



LAO 
65 YEARS OF SERVICE

2008-09 Analysis

MAJOR ISSUES

Health and Social Services



Alternative Approach to Increasing Work Participation in CalWORKs

- Failure to comply with federal work participation requirements could result in penalties in the hundreds of millions of dollars. The Governor proposes a graduated full-family sanction and a five-year time limit for children whose parents cannot or will not meet federal work participation requirements. These policies would address anticipated work participation shortfalls and result in savings of \$471 million. We present alternative approaches to increasing work participation that result in less budgetary savings and fewer children losing aid (see pages C-105 and C-113).



Child Welfare Services (CWS)

- The Governor proposes to reduce county allocations for CWS by \$84 million. We evaluate the potential impacts of this proposal on social worker caseloads and children; and provide alternatives that more narrowly target reductions in CWS expenditures (see page C-118).
- The budget proposes to continue with the development of a new CWS computer system at a total cost of \$247 million. We recommend canceling the proposed new system and instead updating the existing CWS/CMS to provide required functionality, resulting in savings of \$184 million over the next seven years (see page C-124).



In-Home Supportive Services (IHSS) Wages

- Current law grants counties broad discretion to set wage levels and the conditions under which potential providers may list themselves as available to be employed by recipients. To

improve the IHSS labor force and the quality of services for recipients, we recommend enactment of legislation, prior to 2010-11, which ties state participation in wages to the level of training and tenure of IHSS providers (see page C-146).



Reforming Categorical Funding for Public Health Programs

- The state's current process for administration and funding of over 30 public health programs at the local level is fragmented, inflexible, and fails to hold local health jurisdictions (LHJs) accountable for achieving results. We make several recommendations to improve the coordination and integration of these programs so that LHJs can focus on meeting the overall goal of improving the public's health (see page C-52).



Most Proposed Reductions to Provider Reimbursement Could Further Limit Access to Care

- The Governor's budget proposes broad reductions to Medi-Cal health care provider rates and other reimbursements. We find that the majority of these proposed reductions could further limit program enrollees' ability to find providers who are willing to serve them. We recommend that the Legislature reject most of these proposed reductions. We further recommend that the state shift certain federal funds from hospital payments to other health care programs in order to reduce General Fund spending in those programs (see page C-34.)



Pay-for-Performance Program Could Reduce Medi-Cal Costs and Improve Patient Care

- We estimate the implementation of a pay-for-performance (P4P) program in Medi-Cal could eventually save the state tens of millions of dollars while improving patient care. We recommend the Department of Health Care Services (DHCS) take some steps towards implementing a statewide P4P program for all Medi-Cal providers by first implementing a P4P program for managed care plans and requiring the DHCS to report on how a P4P program could be implemented for fee-for-service providers (see page C-40).

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OVERVIEW

Health and Social Services

Compared to the current year, General Fund spending for health and social services programs is proposed to decrease by 0.9 percent to about \$29.3 billion. Most of this net decrease is attributable to a variety of caseload increases which are more than offset by proposed budget-balancing reductions in Medi-Cal reimbursement rates, grants for children receiving California Work Opportunity and Responsibility to Kids, foster care and related payments, In-Home Supportive Services domestic service hours, and county administration of various programs.

