 2005-06

| | | |
|---------------|---------------------------|------------------------|
| 2006: | $\$14 \times 1,040,896 =$ | <u>\$14,573,000</u> TF |
| Total: | \$14 | \$14,573,000 TF |

FY 2006-07

| | | |
|---------------|---------------------------|------------------------|
| 2006: | $\$14 \times 1,093,780 =$ | \$15,313,000 TF |
| 2007: | $\$14 \times 1,093,780 =$ | <u>\$15,313,000</u> TF |
| Total: | \$28 | \$30,626,000 TF |

HIV/AIDS PHARMACY PILOT PROGRAM

REGULAR POLICY CHANGE NUMBER: 18
 IMPLEMENTATION DATE: 9/2005
 ANALYST: Karen Fairgrievies
 FISCAL REFERENCE NUMBER: 1023

| | FY 2005-06 | FY 2006-07 |
|------------------------------|-------------|-------------|
| FULL YEAR COST - TOTAL FUNDS | \$6,620,000 | \$4,218,000 |
| - STATE FUNDS | \$3,310,000 | \$2,109,000 |
| | | |
| PAYMENT LAG | 0.9583 | 1.0000 |
| % REFLECTED IN BASE | 39.18 % | 69.74 % |
| | | |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$3,858,400 | \$1,276,400 |
| STATE FUNDS | \$1,929,190 | \$638,180 |
| FEDERAL FUNDS | \$1,929,200 | \$638,180 |

DESCRIPTION

AB 1367 (Chapter 850, Statutes of 2004) required the Department to establish the HIV/AIDS Pharmacy Pilot Program to evaluate the effectiveness of pharmacist care in improving health outcomes for people with HIV/AIDS. AB 1367 provided for an additional dispensing fee of \$9.50 to participating pharmacies and was implemented in September 2005, retroactive to September 2004. AB 1367 sunsets on January 1, 2008. The first ten pharmacies to apply that had HIV/AIDS patients representing 90% of their total pharmacy patients in May, June, & July 2004 were allowed to participate. All Medi-Cal prescription drug claims from a participating pharmacy will receive the additional \$9.50 dispensing fee.

Medicare Part D began January 1, 2006. The extent of the impact on this pilot program is unknown at this time; however, an overall impact on Medi-Cal's prescription drug program is shown in the MMA Drug Benefit Policy Change.

Assumptions:

1. The total Medi-Cal prescriptions for the ten participating pharmacies were 347,800 between Sept 2004 and Sept 2005.
2. For the remainder of FY 2005-06, the average monthly prescriptions are estimated at 34,900.
3. The average monthly prescription for FY 2006-07 are estimated at 37,000.
4. The additional \$9.50 dispensing fee is retroactive to Sept 1, 2004.

FY 2005-06

| | | |
|--------------------------|--|--------------------|
| FY 2004-05 retro: | 27,800 Rx per month x 10 months x \$9.50 = | \$2,641,000 |
| FY 2005-06 retro: | 34,900 Rx per month x 2 months x \$9.50 = | \$663,000 |
| FY 2005-06 ongoing: | 34,900 Rx per month x 10 months x \$9.50 = | \$3,316,000 |
| Total FY 2005-06: | | \$6,620,000 |

HIV/AIDS PHARMACY PILOT PROGRAM

REGULAR POLICY CHANGE NUMBER: 18

FY 2006-07

FY 2006-07 ongoing: 37,000 Rx per month x 12 months x \$9.50= **\$4,218,000**

CONLAN V. BONTA

REGULAR POLICY CHANGE NUMBER: 19
 IMPLEMENTATION DATE: 10/2006
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 34

| | FY 2005-06 | FY 2006-07 |
|------------------------------|------------|--------------|
| FULL YEAR COST - TOTAL FUNDS | \$0 | \$34,503,000 |
| - STATE FUNDS | \$0 | \$17,251,500 |
| PAYMENT LAG | 1.0000 | 0.8107 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$0 | \$27,971,600 |
| STATE FUNDS | \$0 | \$13,985,790 |
| FEDERAL FUNDS | \$0 | \$13,985,790 |

DESCRIPTION

In *Conlan, Schwarzmer and Stevens v. Bontá*, the Court of Appeals found that the Department failed to provide a procedure whereby Medi-Cal beneficiaries can get reimbursements for the amount paid, not to exceed the rate established for that service under the Medi-Cal program, for services received during the period in which their applications were pending, or any of the 3 months prior to the month of application in which they were eligible, or for which they had to pay a copayment when using other health care coverage, or when a denial of eligibility is reversed by a hearing. The Department has provided a plan to the court setting up a procedure through which beneficiaries who are unable to get reimbursement from the provider for their out-of-pocket expenses can receive direct reimbursement.

Assumptions:

1. Assume that the *Conlan* reimbursement plan will be implemented in July 2006 and that the reimbursements to claimants will begin in October 2006.

New Beneficiaries:

1. Based on a study of Medi-Cal beneficiaries who were newly eligible in March 2002, there were 5,991,271 Medi-Cal beneficiaries in that month, of which 202,000 (3.4%) were new eligibles.
2. Of the new beneficiaries in that month, 1,000 (0.02% of total eligibles) were eligible for one of the three months prior to the month they applied for Medi-Cal. They were all fee-for-service.
3. The average monthly cost for retroactive month eligibility was \$729.
4. Of the new beneficiaries in that month, about 155,000 (2.6% of total eligibles) were determined eligible after the month of application.
5. The average monthly cost for beneficiaries determined eligible after the month of application was \$352.
6. Based on data on applications received daily from 2003, there are 5,000 new beneficiaries added daily. 25% are heads of household.
7. 25% of households are expected to file a claim.

CONLAN V. BONTA**REGULAR POLICY CHANGE NUMBER: 19**

$$\begin{array}{rcl}
 5,000 \times .25 \text{ households} \times .25 \text{ file claim} & = & 313 \text{ claims per day} \\
 313 \times 5 \text{ days} \times 52 \text{ weeks} & = & 81,380 \text{ claims per year}
 \end{array}$$

8. Assume 1% of the claims will be for retroactive months.
9. Assume the cost per claim will be the average monthly cost for a retroactive or pre-determination of eligibility month.
10. The annual cost is expected to be:

$$\begin{array}{rcl}
 81,830 \times .01 \times \$729 & = & \$593,260 \\
 81,830 \times .99 \times \$352 & = & \$28,359,203 \\
 \hline
 & & \$28,953,000
 \end{array}$$

11. Assume the cost in 2006-07 will be mainly reimbursement for out-of-pocket costs for persons eligible for Medi-Cal from June 1997 through June 2006 that are required to be notified of the availability of reimbursement under the provisions of the *Conlan* court order. These costs are expected to be limited due to the fact that it will be difficult to contact beneficiaries for these retroactive periods and the fact that beneficiaries must have receipts to file a claim. As both the beneficiaries and providers are educated on the requirements for providers to repay Medi-Cal beneficiaries for out-of-pocket expenses incurred prior to the determination of eligibility, costs for *Conlan* are expected to be the annual costs identified above. FY 2006-07 costs are expected to be:

$$\$28,953,000 / 12 \text{ months} \times 9 \text{ months} = \$21,714,000$$

Copayments for Beneficiaries with Other Health Coverage:

1. Assume that the 196,000 FFS beneficiaries with other health care coverage other than Healthy Families coverage are the beneficiaries impacted by *Conlan*.
2. 58% are users each month.
3. Assume 25% will be charged copays and request reimbursement.
4. Based on the average number of services per user per month from the November 2005 Estimate, assume the average number of copays per claim is 5.
5. Assume the average cost per copay is \$10.
6. The annual cost is expected to be:

$$\begin{array}{l}
 196,000 \times .58 \text{ users} \times .25 \text{ with copays who file claims} = 28,420 \\
 28,420 \times \$10 \text{ per copay} \times 5 \text{ copays} \times 12 \text{ months} = \$17,052,000
 \end{array}$$

7. The 2006-07 costs are expected to be:

$$\$17,052,000 / 12 \text{ months} \times 9 \text{ months} = \$12,789,000$$

| Total: | Annual | | 2006-07 | |
|---------------|---------------------|---------------------|---------------------|---------------------|
| | Total | GF | Total | GF |
| New Eligibles | \$28,953,000 | \$14,476,000 | \$21,714,000 | \$10,857,000 |
| Copayment | \$17,052,000 | \$8,526,000 | \$12,789,000 | \$6,395,000 |
| Total | \$46,005,000 | \$23,002,000 | \$34,503,000 | \$17,252,000 |

CDSS SHARE OF COST PAYMENT FOR IHSS

REGULAR POLICY CHANGE NUMBER: 22
 IMPLEMENTATION DATE: 11/2005
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 1067

| | FY 2005-06 | FY 2006-07 |
|------------------------------|--------------|--------------|
| FULL YEAR COST - TOTAL FUNDS | \$0 | \$0 |
| - STATE FUNDS | \$4,064,000 | \$5,418,500 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$0 | \$0 |
| STATE FUNDS | \$4,064,000 | \$5,418,500 |
| FEDERAL FUNDS | -\$4,064,000 | -\$5,418,500 |

DESCRIPTION

The California Department of Social Services (CDSS) and the California Department of Health Services (CDHS) have implemented a process that enables Medi-Cal In-Home Supportive Services (IHSS) recipients who have a Medi-Cal share-of-cost (SOC) higher than their IHSS SOC to be eligible for Medi-Cal at the beginning of each month. Each IHSS recipient with a Medi-Cal SOC that exceeds his/her IHSS SOC must meet the Medi-Cal SOC obligation to establish Medi-Cal eligibility.

Prior to the complete automation of the Case Management, Information, and Payrolling System (CMIPS), the IHSS payroll computer system, an interim process will reconcile the difference between the IHSS and Medi-Cal SOC. Based on an Interagency Agreement (IA) CDSS will transfer funds to CDHS to pay the Medi-Cal SOC for IHSS recipients. CDHS will repay the federal government the FFP for the services that should have been paid by the beneficiary as part of the SOC.

When CMIPS is fully automated, CDSS will fund services for each IHSS recipient in an amount equal to the difference between the monthly Medi-Cal SOC and the IHSS SOC.

This policy change identifies the funds that will be repaid to CDHS and the federal government. The projected amounts to be reimbursed from the IHSS SOC fund, Item 4260-601-0942001 are included in the Management Summary funding pages as part of Reimbursements, Item 4260-610-0995 and are:

| | Amount |
|------------|--------------|
| FY 2005-06 | \$8,128,000 |
| FY 2006-07 | \$10,837,000 |

This reflects three quarters of payment in FY 2005-06, and four quarters in FY 2006-07.

SCHIP FUNDING FOR PRENATAL CARE

REGULAR POLICY CHANGE NUMBER: 23
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Cheri Johnson
 FISCAL REFERENCE NUMBER: 1007

| | FY 2005-06 | FY 2006-07 |
|------------------------------|----------------|---------------|
| FULL YEAR COST - TOTAL FUNDS | \$0 | \$0 |
| - STATE FUNDS | -\$183,405,950 | -\$94,144,700 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$0 | \$0 |
| STATE FUNDS | -\$183,405,950 | -\$94,144,700 |
| FEDERAL FUNDS | \$183,405,950 | \$94,144,700 |

DESCRIPTION

In order to maximize revenues, the 2005-06 Budget Act and AB 131 (Chapter 80, Statutes of 2005), the Health Trailer Bill, required MRMIB to file a State Plan Amendment (SPA) in the State Children's Health Insurance Program (SCHIP) to claim 65% federal funding for prenatal care provided to women currently ineligible for federal funding for this care. The cost for this care has been 100% General Fund.

Assumptions:

- The SPA was filed on June 30, 2005, and approved on March 28, 2006, to allow SCHIP funding to be claimed for FY 2004-05 and FY 2005-06 in FY 2005-06.
- The cost of prenatal care for undocumented women was \$138,286,000 in 2004-05; and is estimated to be \$139,754,000 in 2005-06 and \$142,482,000 in 2006-07.

| | | |
|-------------|---------------------------------|-------------------|
| FY 2004-05: | \$138,286,000 x .65 SCHIP FFP = | \$89,886,000 FFP |
| FY 2005-06: | \$139,754,000 x .65 SCHIP FFP = | \$90,840,000 FFP |
| FY 2006-07: | \$142,482,000 x .65 SCHIP FFP = | \$92,613,000 FFP |
| | 2005-06 Claiming = | \$180,726,000 FFP |
| | 2006-07 Claiming = | \$92,613,000 FFP |
- The cost of prenatal care for legal immigrants who have been in the country for less than five years is expected to be \$2,356,000 in each of FY 2004-05, FY 2005-06 and FY 2006-07.

$$\$2,356,000 \times .65 \text{ SCHIP FFP} = \$1,531,000 \text{ FFP}$$

Lagged amounts (due to quarterly claiming) are as follows:

| | | |
|-------------|--------------------------------|-----------------|
| FY 2005-06: | 100% of 04-05 + 75% of 05-06 = | \$2,680,000 FFP |
| FY 2006-07: | 25% of 05-06 + 75% of 06-07 = | \$1,531,000 FFP |

SCHIP FUNDING FOR PRENATAL CARE**REGULAR POLICY CHANGE NUMBER: 23**

4. The federal funding received on a cash basis will be:

FY 2005-06 Savings: \$180,726,000 + \$2,680,000 = \$183,406,000

FY 2006-07 Savings: \$92,613,000 + \$1,531,000 = \$94,144,000

5. **Funding for prenatal care for undocumented women, and for legal immigrants who have been in the country for less than five years, is being shifted from the Medi-Cal Item, 4260-101, to the Healthy Families Item, 4260-113.

\$1800 DENTAL CAP FOR ADULTS

REGULAR POLICY CHANGE NUMBER: 24
 IMPLEMENTATION DATE: 7/2006
 ANALYST: Jenn Brooks
 FISCAL REFERENCE NUMBER: 1064

| | FY 2005-06 | FY 2006-07 |
|------------------------------|------------|--------------|
| FULL YEAR COST - TOTAL FUNDS | \$0 | -\$3,126,000 |
| - STATE FUNDS | \$0 | -\$1,563,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$0 | -\$3,126,000 |
| STATE FUNDS | \$0 | -\$1,563,000 |
| FEDERAL FUNDS | \$0 | -\$1,563,000 |

DESCRIPTION

As part of Medi-Cal Redesign, the Budget Act of 2005 included revising dental benefits for adults to align them with the benefits available through commercial plans, by limiting services available to adults to \$1,800 per calendar year, effective January 2006. Emergency services, federally mandated services, dentures, maxillofacial services, complex oral and maxillofacial surgery and long-term care beneficiaries that have long-term care aide codes or reside in either a skilled nursing facility or an intermediate care facility, are exempt from this limit.

Assumptions:

1. A total of 6,824 beneficiaries are expected to be impacted by the \$1,800 dental cap. 3,753 are seniors or persons with disabilities and 3,071 are in all other aid categories.
2. Based on calendar year 2004 data, the annual savings is estimated to be \$3,126,000. Anticipated savings have decreased from previous estimates due, in part, to the implementation of service restrictions and payment reductions required under SBX1 26.
3. For the clients of the Regional Centers for the Developmentally Disabled who are among those impacted by the cap, it is assumed that the costs in excess of \$1,800 will become Regional Center costs at 100% GF. Costs are expected to total \$85,000 for FY 2005-06 and \$184,000 annually thereafter. These costs will be reflected in the California Department of Developmental Services' budget.
4. The savings identified will be realized by an adjustment to the capitation rate paid to Delta Dental.

ADULT DAY HEALTH CARE REFORMS

REGULAR POLICY CHANGE NUMBER: 25
 IMPLEMENTATION DATE: 3/2007
 ANALYST: Shelley Stankeivicz
 FISCAL REFERENCE NUMBER: 1074

| | FY 2005-06 | FY 2006-07 |
|------------------------------|------------|---------------|
| FULL YEAR COST - TOTAL FUNDS | \$0 | -\$18,957,000 |
| - STATE FUNDS | \$0 | -\$9,478,500 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$0 | -\$18,957,000 |
| STATE FUNDS | \$0 | -\$9,478,500 |
| FEDERAL FUNDS | \$0 | -\$9,478,500 |

DESCRIPTION

The current reimbursement rate for Adult Day Health Care (ADHC) is 90% of the nursing facility-level A rate. This is a bundled, all-inclusive rate for all ADHC services. The rate was set by a court settlement in 1993.

Trailer bill language will be proposed to institute several ADHC reforms. The proposals are:

1. Unbundle the current all-inclusive procedure code for ADHC into its component services. The maximum rate per day would remain at 90% of the NF-A rate. Only the bundled procedure code that includes the ADHCs' overhead and unskilled services would require prior authorization, and ADHCs would "bill direct" for ancillary and skilled services.
2. Tighten medical criteria so that only those recipients that truly require specific services can receive authorization for ADHC.
3. Have CDA perform post-payment audits of participant charts during their regular surveys to ensure that services billed were actually provided and were medically necessary, and recoup inappropriate payments from the ADHCs.
4. Add Medi-Cal field office staff to do on-site approvals of requests for prior authorization, to allow review of patients' medical records.

| <i>(Dollars in thousands)</i> | Annual Savings | | 06-07 Savings (lagged) | |
|-------------------------------|---------------------------------------|-----------------|------------------------|-----------------|
| | TF | GF | TF | GF |
| Unbundle Rates | \$79,052 | \$39,526 | \$16,186 | \$8,093 |
| Tighten Med. Criteria | \$32,582 | \$16,291 | \$2,064 | \$1,032 |
| Post-Payment Audits | <i>Indeterminate out-year savings</i> | | | |
| On-Site TARs | \$11,177 | \$ 5,588 | \$708 | \$354 |
| Totals | \$122,811 | \$61,405 | \$18,958 | \$ 9,479 |

FLUORIDE VARNISH

REGULAR POLICY CHANGE NUMBER: 26
 IMPLEMENTATION DATE: 5/2006
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1025

| | FY 2005-06 | FY 2006-07 |
|------------------------------|------------|-------------|
| FULL YEAR COST - TOTAL FUNDS | \$24,000 | \$4,118,000 |
| - STATE FUNDS | \$12,000 | \$2,059,000 |
| PAYMENT LAG | 0.2620 | 0.9595 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$6,300 | \$3,951,200 |
| STATE FUNDS | \$3,140 | \$1,975,610 |
| FEDERAL FUNDS | \$3,140 | \$1,975,610 |

DESCRIPTION

Effective May 2006, fluoride varnish will be an added service provided by medical providers who routinely see pregnant women and young children and can intervene earlier to prevent childhood tooth decay.

Assumptions:

1. Of the 799,802 Medi-Cal eligibles (0-5yrs) who had EPSDT visits, 533,500 suffer from tooth decay by the third grade.
2. 2.4 restorations (\$84) per child are performed.
3. Physician cost of providing 2 varnish applications is \$36.
4. Medi-Cal eligibles (0-5 yrs) who had EPSDT visits will have an average of 2 fluoride varnish applications per year.
5. 0.05% of Medi-Cal dental eligibles reporting EPSDT visits will use this service in FY 2005-06, and 20% in FY 2006-07.
6. There will be a 69.4% reduction rate of tooth decay between varnish vs. non-varnish groups.
7. It will take approximately 9 months from implementation to realize a preventive effect from fluoride varnish. Due to the 9 month lag, savings from the FY 2005-06 provision of fluoride varnish of \$27,000 is expected to materialize in February 2007. FY 2006-07 reflects 5 months of savings.
8. The savings identified will be realized by an adjustment to the capitation rate paid to Delta Dental.
9. It is estimated 67% of beneficiaries are Managed Care and 33% are Fee-for-Service.

FLUORIDE VARNISH

REGULAR POLICY CHANGE NUMBER: 26

Dental costs with no fluoride varnish treatment for those suffering from tooth decay by the third grade = \$60,328,000 (periodic exam \$8,302,000 + X-ray \$5,535,000 + restoration \$46,491,000).

Dental costs with fluoride varnish treatment for those suffering from tooth decay by the third grade = \$28,063,000 (periodic exam \$8,302,000 + X-ray \$5,535,000 + restoration \$14,226,000).

| | | |
|--|--|----------------------------------|
| Annual savings : | $-\$60,328,000 + \$28,063,000 =$ | $-\$32,265,000$ |
| FY 2006-07 savings: | $-\$32,265,000 \times .005 \times 3/12 - \$27,000 =$ | $-\$67,000$ |
| Physician costs to apply varnish (lagged 0.262 CY, 0.971 BY) | | |
| Annual costs : | $\$36 \times 799,802 =$ | $\$28,793,000$ |
| FY 2005-06 cost: | $\$28,793,000 \times .005 \times 2/12 \times .262 =$ | $\$6,000$ |
| FY 2006-07 cost: | $\$28,793,000 \times .2 \times .971 =$ | $\$5,592,000$ |
| NET FY 2005-06 savings/costs: | $\$6,000 =$ | $\\$6,000$ |
| NET FY 2006-07 savings/costs: | $-\$67,000 + \$5,592,000 =$ | $\\$5,525,000$ |

| | <u>FY 2005-06</u> | <u>FY 2006-07</u> |
|-----------------|-------------------|--------------------|
| Fee-for-Service | \$8,000 | \$1,359,000 |
| Managed Care | \$16,000 | \$2,759,000 |
| Total | \$24,000 | \$4,118,000 |

MMA MEDICARE DRUG BENEFIT

REGULAR POLICY CHANGE NUMBER: 28
 IMPLEMENTATION DATE: 1/2006
 ANALYST: Karen Fairgrievies
 FISCAL REFERENCE NUMBER: 1022

| | FY 2005-06 | FY 2006-07 |
|------------------------------|------------------|------------------|
| FULL YEAR COST - TOTAL FUNDS | -\$1,550,609,000 | -\$3,381,325,000 |
| - STATE FUNDS | -\$775,304,500 | -\$1,690,662,500 |
| PAYMENT LAG | 0.8864 | 0.9970 |
| % REFLECTED IN BASE | 28.19 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -\$986,999,600 | -\$3,371,181,000 |
| STATE FUNDS | -\$493,499,800 | -\$1,685,590,510 |
| FEDERAL FUNDS | -\$493,499,800 | -\$1,685,590,510 |

DESCRIPTION

On Jan. 1, 2006, Medicare's Part D benefit began. Part D provides a prescription drug benefit to all Medicare eligibles who enroll in a Part D plan. Prior to this date, dual eligibles (those who qualify for both Medi-Cal and Medicare) received drug benefits through Medi-Cal. Part D will cover drugs in 209 drug categories along with insulin and insulin-related medical supplies. This policy change shows the full savings of dual eligible pharmacy costs. However, some drugs are excluded from Medicare Part D and are shown in the Medi-Cal Continuation of Part D Excluded policy change.

Assumptions:

1. January - June 2006 estimated average monthly dual eligibles are 1,006,000. 865,660 (86.05%) are in Medi-Cal FFS.
2. The estimated pharmacy cost for these dual eligibles for January - June 2006 is \$1,791.24 per person (\$298.54 per month.)
3. FY 2006-07 estimated average monthly dual eligibles are 1,043,000. 897,500 are in Medi-Cal FFS.
4. The estimated pharmacy cost for these dual eligibles for FY 2006-07 is \$3,767.49 per person (\$313.96 per month.)

| FY 2005-06 | | Savings (Rounded) |
|----------------|------------------------------|----------------------------|
| Duals' Rx | \$1,791.24 x 865,660 duals = | (\$1,550,609,000) |
| Excluded Drugs | \$103.02 x 865,660 duals = | \$89,181,000 |
| Part D Savings | \$1,688.22 x 865,660 duals = | (\$1,461,428,000) |

MMA MEDICARE DRUG BENEFIT

REGULAR POLICY CHANGE NUMBER: 28

| FY 2006-07 | | Savings (Rounded) |
|-------------------|------------------------------|--------------------------|
| Duals' Rx | \$3,767.49 x 897,500 duals = | (\$3,381,325,000) |
| Excluded Drugs | \$216.68 x 897,500 duals = | \$194,472,000 |
| Part D Savings | \$3,550.81 x 897,500 duals = | <u>(\$3,186,853,000)</u> |

* Savings from dual eligibles in Managed Care is shown in the MMA Managed Care Capitation Savings.