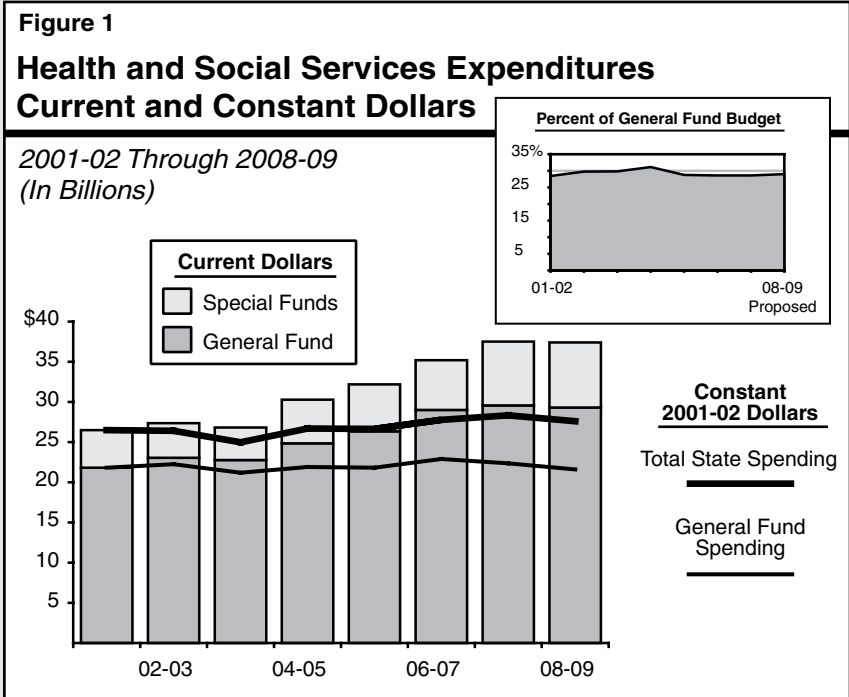
EXPENDITURE PROPOSAL AND TRENDS

Budget Year. The budget proposes General Fund expenditures of \$29.3 billion for health and social services programs in 2008-09, which is 29 percent of total proposed General Fund expenditures. Figure 1 shows health and social services spending from 2001-02 through 2008-09. The proposed General Fund budget for 2008-09 is \$300 million (0.9 percent) below proposed spending for 2007-08. The overview reflects the Governor's January 10 budget plan and does not reflect technical adjustments, provided at a later date, that we describe in our analysis of the Medi-Cal Program. The reduction reflects budget-balancing reductions (BBRs) proposed for these programs by the Governor. Special funds spending for health and social services is proposed to increase by about \$170 million (2.1 percent) to about \$8.1 billion. Most of this special funds growth is due to an increase in realignment payments to local government.

Historical Trends. Figure 1 (see next page) shows that General Fund expenditures (current dollars) for health and social services programs are projected to increase by \$7.5 billion (or 34 percent) from 2001-02 through 2008-09. This represents an average annual increase of 4.3 percent. Similarly, combined General Fund and special funds expenditures are projected to increase by about \$10.9 billion (41 percent) from 2001-02 through 2008-09, an average annual growth rate of 5 percent.

Adjusting for Inflation. Figure 1 also displays the spending for these programs adjusted for inflation (constant dollars). On this basis, General

Fund expenditures are estimated to decrease by 1 percent from 2001-02 through 2008-09. Compared to the current year, General Fund spending for 2008-09 is proposed to decline by 3.3 percent in constant dollars. Combined General Fund and special funds expenditures are estimated to increase by 4.2 percent during this same period, an average annual increase of less than 1 percent.



CASELOAD TRENDS

Caseload trends are one important factor influencing health and social services expenditures. Figures 2 and 3 illustrate the budget’s projected caseload trends for the largest health and social services programs. Figure 2 shows Medi-Cal caseload trends over the last decade, divided into four groups: (1) families and children, (2) refugees and undocumented persons, (3) disabled beneficiaries, and (4) aged persons (who are primarily recipients of Supplemental Security Income/State Supplementary Program [SSI/SSP]). Figure 3 shows the caseloads for California Work Opportunity and Responsibility to Kids (CalWORKs) and SSI/SSP.

Medi-Cal Caseload. The Governor’s budget plan assumes that the current-year caseload for Medi-Cal will increase by 51,600 individuals, or almost 2 percent, over the number assumed in the 2007-08 Budget Act. As

Figure 2

**Budget Forecasts Continued Growth
In Medi-Cal Caseloads**

*1998-99 Through 2008-09
(In Millions)*

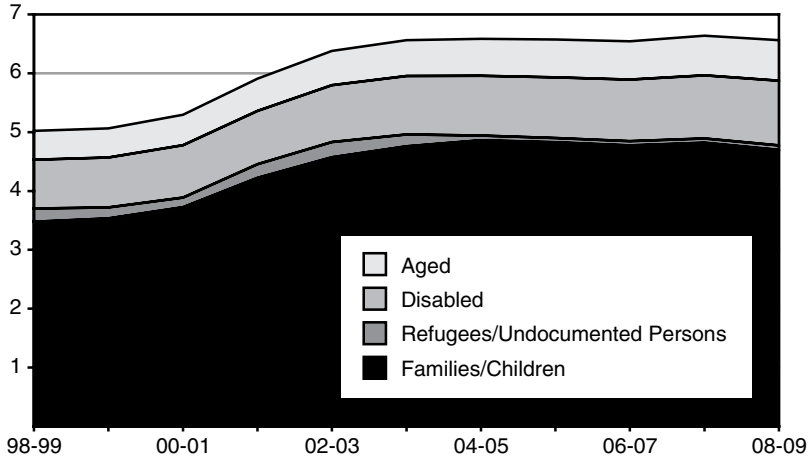
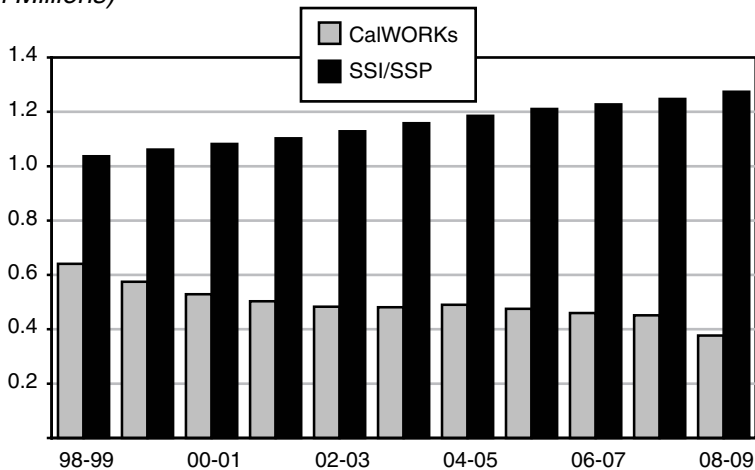