QUALITY IMPROVEMENT ASSESSMENT FEE

REGULAR POLICY CHANGE NUMBER: 32
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Shelley Stankeivicz
 FISCAL REFERENCE NUMBER: 68

| | FY 2005-06 | FY 2006-07 |
|------------------------------|--------------|-------------|
| FULL YEAR COST - TOTAL FUNDS | \$97,455,000 | \$2,736,000 |
| - STATE FUNDS | \$48,727,500 | \$1,368,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$97,455,000 | \$2,736,000 |
| STATE FUNDS | \$48,727,500 | \$1,368,000 |
| FEDERAL FUNDS | \$48,727,500 | \$1,368,000 |

DESCRIPTION

The Department is increasing payments to managed care plans by drawing down federal matching funds to reimburse plans for a 6% Quality Improvement Assessment Fee (QIF). Managed care plan rates were adjusted to include QIF on their anniversary dates. This policy change budgets the QIF from July 1, 2005 until the effective date of the new rates that include QIF.

Assumptions:

1. The fee would be paid to the General Fund, and would be paid by the Medi-Cal managed care plans classified as managed care organizations (MCO).
2. Managed care plans will receive a rate increase to cover the cost of the fee.
3. The fee and the rate increase are effective July 2005. The fee is due 15 days after the end of the month.
4. The State will share the additional General Fund available with the MCOs.
5. Two-Plan Model - Effective October 1, 2005, QIF adjustments were included in each plan's new rates and were budgeted in PC 29 - Two Plan Model. This policy change budgets the QIF cost for the period prior to the effective date of the new rates, July 1, 2005 through September 30, 2005.
6. Geographic Managed Care (GMC) - Effective January 1, 2006, QIF adjustments were included in each plans new rates and were budgeted in PC 31- Geographic Managed Care. This policy change budgets the QIF cost for the period prior to the effective date of the new rates, July 1, 2005 through December 31, 2005.

QUALITY IMPROVEMENT ASSESSMENT FEE

REGULAR POLICY CHANGE NUMBER: 32

| | | FY 2005-06 | FY 2006-07 |
|---|-----------|---------------------|--------------------|
| 6% fee to be paid by plans: | | \$61,369,000 | \$1,879,000 |
| Rate increase to be paid to plans: | GF | \$48,727,500 | \$1,368,000 |
| | FF | \$48,727,500 | \$1,368,000 |
| | TF | \$97,455,000 | \$2,736,000 |
| Net increase in funding to managed care plans: | | \$36,086,000 | \$857,000 |
| Savings to the GF: | | \$61,369,000 | \$1,879,000 |
| Rate Increase (GF): | | -\$48,727,500 | -\$1,368,000 |
| Net GF Savings: | | \$12,641,500 | \$511,000 |

This policy change budgets only the QIF rate increase costs up to the date that the QIF is included in the new rates for each plan. QIF costs from that date forward are included in the policy changes for the various managed care plans. For the Two-Plan Model, QIF costs from July 1, 2005 through September 30, 2005 are included in this policy change. For GMC, QIF costs from July 1, 2005 through December 31, 2005 are included in this policy change. Beginning in FY 2006-07, all Two-Plan Model and GMC rates will include QIF. Kaiser (Marin and Sonoma Counties) and AIDS Healthcare Foundation are the only plans whose QIF costs are included in this policy change in 2006-07.

CAL OPTIMA 3% RATE INCREASE

REGULAR POLICY CHANGE NUMBER: 36
 IMPLEMENTATION DATE: 10/2005
 ANALYST: Shelley Stankeivicz
 FISCAL REFERENCE NUMBER: 1052

| | <u>FY 2005-06</u> | <u>FY 2006-07</u> |
|------------------------------|-------------------|-------------------|
| FULL YEAR COST - TOTAL FUNDS | \$16,561,000 | \$22,402,000 |
| - STATE FUNDS | \$8,296,500 | \$11,222,500 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$16,561,000 | \$22,402,000 |
| STATE FUNDS | \$8,296,500 | \$11,222,500 |
| FEDERAL FUNDS | \$8,264,500 | \$11,179,500 |

DESCRIPTION

The Budget Act of 2005 includes a 3% rate increase for CalOPTIMA, a County Organized Health System operating in Orange County. The effective date of the rate increase is October 1, 2005.

| | Total Fund | General Fund |
|-------------------|---------------------|---------------------|
| FY 2005-06 | \$16,561,000 | \$11,062,000 |
| FY 2006-07 | \$22,402,000 | \$11,222,000 |

MANAGED CARE INTERGOVERNMENTAL TRANSFER

REGULAR POLICY CHANGE NUMBER: 38
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Shelley Stankeivicz
 FISCAL REFERENCE NUMBER: 1054

| | FY 2005-06 | FY 2006-07 |
|------------------------------|-------------|-------------|
| FULL YEAR COST - TOTAL FUNDS | \$8,000,000 | \$8,000,000 |
| - STATE FUNDS | \$4,000,000 | \$4,000,000 |
| | | |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| | | |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$8,000,000 | \$8,000,000 |
| STATE FUNDS | \$4,000,000 | \$4,000,000 |
| FEDERAL FUNDS | \$4,000,000 | \$4,000,000 |

DESCRIPTION

The County of San Mateo will transfer funds to the Department for the purpose of providing capitation rate increases to the Health Plan of San Mateo (HPSM). These funds will be used for the nonfederal share of capitation rate increases paid to HPSM. The transfer of funds began February 2006 and was effective retroactively to July 2005.

| | FY 2005-06 | FY 2006-07 |
|--|--------------------|--------------------|
| | Reimbursements | |
| County of San Mateo for Health Plan of San Mateo | \$4,000,000 | \$4,000,000 |
| Increased Capitation Costs Health Plan of San Mateo | | |
| Total Funds | \$8,000,000 | \$8,000,000 |
| State Funds | \$4,000,000 | \$4,000,000 |

The State Funds above are the reimbursement from the County of San Mateo.

STANISLAUS 2-PLAN MODEL RECONVERSION

REGULAR POLICY CHANGE NUMBER: 39
 IMPLEMENTATION DATE: 8/2005
 ANALYST: Shelley Stankeivicz
 FISCAL REFERENCE NUMBER: 69

| | FY 2005-06 | FY 2006-07 |
|------------------------------|--------------|---------------|
| FULL YEAR COST - TOTAL FUNDS | -\$9,814,000 | -\$14,135,000 |
| - STATE FUNDS | -\$4,938,500 | -\$7,105,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -\$9,814,000 | -\$14,135,000 |
| STATE FUNDS | -\$4,938,500 | -\$7,105,000 |
| FEDERAL FUNDS | -\$4,875,500 | -\$7,030,000 |

DESCRIPTION

Previously Stanislaus County was a fully converted two-plan Medi-Cal managed care county until the Commercial Plan (CP), Omni, terminated its contract in 1999. Fee-for-Service (FFS) was restored in Stanislaus as an option for beneficiaries pending the procurement of a CP. Stanislaus converted back to an operational two-plan Medi-Cal managed care county beginning August 2005. The new CP is Health Net.

Six zip code areas do not have mandatory enrollment in Stanislaus County. Beneficiaries in those six zip codes have the option to voluntarily enroll in the local initiative, remain in FFS, or effective June 2006, the added option to voluntarily enroll in the CP.

In the first year the shift from FFS to managed care results in increased cost due to the payment lags in the FFS system. The Two-Plan Model policy change reflects costs for the eligibles in the new Stanislaus CP. This policy change reflects the shift of costs out of FFS.

| | FY 2005-06 | FY 2006-07 |
|--------------------------------|--------------|---------------|
| Stanislaus CP Capitation Costs | \$11,776,000 | \$14,135,000 |
| FFS Payment Lag | x .8334 | x 1.0 |
| FFS Lagged Savings | -\$9,814,000 | -\$14,135,000 |

RISK PAYMENTS FOR MANAGED CARE PLANS

REGULAR POLICY CHANGE NUMBER: 40
 IMPLEMENTATION DATE: 7/2000
 ANALYST: Shelley Stankeivicz
 FISCAL REFERENCE NUMBER: 65

| | FY 2005-06 | FY 2006-07 |
|------------------------------|-------------|-------------|
| FULL YEAR COST - TOTAL FUNDS | \$5,775,000 | \$6,300,000 |
| - STATE FUNDS | \$2,887,500 | \$3,150,000 |
| | | |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| | | |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$5,775,000 | \$6,300,000 |
| STATE FUNDS | \$2,887,500 | \$3,150,000 |
| FEDERAL FUNDS | \$2,887,500 | \$3,150,000 |

DESCRIPTION

County Organized Health Systems and the Two-Plan Model Medi-Cal managed care health care plans have the option of receiving rates with reinsurance. Reinsurance payments are made to participating plans when an individual beneficiary's cost exceeds a specified amount. Plans selecting reinsurance protection receive slightly lower monthly capitation rates.

Currently, the only plan which participates in reinsurance is Santa Barbara Regional Health Initiative.

SAN DIEGO COMMUNITY HEALTH GROUP AUGMENTATION

REGULAR POLICY CHANGE NUMBER: 43
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Shelley Stankeivicz
 FISCAL REFERENCE NUMBER: 1055

| | FY 2005-06 | FY 2006-07 |
|------------------------------|-------------|-------------|
| FULL YEAR COST - TOTAL FUNDS | \$3,000,000 | \$3,000,000 |
| - STATE FUNDS | \$1,500,000 | \$1,500,000 |
| | | |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| | | |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$3,000,000 | \$3,000,000 |
| STATE FUNDS | \$1,500,000 | \$1,500,000 |
| FEDERAL FUNDS | \$1,500,000 | \$1,500,000 |

DESCRIPTION

The Budget Act of 2005 includes an augmentation of \$3,000,000 (\$1,500,000 GF) annually for the San Diego Community Health Group to maintain fiscal solvency, as directed by the Department of Managed Health Care and a corrective action plan.

PCCM AIDS HEALTHCARE FDN EXPANSION

REGULAR POLICY CHANGE NUMBER: 44
 IMPLEMENTATION DATE: 10/2006
 ANALYST: Shelley Stankeivicz
 FISCAL REFERENCE NUMBER: 70

| | FY 2005-06 | FY 2006-07 |
|------------------------------|------------|-------------|
| FULL YEAR COST - TOTAL FUNDS | \$0 | \$1,616,000 |
| - STATE FUNDS | \$0 | \$808,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$0 | \$1,616,000 |
| STATE FUNDS | \$0 | \$808,000 |
| FEDERAL FUNDS | \$0 | \$808,000 |

DESCRIPTION

AIDS Healthcare Foundation (AHF) located in Los Angeles County will expand into San Bernardino and Riverside Counties in October 2006. The scope of services will be the same scope of services provided by AHF in Los Angeles. This policy change shifts the costs from fee-for-service to managed care.

| County | Projected Enrollment | | |
|------------------------------|------------------------------|--------------------|-----------|
| | Start Date | June 2006 | June 2007 |
| San Bernardino | 10/06 | 0 | 270 |
| Riverside | 10/06 | 0 | 250 |
| | Projected Costs - Both Plans | | |
| | FY 2005-06 | FY 2006-07 | |
| Managed Care Costs | \$0 | \$6,464,000 | |
| Lagged FFS Savings | \$0 | - 4,848,000 | |
| Total Cost of Shift** | \$0 | \$1,616,000 | |

**In the first twelve months of operation, the shift from FFS to Managed Care results in increased costs due to the payment lags in the FFS system.

FFS COSTS FOR MANAGED CARE ENROLLEES

REGULAR POLICY CHANGE NUMBER: 46
 IMPLEMENTATION DATE: 1/2006
 ANALYST: Shelley Stankeivicz
 FISCAL REFERENCE NUMBER: 1082

| | FY 2005-06 | FY 2006-07 |
|------------------------------|------------|------------|
| FULL YEAR COST - TOTAL FUNDS | \$0 | \$0 |
| - STATE FUNDS | \$0 | \$0 |
| | | |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| | | |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$0 | \$0 |
| STATE FUNDS | \$0 | \$0 |
| FEDERAL FUNDS | \$0 | \$0 |

DESCRIPTION

This is an informational policy change displaying the Medi-Cal fee-for-service (FFS) expenditures for Medi-Cal managed care plan enrollees. FFS expenditures occur for managed care enrollees for covered Medi-Cal services excluded by the health plan contract. In FY 2004 FFS payments for managed care enrollees totaled \$927,502,000.

| | Expenditures by Aid Category | | |
|--------------|------------------------------|---------------|---------------|
| | Other | CCS/GHPP | Total |
| Families | \$194,183,000 | \$251,112,000 | \$445,295,000 |
| Disabled | 174,406,000 | 142,477,000 | 316,883,000 |
| Aged | 83,395,000 | 35,000 | 83,430,000 |
| 200% Poverty | 7,055,000 | 17,854,000 | 24,909,000 |
| MI Child | 4,247,000 | 11,290,000 | 15,537,000 |
| 133% Poverty | 5,974,000 | 8,005,000 | 13,979,000 |
| Other | 8,817,000 | 80,000 | 8,897,000 |
| 100% Poverty | 2,539,000 | 5,039,000 | 7,578,000 |
| Blind | 2,833,000 | 3,206,000 | 6,039,000 |
| MI Adults | 3,906,000 | 1,049,000 | 4,955,000 |
| Total | \$487,355,000 | \$440,147,000 | \$927,502,000 |

MMA -- MANAGED CARE CAPITATION SAVINGS

REGULAR POLICY CHANGE NUMBER: 47
 IMPLEMENTATION DATE: 1/2006
 ANALYST: Shelley Stankeivicz
 FISCAL REFERENCE NUMBER: 1048

| | FY 2005-06 | FY 2006-07 |
|------------------------------|----------------|----------------|
| FULL YEAR COST - TOTAL FUNDS | -\$112,994,000 | -\$225,988,000 |
| - STATE FUNDS | -\$56,497,000 | -\$112,994,000 |
| | | |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| | | |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -\$112,994,000 | -\$225,988,000 |
| STATE FUNDS | -\$56,497,000 | -\$112,994,000 |
| FEDERAL FUNDS | -\$56,497,000 | -\$112,994,000 |

DESCRIPTION

Under The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), the Medicare program is providing prescription drug coverage (Part D) for Medicare/Medicaid dual eligible enrollees effective January 1, 2006. The Part D requirement resulted in lower managed care capitation payments for managed care plans for the pharmaceutical services that will be covered under Part D for the dual eligible enrollees in the Aged, Blind, Disabled, and Long Term Care groups.

| | FY 2005-06 | |
|---------------------------|-----------------------|----------------------|
| Capitation Savings | Total Funds | General Fund |
| COHS | -\$91,097,000 | -\$45,549,000 |
| Two-Plan/GMC/Other | -\$21,897,000 | -\$10,949,000 |
| Total (Eff. 1/06) | -\$112,994,000 | -\$56,498,000 |

| | | |
|--------------------|----------------|----------------|
| Annualized Savings | -\$225,988,000 | -\$112,994,000 |
|--------------------|----------------|----------------|

| | FY 2006-07 | |
|--------------------------|-----------------------|-----------------------|
| Capitation Saving | Total Funds | General Fund |
| COHS | -\$182,194,000 | -\$91,097,000 |
| Two-Plan/GMC/Other | -\$43,794,000 | -\$21,897,000 |
| Total Savings | -\$225,988,000 | -\$112,994,000 |

HOSP FINANCING - DPH AND NDPH DSH PMT

REGULAR POLICY CHANGE NUMBER: 51
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 1073

| | <u>FY 2005-06</u> | <u>FY 2006-07</u> |
|------------------------------|-------------------|-------------------|
| FULL YEAR COST - TOTAL FUNDS | \$1,620,584,000 | \$1,454,133,000 |
| - STATE FUNDS | \$674,810,000 | \$591,754,500 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$1,620,584,000 | \$1,454,133,000 |
| STATE FUNDS | \$674,810,000 | \$591,754,500 |
| FEDERAL FUNDS | \$945,774,000 | \$862,378,500 |

DESCRIPTION

Effective July 1, 2005, based on the Special Terms and Conditions of the Medi-Cal Hospital/Uninsured Care Demonstration (MH/UCD), the federal Disproportionate Share Hospital (DSH) allotment is only available for uncompensated Medi-Cal and uninsured costs incurred by designated public hospitals (DPHs) and nondesignated public hospitals (NDPHs).

DPHs will receive their allocation of federal DSH payments from the Demonstration DSH Fund based on the hospitals' certified public expenditures (CPEs), up to 100 percent of uncompensated Medi-Cal and uninsured costs. DPHs may also receive allocation of federal and nonfederal DSH payments through intergovernmental transfer-funded payments for expenditures above 100 percent of costs up to 175 percent of the hospitals' uncompensated Medi-Cal and uninsured costs.

NDPHs will receive their allocation from the Demonstration DSH Fund and State General Fund based on CPEs up to 100 percent of the hospitals' uncompensated Medi-Cal and uninsured costs.

The California DSH federal allotments for Federal Fiscal Years 2006 and 2007 are \$1,032,580,000.

The General Fund (GF) reflected in this policy change is paid from Item 4260-101-0001, the FFP from Item 4260-601-7502 or 4260-101-0890, and the IGTs from Item 4260-606-0834. It is assumed that the DSH payments will be made as follows on a cash basis:

| DSH YR | SFY | TF | GF | FFP | IGT |
|----------|---------------------|------------------------|--------------------|----------------------|----------------------|
| FFY 2006 | 2005-06 | \$1,620,584,000 | \$3,412,000 | \$945,774,000 | \$671,398,000 |
| FFY 2006 | 2006-07 | \$148,980,000 | \$1,137,000 | \$86,807,000 | \$61,036,000 |
| FFY 2007 | 2006-07 | \$1,305,153,000 | \$4,549,000 | \$775,572,000 | \$525,032,000 |
| | 2006-07 Tot. | \$1,454,133,000 | \$5,686,000 | \$862,379,000 | \$586,068,000 |

SNF RATE CHANGES AND QA FEE

REGULAR POLICY CHANGE NUMBER: 52
 IMPLEMENTATION DATE: 8/2005
 ANALYST: Karen Fairgrievies
 FISCAL REFERENCE NUMBER: 1021

| | FY 2005-06 | FY 2006-07 |
|------------------------------|---------------|---------------|
| FULL YEAR COST - TOTAL FUNDS | \$842,691,000 | \$786,619,000 |
| - STATE FUNDS | \$421,345,500 | \$393,309,500 |
| PAYMENT LAG | 0.9553 | 0.9700 |
| % REFLECTED IN BASE | 26.26 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$593,623,700 | \$763,020,400 |
| STATE FUNDS | \$296,811,870 | \$381,510,220 |
| FEDERAL FUNDS | \$296,811,870 | \$381,510,220 |

DESCRIPTION

AB 1629 (Chapter 875, Statutes of 2004) required the Department to provide a cost of living adjustment (COLA), implement a facility-specific rate methodology, and impose a quality assurance (QA) fee for freestanding skilled nursing facilities (NF-Bs), including adult subacute days and excluding pediatric subacute and rural swing days. The QA fee and rate methodology sunset on July 31, 2008. The State General Fund and the NF-Bs will share in the increased FFP generated by the QA fee.

Assumptions:

1. The QA fee is expected to generate \$116 million SGF for FY 2004-05, \$231 million SGF for FY 2005-06, and \$243 million for FY 2006-07.
2. Only the cost of the rate increase and the QA fee will be reflected in the Medi-Cal budget.
3. A State Plan Amendment (SPA) was approved in September 2005.
4. The COLA (implemented October 2005) and a 3% QA Fee rate increase (implemented March 2006) are retroactive to August 2004.
5. The rate methodology change and an increase to a 6% QA Fee rate increase will go into effect in April 2006, retroactive to August 1, 2005.

SNF RATE CHANGES AND QA FEE

REGULAR POLICY CHANGE NUMBER: 52

| | FY 2005-06 | FY 2006-07 |
|----------------------|--------------------------------|--------------------------------|
| FY 04-05 FFS Retro | \$224,977,000 TF | |
| Managed Care Retro | \$37,395,000 TF | |
| FY 05-06 FFS | \$543,283,000 TF | \$570,362,000 TF |
| Managed Care | <u>\$37,036,000 TF</u> | <u>\$41,725,000 TF</u> |
| | \$842,691,000 TF | \$612,087,000 TF |
| | | |
| FY 06-07 FFS | | \$149,350,000 TF |
| Managed Care | | <u>\$25,182,000 TF</u> |
| | | \$174,532,000 TF |
| | | |
| FY Total Cost | <u>\$842,691,000 TF</u> | <u>\$786,619,000 TF</u> |

HOSP FINANCING-DPH INTERIM PAYMENT

REGULAR POLICY CHANGE NUMBER: 55
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 1075

| | FY 2005-06 | FY 2006-07 |
|------------------------------|---------------|---------------|
| FULL YEAR COST - TOTAL FUNDS | \$735,348,000 | \$767,703,000 |
| - STATE FUNDS | \$0 | \$0 |
| PAYMENT LAG | 0.6766 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$497,536,500 | \$767,703,000 |
| STATE FUNDS | \$0 | \$0 |
| FEDERAL FUNDS | \$497,536,460 | \$767,703,000 |

DESCRIPTION

Effective July 1, 2005, based on the Special Terms and Conditions of the Medi-Cal Hospital/Uninsured Care Demonstration, Designated Public Hospitals (DPHs) will no longer receive negotiated per diem payments for inpatient hospital costs for services rendered to Medi-Cal beneficiaries on and after July 1, 2005. Per diem payments consisted of GF and FFP.

DPHs will now receive estimated interim payments based on certified public expenditures for providing inpatient hospital care to Medi-Cal beneficiaries. Interim payments will be all FFP and will be one-half of the certified public expenditures by the hospitals.

Assumptions:

1. Based on hospitals' FY 2004-05 filed Medi-Cal Cost Reports, assume hospital inpatient costs and additional allowable costs are \$1,398,000,000.
2. Assume costs will increase at the rate identified in the Consumer Price Index (CPI) - All Urban Consumers for hospitals and related services.
3. The annual CPI for 2005 was 5.2%.
4. The annual CPI for 2006 is assumed to be 4.4% (based on the trend for the last three years).

| | | | |
|------------|-------------------|------------------------------------|-----------------|
| FY 2005-06 | \$1,398,000,000 + | $(\$1,398,000,000 \times 1.052) =$ | \$1,470,696,000 |
| FY 2006-07 | \$1,470,696,000 + | $(\$1,470,696,000 \times 1.044) =$ | \$1,535,407,000 |

| | FY 2005-06 | FY 2006-07 |
|--------------|----------------------|----------------------|
| Hospital CPE | \$1,470,696,000 | \$1,535,407,000 |
| FFP | \$735,348,000 | \$767,703,000 |

HOSP FINANCING - SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 56
 IMPLEMENTATION DATE: 9/2005
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 1072

| | FY 2005-06 | FY 2006-07 |
|------------------------------|---------------|---------------|
| FULL YEAR COST - TOTAL FUNDS | \$400,519,000 | \$633,169,000 |
| - STATE FUNDS | \$0 | \$0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$400,519,000 | \$633,169,000 |
| STATE FUNDS | \$0 | \$0 |
| FEDERAL FUNDS | \$400,519,000 | \$633,169,000 |

DESCRIPTION

Effective July 1, 2005, based on the Special Terms and Conditions (STC) of the Medi-Cal Hospital/Uninsured Care Demonstration, a Safety Net Care Pool (SNCP) is established to support the provision of services to the uninsured. The SNCP makes available \$586 million in federal matching dollars. The SNCP is to be distributed according to the requirements specified in SB 1100. SNCP funds cannot be used for costs associated with the provision of non-emergency care to unqualified aliens. To comply with this provision, services that can be identified as being provided to undocumented aliens will not be claimed. For programs where services provided to undocumented aliens cannot be identified, total expenditures to be matched with SNCP funds are reduced by 17.79 percent.

As authorized by the Special Terms and Conditions of the MH/UCD, the Department will claim FFP for expenditures for four State-only funded programs. All federal SNCP funds claimed and received will be deposited in the Health Care Support Fund Item 4260-601-7503 and then distributed to the appropriate program. The MIA LTC, BCCTP, CCS, and GHPP FFP is budgeted in separate policy changes within the Medi-Cal Estimate.

| | FY 2005-06 | FY 2006-07 |
|--|--------------|--------------|
| GHPP | \$8,071,000 | \$19,149,000 |
| CCS | \$22,754,000 | \$53,304,000 |
| Total (In separate Medi-Cal PCs and in Family Health Est.) | \$30,825,000 | \$72,453,000 |
| MIA LTC | \$9,949,000 | \$24,031,000 |
| BCCTP | \$362,000 | \$692,000 |
| Total (In separate Medi-Cal PCs) | \$10,311,000 | \$24,723,000 |

HOSP FINANCING - SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 56

FFP available for hospitals:

FY 2005-06: \$586,000,000 - \$30,825,000 - \$10,311,000 = \$544,864,000

FY 2006-07: \$586,000,000 - \$72,453,000 - \$24,723,000 = \$488,824,000

FFP provided to private and non-designated public hospitals may have to be matched with GF to maintain the balance between the hospital types as required by SB 1100. The amount of GF needed, if any, will be determined when the Department receives the information on the actual costs from the hospitals.

Expected payments to hospitals:

| SNCP FY (Sept - Aug) | FY | Payment |
|---------------------------------|----------------|----------------------|
| 2005-06 | 2005-06 | \$400,519,000 |
| 2005-06 | 2006-07 | \$144,345,000 |
| 2006-07 | 2006-07 | \$488,824,000 |
| Total | 2006-07 | \$633,169,000 |

HOSP FINANCING - PRIVATE DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER: 58
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 1071

| | FY 2005-06 | FY 2006-07 |
|------------------------------|---------------|---------------|
| FULL YEAR COST - TOTAL FUNDS | \$348,780,000 | \$542,546,000 |
| - STATE FUNDS | \$174,390,000 | \$271,273,000 |
| | | |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| | | |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$348,780,000 | \$542,546,000 |
| STATE FUNDS | \$174,390,000 | \$271,273,000 |
| FEDERAL FUNDS | \$174,390,000 | \$271,273,000 |

DESCRIPTION

Effective July 1, 2005, based on the Special Terms and Conditions of the Medi-Cal Hospital/Uninsured Care Demonstration, private hospitals will receive Medi-Cal DSH replacement payment adjustments. The payment adjustments provided will satisfy the State's payment obligations, if any, with respect to those hospitals under Federal DSH statute. The federal share of these payments will be regular Title XIX funding and will not be claimed from the federal DSH allotment. The non-federal share of these payments will be State General Fund. It is assumed that the DSH payments will be made as follows on a cash basis:

| DSH YR | FY | TF | GF | FFP |
|----------|----------------------|----------------------|----------------------|----------------------|
| FFY 2006 | 2005-06 | \$348,780,000 | \$174,390,000 | \$174,390,000 |
| FFY 2006 | 2006-07 | \$116,260,000 | \$58,130,000 | \$58,130,000 |
| FFY 2007 | 2006-07 | \$426,286,000 | \$213,143,000 | \$214,143,000 |
| | Total 2006-07 | \$542,546,000 | \$271,273,000 | \$271,273,000 |

DSH PAYMENTS

REGULAR POLICY CHANGE NUMBER: 59
 IMPLEMENTATION DATE: 7/1992
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 73

| | FY 2005-06 | FY 2006-07 |
|------------------------------|---------------|------------|
| FULL YEAR COST - TOTAL FUNDS | \$281,611,000 | \$0 |
| - STATE FUNDS | \$140,805,500 | \$0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$281,611,000 | \$0 |
| STATE FUNDS | \$140,805,500 | \$0 |
| FEDERAL FUNDS | \$140,805,500 | \$0 |

DESCRIPTION

SB 855 (Chapter 279/91) established the Medi-Cal Inpatient Payment Adjustment (MIPA) Fund (Item 4260-606-0834). Public (transferor) entities make intergovernmental transfers (IGTs) to the MIPA Fund. Funds are allocated from the MIPA Fund to Disproportionate Share Hospitals (DSH) by the Department and matched by federal funds.

Assumptions:

California's DSH federal allotments for Federal Fiscal Years (FFY) 2004 and 2005 are \$1,032,580,000.

- The total DSH program amounts for FFYs 2004 and 2005 are \$2,065,160,000.
- Effective July 1, 2005, based on the Special Terms and Conditions of the Medi-Cal Hospital/Uninsured Demonstration (MH/UCD) Project, the federal DSH allotments are only available for uncompensated Medi-Cal and uninsured costs incurred by designated and non-designated public hospitals. See the Hospital Financing DSH payments policy change for DSH payments under the MH/UCD.
- This policy change reflects remaining payments for FY 2003-04 and FY 2004-05 that will be paid in FY 2005-06.

| DSH YR | SFY | Qtr | Total |
|----------|--------------|-----|----------------------|
| FFY 2004 | 2005-06 | 3 | \$21,133,000 |
| FFY 2004 | 2005-06 | 4 | \$948,000 |
| FFY 2005 | 2005-06 | 4 | \$259,530,000 |
| | Total | | \$281,611,000 |

DSH PAYMENTS**REGULAR POLICY CHANGE NUMBER: 59**

4. The remaining DSH administrative fee for FY 2003-04 and FY 2004-05, totaling \$4,630,000 will be allocated from the MIPA Fund to the Health Care Deposit Fund for Medi-Cal in FY 2005-06.
5. The \$85 million DSH administrative fee is eliminated by SB 1100 for FY 2005-06 and any subsequent state fiscal years during the MH/UCD. The administrative fee is reflected in the Management Summary.

HOSP FINANCING - PRIVATE HOSPITAL SUPP PMT

REGULAR POLICY CHANGE NUMBER: 61
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 1085

| | FY 2005-06 | FY 2006-07 |
|------------------------------|---------------|---------------|
| FULL YEAR COST - TOTAL FUNDS | \$245,800,000 | \$246,742,000 |
| - STATE FUNDS | \$122,900,000 | \$123,371,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$245,800,000 | \$246,742,000 |
| STATE FUNDS | \$122,900,000 | \$123,371,000 |
| FEDERAL FUNDS | \$122,900,000 | \$123,371,000 |

DESCRIPTION

Effective July 1, 2005, based on the Special Terms and Conditions of the Medi-Cal Hospital/Uninsured Care Demonstration (MH/UCD), supplemental reimbursement will be available to private hospitals. Private hospitals will receive payments from the newly established Private Hospital Supplemental Fund using State General Fund, intergovernmental transfers (IGTs), and interest accrued in the Private Hospital Supplemental Fund as the non-federal share of costs. Interest accrued in a fiscal year is assumed to be paid in the subsequent fiscal year. 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 688).

SB 1100 (Chapter 560, Statutes of 2005) requires the Department to transfer \$118,400,000 annually from the General Fund to the Private Hospital Supplemental Fund to be used for the non-federal share of the supplemental payments. Part of the distribution of the Private Hospital Supplemental Fund will be based on the requirements specified in SB 1100, while the remainder will be subject to negotiations with the California Medical Assistance Commission.

The GF reflected in this policy change is paid from the Private Hospital Supplemental Fund, Item 4260-601-3097. The source of the GF is the Medi-Cal GF Item 4260-101-0001.

(Dollars in Thousands)

| | FY 2005-06 | | | |
|---------------|------------------|------------------|----------------|------------------|
| | TF | GF | SF | FFP |
| Appropriation | \$236,800 | \$118,400 | - | \$118,400 |
| IGT | \$9,000 | - | \$4,500 | \$4,500 |
| Total | \$245,800 | \$118,400 | \$4,500 | \$122,900 |

HOSP FINANCING - PRIVATE HOSPITAL SUPP PMT

REGULAR POLICY CHANGE NUMBER: 61

(Dollars in Thousands)

| | FY 2006-07 | | | |
|---|-------------------|------------------|----------------|------------------|
| | TF | GF | SF | FFP |
| Appropriation | \$236,800 | \$118,400 | - | \$118,400 |
| FY 2005-06 GF expenditure based on interest earned through Feb. 2006 | \$942 | \$471 | - | \$471 |
| IGT | \$9,000 | - | \$4,500 | \$4,500 |
| Total | \$246,742 | \$118,871 | \$4,500 | \$123,371 |

CAPITAL PROJECT DEBT REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 62
 IMPLEMENTATION DATE: 7/1991
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 82

| | FY 2005-06 | FY 2006-07 |
|------------------------------|---------------|---------------|
| FULL YEAR COST - TOTAL FUNDS | \$124,923,000 | \$101,012,000 |
| - STATE FUNDS | \$62,461,500 | \$50,506,000 |
| | | |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| | | |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$124,923,000 | \$101,012,000 |
| STATE FUNDS | \$62,461,500 | \$50,506,000 |
| FEDERAL FUNDS | \$62,461,500 | \$50,506,000 |

DESCRIPTION

SB 1732 (Chapter 1635, Statutes of 1988), and SB 2665 (Chapter 1310, Statutes of 1990) authorize Medi-Cal reimbursement of revenue and general obligation bond debt for principal and interest costs incurred in the construction, renovation and replacement of qualifying hospital facilities, i.e., disproportionate share contract hospitals.

Estimates include any FMAP changes. These funds are budgeted in Items 4260-102-0001 and 4260-102-0890.

| | FY 2005-06 | FY 2006-07 |
|-----------------------|----------------------|----------------------|
| Total Payments | \$124,923,000 | \$101,012,000 |
| State Funds | \$62,461,500 | 50,506,000 |

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 64
 IMPLEMENTATION DATE: 4/2004
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 78

| | <u>FY 2005-06</u> | <u>FY 2006-07</u> |
|------------------------------|-------------------|-------------------|
| FULL YEAR COST - TOTAL FUNDS | \$125,000,000 | \$130,000,000 |
| - STATE FUNDS | \$0 | \$0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$125,000,000 | \$130,000,000 |
| STATE FUNDS | \$0 | \$0 |
| FEDERAL FUNDS | \$125,000,000 | \$130,000,000 |

DESCRIPTION

AB 915 (Chapter 747, Statutes of 2002) created a supplemental reimbursement program for publicly owned or operated hospital outpatient departments. Hospitals will now receive outpatient supplemental payments based on certified public expenditures for providing outpatient hospital care to Medi-Cal beneficiaries. The supplemental amount, when combined with the amount received from all other sources of reimbursement, cannot exceed 100% of the costs of providing services to Medi-Cal beneficiaries by the participating facilities. The non-federal match used to draw down FFP is paid exclusively with funds from the participating facilities and does not involve General Fund dollars.

Payments of \$125 million FFP will be made in June 2006 for services provided in FY 2004-05; payments of \$130 million are expected to be made in June 2007 for services provided in FY 2005-06.

Projected costs are as follows:

| | <u>FY 2005-06</u> | <u>FY 2006-07</u> |
|------------------------|----------------------|----------------------|
| FY 2004-05 FFP payment | \$125,000,000 | |
| FY 2005-06 FFP payment | | \$130,000,000 |
| Total | \$125,000,000 | \$130,000,000 |

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 65
 IMPLEMENTATION DATE: 8/2005
 ANALYST: Karen Fairgrievies
 FISCAL REFERENCE NUMBER: 1046

| | FY 2005-06 | FY 2006-07 |
|------------------------------|---------------|---------------|
| FULL YEAR COST - TOTAL FUNDS | \$110,184,000 | \$185,355,000 |
| - STATE FUNDS | \$55,092,000 | \$92,677,500 |
| PAYMENT LAG | 0.8808 | 0.9602 |
| % REFLECTED IN BASE | 63.90 % | 15.01 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$35,035,100 | \$151,263,400 |
| STATE FUNDS | \$17,517,540 | \$75,631,700 |
| FEDERAL FUNDS | \$17,517,540 | \$75,631,700 |

DESCRIPTION

For FY 2005-06, the LTC rates received a two-year increase, after being frozen in FY 2004-05 at the FY 2003-04 rates. The LTC rate adjustment includes Nursing Facility-As (NF-A), Distinct Part Nursing Facility-Bs (DP/NF-Bs), Rural Swing Beds, Distinct Part Subacute, Pediatric Subacute, and ICF-DD facilities. The NF-B rate increase is defined by AB 1629 (Chapter 875, Statutes of 2004) and is included in the SNF Rate Changes and QA Fee policy change.

Assumptions:

1. The cumulative weighted increase for NF-As, DP/NF-Bs, Rural Swing Beds, Distinct Part Subacute, and Pediatric Subacutes was 14.40% in FY 2005-06. The estimated FY 2006-07 increase for these facilities is 7.20%
2. For ICF-DDs, including Habilitative and Nursing, the cumulative weighted increase was 6.68% in FY 2005-06. The estimated FY 2006-07 increase for these facilities is 3.08%.
3. FY 2005-06 rate increases were effective August 2005. FY 2006-07 rate increases will be effective August 2006.
4. Costs for some managed care programs have been included in this policy change. The LTC increases have been incorporated into the capitation rates for SCAN, PACE, Two Plan, and AIDS Healthcare Foundation and are not included in this policy change. The total estimated annual cost for all managed care plans is estimated to be \$13,216,000.

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 65

| | FY 2005-06 | FY 2006-07 |
|--------------------------------|-------------------------|-------------------------|
| FFS ICF-DDs: | \$26,714,000 | \$14,181,000 |
| FFS other LTC: | <u>\$86,420,000</u> | <u>\$49,433,000</u> |
| Annual FFS: | \$113,134,000 | \$63,614,000 |
| | * 11/12 months | * 11/12 months |
| FY Increase: | <u>\$103,706,000</u> | <u>\$58,312,000</u> |
| Managed Care: | <u>\$6,478,000</u> | <u>\$7,431,000</u> |
| FY Cost: | \$110,184,000 TF | \$65,743,000 |
| FY 2005-06 Annual Increase: | | <u>\$119,612,000</u> |
| FY Cost: | | \$185,355,000 TF |

HOSP FINANCING-DPH PHYSICIAN & NON-PHYSICIAN

REGULAR POLICY CHANGE NUMBER: 66
 IMPLEMENTATION DATE: 7/2006
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 1078

| | FY 2005-06 | FY 2006-07 |
|------------------------------|------------|--------------|
| FULL YEAR COST - TOTAL FUNDS | \$0 | \$96,763,000 |
| - STATE FUNDS | \$0 | \$0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$0 | \$96,763,000 |
| STATE FUNDS | \$0 | \$0 |
| FEDERAL FUNDS | \$0 | \$96,763,000 |

DESCRIPTION

Effective July 1, 2005, based on the Terms and Conditions of the Medi-Cal Hospital/Uninsured Care Demonstration, supplemental reimbursement based on certified public expenditures will be available to designated public hospitals for their costs incurred for physician and non-physician practitioner services. The supplemental reimbursement under the MH/UCD is available only for costs provided to Medi-Cal beneficiaries who are patients of the hospital or its affiliated hospital and non-hospital settings. Reimbursements are for costs that are in excess of the payments received on a per-visit or per-procedure basis for such services from any Medi-Cal source of reimbursement.

Assumptions:

1. Based on data provided by the California Association of Public Hospitals and Health Systems, assume the physician/non-physician costs from the Medi-Cal cost reports for FY 2004-05 that are in excess of any Medi-Cal payment are \$90,000,000.
2. Assume costs will increase at the rate identified in the Consumer Price Index (CPI) - All Urban Consumers for hospitals and related services.
3. The annual CPI for 2005 was 5.2%.
4. The annual CPI for 2006 is assumed to be 4.4% (based on the trend for the last three years)..
5. Assume payments for FY 2005-06 and FY 2006-07 will be paid in FY 2006-07.

FY 2005-06: \$90,000,000 x 1.052 = \$94,680,000 (\$47,340,000 FFP)

FY 2006-07: \$94,680,000 x 1.044 = \$98,846,000 (\$49,423,000 FFP)

Total to be paid in **FY 2006-07 = \$96,763,000 FFP**

FFP FOR LOCAL TRAUMA CENTERS

REGULAR POLICY CHANGE NUMBER: 70
 IMPLEMENTATION DATE: 2/2006
 ANALYST: Karen Fairgrievies
 FISCAL REFERENCE NUMBER: 104

| | FY 2005-06 | FY 2006-07 |
|------------------------------|--------------|--------------|
| FULL YEAR COST - TOTAL FUNDS | \$55,314,000 | \$24,000,000 |
| - STATE FUNDS | \$27,657,000 | \$12,000,000 |
| | | |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| | | |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$55,314,000 | \$24,000,000 |
| STATE FUNDS | \$27,657,000 | \$12,000,000 |
| FEDERAL FUNDS | \$27,657,000 | \$12,000,000 |

DESCRIPTION

In the Budget Act of 2003 and the Health Care Trailer Bill (AB 1762), the Legislature authorized Los Angeles and Alameda Counties to transfer funds to the Medi-Cal program to be matched with Title XIX federal funds. Under the authority of Sections 14164 and 14087.3 of the Welfare and Institutions Code, the Department will use the funds to offset costs of care at local trauma care centers throughout the counties. Payments for Alameda County began in February 2006 and are retroactive to July 1, 2003. Payments for Los Angeles County are expected to begin in April 2006 and to be retroactive to July 1, 2003. The State Plan Amendment was approved March 31, 2005.

The non-federal match is paid by Los Angeles and Alameda Counties through the Special Deposit Fund 4260-601-0942142:

FY 2005-06

| | |
|-----------------------|---------------------|
| FY 2003-04 Retro: | \$ 7,157,000 |
| FY 2004-05 Retro: | \$ 8,500,000 |
| FY 2005-06 Ongoing: | \$12,000,000 |
| Fund 4260-601-0942142 | \$27,657,000 |
| FFP match | \$27,657,000 |
| Total | \$55,314,000 |

FY 2006-07

| | |
|--------------------------------|---------------------|
| Fund 4260-601-0942142 Ongoing: | \$12,000,000 |
| FFP match | \$12,000,000 |
| Total | \$24,000,000 |

MMA 100-DAY PRESCRIPTION SUPPLY

REGULAR POLICY CHANGE NUMBER: 71
 IMPLEMENTATION DATE: 12/2005
 ANALYST: Karen Fairgrievies
 FISCAL REFERENCE NUMBER: 1090

| | FY 2005-06 | FY 2006-07 |
|------------------------------|---------------|------------|
| FULL YEAR COST - TOTAL FUNDS | \$109,721,000 | \$0 |
| - STATE FUNDS | \$54,860,500 | \$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 |

DESCRIPTION

Medicare's Part D prescription drug plan began on January 1, 2006. Medi-Cal beneficiaries who also qualify for Medicare (dual eligibles) will no longer receive prescription drugs from Medi-Cal, with the exception of a few classes shown in the policy change for Medi-Cal Continuation of Part D Excluded Drug Coverage. Medicare Part D will administer the majority of their prescription drugs.

Assumptions:

1. Medi-Cal allows a 100-day supply of most prescription drugs. Approximately 22% of dual eligible prescriptions in 2004-05 were over a 30-day supply, with 5.2% at a 100-day supply.
2. Due to the concern that Part D would interrupt a dual eligible's prescription drug service or that prescribed drug would no longer be available, the Department experienced an increase in the prescriptions for over 30-days' supply and for the 100-day supply.
3. Prescriptions for over 30-days' supply increased to 29% of the total, with 9% at a 100-day supply.
4. There was also an increase in overall prescriptions; 513,000 additional prescriptions were filled during December.

| | TF | GF |
|---------------------------|----------------------|----------------------|
| Increase in days supply | \$ 57,305,000 | \$ 28,652,500 |
| Increase in prescriptions | \$ 52,416,000 | \$ 26,208,000 |
| Total cost | \$109,721,000 | \$ 54,860,500 |

CERTIFICATION PAYMENTS FOR DP-NFS

REGULAR POLICY CHANGE NUMBER: 72
 IMPLEMENTATION DATE: 6/2002
 ANALYST: Karen Fairgrievies
 FISCAL REFERENCE NUMBER: 86

| | FY 2005-06 | FY 2006-07 |
|------------------------------|--------------|--------------|
| FULL YEAR COST - TOTAL FUNDS | \$37,000,000 | \$36,000,000 |
| - STATE FUNDS | \$0 | \$0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$37,000,000 | \$36,000,000 |
| STATE FUNDS | \$0 | \$0 |
| FEDERAL FUNDS | \$37,000,000 | \$36,000,000 |

DESCRIPTION

The Budget Act of 2001, authorized payment of federal financial participation (FFP) based on Certified Public Expenditures (CPE) to Nursing Facilities (NF) that are Distinct Parts (DP) of acute care hospitals. The acute care hospital must be owned and operated by a public entity, such as a city, county, or health care district. This program is designed to allow DP-NFs to claim federal financial participation on the difference between their projected costs and the amount Medi-Cal currently pays under the existing program.

Payments are not made through the fiscal intermediary; consequently, they are not reflected in the Medi-Cal base trend data and must be budgeted in this policy change. Base expenditures projected for FY 2005-06 and FY 2006-07 are \$36,000,000 FFP in each fiscal year.

The Department froze DP-NFs' "projected cost per patient per day" rates in FY 2004-05. In February 2005, it was determined that this rate should not have been frozen. With an unfrozen rate, additional facilities met the requirements for FFP based on CPEs. FFP totaling \$3.3 million to these facilities for FY 2004-05 is expected to be paid in early FY 2005-06.

Some facilities were found to have overstated their Medi-Cal days and now must repay the FFP. The payments are expected to occur in FY 2005-06 for a total of \$2.3 million.

| | FY 2005-06 | FY 2006-07 |
|------------------------------|---------------------|---------------------|
| Base FFP based on CPEs | \$36,000,000 | \$36,000,000 |
| "Frozen" rate payments | \$3,300,000 | \$0 |
| Overstated facility payments | \$(2,300,000) | \$0 |
| Total | \$37,000,000 | \$36,000,000 |

FQHC RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 73
 IMPLEMENTATION DATE: 8/2004
 ANALYST: Karen Fairgrievs
 FISCAL REFERENCE NUMBER: 161

| | FY 2005-06 | FY 2006-07 |
|------------------------------|--------------|--------------|
| FULL YEAR COST - TOTAL FUNDS | \$31,814,000 | \$25,291,000 |
| - STATE FUNDS | \$15,907,000 | \$12,645,500 |
| PAYMENT LAG | 0.9975 | 0.9955 |
| % REFLECTED IN BASE | 89.80 % | 92.59 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$3,236,900 | \$1,865,600 |
| STATE FUNDS | \$1,618,460 | \$932,810 |
| FEDERAL FUNDS | \$1,618,460 | \$932,820 |

DESCRIPTION

Changes have been made in the payments to FQHCs and RHCs to reflect the costs of managed care differential payments, additional payments for services to Medicare Crossover and CHDP beneficiaries, and scope of service changes authorized by the Benefits Improvement and Protection Act (BIPA 2000).

Assumptions:

1. Retroactive payments are for the FQHCs' year end 2001 through 2004.
2. Scope of Service settlements for 25 facilities were completed for retroactive payments for January 2001 through June 2004 in FY 04-05. An estimated 92 facilities will have settlements completed and paid in FY 2005-06.
3. Ongoing rate adjustments for scope of service changes will occur at the same time the retroactive payments are made.
4. Ongoing managed care and crossover adjustments are made each year.
5. The cessation of cost audits of FQHCs will result in a loss of savings of \$10,000,000 annually starting July 2003 and is fully incorporated in the base data.

FQHC RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 73

| <i>(Dollars in Thousands)</i> | FY 2005-06 | FY 2006-07 |
|-------------------------------|-------------------|-------------------|
| Scope of Service | | |
| Retroactive 2001-04 | \$21,672 | \$0 |
| Retroactive 2005-06 | \$0 | \$11,785 |
| Impact of Retro | \$378 | \$752 |
| Managed Care | \$5,616 | \$6,043 |
| Impact of Retro | \$730 | \$2,247 |
| Medicare Crossovers | \$2,419 | \$2,603 |
| Impact of Retro | \$315 | \$968 |
| CHDP/EPSTD | \$605 | \$651 |
| Impact of Retro | \$79 | \$242 |
| Total | \$31,814 | \$25,291 |

HOSP FINANCING - DISTRESSED HOSPITAL FUND

REGULAR POLICY CHANGE NUMBER: 74
 IMPLEMENTATION DATE: 6/2007
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 1070

| | FY 2005-06 | FY 2006-07 |
|------------------------------|------------|--------------|
| FULL YEAR COST - TOTAL FUNDS | \$0 | \$53,680,000 |
| - STATE FUNDS | \$0 | \$26,840,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$0 | \$53,680,000 |
| STATE FUNDS | \$0 | \$26,840,000 |
| FEDERAL FUNDS | \$0 | \$26,840,000 |

DESCRIPTION

Effective July 1, 2005, based on the Special Terms and Conditions of the Medi-Cal Hospital/Uninsured Care Demonstration, a Distressed Hospital Fund, Fund 8033, is established for hospitals that participate in selective provider contracting. SB 1100 requires the transfer of 20 percent per year of the balance of the Emergency Services and Supplemental Payments (ESSP) Fund (SB 1255, Voluntary Governmental Transfer) to the Distressed Hospital Fund. The balance is currently \$65,150,000. This funding along with the federal matching funds, any interest that accrued in the ESSP Fund, and any interest that has accrued in the Distressed Hospital Fund will be distributed through negotiations between the hospitals and the California Medical Assistance Commission (CMAC).

Contract hospitals that meet the following requirements, as determined by CMAC, are eligible for distressed funds:

1. The hospital serves a substantial volume of Medi-Cal patients.
2. The hospital is a critical component of the Medi-Cal program's health care delivery system.
3. The hospital is facing a significant financial hardship.

The State Funds reflected in this policy change are paid from the Distressed Hospital Fund, Item 4260-601-8033. The source of the State Funds are the ESSP Fund, Item 4260-601-0693. In FY 2006-07 payments will be made for the FY 2005-06 and FY 2006-07 share of the fund. It is assumed Distressed Hospital payments will be made as follows on a cash basis:

HOSP FINANCING - DISTRESSED HOSPITAL FUND

REGULAR POLICY CHANGE NUMBER: 74

| | FY 2006-07 | | |
|--|---------------------|---------------------|---------------------|
| | TF | SF | FFP |
| FY 2005-06 \$65,150,000 X .20 | \$26,060,000 | \$13,030,000 | \$13,030,000 |
| FY 2005-06 Interest earned in Fund 0693 | \$772,000 | \$386,000 | \$386,000 |
| FY 2006-07 \$65,150,000 X .20 | \$26,060,000 | \$13,030,000 | \$13,030,000 |
| FY 2006-07 Interest earned in Fund 0693 | \$664,000 | \$332,000 | \$332,000 |
| Interest earned in Fund 8033 through Feb. 2006 | \$124,000 | \$62,000 | \$62,000 |
| Total | \$53,680,000 | \$26,840,000 | \$26,840,000 |

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 78
 IMPLEMENTATION DATE: 10/2005
 ANALYST: Karen Fairgrievies
 FISCAL REFERENCE NUMBER: 96

| | FY 2005-06 | FY 2006-07 |
|------------------------------|-------------|--------------|
| FULL YEAR COST - TOTAL FUNDS | \$9,926,000 | \$16,950,000 |
| - STATE FUNDS | \$4,963,000 | \$8,475,000 |
| PAYMENT LAG | 0.8113 | 0.9373 |
| % REFLECTED IN BASE | 14.61 % | 8.90 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$6,876,400 | \$14,473,300 |
| STATE FUNDS | \$3,438,210 | \$7,236,640 |
| FEDERAL FUNDS | \$3,438,210 | \$7,236,640 |

DESCRIPTION

1. Hospice Services

Pursuant to state regulations, Medi-Cal hospice 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 increases in payment rates for hospice care services based on corresponding Medicare rates. Total expenditures for hospice services for FY 2004-05 were \$42,784,000. This policy change budgets the increase that was effective October 1, 2005 and estimates the increase for FY 2006-07.

2. Hospice Room and Board

Hospice room and board rates had been set at 95% of the weighted statewide average rate for NF-As and NF-Bs. In February 2003, the Department changed the methodology to tie each hospice facility's room and board rate to 95% of the individual facility's affiliated nursing facility rate and included ICF-DDs, ICF-DD Hs, & Ns. This was done to comply with the CMS Medicaid Manual requirements. This policy change assumes hospice room and board rates will be increased with the adoption of AB 1629 and its related State Plan Amendments. Total expenditures for hospice room and board for FY 2004-05 were \$74,262,000. The rate changes effective August 2004 were paid in January 2006. The August 2005 rate increase and quality assurance fee are expected to be paid out retroactively in April 2006.

| | FY 2005-06 | | FY 2006-07 |
|-------------------------------|--------------------|----|------------------------|
| FY 2005-06 Hospice Services : | \$2,415,000 | TF | \$3,220,000 TF |
| FY 2005-06 Room & Board : | \$7,511,000 | TF | \$8,194,000 TF |
| FY 2006-07 Hospice Services : | | | \$1,679,000 TF |
| FY 2006-07 Room & Board : | | | \$3,857,000 TF |
| Total : | \$9,926,000 | TF | \$16,950,000 TF |

ANTI-FRAUD BIC CLAIMS REPROCESSING

REGULAR POLICY CHANGE NUMBER: 79
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Karen Fairgrievies
 FISCAL REFERENCE NUMBER: 1094

| | <u>FY 2005-06</u> | <u>FY 2006-07</u> |
|------------------------------|-------------------|-------------------|
| FULL YEAR COST - TOTAL FUNDS | \$6,052,000 | \$9,808,000 |
| - STATE FUNDS | \$3,026,000 | \$4,904,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 53.70 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$2,802,100 | \$9,808,000 |
| STATE FUNDS | \$1,401,040 | \$4,904,000 |
| FEDERAL FUNDS | \$1,401,040 | \$4,904,000 |

DESCRIPTION

As part of a fraud prevention effort, the Department issued new Medi-Cal Beneficiary Identification Cards (BICs) with new ID numbers to selected groups of beneficiaries beginning in February 2002. Providers were required to use the new identification numbers and correct issue dates to have their claims adjudicated. Hospitals, long term care facilities, and certain clinics were excluded from the new billing requirements. Physician and other providers associated with these excluded entities encountered difficulties obtaining the new BIC information from the patients and the excluded entities, which led to their claims being denied.

In February 2005, an additional exemption based on the place of service was added to ensure that the Department is appropriately paying for care provided. This new policy was effective retroactively. Medi-Cal began reprocessing those claims with a date of service from February 2002 through February 2005 in July 2005. The reprocessing of claims should be completed in January 2007. Payments to providers are made as the reprocessed claims are adjudicated.

Total payments from the retroactive reprocessing of 1,638,896 claims are estimated to be \$15,860,000 TF (\$7,930,000 GF.) \$3,250,000 was paid through February 2006 and an additional \$2,802,000 is expected to be paid this fiscal year. The remaining \$9,808,000 is expected to be paid in FY 2006-07.

ANNUAL MEI INCREASE FOR FQHCS/RHCS

REGULAR POLICY CHANGE NUMBER: 80
 IMPLEMENTATION DATE: 10/2005
 ANALYST: Karen Fairgrievies
 FISCAL REFERENCE NUMBER: 88

| | FY 2005-06 | FY 2006-07 |
|------------------------------|--------------|--------------|
| FULL YEAR COST - TOTAL FUNDS | \$17,653,000 | \$39,977,000 |
| - STATE FUNDS | \$8,826,500 | \$19,988,500 |
| | | |
| PAYMENT LAG | 0.7870 | 0.9101 |
| % REFLECTED IN BASE | 62.18 % | 28.35 % |
| | | |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$5,254,300 | \$26,068,500 |
| STATE FUNDS | \$2,627,150 | \$13,034,230 |
| FEDERAL FUNDS | \$2,627,150 | \$13,034,230 |

DESCRIPTION

This Policy Change budgets the annual Medicare Economic Index (MEI) increase for all federally qualified health centers (FQHCs) and rural health clinics (RHCs) that have opted for prospective payment system (PPS) reimbursement. The annual ongoing MEI increases will be applied each October. The annual MEI for October 1, 2004 was 2.9%. For October 2005, the annual MEI increase was 3.1%

Assumptions:

1. FY 04-05 FQHC/RHC expenditures were \$759,285,000.
2. The MEI Increase effective October 1, 2006 will be 2.8%.

FY 2005-06:

2005 Increase: $\$759,285,000 \times 3.1\% \times 9/12 =$ **\$17,653,000**

FY 2006-07:

2005 Increase: $\$759,285,000 \times 3.1\% =$ \$23,538,000
 2006 Increase: $\$782,823,000 \times 2.8\% \times 9/12 =$ \$16,439,000
\$39,977,000

HEALTHY FAMILIES - CDMH

REGULAR POLICY CHANGE NUMBER: 81
 IMPLEMENTATION DATE: 7/1998
 ANALYST: Jenn Brooks
 FISCAL REFERENCE NUMBER: 89

| | <u>FY 2005-06</u> | <u>FY 2006-07</u> |
|------------------------------|-------------------|-------------------|
| FULL YEAR COST - TOTAL FUNDS | \$15,490,000 | \$16,998,000 |
| - STATE FUNDS | \$0 | \$0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$15,490,000 | \$16,998,000 |
| STATE FUNDS | \$0 | \$0 |
| FEDERAL FUNDS | \$15,490,000 | \$16,998,000 |

DESCRIPTION

This policy change reflects the FFP portion only for the program cost of providing additional services to severely emotionally disturbed children who have exhausted Healthy Families mental health benefits. This estimate was provided by the California Department of Mental Health (CDMH). The budgeted FFP amounts are the cash amounts.

*Funding is through Item 4260-113-0890 (Title XXI).

| Mental Health Services | <u>FY 2005-06</u> | <u>FY 2006-07</u> |
|-------------------------------|---------------------|---------------------|
| CDHS FFP | \$15,490,000 | \$16,998,000 |
| County Funding | \$7,877,000 | \$8,867,000 |
| CDMH GF | \$98,000 | \$98,000 |
| TOTAL | <u>\$23,465,000</u> | <u>\$25,963,000</u> |

FMAP changes are reflected in this policy change.

ORTHOPAEDIC HOSPITAL - LAB SERVICES

REGULAR POLICY CHANGE NUMBER: 83
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Karen Fairgrievies
 FISCAL REFERENCE NUMBER: 1089

| | FY 2005-06 | FY 2006-07 |
|------------------------------|-------------|--------------|
| FULL YEAR COST - TOTAL FUNDS | \$6,406,000 | \$14,594,000 |
| - STATE FUNDS | \$3,203,000 | \$7,297,000 |
| | | |
| PAYMENT LAG | 0.8916 | 1.0000 |
| % REFLECTED IN BASE | 52.96 % | 23.71 % |
| | | |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$2,686,700 | \$11,133,800 |
| STATE FUNDS | \$1,343,360 | \$5,566,880 |
| FEDERAL FUNDS | \$1,343,370 | \$5,566,880 |

DESCRIPTION

The Orthopaedic Hospital vs. Belshé settlement required the Department to increase the Medi-Cal outpatient laboratory reimbursement rates. Outpatient laboratory rates are to have an upper payment limit (UPL) equal to the Medicare rate in place on the date of service for claims from January 1, 2002 through June 30, 2005. The Department originally set the UPL at the 2001 Medicare rate and future year Medicare rates were not adjusted.

In June 2005, the Department adjusted the rates for the current fiscal year. In October 2005, the Department began the reimbursement for the previous fiscal years. The processing of the retroactive payments is expected to take 22 months.

Estimated Retroactive Reimbursement By Accrued Fiscal Year

| | |
|-------------|--------------|
| FY 2002-03: | \$4,506,000 |
| FY 2003-04: | \$4,467,000 |
| FY 2004-05: | \$4,245,000 |
| Total: | \$13,218,000 |

Estimated Payments by Fiscal Year FY 2005-06

| | |
|-------------------------|--------------------|
| Retro: | \$2,161,000 |
| FY 2005-06 Ongoing: | \$4,245,000 |
| FY 2005-06 Total | \$6,406,000 |

Estimated Payments by Fiscal Year FY 2006-07:

| | |
|-------------------------|---------------------|
| Retro: | \$10,349,000 |
| FY 2005-06 Ongoing: | \$4,245,000 |
| FY 2006-07 Total | \$14,594,000 |

The last retroactive payments of \$708,000 are expected to occur in FY 2007-08. The settlement did not require increases in the outpatient laboratory services rates in 2006 or 2007.

NON-CONTRACT HOSP. 10% INTERIM RATE RED.

REGULAR POLICY CHANGE NUMBER: 84
 IMPLEMENTATION DATE: 4/2006
 ANALYST: Karen Fairgrievies
 FISCAL REFERENCE NUMBER: 178

| | <u>FY 2005-06</u> | <u>FY 2006-07</u> |
|------------------------------|-------------------|-------------------|
| FULL YEAR COST - TOTAL FUNDS | \$10,631,000 | \$42,523,000 |
| - STATE FUNDS | \$5,315,500 | \$21,261,500 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$10,631,000 | \$42,523,000 |
| STATE FUNDS | \$5,315,500 | \$21,261,500 |
| FEDERAL FUNDS | \$5,315,500 | \$21,261,500 |

DESCRIPTION

The interim rate of payment for non-contract hospital inpatient services is calculated to approximate the reimbursable cost to the hospitals for providing services to Medi-Cal beneficiaries. The interim payment provides payments for services provided through the hospitals' fiscal year. Costs are then reconciled using hospital cost reports filed within five months of a hospital's fiscal year end. If the cost of providing services is greater than the interim payment, the hospital is reimbursed the difference. If costs are lower, the hospital must reimburse the difference to Medi-Cal.

The Trailer Bill of 2004 reduced non-contract interim hospital payments for acute inpatient services by 10%, effective September 1, 2004, for claims with dates of service after July 1, 2004. The Trailer Bill also specified that the reconciliation for this period will be the lesser of the hospital's actual cost or the audited cost per day for 2003.

This was a one-year rate reduction for which savings will occur over two fiscal years and is 100% reflected in the base trends. This policy change reflects the reconciliations only. Reconciliations are estimated to begin in April 2006. It is assumed that all the savings that were realized will be repaid in FY 2005-06 (20%) and FY 2006-07 (80%).

\$561,482,000 Non-contract hospital payments
 - \$ 1,231,000 Claims paid prior to Sept 2004
 - \$28,715,000 Administrative Days
 \$531,536,000 x 10% = \$53,154,000 (\$26,577,000 GF)

FY 2005-06: \$53,154,000 x 20% = **\$10,631,000**
FY 2006-07: \$53,154,000 x 80% = **\$42,523,000**

DSH OUTPATIENT PAYMENT METHOD CHANGE

REGULAR POLICY CHANGE NUMBER: 85
 IMPLEMENTATION DATE: 1/2005
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1038

| | <u>FY 2005-06</u> | <u>FY 2006-07</u> |
|------------------------------|-------------------|-------------------|
| FULL YEAR COST - TOTAL FUNDS | \$10,000,000 | \$10,000,000 |
| - STATE FUNDS | \$5,000,000 | \$5,000,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$10,000,000 | \$10,000,000 |
| STATE FUNDS | \$5,000,000 | \$5,000,000 |
| FEDERAL FUNDS | \$5,000,000 | \$5,000,000 |

DESCRIPTION

This policy change reflects the change in payment methodology for the Outpatient Disproportionate Share Hospital (DSH) program. Outpatient DSH has a total cap of \$10,000,000 when combined with federal matching funds.

Prior to January 1, 2005, the Department paid each hospital by authorizing the Fiscal Intermediary to increase each hospital's claims by a percentage factor using the methodology specified in statute. In order to provide a more efficient way to reimburse hospitals, effective January 1, 2005 eligible providers are reimbursed on a quarterly basis through a payment action notice (PAN). The payment represents one quarter of the total annual amount due to each eligible hospital. Due to the payment being made at the end of a quarter, the last quarter of each fiscal year will be paid the following fiscal year.

Assumption:

- For FY 2005-06, FY 2006-07, and annually, assume a total of \$10,000,000 will be paid through PANs.

| | <u>FY 2005-06</u> | <u>FY 2006-07</u> |
|----------------|-------------------|-------------------|
| Annual Payment | \$10,000,000 | \$10,000,000 |

MINOR CONSENT SETTLEMENT

REGULAR POLICY CHANGE NUMBER: 86
 IMPLEMENTATION DATE: 7/2003
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 103

| | FY 2005-06 | FY 2006-07 |
|------------------------------|-------------|-------------|
| FULL YEAR COST - TOTAL FUNDS | \$9,836,000 | \$9,467,000 |
| - STATE FUNDS | \$9,836,000 | \$9,467,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$9,836,000 | \$9,467,000 |
| STATE FUNDS | \$9,836,000 | \$9,467,000 |
| FEDERAL FUNDS | \$0 | \$0 |

DESCRIPTION

On June 17, 2002, the Department, Los Angeles County, and the U.S. Department of Justice executed a settlement agreement concerning an audit by the federal Office of the Inspector General relating to the incorrect claiming of FFP for services (especially mental health services) provided to minor consent eligibles from 1993 to 1999. The terms of the settlement include payment of \$73.5 million plus interest, of which Los Angeles County paid \$6.8 million. The balance of \$66,500,000 plus interest will be withheld from California's Medicaid payments over the next ten years, with the first "adjustment" made on July 1, 2003. The first adjustment was \$13,900,346 and it included accrued interest of \$4,156,250.

Additionally, the Department and Los Angeles County entered into a separate agreement in which the County agreed to reimburse the Department \$1,559,353 plus interest. \$59,353 was due on August 1, 2003. The remaining \$1,500,000 with 5% interest that commenced June 15, 2003, was due in five annual installments commencing August 1, 2003. The payments due August 1 of 2003 and 2004 were paid on December 6, 2004. In August 2005, Los Angeles County paid the entire balance owed to the Department.

| | FY 2005-06 | FY 2006-07 |
|-----------------------------------|-------------|-------------|
| Settlement Adjustments | \$9,836,000 | \$9,467,000 |
| LA Co. Principal & Int. Due 2005* | -345,000 | |
| LA Co. Principal Reimb. Due 2006* | -300,000 | |
| LA Co. Principal Reimb. Due 2007* | -300,000 | |
| Net General Fund Cost | \$8,891,000 | \$9,467,000 |

* The LA County reimbursements will be shown in 4260-610-0995 in the Management Summary.

VOLUNTARY GOVERNMENTAL TRANSFERS

REGULAR POLICY CHANGE NUMBER: 88
 IMPLEMENTATION DATE: 7/1990
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 74

| | <u>FY 2005-06</u> | <u>FY 2006-07</u> |
|------------------------------|-------------------|-------------------|
| FULL YEAR COST - TOTAL FUNDS | \$8,525,000 | \$0 |
| - STATE FUNDS | \$4,262,500 | \$0 |
| | | |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| | | |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$8,525,000 | \$0 |
| STATE FUNDS | \$4,262,500 | \$0 |
| FEDERAL FUNDS | \$4,262,500 | \$0 |

DESCRIPTION

The Emergency Services and Supplemental Payments Fund (Item 4260-101-0693) allows public entities to transfer funds to the Medi-Cal Program to be matched with federal funds. The combined funds are used to reimburse select hospitals having Selective Provider Contracting Program (SPCP) contracts to provide enhanced inpatient services.

The Department replaced the SPCP waiver, which expired on August 31, 2005, with the Medi-Cal Hospital/Uninsured Care Demonstration (MH/UCD) waiver.

This policy change reflects remaining payments for FY 2004-05 that will be paid in FY 2005-06.

| | |
|----------|-------------------|
| | <u>FY 2005-06</u> |
| Payments | \$ 8,525,000 |

SRH OUTPATIENT PAYMENT METHOD CHANGE

REGULAR POLICY CHANGE NUMBER: 89
 IMPLEMENTATION DATE: 1/2005
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1039

| | <u>FY 2005-06</u> | <u>FY 2006-07</u> |
|------------------------------|-------------------|-------------------|
| FULL YEAR COST - TOTAL FUNDS | \$8,000,000 | \$8,000,000 |
| - STATE FUNDS | \$4,000,000 | \$4,000,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$8,000,000 | \$8,000,000 |
| STATE FUNDS | \$4,000,000 | \$4,000,000 |
| FEDERAL FUNDS | \$4,000,000 | \$4,000,000 |

DESCRIPTION

This policy change reflects the change in payment methodology for the Outpatient Small and Rural Hospital (SRH) program. Outpatient SRH has a total cap of \$8,000,000 when combined with federal matching funds.

Prior to January 1, 2005, the Department paid each hospital by authorizing the Fiscal Intermediary to increase each hospital's claims by a percentage factor using the methodology specified in statute. In order to provide a more efficient way to reimburse hospitals, effective January 1, 2005 eligible providers are reimbursed on a quarterly basis through a payment action notice (PAN). The payment represents one quarter of the total annual amount due to each eligible hospital. Due to the payment being made at the end of a quarter, the last quarter of each fiscal year will be paid the following fiscal year.

Assumption:

1. For FY 2005-06, FY 2006-07, and annually, assume a total of \$8,000,000 will be paid through PANs.

| | <u>FY 2005-06</u> | <u>FY 2006-07</u> |
|----------------|-------------------|-------------------|
| Annual Payment | \$8,000,000 | \$8,000,000 |

NURSE-TO-PATIENT RATIOS FOR HOSPITALS

REGULAR POLICY CHANGE NUMBER: 90
 IMPLEMENTATION DATE: 1/2004
 ANALYST: Cheri Johnson
 FISCAL REFERENCE NUMBER: 101

| | FY 2005-06 | FY 2006-07 |
|------------------------------|-------------|--------------|
| FULL YEAR COST - TOTAL FUNDS | \$5,844,000 | \$14,682,000 |
| - STATE FUNDS | \$2,922,000 | \$7,341,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$5,844,000 | \$14,682,000 |
| STATE FUNDS | \$2,922,000 | \$7,341,000 |
| FEDERAL FUNDS | \$2,922,000 | \$7,341,000 |

DESCRIPTION

AB 394 (Ch.945/1999) required the Department to adopt regulations that establish minimum, specific licensed nurse-to-patient ratios by nurse classification and hospital unit for general acute care and psychiatric hospitals. The regulations specify the number of patients that may be assigned per licensed nurse in the following hospital units: critical care, burn, labor and delivery, postanesthesia, emergency, surgery, pediatric, step-down/intermediate care, specialty care, telemetry, general medical care, subacute care, and transitional inpatient care.

Assumptions:

1. The initial regulations became effective January 1, 2004.
2. The Department adopted emergency regulations to defer the nurse-to-patient ratio change from 1:6 to 1:5 for medical, surgical and mixed units from January 1, 2005, till January 1, 2008. An injunction prohibits implementation of these regulations.
3. Non-contract hospital costs lag 2 years due to the cost settlement process. This policy change includes:
 - *The 2003-04 costs for nurse staffing ratio increases implemented in January 2004, which are expected to be paid in 2005-06.
 - *The 2004-05 costs for nurse staffing ratio increases implemented in January 2004 and January 2005, which are expected to be paid in 2006-07.
4. Contract hospital costs are part of California Medical Assistance Commission negotiations; there are not separate negotiations for specific items such as the change in nurse staffing ratio.
5. Managed care costs have been incorporated into the managed care rates and are budgeted in the managed care policy changes.

HOSP FINANCING - NDPH SUPPLEMENTAL PMT

REGULAR POLICY CHANGE NUMBER: 92
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 1076

| | <u>FY 2005-06</u> | <u>FY 2006-07</u> |
|------------------------------|-------------------|-------------------|
| FULL YEAR COST - TOTAL FUNDS | \$3,800,000 | \$3,818,000 |
| - STATE FUNDS | \$1,900,000 | \$1,909,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$3,800,000 | \$3,818,000 |
| STATE FUNDS | \$1,900,000 | \$1,909,000 |
| FEDERAL FUNDS | \$1,900,000 | \$1,909,000 |

DESCRIPTION

Effective July 1, 2005, based on the Special Terms and Conditions of the Medi-Cal Hospital/Uninsured Care Demonstration, supplemental reimbursement will be available to nondesignated public hospitals (NDPHs). NDPHs will receive payments from the newly established NDPH Supplemental Fund using State General Fund 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).

SB 1100 (Chapter 560, Statutes of 2005) requires the Department to transfer \$1,900,000 annually from the General Fund to the NDPH Supplemental Fund to be used for the non-federal share of payments. Distribution of the NDPH Supplemental Fund will be determined through negotiations with the California Medical Assistance Commission.

The GF reflected in this policy change is paid from the NDPH Fund, Item 4260-601-3096. The source of the GF is the Medi-Cal GF Item, 4260-101-0001.

| | <u>FY 2005-06</u> | | |
|---------------|--------------------|--------------------|--------------------|
| | TF | GF | FFP |
| Appropriation | \$3,800,000 | \$1,900,000 | \$1,900,000 |
| Total | \$3,800,000 | \$1,900,000 | \$1,900,000 |

HOSP FINANCING - NDPH SUPPLEMENTAL PMT

REGULAR POLICY CHANGE NUMBER: 92

| | FY 2006-07 | | |
|---|--------------------|--------------------|--------------------|
| | TF | GF | FFP |
| Appropriation | \$3,800,000 | \$1,900,000 | \$1,900,000 |
| FY 2005-06 GF expenditure based on interest earned through Feb. 2006 | \$18,000 | \$9,000 | \$9,000 |
| Total | \$3,818,000 | \$1,909,000 | \$1,909,000 |

WEEKLY FORMULARY PRICING UPDATE

REGULAR POLICY CHANGE NUMBER: 93
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Karen Fairgrievies
 FISCAL REFERENCE NUMBER: 1034

| | <u>FY 2005-06</u> | <u>FY 2006-07</u> |
|------------------------------|-------------------|-------------------|
| FULL YEAR COST - TOTAL FUNDS | \$8,146,000 | \$8,500,000 |
| - STATE FUNDS | \$4,073,000 | \$4,250,000 |
| | | |
| PAYMENT LAG | 0.9404 | 1.0000 |
| % REFLECTED IN BASE | 89.70 % | 92.59 % |
| | | |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$789,000 | \$629,800 |
| STATE FUNDS | \$394,520 | \$314,920 |
| FEDERAL FUNDS | \$394,520 | \$314,920 |

DESCRIPTION

The Health Trailer Bill of 2005 required the Department to implement weekly formulary pricing for prescription drugs. With the Department having reduced drug reimbursements to AWP-17%, beginning September 2004, the reimbursement price pharmacies receive is close to their acquisition price and could fall below their acquisition price with an increase in drug costs and monthly price updates. Drug price changes and pharmacy drug purchases are a daily occurrence.

It is estimated that weekly price updates will cost \$8,500,000 annually. The Department implemented manual pricing updates for most drugs on July 19, 2005. Electronic updates for all drugs began January 1, 2006. The Department will make retroactive adjustments back to July 19, 2005 for those drugs that were not updated manually.

FY 2005-06: $\$8,500,000 \times 11.5/12 = \$8,146,000$

Medicare Part D began January 1, 2006. Part D will assume the majority of drug benefits for those dually enrolled in Medi-Cal and Medicare. The extent of the impact on the cost of weekly formulary pricing is unknown at this time. However, an overall impact of Part D on Medi-Cal's prescription drug program is shown in the MMA Drug Benefit Policy Change.

CHA V. BONTA - 1996-97 DP/NF RATES

REGULAR POLICY CHANGE NUMBER: 94
 IMPLEMENTATION DATE: 2/2006
 ANALYST: Karen Fairgrievies
 FISCAL REFERENCE NUMBER: 1033

| | FY 2005-06 | FY 2006-07 |
|------------------------------|-------------|------------|
| FULL YEAR COST - TOTAL FUNDS | \$3,133,000 | \$0 |
| - STATE FUNDS | \$1,566,500 | \$0 |
| | | |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| | | |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$3,133,000 | \$0 |
| STATE FUNDS | \$1,566,500 | \$0 |
| FEDERAL FUNDS | \$1,566,500 | \$0 |

DESCRIPTION

The California Healthcare Association (CHA) v. Bontá lawsuit sought to increase 1996-97 Medi-Cal rates to hospital-based distinct-part nursing facilities (DP/NFs). The Department has agreed to pay a maximum rate of \$218.05 to DP/NFs for FY 1996-97. This settlement was finalized in May 2005 and the federal government approved their federal financial participation (FFP) in August 2005. Payment was made in February 2006 through EDS.

Total costs are \$3,133,000 in FY 2005-06.

TWO-PLAN MODEL NOTICES OF DISPUTE

REGULAR POLICY CHANGE NUMBER: 96
 IMPLEMENTATION DATE: 7/1998
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 95

| | FY 2005-06 | FY 2006-07 |
|------------------------------|-------------|-------------|
| FULL YEAR COST - TOTAL FUNDS | \$1,000,000 | \$1,000,000 |
| - STATE FUNDS | \$1,000,000 | \$1,000,000 |
| | | |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| | | |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$1,000,000 | \$1,000,000 |
| STATE FUNDS | \$1,000,000 | \$1,000,000 |
| FEDERAL FUNDS | \$0 | \$0 |

DESCRIPTION

This policy change includes funds for settlement agreements for disputes between the Department and the Two-Plan managed care models.

OUT-OF-STATE HOSPITAL JUDGMENT

REGULAR POLICY CHANGE NUMBER: 97
 IMPLEMENTATION DATE: 1/2004
 ANALYST: Karen Fairgrievs
 FISCAL REFERENCE NUMBER: 208

| | FY 2005-06 | FY 2006-07 |
|------------------------------|------------|------------|
| FULL YEAR COST - TOTAL FUNDS | \$384,000 | \$375,000 |
| - STATE FUNDS | \$192,000 | \$187,500 |
| | | |
| PAYMENT LAG | 0.9336 | 0.8262 |
| % REFLECTED IN BASE | 70.41 % | 13.91 % |
| | | |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$106,100 | \$266,700 |
| STATE FUNDS | \$53,040 | \$133,360 |
| FEDERAL FUNDS | \$53,040 | \$133,360 |

DESCRIPTION

Out-of-state hospitals have been reimbursed for acute care inpatient services at the lesser of the out-of-state hospital's actual billed charges or the most recent statewide average of the rates paid to all California hospitals as reported by the California Medical Assistance Commission (CMAC) in its annual report to the Legislature. A Judgment Pursuant to Stipulation, issued April 21, 2004, in the consolidated cases of *Chandler Regional Medical Center, et al. v. California Department of Health Services*, and *Arizona Burn Center, et al. v. California Department of Health Services* requires that, effective for days of service on or after January 1, 2004, Medi-Cal rates for acute care inpatient services paid to out-of-state hospitals shall be the lesser of a hospital's actual billed charges or the most recent statewide average of the rates paid to CMAC contract hospitals with at least 300 beds, as reported by CMAC in its annual report to the Legislature.

The settlement also called for a \$5,500,000 lump sum payment to the hospitals. The lump sum payment with interest was paid in September 2004. The retroactive rate increase (to January 1, 2004) and ongoing increase were implemented April 2005.

The settlement increased 2004 rates by \$126 per day and 2005 rates by \$16 per day. For budgeting purposes, it is assumed that the 2006 rate increase will be equal to the 2005 increase, \$16.

FFP REPAYMENT-SPECIALTY MENTAL HEALTH

REGULAR POLICY CHANGE NUMBER: 99
IMPLEMENTATION DATE: 5/2005
ANALYST: Jenn Brooks
FISCAL REFERENCE NUMBER: 1051

| | FY 2005-06 | FY 2006-07 |
|-------------------------------------|--------------|------------|
| FULL YEAR COST - TOTAL FUNDS | \$0 | \$0 |
| - STATE FUNDS | \$1,900,000 | \$0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$0 | \$0 |
| STATE FUNDS | \$1,900,000 | \$0 |
| FEDERAL FUNDS | -\$1,900,000 | \$0 |

DESCRIPTION

The Department has agreed to repay CMS for an overpayment within the Specialty Mental Health Services Waiver administered by CDMH through an Interagency Agreement with CDHS. In its oversight role, CDMH identified overpayments to Tri-Cities, a subcontractor of the Los Angeles County Mental Health Plan, of approximately \$6.3 million in FFP for Fiscal Years 1996-97, 1998-99, 2001-02, 2002-03, and 2003-04.

On February 13, 2004, Tri-Cities, a Joint Powers Authority composed of the cities of Claremont, La Verne, and Pomona, filed Chapter 9 bankruptcy. As part of the bankruptcy proceedings, Tri-Cities identified the total overpayment amount as \$9.1 million in FFP. However, the audits are now complete and the total overpayment amount has been determined to be \$8.2 million. CDHS repaid \$6.3 million to CMS in FY 2004-05. The remainder due to CMS is \$1.9 million, which is expected to be paid in FY 2005-06.

HOSP FINANCING-MIA LTC

REGULAR POLICY CHANGE NUMBER: 100
 IMPLEMENTATION DATE: 9/2005
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 1079

| | <u>FY 2005-06</u> | <u>FY 2006-07</u> |
|------------------------------|-------------------|-------------------|
| FULL YEAR COST - TOTAL FUNDS | \$0 | \$0 |
| - STATE FUNDS | -\$12,103,000 | -\$24,031,000 |
| PAYMENT LAG | 0.8220 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$0 | \$0 |
| STATE FUNDS | -\$9,948,670 | -\$24,031,000 |
| FEDERAL FUNDS | \$9,948,670 | \$24,031,000 |

DESCRIPTION

Effective September 1, 2005, based on the Special Terms and Conditions of the Medi-Cal Hospital/Uninsured Care Demonstration, the Department may claim federal reimbursement for the Medically Indigent Adult Long-Term Care (MIA LTC) program from the Safety Net Care Pool funding established by the MH/UCD. The MIA LTC program is a State-Only funded program that covers persons ages 21 to 65 who do not have linkage to another program and who are citizens or legal residents and are residing in a Nursing Facility Level A or B.

This policy change reflects the adjustment for the 50 percent federal reimbursement received by the Department for the MIA LTC program claims based on the certification of public expenditures. The General Fund savings created will be used to support safety net hospitals under the MH/UCD.

The FFP is budgeted in the Health Care Support Fund Item 4260-601-7503.

| | <u>Est. Total Expenditures</u> | <u>FFP</u> |
|-------------------|--------------------------------|---------------------|
| FY 2005-06 | \$24,206,000 | \$12,103,000 |
| FY 2006-07 | \$48,063,000 | \$24,031,000 |

HOSP FINANCING - BCCTP

REGULAR POLICY CHANGE NUMBER: 101
 IMPLEMENTATION DATE: 9/2005
 ANALYST: Cheri Johnson
 FISCAL REFERENCE NUMBER: 1084

| | FY 2005-06 | FY 2006-07 |
|------------------------------|------------|------------|
| FULL YEAR COST - TOTAL FUNDS | \$0 | \$0 |
| - STATE FUNDS | -\$446,000 | -\$693,000 |
| PAYMENT LAG | 0.8110 | 0.9990 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$0 | \$0 |
| STATE FUNDS | -\$361,710 | -\$692,310 |
| FEDERAL FUNDS | \$361,710 | \$692,310 |

DESCRIPTION

The Budget Act of 2001 (Ch. 106/2001) authorized the Breast and Cervical Cancer Treatment Program (BCCTP) effective January 1, 2002, for women under 200% of the FPL.

A State-Only program covers women aged 65 or older, women with inadequate health coverage, undocumented women, and males for cancer treatment only. The coverage term is 18 months for breast cancer and 2 years for cervical cancer. Beneficiaries are screened through Centers for Disease Control (CDC) and Family PACT providers.

Effective September 1, 2005, based on the Special Terms and Conditions of the Medi-Cal Hospital Uninsured Care Demonstration (MH/UCD) waiver, the Department may claim federal reimbursement for State-Only BCCTP costs from the Safety Net Care Pool funding established in the MH/UCD. Funding is claimed for services provided to undocumented aliens under aid code 0U.

This policy change reflects the adjustment for the 50% federal reimbursement received by the Department for the State-Only BCCTP, based on the certification of public expenditures. The General Fund savings created from the federalization of the State-Only BCCTP will be used to support safety net hospitals under the MH/UCD.

Assumptions:

1. As of March 2006, 462 fee-for-service (FFS) eligibles were eligible for State-Only services in Aid Codes 0R (other health coverage) and 0T (women over 65, and men).
2. Based on actual claims by month of service in FY 2004-05, State-Only costs are estimated to be \$892,000 GF in FY 2005-06 and \$1,386,000 GF in FY 2006-07.

HOSP FINANCING - BCCTP

REGULAR POLICY CHANGE NUMBER: 101

3. The GF savings due to federal funding through the Safety Net Care Pool is estimated to be:

FY 2005-06: $\$892,000 \times .5 = \$446,000$ GF savings

FY 2006-07: $\$1,386,000 \times .5 = \$693,000$ GF savings

The FFP is budgeted in the Health Care Support Fund Item 4260-601-7503.

FAMILY PACT STERILIZATION POLICY

REGULAR POLICY CHANGE NUMBER: 102
 IMPLEMENTATION DATE: 2/2006
 ANALYST: Cheri Johnson
 FISCAL REFERENCE NUMBER: 1086

| | FY 2005-06 | FY 2006-07 |
|------------------------------|------------|--------------|
| FULL YEAR COST - TOTAL FUNDS | \$0 | \$0 |
| - STATE FUNDS | -\$835,000 | -\$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 | -\$835,000 | -\$2,000,000 |
| FEDERAL FUNDS | \$835,000 | \$2,000,000 |

DESCRIPTION

Effective January 1, 1997, family planning services were expanded under the Family PACT program to provide contraceptive services to more persons in need of such services who have incomes under 200% of poverty.

A Section 1115 demonstration project waiver was approved by CMS effective December 1, 1999. Family planning services and testing for sexually transmitted infections (STIs) (about 87% of FPACT costs) are eligible for 90% FFP; treatment of STIs and other family planning companion services (about 11% of costs) are eligible for the Title XIX FMAP; and treatment of other medical conditions, including inpatient care for complications from family planning services and sterilizations (about 2% of costs) are not eligible for FFP. Within these categories, costs for undocumented persons (assumed to be 13.95% of the Family PACT population) are budgeted at 100% GF.

The original waiver expired on November 30, 2004. An extension through March 31, 2006, then one-month increments, was granted by CMS. On May 27, 2004, the Department submitted an application for a 3-year renewal. The renewal request is being evaluated by CMS.

The Department revised the Family PACT sterilization policy to conform with Federal guidelines to draw down 90% FFP for sterilization procedures (currently 0% FFP). The new guidelines were implemented February 1, 2006.

Assumptions:

1. The Department will provide sterilizations only for people aged 21 or over.
2. The Department will implement a 30 day waiting period.
3. Based on analysis of procedure codes for 2003-04 data, the estimated annual FFP increase is \$2,000,000.

FAMILY PACT STERILIZATION POLICY

REGULAR POLICY CHANGE NUMBER: 102

2005-06 FFP increase:

\$2,000,000 / 12 months = \$167,000 monthly

\$167,000 x 5 months = **\$835,000**

2006-07 FFP increase:

\$2,000,000

CIGARETTE AND TOBACCO SURTAX FUNDS

REGULAR POLICY CHANGE NUMBER: 103
 IMPLEMENTATION DATE: 1/2006
 ANALYST: Karen Fairgrievies
 FISCAL REFERENCE NUMBER: 1087

| | FY 2005-06 | FY 2006-07 |
|------------------------------|------------|------------|
| FULL YEAR COST - TOTAL FUNDS | \$0 | \$0 |
| - STATE FUNDS | \$0 | \$0 |
| | | |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| | | |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$0 | \$0 |
| STATE FUNDS | \$0 | \$0 |
| FEDERAL FUNDS | \$0 | \$0 |

DESCRIPTION

Cigarette and Tobacco Products Surtax (CTPS/Proposition 99) funds have been allocated to aid in the funding of the *Orthopaedic Hospital* settlement for FY 2005-06 and FY 2006-07. The *Orthopaedic Hospital* settlement increased hospital outpatient rates by a total of 43.44% between 2001 and 2004.

FY 2005-06

| | | |
|---------------------------|---------------|---------------------|
| Hospital Services Account | 4260-101-0232 | \$5,823,000 |
| Unallocated Account | 4260-101-0236 | \$20,008,000 |
| Total | | \$25,831,000 |

FY 2006-07

| | | |
|---------------------------|---------------|---------------------|
| Hospital Services Account | 4260-101-0232 | \$18,000,000 |
| Unallocated Account | 4260-101-0236 | \$18,784,000 |
| Total | | \$36,784,000 |

This funding is identified in the management summary funding pages.

NON FFP DRUGS

REGULAR POLICY CHANGE NUMBER: 104
 IMPLEMENTATION DATE: 7/2001
 ANALYST: Karen Fairgrievies
 FISCAL REFERENCE NUMBER: 108

| | FY 2005-06 | FY 2006-07 |
|------------------------------|------------|------------|
| FULL YEAR COST - TOTAL FUNDS | \$0 | \$0 |
| - STATE FUNDS | \$536,000 | \$536,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$0 | \$0 |
| STATE FUNDS | \$536,000 | \$536,000 |
| FEDERAL FUNDS | -\$536,000 | -\$536,000 |

DESCRIPTION

Federal Medicaid rules specify that there is no FFP for drugs provided by state Medicaid Programs if the manufacturer of the drug has not signed a rebate contract with the Centers for Medicare and Medicaid Services (CMS). The Department has established claiming procedures to ensure that FFP is claimed correctly. The projected additional State General Fund dollars needed to correctly fund these costs are \$536,000 in FY 2005-06 and \$536,000 FY 2006-07.

Medicare Part D began on January 1, 2006. Part D will assume the majority of drug benefits for those dually enrolled in Medi-Cal and Medicare. The actual impact on non-FFP drugs after the implementation of Part D is unknown at this time; however, the overall impact of Part D on Medi-Cal's prescription drug program has been incorporated into the MMA Drug Benefit Policy Changes.

INDIAN HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER: 105
 IMPLEMENTATION DATE: 4/1998
 ANALYST: Jenn Brooks
 FISCAL REFERENCE NUMBER: 111

| | FY 2005-06 | FY 2006-07 |
|------------------------------|--------------|--------------|
| FULL YEAR COST - TOTAL FUNDS | \$0 | \$0 |
| - STATE FUNDS | -\$5,511,000 | -\$5,511,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$0 | \$0 |
| STATE FUNDS | -\$5,511,000 | -\$5,511,000 |
| FEDERAL FUNDS | \$5,511,000 | \$5,511,000 |

DESCRIPTION

CMS will provide 100% federal funds for services provided by Indian health clinics to Native Americans eligible for Medi-Cal. This policy change reflects the additional federal financial participation for those identifiable services entitled to full federal funding.

Assumptions:

1. Not all Indian health clinics have chosen to participate in this program at this time.
2. Based on actual federal funds claimed for FY 2004-05, the Department has projected \$5,511,000 in reimbursement for FY 2005-06 and FY 2006-07.

STATE-ONLY IMD ANCILLARY SERVICES

REGULAR POLICY CHANGE NUMBER: 106
 IMPLEMENTATION DATE: 7/1999
 ANALYST: Jenn Brooks
 FISCAL REFERENCE NUMBER: 35

| | FY 2005-06 | FY 2006-07 |
|------------------------------|---------------|---------------|
| FULL YEAR COST - TOTAL FUNDS | \$0 | \$0 |
| - STATE FUNDS | \$12,455,000 | \$11,900,000 |
| | | |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| | | |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$0 | \$0 |
| STATE FUNDS | \$12,455,000 | \$11,900,000 |
| FEDERAL FUNDS | -\$12,455,000 | -\$11,900,000 |

DESCRIPTION

This policy change includes funds to repay improperly claimed FFP for ancillary services for Medi-Cal beneficiaries residing in institutions for mental diseases (IMDs). Services provided to Medi-Cal eligibles who are under age 65 and residing in IMDs are not eligible for FFP. Ancillary services (e.g. physician services, blood, plasma, laboratory services, etc.) for beneficiaries residing in IMDs became totally state funded as of July 1, 1999. Because separate aid codes or other identifiers are not available to indicate a Medi-Cal beneficiary is residing in an IMD, FFP for those individuals is being improperly claimed by the automated system. Repayment of the FFP is calculated retrospectively based on information submitted by the Medi-Cal mental health managed care plan in each county.

This policy change reflects FMAP changes.

| | TF | FFP Repayment | FY FFP Repaid |
|-------------------------------------|--------------|------------------|------------------|
| Services Rec'd 10/01/03-09/30/04 | \$23,367,000 | \$12,455,000 | 2005-06 |
| 10/01/04-09/30/05 | \$23,799,000 | \$11,900,000 | 2006-07 |

INPATIENT PSYCHIATRIC CARE-IMD

REGULAR POLICY CHANGE NUMBER: 107
 IMPLEMENTATION DATE: 7/2003
 ANALYST: Jenn Brooks
 FISCAL REFERENCE NUMBER: 36

| | FY 2005-06 | FY 2006-07 |
|------------------------------|--------------|------------|
| FULL YEAR COST - TOTAL FUNDS | \$0 | \$0 |
| - STATE FUNDS | \$2,187,000 | \$0 |
| | | |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| | | |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$0 | \$0 |
| STATE FUNDS | \$2,187,000 | \$0 |
| FEDERAL FUNDS | -\$2,187,000 | \$0 |

DESCRIPTION

Federal Audit CIN A-09-00055 concluded that FFP was incorrectly claimed for 22 to 64 year old state mental health hospital patients temporarily released to acute care hospitals. The FFP repayment is estimated at \$552,000. CDHS already paid \$284,000. The FY 2005-06 payment is for the balance, which is \$268,000.

TO BE REPAID: FY 2005-06: \$268,000 FY 2006-07: \$0

Federal Audit CIN A-09-02-00061 concluded that FFP was incorrectly claimed for 22 to 64 year old residents of private IMDs temporarily released to acute care hospitals. The annual FFP repayment is estimated at \$885,696. The CY repayment is for the period of July 2003 through August 2005. Because of system changes implemented in August 2005, CDHS will no longer pay inpatient claims for this population, as of September 2005, so no ongoing repayment of FFP will be necessary.

TO BE REPAID: FY 2005-06: \$1,919,000 FY 06-07: \$0

FFP Repaid in FY 2005-06:

| | |
|-------------------------------------|--------------------|
| IMD Acute Care (State Facilities) | \$268,000 |
| IMD Acute Care (Private Facilities) | \$1,919,000 |
| Total | \$2,187,000 |

MEDICAL SUPPORT ENHANCEMENTS

REGULAR POLICY CHANGE NUMBER: 108
 IMPLEMENTATION DATE: 11/2006
 ANALYST: Jenn Brooks
 FISCAL REFERENCE NUMBER: 1065

| | FY 2005-06 | FY 2006-07 |
|------------------------------|------------|--------------|
| FULL YEAR COST - TOTAL FUNDS | \$0 | -\$1,224,000 |
| - STATE FUNDS | \$0 | -\$612,000 |
| PAYMENT LAG | 1.0000 | 0.7900 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$0 | -\$967,000 |
| STATE FUNDS | \$0 | -\$483,480 |
| FEDERAL FUNDS | \$0 | -\$483,480 |

DESCRIPTION

The Budget Act of 2003 included savings for a Medical Support Enhancement program. This program is designed to extend the IV-D Children program statewide. The IV-D Children program requires, through court orders, absent parents who have private health insurance, or who can afford cost-effective, county-acquired insurance, to pay for the health insurance needs of their children. The enhancement to the California Child Support Automation System (CCSAS) will allow for the automation of processing other health care coverage (OHC) referrals.

Assumptions:

- Automation will result in the determination of OHC immediately, rather than the one month delay for manual processing. Therefore, there will be one additional month of OHC per case.
- 2,400 OHC referrals from counties are received each month.
- 90% have OHC.
- The average amount of OHC savings is \$70.85 per beneficiary per month based on a comparison of calendar year 2004 costs for children with and without OHC.
- The enhancement will be implemented in October 2006 and savings will begin in November 2006.

2,400 x .9 x \$70.85 = \$153,036 monthly savings
 \$153,036 x 12 = \$1,836,432 in total funds annual savings
 \$153,036 x 8 = **\$1,224,000 in FY 2006-07 savings**

ANTI-FRAUD EXPANSION FOR FY 2006-07

REGULAR POLICY CHANGE NUMBER: 109
 IMPLEMENTATION DATE: 7/2006
 ANALYST: Karen Fairgrievies
 FISCAL REFERENCE NUMBER: 1093

| | FY 2005-06 | FY 2006-07 |
|------------------------------|------------|---------------|
| FULL YEAR COST - TOTAL FUNDS | \$0 | -\$68,159,000 |
| - STATE FUNDS | \$0 | -\$34,079,500 |
| PAYMENT LAG | 1.0000 | 0.7690 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$0 | -\$52,414,300 |
| STATE FUNDS | \$0 | -\$26,207,140 |
| FEDERAL FUNDS | \$0 | -\$26,207,140 |

DESCRIPTION

Based on additional staffing provided in the FY 2000-01 and FY 2003-04 Budgets, the Department expanded its anti-fraud activities. Actual activities that the Department's Audits and Investigations Division (A&I) has indicated it will begin in FY 2006-07 are multiplied by the estimated average savings in provider payments per reported action from FY 2003-04.

The estimated savings takes shifts in beneficiary costs into account by using the "findings to paid claims ratio" from anti-fraud audits as reported by A&I. This ratio demonstrates the amount of legitimate claims vs. fraudulent/erroneous claims and was applied to Denied Reenrollments, Withholds, and Temporary Suspensions. Audits for Recoveries (AFR) were added to the anti-fraud savings calculations. The Department is determining additional methods to allow for a more precise savings calculation.

SAVINGS

(Dollars in Thousands)

| Activity | FY 2006-07 Annualized | |
|--|-----------------------|------------------|
| Denied Reenrollments | \$2,622 | \$4,841 |
| Withholds and Temporary Suspensions | \$17,808 | \$32,877 |
| Special Claims Review | \$22,170 | \$40,930 |
| AFR Residual | \$4,968 | \$9,172 |
| Trust Accounts | \$542 | \$1,000 |
| Rx Compliance | \$621 | \$1,146 |
| Procedure Code Limits | \$14,237 | \$26,283 |
| Beneficiary Care Mgmt | \$293 | \$540 |
| Self Audits | \$858 | \$1,584 |
| Lab Reviews | \$4,040 | \$7,458 |
| Savings Total | \$68,159 | \$125,831 |

ENTERAL NUTRITION PRODUCTS

REGULAR POLICY CHANGE NUMBER: 111
 IMPLEMENTATION DATE: 1/2006
 ANALYST: Karen Fairgrievs
 FISCAL REFERENCE NUMBER: 1091

| | <u>FY 2005-06</u> | <u>FY 2006-07</u> |
|------------------------------|-------------------|-------------------|
| FULL YEAR COST - TOTAL FUNDS | -\$500,000 | -\$1,000,000 |
| - STATE FUNDS | -\$250,000 | -\$500,000 |
| PAYMENT LAG | 0.8864 | 0.9970 |
| % REFLECTED IN BASE | 29.42 % | 15.39 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -\$312,800 | -\$843,600 |
| STATE FUNDS | -\$156,400 | -\$421,780 |
| FEDERAL FUNDS | -\$156,410 | -\$421,780 |

DESCRIPTION

Medi-Cal covers enteral nutrition products for beneficiaries who are unable to eat regular food. Medi-Cal spends approximately \$65 million dollars a year on enteral nutrition products. The Department implemented a rate reduction and has begun contracting with manufacturers for a lower maximum acquisition price.

The negotiation process with manufacturers began in 2002 and was delayed due to legal issues. With these issues resolved, the Department had its first contracts in place by January 2006 and will have all contracts in place by June 2007.

The FY 2005-06 savings is estimated to be \$500,000 and the FY 2006-07 savings is estimated at \$1,000,000.

This policy change was formerly a component of the Drug Budget Reduction policy change.

INPATIENT PSYCHIATRIC CARE SAVINGS

REGULAR POLICY CHANGE NUMBER: 113
 IMPLEMENTATION DATE: 9/2005
 ANALYST: Jenn Brooks
 FISCAL REFERENCE NUMBER: 1062

| | FY 2005-06 | FY 2006-07 |
|------------------------------|--------------|--------------|
| FULL YEAR COST - TOTAL FUNDS | -\$1,476,000 | -\$1,771,000 |
| - STATE FUNDS | -\$1,476,000 | -\$1,771,000 |
| PAYMENT LAG | 0.7160 | 0.9970 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -\$1,056,800 | -\$1,765,700 |
| STATE FUNDS | -\$1,056,820 | -\$1,765,690 |
| FEDERAL FUNDS | \$0 | \$0 |

DESCRIPTION

Federal Audit CIN A-09-02-00061 concluded that FFP was incorrectly claimed for hospital inpatient services for 22 to 64 year old residents of private institutions for mental diseases (IMDs). CDHS was required to repay the federal government for the federal cost of these services. Because of system changes implemented at the end of August 2005, CDHS will be able to deny these claims prior to payment. This will result in a savings to CDHS of approximately \$1,771,000 GF annually, beginning in September 2005.

FFP repayment for this audit finding for the period prior to the system changes is shown in the Inpatient Psychiatric Care - IMD Policy Change.

Assumptions:

1. The annual FFP repayment was determined to be \$885,500.

$$\$885,500 \times 2 \text{ (GF and FFP)} = \$1,771,000 \text{ in annual savings}$$

2. FY 2005-06 savings:

$$\$1,771,000 \times 10/12 = \$1,476,000$$

MEDICAL SUPPLY CONTRACTING

REGULAR POLICY CHANGE NUMBER: 114
 IMPLEMENTATION DATE: 11/2005
 ANALYST: Karen Fairgrievies
 FISCAL REFERENCE NUMBER: 1095

| | FY 2005-06 | FY 2006-07 |
|------------------------------|--------------|--------------|
| FULL YEAR COST - TOTAL FUNDS | -\$2,238,000 | -\$7,051,000 |
| - STATE FUNDS | -\$1,119,000 | -\$3,525,500 |
| PAYMENT LAG | 0.8995 | 0.9591 |
| % REFLECTED IN BASE | 46.31 % | 16.08 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -\$1,080,800 | -\$5,675,200 |
| STATE FUNDS | -\$540,410 | -\$2,837,590 |
| FEDERAL FUNDS | -\$540,410 | -\$2,837,590 |

DESCRIPTION

The Department began contracting with medical supply contractors to allow for a change in the Maximum Allowable Product Code (MAPC) from the Average Wholesale Price (AWP) to the Wholesale Selling Price (WSP). This change lowers Medi-Cal's reimbursement rates. The first categories of medical supplies with contracts are catheters, ostomy, wound care, and incontinence.

In FY 2005-06, incontinence briefs and catheters will be changed to the WSP reimbursement rate for an estimated savings of \$2.2 million. During FY 2006-07, the remaining listed Medical Supplies are expected to change to WSP for an estimated savings of \$7.05 million.

| Medical Supply | Implementation Date | Annual Savings | FY 2005-06 | FY 2006-07 |
|-----------------|---------------------|--------------------|--------------------|--------------------|
| Incontinence | | | | |
| Briefs | 01/2006 | \$2,201,000 | \$1,101,000 | \$2,201,000 |
| Underpads | 08/2006 | \$963,000 | | \$ 883,000 |
| Pads/Pants | 01/2007 | \$1,676,000 | | \$ 838,000 |
| Creams & Washes | | | | |
| | 01/2007 | \$1,333,000 | | \$ 667,000 |
| Catheters | 11/2005 | \$1,706,000 | \$1,137,000 | \$1,706,000 |
| Ostomy | 10/2006 | \$200,000 | | \$ 150,000 |
| Wound Care | 08/2006 | \$661,000 | | \$ 606,000 |
| Total | | \$8,740,000 | \$2,238,000 | \$7,051,000 |

EDS COST CONTAINMENT PROJECTS

REGULAR POLICY CHANGE NUMBER: 116
 IMPLEMENTATION DATE: 7/1993
 ANALYST: Jenn Brooks
 FISCAL REFERENCE NUMBER: 124

| | FY 2005-06 | FY 2006-07 |
|------------------------------|---------------|---------------|
| FULL YEAR COST - TOTAL FUNDS | -\$14,683,000 | -\$12,414,000 |
| - STATE FUNDS | -\$7,071,100 | -\$5,936,600 |
| PAYMENT LAG | 0.9162 | 0.9983 |
| % REFLECTED IN BASE | 88.20 % | 78.02 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -\$1,587,400 | -\$2,724,000 |
| STATE FUNDS | -\$764,470 | -\$1,302,650 |
| FEDERAL FUNDS | -\$822,940 | -\$1,421,310 |

DESCRIPTION

Electronic Data Systems (EDS) is implementing the following proposals to contain Medi-Cal costs, which are not yet fully reflected in the base estimate:

| Project Number | Impl. Date | Title | FY 2005-06 Savings | FY 2006-07 Savings |
|----------------|------------|-------------------------------|---------------------|---------------------|
| 04-17 | 23-May-05 | Valid Ref. Provider No. | \$7,200,000 | \$7,200,000 |
| 05-02 | 01-Aug-05 | Medicare Nebulizer Drugs | \$2,750,000 | \$3,000,000 |
| 05-04 | 25-Mar-05 | Birth Control Patches | \$76,000 | \$76,000 |
| 05-04B | 25-Mar-05 | Birth Control Patches (FPACT) | \$600,000 | \$600,000 |
| 02-14 | 30-Jan-06 | Home Visits with E&Ms | \$410,000 | \$984,000 |
| 05-07 | 13-Aug-05 | Max Qty. for New GCN Seq. No. | \$165,000 | \$180,000 |
| 01-13 | 24-Nov-05 | Human Papilloma Virus | \$218,000 | \$374,000 |
| 03-18 | 1-Nov-04 | Pulse Oximetry | \$254,000 | N/A (100% in Base) |
| 04-05 | 20-Dec-04 | Medicare Drug Coverage | \$3,000,000 | N/A (100% in Base) |
| 03-20 | 1-Dec-04 | Provider Specialty | \$10,000 | N/A (100% in Base) |
| TOTAL | | | \$14,683,000 | \$12,414,000 |

NON-CONTRACT HOSPITAL AUDITS

REGULAR POLICY CHANGE NUMBER: 117
 IMPLEMENTATION DATE: 6/2005
 ANALYST: Karen Fairgrievies
 FISCAL REFERENCE NUMBER: 172

| | FY 2005-06 | FY 2006-07 |
|------------------------------|---------------|---------------|
| FULL YEAR COST - TOTAL FUNDS | -\$16,876,000 | -\$16,876,000 |
| - STATE FUNDS | -\$8,438,000 | -\$8,438,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 85.19 % | 81.53 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -\$2,499,300 | -\$3,117,000 |
| STATE FUNDS | -\$1,249,670 | -\$1,558,500 |
| FEDERAL FUNDS | -\$1,249,670 | -\$1,558,500 |

DESCRIPTION

The Department's Audits and Investigations Division audits/reviews 100% of the acute care hospital cost reports filed each year. Due to limited staffing, a number of cost reports filed by non-contract hospitals had been reduced to desk audits/reviews and did not receive a full scope field audit. A hospital that provides care to Medi-Cal beneficiaries but does not have a contract with the California Medical Assistance Commission is a "non-contract hospital". During the performance of a field audit, procedures are performed to test the validity and accuracy of the hospital's allowable costs and billings more extensively than during a limited desk review.

The Budget Act of 2004 added 20 positions to increase the number of field audits/reviews performed on non-contract hospitals and related home office organizations.

Assumptions:

1. Additional audit staff were hired between July 1 and September 1, 2004.
2. Audits savings began April 2005.
3. Hospitals have 60 days from receipt of the audit report to begin paying back the audit amount.
4. Estimated increase in recovery for FY 2005-06 and FY 2006-07 is \$98,988 TF per hospital.
5. An estimated 174 hospitals will be audited in each year.

FY 2005-06 and FY 2006-07 Savings:

174 x \$98,988 = **\$16,876,000** TF (\$8,438,000 GF)

AGED DRUG REBATE RESOLUTION

REGULAR POLICY CHANGE NUMBER: 118
 IMPLEMENTATION DATE: 4/2004
 ANALYST: Karen Fairgrievies
 FISCAL REFERENCE NUMBER: 43

| | FY 2005-06 | FY 2006-07 |
|------------------------------|---------------|---------------|
| FULL YEAR COST - TOTAL FUNDS | -\$30,000,000 | -\$15,000,000 |
| - STATE FUNDS | -\$15,000,000 | -\$7,500,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -\$30,000,000 | -\$15,000,000 |
| STATE FUNDS | -\$15,000,000 | -\$7,500,000 |
| FEDERAL FUNDS | -\$15,000,000 | -\$7,500,000 |

DESCRIPTION

The Legislature approved funding in the Budget Act of 2003 for the Department to add additional staff to resolve aged drug rebate payment disputes.

Between 1991 and 2002 the Medi-Cal program accumulated large rebate disputes with participating drug companies which was cited in an audit of the rebate program by the Office of Inspector General (OIG). The Department estimated \$29.5 million of the outstanding balance as being potentially collectable. An approved Budget Change Proposal (BCP) added four staff in FY 2002-03 to resolve these aged disputes and recover additional rebate amounts.

Eleven additional staff were approved for FY 2003-04 to provide a more intensive effort to resolve these disputes. The Department has been successful at collecting a greater amount than originally estimated. It is assumed that all limited term positions will be continued in FY 2006-07. FY 2005-06 rebate resolutions will come from several large manufacturers with several years of unpaid aged rebates, allowing the Department to receive an estimated \$30 million in aged drug rebate resolutions. The remainder of the aged drug rebates in dispute are from a higher number of drug manufacturers with lower balances. The Department is expecting the resolutions obtained in FY 2006-07 to require more staff time and result in \$15 million in additional rebates.

Aged Rebate Disputes from the Drug Budget Reduction policy change are now included as part of the Aged Drug Rebate Resolution.

| | | |
|-----------------|--------------------|------------------------|
| Savings: | FY 2003-04: | \$ 7,200,000 TF |
| | FY 2004-05: | \$16,900,000 TF |
| | FY 2005-06: | \$30,000,000 TF |
| | FY 2006-07: | \$15,000,000 TF |
| | Total: | \$69,000,000 TF |

CANTWELL MEDICAL PHARMACY AUDIT SETTLEMENT

REGULAR POLICY CHANGE NUMBER: 119
 IMPLEMENTATION DATE: 3/2006
 ANALYST: Karen Fairgrievies
 FISCAL REFERENCE NUMBER: 1096

| | FY 2005-06 | FY 2006-07 |
|------------------------------|---------------|------------|
| FULL YEAR COST - TOTAL FUNDS | -\$14,584,000 | \$0 |
| - STATE FUNDS | -\$7,292,000 | \$0 |
| | | |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| | | |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -\$14,584,000 | \$0 |
| STATE FUNDS | -\$7,292,000 | \$0 |
| FEDERAL FUNDS | -\$7,292,000 | \$0 |

DESCRIPTION

As a result of an Audits and Investigations Division audit for recovery, the Department will receive a reimbursement of \$18,553,000 (\$9,276,500 GF) from Cantwell Medical Pharmacy, Inc. in FY 2005-06. The audit finding related to improper billing for anti-hemophilia blood factor products.

Assumptions:

1. The Department has \$4,025,000 in the O1B Trust Account for payments to Cantwell Medical Pharmacy that have been held. This amount was held prior to a checkwrite being issued. This payable will be eliminated and credited toward Cantwell's settlement payment.
2. The Department has a credit owed by Cantwell Medical Pharmacy from the reprocessing of claims in the amount of \$56,000. This credit will be applied to Cantwell's audit settlement and is included in this policy change.
3. The Department has \$947,000 in the O1B Anti-Fraud Account for payments to Cantwell Medical Pharmacy that have been held. This amount has been included in the Department's checkwrites. This amount will be transferred to the Health Care Deposit Fund. Because these payments have been included in a checkwrite, this policy change will add this transfer of funds.
4. The Department has earned \$192,000 in interest from the withheld funds. This interest will be transferred to the Health Care Deposit Fund and applied towards Cantwell's settlement and is included in this policy change.
5. The Department expects to receive an additional \$13,445,000 from Cantwell Medical Pharmacy to complete the settlement.

CANTWELL MEDICAL PHARMACY AUDIT SETTLEMENT

REGULAR POLICY CHANGE NUMBER: 119

| | Total Funds | General Funds |
|-------------------------|--------------------|----------------------|
| Total Settlement | \$ (18,553,000) | \$ (9,276,500) |
| O1B Trust Account | \$ 4,025,000 | \$ 2,012,500 |
| Claims Reprocessing* | \$ (56,000) | \$ (28,000) |
| O1B Anti-Fraud Account* | \$ 947,000 | \$ 473,500 |
| Interest Earned* | \$ 192,000 | \$ 96,000 |
| Payment* | \$ (13,445,000) | \$ (6,722,500) |

* Included in policy change.

NEW RECOVERY ACTIVITIES

REGULAR POLICY CHANGE NUMBER: 121
 IMPLEMENTATION DATE: 8/2005
 ANALYST: Jenn Brooks
 FISCAL REFERENCE NUMBER: 1026

| | FY 2005-06 | FY 2006-07 |
|------------------------------|---------------|----------------|
| FULL YEAR COST - TOTAL FUNDS | -\$41,360,000 | -\$150,699,000 |
| - STATE FUNDS | -\$20,680,000 | -\$75,349,500 |
| PAYMENT LAG | 0.7541 | 0.9443 |
| % REFLECTED IN BASE | 45.33 % | 20.49 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -\$17,051,300 | -\$113,146,800 |
| STATE FUNDS | -\$8,525,670 | -\$56,573,380 |
| FEDERAL FUNDS | -\$8,525,670 | -\$56,573,380 |

DESCRIPTION

The Budget Act of 2005 increased the CDHS's Health Insurance and Recovery programs. Staffing augmentations in the Estate Recovery and Personal Injury (PI) Units are expected to increase collections. In addition, staffing augmentations for Health Insurance programs and contracting for other health coverage (OHC) identification will increase private health insurance billings and enrollment in the Health Insurance Premium Payment Program (HIPP). Savings are identified below, by the implementation date of each activity and the current year (CY), budget year (BY) and annual savings. Payment lag factors have been applied to the CY and BY savings estimates below. (Percent in base calculations not reflected below.)

| | Program | Imp. Date | FY 2005-06 Savings (Lagged) | FY 2006-07 Savings (Lagged) | Annual Savings |
|----|---|----------------|-----------------------------------|-----------------------------------|----------------------|
| 1 | Recover PI Expenses of Managed Care Beneficiaries | 03/06 | \$167,000 | \$1,933,000 | \$2,400,000 |
| 2 | Enhance Estate Recover/ Pers. Injury Collections | 12/08 | \$0 | \$0 | \$5,000,000 |
| 3a | OHC Augmentation/ Deflected Pmts.* | 11/05 | \$15,084,000 | \$77,187,000 | \$86,583,000 |
| 3b | OHC Augmentation/ Incr. Recoveries | 03/06 | \$117,000 | \$1,353,000 | \$1,680,000 |
| 4 | Private Health Insurance Billings (HIR) Group Rec. | 12/05 | \$700,000 | \$3,350,000 | \$3,600,000 |
| 5a | OHC Identification/ Deflected Payments | 04/06 | \$385,000 | \$12,675,000 | \$20,000,000 |
| 5b | OHC Identification/ Increase Recoveries | 04/06 | \$50,000 | \$580,000 | \$720,000 |
| 5c | Medicare Buy-In System | 08/05 02/06 | \$14,688,000 | \$45,227,000 | \$47,000,000 |
| | Total | | \$31,191,000 | \$142,305,000 | \$166,963,000 |

NEW RECOVERY ACTIVITIES**REGULAR POLICY CHANGE NUMBER: 121**

*Based on actual data for August 2005 through March 2006, an average of 4,730 segments of OHC are identified each month. Savings are estimated to be \$128 per person per month, based on a comparison of calendar year 2004 costs for Medi-Cal beneficiaries with and without OHC. It is assumed that the savings will phase in over a 12-month period beginning in November 2005.

NEW THERAPEUTIC CATEGORY REVIEWS/REBATES

REGULAR POLICY CHANGE NUMBER: 122
 IMPLEMENTATION DATE: 7/2004
 ANALYST: Karen Fairgrievies
 FISCAL REFERENCE NUMBER: 114

| | FY 2005-06 | FY 2006-07 |
|------------------------------|----------------|----------------|
| FULL YEAR COST - TOTAL FUNDS | -\$117,350,000 | -\$130,600,000 |
| - STATE FUNDS | -\$58,675,000 | -\$65,300,000 |
| PAYMENT LAG | 0.9966 | 1.0000 |
| % REFLECTED IN BASE | 88.63 % | 81.93 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -\$13,297,300 | -\$23,599,400 |
| STATE FUNDS | -\$6,648,660 | -\$11,799,710 |
| FEDERAL FUNDS | -\$6,648,670 | -\$11,799,710 |

DESCRIPTION

The Budget Act of 2003 included funding to add staff positions to perform new annual drug Therapeutic Category Reviews (TCRs). Drugs are organized into 114 therapeutic categories. The Department regularly conducts TCRs on these drugs to determine safety, efficacy, essential need, potential for misuse, and cost, prior to including drugs in the List of Contract Drugs. The new staff will increase the number of annual TCRs by four.

Assumptions:

1. Rebate savings will commence seven months after contracts are signed.
2. FY 2003-04 TCR 3 savings began 8/1/04 as a restriction to generic over-the-counter drugs with a maximum allowable ingredient cost.

| FY 2003-04 | Contract Date | Annual Savings |
|--|------------------|-------------------|
| TCR#1. HMG-CoA Reductase Inhibitors (Hypercholesterolemia) | 7/1/2004 | \$18,200,000 |
| TCR#2. Angiotensin Converting Enzyme (ACE) Inhibitors and Angiotensin Receptor blockers (ARB) (cardiac drugs) | 7/1/2004 | \$ 8,200,000 |
| TCR#3. Non-sedating Antihistamines | 8/1/2004 | \$15,000,000 |
| TCR#4. Antidepressants | 12/1/2004 | \$11,000,000 |

NEW THERAPEUTIC CATEGORY REVIEWS/REBATES

REGULAR POLICY CHANGE NUMBER: 122

| | Contract Date | Annual Savings |
|---|--------------------------|---------------------------|
| FY 2004-05 | | |
| TCR#1. Proton Pump Inhibitors | 1/1/2005 | \$66,000,000 |
| TCR#2. Single Source Non-Steroidal Anti-Inflammatory Drug | 3/1/2005 | \$ 1,000,000 |
| TCR#3. Single Source Long Acting Oral Opioid Capsules/Tablets | 8/1/2005 | \$ 6,800,000 |
| TCR#4. Ocular Prostaglandin Analogs | 9/1/2005 | \$ 2,000,000 |
| FY 2005-06 | | |
| TCR#1. Non-Benzodiazepine Sedative Hypnotics | 7/1/2005 | \$ 2,000,000 |
| TCR#2. Papain/Urea and Papain/Urea/Chlorophyllin Ointments/Sprays | 9/1/2005 | \$ 400,000 |
| TCR#3 | To Be Determined | |
| TCR#4 | To Be Determined | |

SERONO AND U.S. AFFILIATES SETTLEMENT

REGULAR POLICY CHANGE NUMBER: 123
 IMPLEMENTATION DATE: 2/2006
 ANALYST: Karen Fairgrievies
 FISCAL REFERENCE NUMBER: 1097

| | FY 2005-06 | FY 2006-07 |
|------------------------------|---------------|------------|
| FULL YEAR COST - TOTAL FUNDS | -\$42,156,000 | \$0 |
| - STATE FUNDS | -\$42,156,000 | \$0 |
| | | |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| | | |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -\$42,156,000 | \$0 |
| STATE FUNDS | -\$42,156,000 | \$0 |
| FEDERAL FUNDS | \$0 | \$0 |

DESCRIPTION

As part of a federal settlement, the State of California has settled with Serono, S.A. under the False Claims Act. Serono is the maker of Serostim, an anti-wasting drug mainly used by AIDS patients.

The agreement settled an investigation into the company's sales and pricing practices for Serostim which focused on whether Serono violated federal and state false claims act or anti-kickback laws which prohibit drug companies from offering incentives to doctors to prescribe a drug. These practices resulted in increased Medi-Cal reimbursements for unnecessary Serostim prescriptions from 1997 to 2004.

The settlement was reached in October 2005 and payment was received in March 2006. The State of California's settlement is \$215,754,000 and will be distributed as follows:

| | |
|--|---------------------|
| Federal Government | \$108,495,000 |
| California False Claims Act Fund (DOJ) | \$47,847,000 |
| Relator's Fee | \$17,256,000 |
| Health Care Deposit Fund (GF) | \$42,156,000 |

5% PROVIDER PAYMENT DECREASE - AB 1735

REGULAR POLICY CHANGE NUMBER: 124
 IMPLEMENTATION DATE: 1/2006
 ANALYST: Karen Fairgrievies
 FISCAL REFERENCE NUMBER: 1088

| | FY 2005-06 | FY 2006-07 |
|------------------------------|---------------|---------------|
| FULL YEAR COST - TOTAL FUNDS | -\$32,350,000 | -\$66,078,000 |
| - STATE FUNDS | -\$15,249,000 | -\$31,243,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 23.44 % | 12.26 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -\$24,767,200 | -\$57,976,800 |
| STATE FUNDS | -\$11,674,630 | -\$27,412,610 |
| FEDERAL FUNDS | -\$13,092,530 | -\$30,564,230 |

DESCRIPTION

The Budget Act of 2003 reduced selected provider payments by 5%, effective January 1, 2004. On December 23, 2003, the Department was enjoined from implementing this payment reduction in fee-for-service Medi-Cal by federal court order. The managed care payment reduction was implemented. The Department appealed the action and on August 2, 2005, the decision was reversed. AB 1735 (Chapter 719, Statutes of 2005) changed the effective date of the 5% payment reduction from January 1, 2004 to January 1, 2006.

The 5% payment decrease would have expired December 31, 2006. However, SB 912 (Chapter 8, Statutes of 2006) rescinded the payment reduction effective March 4, 2006. Therefore, the 5% payment reduction was in effect January 1 through March 3, 2006.

Exempt from the payment reduction were services provided through California Children's Services Program, the Genetically Handicapped Persons Program, the Child Health and Disability Prevention Program, the Breast and Cervical Cancer Early Detection Program, Clinical labs, RHC/FQHC, ADHC, DME, and certified hospices. Pharmacies were also excluded from this reduction due to the pharmacy reduction to the Average Wholesale Price - 17% implemented in September 2004.

It is estimated that \$16,722,000 in savings have been incurred during January 1 through March 3, 2006. However, due to payment lags, \$14,789,000 TF (\$6,979,000 GF) in savings will be realized in FY 2005-06 and the remaining \$1,931,000 TF (\$918,000 GF) will be realized in FY 2006-07. Additional savings will be incurred for Dental Services; this savings is reflected in the Dental rates in the Dental Base Policy Change and is not expected to be realized until FY 2006-07.

Due to payment lags and data trends, this policy change only budgets the savings due to AB 1735, the 5% payment reduction from January 1 through December 31, 2006. The costs due SB 912, the rescinding of the 5% Provider Payment Reduction, are budgeted in policy change 5% Provider Payment Reduction SB 912.

5% PROVIDER PAYMENT DECREASE - AB 1735

REGULAR POLICY CHANGE NUMBER: 124

| Total Funds (Cash Basis) | | | |
|---------------------------------|--|--|--------------------------------------|
| Provider Type | AB 1735 Savings (Jan - June 2006) | SB 912 Cost (March 4 - June 2006) | Net Savings (Jan 1 - March 3) |
| FY 2005-06 | | | |
| Physicians | \$14,658,000 | \$7,781,000 | \$ 6,877,000 |
| Other Medical | \$11,927,000 | \$6,665,000 | \$ 5,262,000 |
| Medical Transportation | \$2,012,000 | \$1,118,000 | \$ 894,000 |
| Other Services | \$1,019,000 | \$775,000 | \$ 632,000 |
| Home Health | \$2,346,000 | \$1,222,000 | \$ 1,124,000 |
| Total | \$32,350,000 | \$17,561,000 | \$14,789,000 |
| Provider Type | AB 1735 Savings (July - Dec 2006) | SB 912 Cost (July - Dec 2006) | Net Savings (July - Dec 2006) |
| FY 2006-07 | | | |
| Physicians | \$32,557,000 | \$31,413,500 | \$1,143,500 |
| Other Medical | \$22,022,000 | \$21,517,500 | \$504,500 |
| Medical Transportation | \$3,892,000 | \$3,783,000 | \$109,000 |
| Other Services | \$2,670,000 | \$2,609,500 | \$60,500 |
| Home Health | \$4,937,000 | \$4,823,500 | \$113,500 |
| Total | \$66,078,000 | \$64,147,000 | \$1,931,000 |
| Jan - Dec 2006 Total | \$98,428,000 | \$81,708,000 | \$16,720,000 |

ANTI-FRAUD EXPANSION FOR FY 2005-06

REGULAR POLICY CHANGE NUMBER: 125
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Karen Fairgrievies
 FISCAL REFERENCE NUMBER: 1018

| | FY 2005-06 | FY 2006-07 |
|------------------------------|---------------|----------------|
| FULL YEAR COST - TOTAL FUNDS | -\$74,660,000 | -\$137,834,000 |
| - STATE FUNDS | -\$37,330,000 | -\$68,917,000 |
| PAYMENT LAG | 0.7690 | 0.9700 |
| % REFLECTED IN BASE | 54.80 % | 25.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -\$25,950,900 | -\$100,274,200 |
| STATE FUNDS | -\$12,975,460 | -\$50,137,120 |
| FEDERAL FUNDS | -\$12,975,460 | -\$50,137,120 |

DESCRIPTION

Based on additional staffing provided in the FY 2000-01 and FY 2003-04 Budgets, the Department expanded its anti-fraud activities. Actual activities that the Department's Audits and Investigations Division (A&I) has indicated it will begin in FY 2005-06 are multiplied by the estimated average savings in provider payments per reported action from FY 2003-04.

The estimated savings takes shifts in beneficiary costs into account by using the "findings to paid claims ratio" from anti-fraud audits as reported by A&I. This ratio demonstrates the amount of legitimate claims vs. fraudulent/erroneous claims. It was applied to Denied Reenrollments, Withholds, and Temporary Suspensions. Audits for Recoveries (AFR) were added to the anti-fraud savings calculations. The Department is determining additional methods to allow for a more precise savings calculation.

SAVINGS*(Dollars in Thousands)*

| Activity | FY 2005-06 | FY 2006-07 |
|--|-----------------|------------------|
| Denied Reenrollments | \$11,222 | \$20,718 |
| Withholds and Temporary Suspensions | \$17,808 | \$32,877 |
| AFR Residual | \$4,968 | \$9,172 |
| Special Claims Review | \$22,170 | \$40,930 |
| Trust Accounts | \$542 | \$1,000 |
| Compliance Audits | \$298 | \$550 |
| Procedure Code Limits | \$14,237 | \$26,283 |
| Beneficiary Care Mgmt | \$183 | \$338 |
| Lab Reviews | \$3,232 | \$5,966 |
| Savings Total | \$74,660 | \$137,834 |

FAMILY PACT DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 126
 IMPLEMENTATION DATE: 12/1999
 ANALYST: Karen Fairgrievies
 FISCAL REFERENCE NUMBER: 51

| | FY 2005-06 | FY 2006-07 |
|------------------------------|---------------|---------------|
| FULL YEAR COST - TOTAL FUNDS | -\$99,273,000 | -\$18,134,000 |
| - STATE FUNDS | -\$31,144,200 | -\$5,814,800 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -\$99,273,000 | -\$18,134,000 |
| STATE FUNDS | -\$31,144,200 | -\$5,814,800 |
| FEDERAL FUNDS | -\$68,128,800 | -\$12,319,200 |

DESCRIPTION

Rebates for drugs covered through the Family PACT (FPACT) program are obtained by the Department from the drug companies involved. Rebates are estimated by using the actual FFS trend data for drug expenditures, and applying a historical percentage of the actual amounts collected to the trend projection.

Assumptions:

- 100% State General Fund applied to 13.95% of the FPACT rebates to account for undocumented persons for FY 2005-06. For FY 2006-07, a 17.79% undocumented persons factor was assumed.
- Regular FMAP percentage applied to 22.043% of the FPACT rebates to account for the purchase of non-family planning drugs.
- Family planning percentage (90% FFP) applied to 64.007% of the FPACT rebates.
- In FY 05-06, the Department received a one-time FPACT payment of \$64 million from prior unpaid payments.

(Dollars in Thousands)

| Fiscal Year | FPACT Drug Trends | FPACT Rebate | |
|---------------|-------------------|--------------|---------|
| FY 02-03 | \$82,789 | (\$10,956) | Accrual |
| FY 03-04 | \$104,938 | (\$26,753) | Cash |
| FY 04-05 | \$107,510 | (\$30,740) | Cash |
| FY 05-06 Est. | | (\$99,273) | Cash |
| FY 06-07 Est. | | (\$18,134) | Cash |

HOSP FINANCING - INPATIENT BASE REDUCTION

REGULAR POLICY CHANGE NUMBER: 128
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 1069

| | FY 2005-06 | FY 2006-07 |
|------------------------------|----------------|----------------|
| FULL YEAR COST - TOTAL FUNDS | -\$531,493,000 | -\$813,634,000 |
| - STATE FUNDS | -\$265,746,500 | -\$406,817,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -\$531,493,000 | -\$813,634,000 |
| STATE FUNDS | -\$265,746,500 | -\$406,817,000 |
| FEDERAL FUNDS | -\$265,746,500 | -\$406,817,000 |

DESCRIPTION

Effective July 1, 2005, based on the Medi-Cal Hospital/Uncompensated Care Demonstration (MH/UCD), Designated Public Hospitals (DPHs) will no longer receive negotiated per diem payments for inpatient hospital costs for services rendered to Medi-Cal beneficiaries on and after July 1, 2005. Per diem payments consisted of GF and FFP.

DPHs will instead receive estimated interim payments based on certified public expenditures for providing inpatient hospital care to Medi-Cal beneficiaries. Interim payments will be all FFP.

This policy change reflects the reduction to the base estimate for per diem payments that are no longer made for services rendered on and after July 1, 2005. Inpatient hospital costs for refugees, State only program eligibles, and non-emergency services to qualified aliens will not be reduced from the base.

Assumptions:

1. Assume expenditures will continue to increase by the current Medi-Cal hospital trends for users, units of service, and cost per unit.
2. Based on date of service claims from July 2004 through June 2005 paid in FY 2004-05, per diem expenditures were \$498,161,461. Applying trends, the Department estimates \$531,493,000 in per diem expenditure would have been paid out in FY 2005-06 for services rendered on and after July 1, 2005.
3. Based on paid claims in FY 2004-05 regardless of the date of service for the claim, per diem expenditures were \$728,831,106. Applying trends, the Department estimates \$813,634,000 in full year per diem expenditures would have been paid out in FY 2006-07.

HOSP FINANCING - INPATIENT BASE REDUCTION

REGULAR POLICY CHANGE NUMBER: 128

4. Due to negotiations on the procedures for claiming CPEs under the MH/UCD waiver, hospitals continued to receive their negotiated per diem rates through March 2006. With approval of the procedures, the hospital claims are being reprocessed and the GF is being repaid.
5. Due to the negotiations on the MH/UCD waiver, hospitals continued to receive negotiated per diem rates through April 2006, with approval of the waiver, the hospital claims are being reprocessed and the GF being repaid.

STATE SUPPLEMENTAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 129
 IMPLEMENTATION DATE: 1/1991
 ANALYST: Karen Fairgrievies
 FISCAL REFERENCE NUMBER: 54

| | FY 2005-06 | FY 2006-07 |
|------------------------------|----------------|----------------|
| FULL YEAR COST - TOTAL FUNDS | -\$648,532,000 | -\$341,651,000 |
| - STATE FUNDS | -\$323,256,800 | -\$170,293,900 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -\$648,532,000 | -\$341,651,000 |
| STATE FUNDS | -\$323,256,800 | -\$170,293,900 |
| FEDERAL FUNDS | -\$325,275,200 | -\$171,357,100 |

DESCRIPTION

State supplemental drug rebates 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).

Assumptions:

1. Assume .389% of rebates collected are for family planning drugs which have a 90/10 FFP.
2. Medicare Part D began on January 1, 2006. Medicare will assume drug coverage for dual eligibles, decreasing Medi-Cal's drug purchases and rebates. Due to the rebate lag, the effect on rebates will not be seen until FY 06-07.
3. AIDS Healthcare Foundation (as of 1/1/05) and the Health Plan of San Mateo (as of 6/20/05) meet the criteria of a Managed Care Organization (MCO). Under federal law, MCOs can not participate in the federal Medicaid drug rebate program. State Supplement rebates have been reduced by \$2,900,000 TF for FY 2005-06 and \$2,454,000 TF for FY 2006-07.

STATE SUPPLEMENTAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 129

| Fiscal Year | FFS Trends | Supplemental Rebate | |
|----------------------|------------------------|--------------------------------|---------|
| | (Dollars in Thousands) | | |
| FY 01-02 | \$3,410,802 | (\$ 331,177) | Accrual |
| FY 02-03 | \$4,063,052 | (\$ 427,485) | Accrual |
| FY 03-04 | \$4,724,915 | (\$ 496,199) | Cash |
| FY 04-05 | \$4,871,742 | (\$ 577,395) | Cash |
| FY 05-06 Est. | | (\$648,532) | Cash |
| FY 06-07 Est. | | (\$700,797) | Cash |
| Part D rebate impact | | \$359,146 | Cash |
| FY 06-07 Est. | | (\$341,651) | Cash |

FEDERAL DRUG REBATE PROGRAM

REGULAR POLICY CHANGE NUMBER: 130
 IMPLEMENTATION DATE: 7/1990
 ANALYST: Karen Fairgrievies
 FISCAL REFERENCE NUMBER: 55

| | FY 2005-06 | FY 2006-07 |
|------------------------------|------------------|----------------|
| FULL YEAR COST - TOTAL FUNDS | -\$1,459,488,000 | -\$768,172,000 |
| - STATE FUNDS | -\$727,473,200 | -\$382,890,800 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -\$1,459,488,000 | -\$768,172,000 |
| STATE FUNDS | -\$727,473,200 | -\$382,890,800 |
| FEDERAL FUNDS | -\$732,014,800 | -\$385,281,200 |

DESCRIPTION

The State Medi-Cal Drug Discount Program and OBRA 1990 allow the Department to obtain price discounts for drugs. Rebates are estimated by using actual FFS trend data for drug expenditures, and applying a historical percentage of actual amounts collected to the trend projection.

Assumptions:

1. Assume .389% of rebates collected are for family planning drugs which have 90/10 FFP/GF sharing.
2. Medicare Part D began on January 1, 2006. Medicare assumed drug coverage for dual eligibles, decreasing Medi-Cal's drug purchases and rebates. Due to the rebate lag, the effect on rebates will not be seen until FY 2006-07.
3. AIDS Healthcare Foundation (as of 1/1/05) and the Health Plan of San Mateo (as of 6/20/05) meet the criteria of a Managed Care Organization (MCO). Under federal law, MCOs can not participate in the federal Medicaid drug rebate program. Federal rebates have been reduced by \$7,847,000 TF for FY 2005-06 and \$6,874,000 for FY 2006-07.

FEDERAL DRUG REBATE PROGRAM

REGULAR POLICY CHANGE NUMBER: 130

| Fiscal Year | FFS Trends | Federal Rebate | |
|----------------------|-------------------------------|---------------------------|---------|
| | <i>(Dollars in Thousands)</i> | | |
| FY 02-03 | \$4,063,052 | (\$866,227) | Accrual |
| FY 03-04 | \$4,724,915 | (\$973,512) | Cash |
| FY 04-05 | \$4,871,742 | (\$1,300,493) | Cash |
| FY 05-06 Est. | | (\$1,459,488) | Cash |
| FY 06-07 Est. | | (\$1,577,094) | Cash |
| Part D rebate impact | | <u>\$808,922</u> | Cash |
| FY 06-07 Est. | | (\$768,172) | Cash |

ESTATE RECOVERY REGULATIONS

REGULAR POLICY CHANGE NUMBER: 131
 IMPLEMENTATION DATE: 5/2006
 ANALYST: Jenn Brooks
 FISCAL REFERENCE NUMBER: 1043

| | FY 2005-06 | FY 2006-07 |
|------------------------------|------------|------------|
| FULL YEAR COST - TOTAL FUNDS | \$117,000 | \$701,000 |
| - STATE FUNDS | \$58,500 | \$350,500 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$117,000 | \$701,000 |
| STATE FUNDS | \$58,500 | \$350,500 |
| FEDERAL FUNDS | \$58,500 | \$350,500 |

DESCRIPTION

Regulation package R-32-00: Estate Recovery Regulations, is based on the recent settlement agreement in the case of *California Advocates for Nursing Home Reform et al. v. Diana M. Bontá et al.* that requires the Department to make specific amendments to Medi-Cal estate recovery regulations in three different phases. These amendments make a number of clarifying changes to the estate recovery regulations that have a potential fiscal impact and are as follows:

1. Revision of the definition of an estate to include retirement accounts and life insurance policies that revert to the estate. Indeterminate insignificant savings since few accounts/policies revert to the estate.
2. Exclusion of personal care services in the list of services for which recoveries can be made from the estate. No impact as recoveries are not currently collected for personal care services.
3. Addition to regulations that the Department may collect from estates for the cost of institutional care provided to persons under 55. This is not being implemented, because it is not possible to track care given to persons under age 55 long enough for collection.
4. Addition of an exemption from estate recovery for undue hardship when the person seeking the waiver from recovery provided care to the decedent for two or more years while living in the home with the decedent and that care delayed the decedent's admission to a medical or long-term care institution.

ESTATE RECOVERY REGULATIONS

REGULAR POLICY CHANGE NUMBER: 131

Assumptions for hardship exemption:

A. Approximately 42 requests per year will meet the requirements for an exemption for undue hardship.

B. Based on FY 2004-05 data, the average estate recovery collection is \$16,700.

FY 2005-06: $42 \times \$16,700 / 12 \times 2 \text{ mos.} = \$117,000$ lost collections

FY 2006-07: $42 \times \$16,700 = \$701,400$ lost collections

NON-INSTITUTIONAL PROVIDER OVERPAYMENTS

REGULAR POLICY CHANGE NUMBER: 136
 IMPLEMENTATION DATE: 7/2006
 ANALYST: Jenn Brooks
 FISCAL REFERENCE NUMBER: 1103

| | FY 2005-06 | FY 2006-07 |
|------------------------------|------------|---------------|
| FULL YEAR COST - TOTAL FUNDS | \$0 | \$0 |
| - STATE FUNDS | \$0 | \$36,000,000 |
| | | |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| | | |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$0 | \$0 |
| STATE FUNDS | \$0 | \$36,000,000 |
| FEDERAL FUNDS | \$0 | -\$36,000,000 |

DESCRIPTION

CDHS conducted internal audits that identified FFP that was being incorrectly reported for non-institutional provider overpayments. In order to correct the reporting, changes in the Department's COBRA system will be implemented in April 2006, and data sampling will be conducted through June 2006 to test the accuracy of these system changes. Repayment of FFP is anticipated to begin in FY 2006-07, once the changes are fully operational. The Department expects to pay back the 50% share of the newly identified non-institutional provider overpayment cases, which is anticipated to be approximately \$24 million per quarter. On a cash basis, the Department will pay back three quarters of FFP in FY 2006-07, which is \$36 million, and \$48 million annually thereafter.

5% PAYMENT DECREASE RESCISSION - SB 912

REGULAR POLICY CHANGE NUMBER: 139
 IMPLEMENTATION DATE: 3/2006
 ANALYST: Karen Fairgrievies
 FISCAL REFERENCE NUMBER: 1106

| | FY 2005-06 | FY 2006-07 |
|------------------------------|--------------|--------------|
| FULL YEAR COST - TOTAL FUNDS | \$17,561,000 | \$64,147,000 |
| - STATE FUNDS | \$8,270,000 | \$30,325,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$17,561,000 | \$64,147,000 |
| STATE FUNDS | \$8,270,000 | \$30,325,000 |
| FEDERAL FUNDS | \$9,291,000 | \$33,822,000 |

DESCRIPTION

The Budget Act of 2003 reduced selected provider payment by 5%, effective January 1, 2004. On December 23, 2003, the Department was enjoined from implementing this payment reduction in fee-for-service Medi-Cal by federal court order. The managed care payment reduction was implemented. The Department appealed the action and on August 2, 2005, the decision was reversed. AB 1735 (Chapter 719, Statutes of 2005) changed the effective date of the 5% payment reduction from January 1, 2004 to January 1, 2006.

The 5% payment decrease would have expired December 31, 2006. However, SB 912 (Chapter 8, Statutes of 2006) rescinded the payment reduction effective March 4, 2006. Therefore, the 5% payment reduction was in effect January 1 through March 3, 2006.

This policy change budgets the 'restoration' of the 5% effective March 4, 2006.

| Provider Type | Total Funds (Cash Basis) | | |
|------------------------|-----------------------------------|-----------------------------------|-------------------------------|
| | AB 1735 Savings (Jan - June 2006) | SB 912 Cost (March 4 - June 2006) | Net Savings (Jan 1 - March 3) |
| FY 2005-06 | | | |
| Physicians | \$14,658,000 | \$7,781,000 | \$ 6,877,000 |
| Other Medical | \$11,927,000 | \$6,665,000 | \$ 5,262,000 |
| Medical Transportation | \$2,012,000 | \$1,118,000 | \$ 894,000 |
| Other Services | \$1,019,000 | \$775,000 | \$ 632,000 |
| Home Health | \$2,346,000 | \$1,222,000 | \$ 1,124,000 |
| Total | \$32,350,000 | \$17,561,000 | \$14,789,000 |

5% PAYMENT DECREASE RESCISSION - SB 912

REGULAR POLICY CHANGE NUMBER: 139

| Provider Type | AB 1735 Savings (July - Dec 2006) | SB 912 Cost (July - Dec 2006) | Net Savings (July - Dec 2006) |
|-----------------------------|--|--------------------------------------|--------------------------------------|
| FY 2006-07 | | | |
| Physicians | \$32,557,000 | \$31,413,500 | \$1,143,500 |
| Other Medical | \$22,022,000 | \$21,517,500 | \$504,500 |
| Medical Transportation | \$3,892,000 | \$3,783,000 | \$109,000 |
| Other Services | \$2,670,000 | \$2,609,500 | \$60,500 |
| Home Health | \$4,937,000 | \$4,823,500 | \$113,500 |
| Total | \$66,078,000 | \$64,147,000 | \$1,931,000 |
| Jan - Dec 2006 Total | \$98,428,000 | \$81,708,000 | \$16,720,000 |

HOSP FINANCING - ADVANCED GF PAYMENTS TO DPH

REGULAR POLICY CHANGE NUMBER: 140
 IMPLEMENTATION DATE: 3/2006
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 1107

| | FY 2005-06 | FY 2006-07 |
|------------------------------|------------|------------|
| FULL YEAR COST - TOTAL FUNDS | \$0 | \$0 |
| - STATE FUNDS | \$0 | \$0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$0 | \$0 |
| STATE FUNDS | \$0 | \$0 |
| FEDERAL FUNDS | \$0 | \$0 |

DESCRIPTION

Since December 2005, the Department has received requests for advances from nine of the 23 designated public hospitals (DPHs) that are experiencing severe cash flow problems stemming from prolonged negotiations between CMS, the DPHs and the Department over the funding and reimbursement protocol contained in the new section 1115 Medi-Cal Hospital/Uninsured Care Demonstration (MH/UCD) Special Terms and Conditions.

In March 2006, the DPHs who submitted a request for an advance were given an interest-free interim cash relief payment from the GF of \$186,468,000, based on the provisions of Welfare and Institutions Code Section 14153. The advance to the DPHs will be repaid in June of FY 2005-06 when the State is able to claim federal funding from California's federal Disproportionate Share Hospital allotment for payment of funds under the MH/UCD. The Health Care Deposit Fund will be credited with the federal funds claimed. These funds will then be transferred to the GF.

HOSP FINANCING - CCS AND GHPP

REGULAR POLICY CHANGE NUMBER: 141
 IMPLEMENTATION DATE: 9/2005
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 1108

| | FY 2005-06 | FY 2006-07 |
|------------------------------|--------------|--------------|
| FULL YEAR COST - TOTAL FUNDS | \$30,825,000 | \$72,453,000 |
| - STATE FUNDS | \$0 | \$0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$30,825,000 | \$72,453,000 |
| STATE FUNDS | \$0 | \$0 |
| FEDERAL FUNDS | \$30,825,000 | \$72,453,000 |

DESCRIPTION

Effective September 1, 2005, based on the Special Terms and Conditions of the Medi-Cal Hospital/Uninsured Care Demonstration, the Department may claim federal reimbursement for the California Children Services (CCS) Program and Genetically Handicapped Persons Program (GHPP) from the Safety Net Care Pool funding established by the MH/UCD. The CCS program provides diagnostic and treatment services, medical case management, and physical and occupational therapy health care services to children under 21 years of age with CCS-eligible conditions in families unable to afford catastrophic health care costs. The GHPP program provides comprehensive health care coverage for persons over 21 with specified genetic diseases including: cystic fibrosis; hemophilia; sickle cell disease and thalassemia; and chronic degenerative neurological diseases, including phenylketonuria.

This policy change reflects the 50 percent federal reimbursement received by the Department for the CCS and GHPP program claims based on the certification of public expenditures. Total expenditures have been reduced by 17.79 percent to adjust for services provided to undocumented aliens. The FFP received for CCS and GHPP will be deposited in the Health Care Support Fund, Item 4260-601-7503. These funds are transferred to the Family Health Estimate, which is budgeted in Item 4260-111-0001. The General Fund savings created will be used to support safety net hospitals under the MH/UCD.

| | FY 2005-06 FFP | FY 2006-07 FFP |
|--------------|---------------------|---------------------|
| CCS | \$22,754,000 | \$53,304,000 |
| GHPP | \$8,071,000 | \$19,149,000 |
| Total | \$30,825,000 | \$72,453,000 |

ELIG. FOR CHILDREN IN MONTH PRIOR TO SSI/SSP GRANT

REGULAR POLICY CHANGE NUMBER: 142
 IMPLEMENTATION DATE: 2/2007
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 1110

| | FY 2005-06 | FY 2006-07 |
|------------------------------|------------|-------------|
| FULL YEAR COST - TOTAL FUNDS | \$0 | \$2,176,000 |
| - STATE FUNDS | \$0 | \$1,088,000 |
| PAYMENT LAG | 1.0000 | 0.5701 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$0 | \$1,240,500 |
| STATE FUNDS | \$0 | \$620,270 |
| FEDERAL FUNDS | \$0 | \$620,270 |

DESCRIPTION

Currently automatic eligibility for Medi-Cal is provided to Supplemental Security Income/State Supplementary Payment (SSI/SSP) program recipients in the month in which they receive their first SSI/SSP check. This is the month following the month of application for SSI/SSP or the month in which their SSI/SSP eligibility is established, whichever is later. This eligibility is established systematically on the Medi-Cal Eligibility Data System (MEDS), based on information that comes from the Social Security Administration (SSA) through monthly computer files.

The Deficit Reduction Act (DRA) of 2005 creates a mandatory program for disabled individuals under 21 years of age who are determined to be eligible for SSI/SSP and receive their first check in the following month. The DRA provides these individuals with Medicaid eligibility in the month prior to the first month in which they receive a grant. CMS has given the Department approval to establish this eligibility systematically based upon the dates included in the monthly computer data files received from SSA. This mandatory coverage will be effective with the February 2007 month of eligibility.

Assumptions:

1. Based on data from January 2004 through August 2005, an average of 938 persons per month under the age of 21 become SSI/SSP eligible each month who did not request coverage for the three months prior to the month of application. Those that do request retroactive coverage already have Medi-Cal coverage for the month before the SSI grant began.
2. 790 of the 938 are age one or older. It is assumed that those that are under age one are covered under their mothers' cards prior to SSI/SSP eligibility, so they are already covered for the month before the SSI/SSP grant begins.
3. Assume the cost of service in the month prior to the month in which the SSI/SSP grant begins is limited to outpatient and dental costs since these children can already get coverage for this month by applying for retroactive coverage. It is assumed they would have applied for this coverage if they had inpatient costs.

**ELIG. FOR CHILDREN IN MONTH PRIOR TO SSI/SSP
GRANT
REGULAR POLICY CHANGE NUMBER: 142**

4. Based on costs for public assistance and medically needy disabled and blind Medi-Cal beneficiaries under 21 for dates of service in 2004, the average cost per month for outpatient services paid through EDS is \$542.32. The current capitation rate for dental services is \$8.53.

$\$542.32 + \$8.53 = \$551$ monthly outpatient costs

Annual cost:

790 children x \$551 cost a month x 12 months = \$5,223,000 (\$2,611,000 GF)

2006-07:

790 children x \$551 cost a month x 5 months = **\$2,176,000** (\$1,088,000 GF)

HURRICANE KATRINA SECTION 1115 WAIVER

REGULAR POLICY CHANGE NUMBER: 143
 IMPLEMENTATION DATE: 3/2007
 ANALYST: Loretta Wallis
 FISCAL REFERENCE NUMBER: 1112

| | FY 2005-06 | FY 2006-07 |
|------------------------------|------------|--------------|
| FULL YEAR COST - TOTAL FUNDS | \$0 | \$0 |
| - STATE FUNDS | \$0 | -\$2,318,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$0 | \$0 |
| STATE FUNDS | \$0 | -\$2,318,000 |
| FEDERAL FUNDS | \$0 | \$2,318,000 |

DESCRIPTION

The Department is participating in a Hurricane Katrina Section 1115 Demonstration Project waiver. Under this waiver, Katrina evacuees may apply for Medi-Cal coverage between August 28, 2005 and January 31, 2006. Coverage continues for five months from the month of application. The final date of coverage is May 31, 2006, unless that date is extended by Congress. As a result of California's participation in the waiver, 100% of the Medi-Cal costs for the evacuees will be paid for through the waiver.

The federal Deficit Reduction Act of 2005 appropriated funds for the Medicaid costs of the evacuees. CMS has indicated that California may receive a grant award of at least \$1,414,000 as its portion of the funds. Payments above that amount may be made based upon cost reports that identify higher service costs.

Assumptions

1. Katrina eligibles consist of two groups: those receiving CalWORKs, and those receiving Medi-Cal only (identified as aid code 65).
2. The CDSS has preliminarily identified 2,549 CalWORKs Katrina individuals.
3. 313 eligibles have been identified as receiving Medi-Cal only under aid code 65.
4. The average cost per eligible is assumed to be \$324, which is the overall average cost per eligible for 2005-06 from the November 2005 Medi-Cal Estimate.
5. Each eligible is assumed to receive five months of services.
6. It is assumed that all of the federal funds will be claimed in March 2007, to allow time for all claims to be identified.
7. It is assumed that the costs are currently being paid with 50% GF and 50% FFP. This policy change budgets the reimbursement of the 50% GF cost.

HURRICANE KATRINA SECTION 1115 WAIVER

REGULAR POLICY CHANGE NUMBER: 143

CalWORKs:

2,549 eligibles x \$324 x 5 months = \$4,129,000 (\$2,065,500 GF reimbursement)

Medi-Cal Only (Aid Code 65):

313 eligibles x \$324 x 5 months = \$507,000 (\$253,500 GF reimbursement)

Total\$4,129,000 + \$507,000 = \$4,636,000 (**\$2,318,000 GF reimbursement**)

HOSP FINANCING - DPH RATE RECONCILIATION

REGULAR POLICY CHANGE NUMBER: 144
 IMPLEMENTATION DATE: 4/2006
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 1113

| | FY 2005-06 | FY 2006-07 |
|------------------------------|--------------|---------------|
| FULL YEAR COST - TOTAL FUNDS | \$65,232,000 | -\$65,232,000 |
| - STATE FUNDS | \$65,232,000 | -\$65,232,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$65,232,000 | -\$65,232,000 |
| STATE FUNDS | \$65,232,000 | -\$65,232,000 |
| FEDERAL FUNDS | \$0 | \$0 |

DESCRIPTION

Effective July 1, 2005, based on the Medi-Cal Hospital/Uncompensated Care Demonstration (MH/UCD), Designated Public Hospitals (DPHs) will no longer receive negotiated per diem payments for inpatient hospital costs for services rendered to Medi-Cal beneficiaries on and after July 1, 2005. Per diem payments consisted of GF and FFP. DPHs will instead receive estimated interim payments based on certified public expenditures for providing inpatient hospital care to Medi-Cal beneficiaries. Interim payments will be all FFP.

This policy change reflects the reconciliation due to the change in payments for inpatient hospital costs for services rendered to Medi-Cal beneficiaries.

Assumptions:

1. The Department has continued to pay the DPHs the negotiated per diem payments, which consist of 50 percent GF and 50 percent FFP, pending the development of procedures for certifying public expenditures.
2. Assume in April 2006 the new FFP-only interim payment will be paid instead of the negotiated per diem payment.
3. Assume all DPH claims processed under the negotiated per diem payments for services on or after July 1, 2005 will be reprocessed with the new interim payment.
4. Assume the Department will make all the necessary adjustments to claim the correct FFP in FY 2005-06.
5. Assume hospitals whose new interim payment is higher than the negotiated per diem payment will have been underpaid. The Department will reimburse the GF used to pay the negotiated per diem payment, retroactive to July 2005. The hospitals will receive the additional FFP payment above the rates they had already been paid in FY 2005-06.

HOSP FINANCING - DPH RATE RECONCILIATION

REGULAR POLICY CHANGE NUMBER: 144

6. Assume hospitals whose new interim payment is lower than the negotiated per diem payment will have been overpaid. The Department will claim the correct FFP based on the new interim payment and reimburse the GF.
7. The Department has identified \$65,232,000 that will be owed to the GF from hospitals with CPEs below their negotiated rates. This will be reimbursed to the Medi-Cal General Fund from the Physician and Non-Physician Payments when the State Plan Amendment (SPA) is approved in FY 2006-07.
8. Because Policy Change 128, Inpatient Base Reduction, reflects the full savings of eliminating GF payments for DPHs for dates of service after July 1, 2005, this policy change reflects a GF cost of \$65,232,000 in FY 2005-06. It reflects a GF savings in FY 2006-07, when the repayment of the GF paid above the CPEs will be made.

RESTORATION OF PROVIDER PAYMENT DECREASE

REGULAR POLICY CHANGE NUMBER: 146
 IMPLEMENTATION DATE: 1/2007
 ANALYST: Shelley Stankeivicz
 FISCAL REFERENCE NUMBER: 1115

| | FY 2005-06 | FY 2006-07 |
|------------------------------|------------|--------------|
| FULL YEAR COST - TOTAL FUNDS | \$0 | \$65,415,000 |
| - STATE FUNDS | \$0 | \$32,707,500 |
| | | |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| | | |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$0 | \$65,415,000 |
| STATE FUNDS | \$0 | \$32,707,500 |
| FEDERAL FUNDS | \$0 | \$32,707,500 |

DESCRIPTION

Due to the significant budget deficit projected for FY 2003-04, Assembly Bill (AB) 1762 required the Department to reduce specified provider payments by 5%, thereby, requiring payments made to managed care health plans to be reduced by the actuarial equivalent amount of five percent on the specific provider types. This resulted in, approximately, a two percent overall reduction to the capitation rates. The provider payment reduction is to remain in effect until December 31, 2006, at which time, the reduction will be repealed.

All rates for all affected plans will be restored on January 1, 2007. The annual cost for this rate restoration is expected to be \$130,830,000. The FY 2006-07 plan costs for this increase are expected to be:

| Plan | FY 2006-07 Increase |
|----------------------------|------------------------|
| Two-Plan Model | \$45,000,000 |
| Kaiser PHP | \$50,000 |
| PACE | \$20,000 |
| SCAN | \$45,000 |
| AIDS Healthcare Foundation | \$200,000 |
| GMC | \$6,600,000 |
| COHS | \$13,500,000 |
| Totals | \$65,415,000 |

TWO-PLAN MODEL DEFAULT ALGORITHM

REGULAR POLICY CHANGE NUMBER: 147
 IMPLEMENTATION DATE: 12/2005
 ANALYST: Shelley Stankeivicz
 FISCAL REFERENCE NUMBER: 1116

| | FY 2005-06 | FY 2006-07 |
|------------------------------|------------|-------------|
| FULL YEAR COST - TOTAL FUNDS | \$226,000 | \$1,310,000 |
| - STATE FUNDS | \$113,000 | \$655,000 |
| | | |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| | | |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$226,000 | \$1,310,000 |
| STATE FUNDS | \$113,000 | \$655,000 |
| FEDERAL FUNDS | \$113,000 | \$655,000 |

DESCRIPTION

Effective December 2005 a new default assignment methodology was implemented. This change in methodology results from a performance-based algorithm. As a result the Local Initiatives (LI) plans are receiving a higher percentage of members who do not choose a plan within the prescribed amount of time.

| | FY 05-06 | FY 06-07 |
|---------------------|------------------|--------------------|
| Total Fund | \$226,000 | \$1,310,000 |
| General Fund | \$133,000 | \$655,000 |

MEDI-CAL/HF BRIDGE PERFORMANCE STANDARDS

REGULAR POLICY CHANGE NUMBER: 148
 IMPLEMENTATION DATE: 10/2006
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 1010

| | FY 2005-06 | FY 2006-07 |
|------------------------------|------------|-------------|
| FULL YEAR COST - TOTAL FUNDS | \$0 | \$1,495,000 |
| - STATE FUNDS | \$0 | \$523,250 |
| PAYMENT LAG | 1.0000 | 0.7430 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$0 | \$1,110,800 |
| STATE FUNDS | \$0 | \$388,770 |
| FEDERAL FUNDS | \$0 | \$722,010 |

DESCRIPTION

To ensure that all children who are discontinued from Medi-Cal due to increased income have the opportunity to apply for the Healthy Families Program, the Department will implement county performance standards for compliance with the Medi-Cal Bridge to Healthy Families Program (aid code 7X), effective October 2006.

Assumptions:

1. Currently, an estimated 49,777 children are expected to receive the one-month bridge to the Healthy Families Program in 2006-07.
2. Implementation of performance standards is expected to increase the number of children receiving the bridge by 20,000 annually.
3. Assuming an October 2006 implementation, there will be an increase of 15,000 eligibles in 2006-07.
4. Based on fee-for-service and managed care cost data for persons eligible in aid code 7X, the average cost per aid code 7X eligible is \$99.64.

Annual cost: 20,000 x \$99.64 = \$1,993,000 (\$697,550 GF)

FY 2006-07: 15,000 x \$99.64 = \$1,495,000 (\$523,300 GF)

**Funding is from Title XXI SCHIP funds (4260-113) at 65% FFP/35% GF.

SHIFT OF CCS STATE/COUNTY COSTS TO MEDI-CAL

REGULAR POLICY CHANGE NUMBER: 149
 IMPLEMENTATION DATE: 4/2006
 ANALYST: Cheri Johnson
 FISCAL REFERENCE NUMBER: 1117

| | FY 2005-06 | FY 2006-07 |
|------------------------------|-------------|-------------|
| FULL YEAR COST - TOTAL FUNDS | \$6,190,000 | \$5,000,000 |
| - STATE FUNDS | \$3,095,000 | \$2,500,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$6,190,000 | \$5,000,000 |
| STATE FUNDS | \$3,095,000 | \$2,500,000 |
| FEDERAL FUNDS | \$3,095,000 | \$2,500,000 |

DESCRIPTION

On April 4, 2006, the Medi-Cal/California Children Services fiscal intermediary contractor EDS installed an erroneous payment correction (EPC) in the claims payment system. Claims that had been paid as CCS-only for children later determined to be Medi-Cal eligible on a retroactive basis were identified and reprocessed. This reprocessing resulted in a shift of costs for claims which had previously been paid from State General Fund/County CCS-only funds to Medi-Cal funds.

Assumptions:

1. Based on data provided by the Children's Medical Services Branch, the estimated shift is \$6,190,000 in FY 2005-06 and is expected to be \$5,000,000 in FY 2006-07.
2. These costs are currently funded with GF and county funds of \$3,095,000 each in the current year and \$2,500,000 each in the budget year, and would have been eligible for funding under the Medi-Cal Hospital/Uninsured Care Demonstration Waiver Safety Net Care Pool.
3. The total cost to Medi-Cal will be \$6,190,000 (\$3,095,000 GF, \$3,095,000 FFP) in the current year and \$5,000,000 (\$2,500,000 GF, \$2,500,000 FFP) in the budget year.

CAPITATION RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 150
 IMPLEMENTATION DATE: 7/2006
 ANALYST: Shelley Stankeivicz
 FISCAL REFERENCE NUMBER: 1118

| | FY 2005-06 | FY 2006-07 |
|------------------------------|------------|--------------|
| FULL YEAR COST - TOTAL FUNDS | \$0 | \$61,175,000 |
| - STATE FUNDS | \$0 | \$30,587,500 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$0 | \$61,175,000 |
| STATE FUNDS | \$0 | \$30,587,500 |
| FEDERAL FUNDS | \$0 | \$30,587,500 |

DESCRIPTION

The Department of Health Services (DHS) recently conducted a financial review of all Medi-Cal managed care plans to determine if any additional rate adjustments were needed to ensure that all plans would have sufficient resources to provide quality care to Medi-Cal beneficiaries. In April, 2006, six managed care contractors were determined to be in need of a rate increase to minimize the risk of insolvency and maintain compliance with required financial standards. The total cost of the rate increase for each plan was determined based on each plan's required minimum Tangible Net Equity (TNE). The rate increases will be implemented during FY 2006-07. Each individual plan's increase will begin at the start of that plan's new rate period, as follows:

| <u>Plan</u> | <u>Rate Period Begins</u> |
|--|---------------------------|
| Central Coast Alliance for Health (COHS) | January 1, 2007 |
| Health Plan of San Mateo (COHS) | July 1, 2006 |
| Partnership Health Plan (COHS) | July 1, 2006 |
| Santa Barbara Health Authority (COHS) | January 1, 2007 |
| Contra Costa Health Plan (Two-Plan Model) | October 1, 2006 |
| Community Health Group (Geographic Managed Care) | July 1, 2006 |

The total amount of the increase for each plan in FY 2006-07 was adjusted to reflect the funding provided to the plans with the provider rate restoration. Thus, the total increase for each plan was reduced by six months (January - June 2007) of the provider rate increase applicable to the plan.

CAPITATION RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 150

FY 2006-07

| <u>Plan</u> | <u>Total Funds</u> | <u>General Fund</u> |
|-----------------------------------|---------------------------|----------------------------|
| Central Coast Alliance for Health | \$7,670,000 | \$3,835,000 |
| Health Plan of San Mateo | \$7,670,000 | \$3,835,000 |
| Partnership Health Plan | \$25,300,000 | \$12,650,000 |
| Santa Barbara Health Authority | \$4,860,000 | \$2,430,000 |
| Contra Costa Health Plan | \$1,985,000 | \$992,500 |
| Community Health Group | <u>\$13,690,000</u> | <u>\$6,845,000</u> |
| Total | \$61,175,000 | \$30,587,500 |

DENTAL HEALTH FOR CHILDREN

REGULAR POLICY CHANGE NUMBER: 151
 IMPLEMENTATION DATE: 7/2006
 ANALYST: Jenn Brooks
 FISCAL REFERENCE NUMBER: 1120

| | FY 2005-06 | FY 2006-07 |
|------------------------------|------------|-------------|
| FULL YEAR COST - TOTAL FUNDS | \$0 | \$1,500,000 |
| - STATE FUNDS | \$0 | \$750,000 |
| | | |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| | | |
| APPLIED TO BASE | | |
| TOTAL FUNDS | \$0 | \$1,500,000 |
| STATE FUNDS | \$0 | \$750,000 |
| FEDERAL FUNDS | \$0 | \$750,000 |

DESCRIPTION

The Administration is proposing that school-aged children be required to have dental check-ups.