Figure 3

**CalWORKs Caseload to Decline
SSI/SSP Caseloads Increasing Slightly**

*1998-99 Through 2008-09
(In Millions)*



shown in Figure 2, the Governor's budget plan assumes a modest decrease of 73,900 individuals, or a 1.1 percent reduction, in caseload for the budget year in the Medi-Cal Program. The caseload projections for 2008-09 take into account reductions of almost 172,000 individuals attributable to the Governor's proposed reinstatement of quarterly reporting requirements for children and parents. The Medi-Cal budget proposal also reflects caseload growth in several eligibility categories for the aged and disabled.

Healthy Families Program (HFP) Caseload. The Governor's budget plan assumes that the current-year enrollment for HFP will fall short by about 20,500 children compared to the number assumed in the *2007-08 Budget Act*. However, the spending plan further assumes that the program caseload will increase by about 66,000 children, or about 7 percent, during the budget year. The budget proposal estimates that a total of about 954,000 children will be enrolled in HFP as of June 2009.

The CalWORKs and SSI/SSP Caseloads. Figure 3 shows the caseload trend for CalWORKs and SSI/SSP. The SSI/SSP cases are reported as individual persons, while CalWORKs cases are primarily families. For 2008-09, the budget assumes that CalWORKs will serve about 960,000 individuals.

As Figure 3 shows, the CalWORKs caseload declined steadily from 1998-99, essentially leveling out in 2003-04. This period of substantial CalWORKs caseload decline was due to various factors, including the improving economy, lower birth rates for young women, a decline in legal immigration to California, and, since 1999-00, the impact of CalWORKs program interventions (including additional employment services). In 2004-05 the caseload experienced its first year-over-year increase (about 2 percent) in almost a decade. After this one-time increase, the caseload resumed its decline, at just over 3 percent in 2005-06 and 2006-07. For 2007-08 the decline is forecasted to moderate to 1.8 percent. In 2008-09, the caseload is projected to drop by about 16 percent mostly due to policy proposals which (1) increase sanctions on families where the parents do not meet program participation requirements and (2) impose new time limits on children.

The SSI/SSP caseload can be divided into two major components—the aged and the disabled. The aged caseload generally increases in proportion to increases in the eligible population—age 65 or older (increasing at about 1.5 percent per year). This component accounts for about 30 percent of the total caseload. The larger component—the disabled caseload—typically increases by about 2.5 percent per year. Since 1998, the overall caseload has been growing moderately, between 2 percent and 2.5 percent each year. For 2007-08 and 2008-09, the budget forecasts caseload growth of 1.7 percent and 2.1 percent, respectively.

SPENDING BY MAJOR PROGRAM

Figure 4 (see next page) shows expenditures for the major health and social services programs in 2006-07, and as proposed for 2007-08 and 2008-09. Both the current- and budget-year amounts reflect the Governor's BBRs. As shown in the figure, three major benefit payment programs—Medi-Cal, CalWORKs, and SSI/SSP—account for a large share, about two-thirds, of total spending in the health and social services area.

As Figure 4 shows, General Fund spending is proposed to decrease for both Medi-Cal (-3.4 percent) and HFP (-1.5 percent) in the budget year. In contrast, the budget plan proposes increased funding for community mental health services (7.8 percent), mental hospitals (6.9 percent), and regional centers (5.4 percent). Despite the increases in these three programs, the significant cuts proposed in the Medi-Cal Program result in an overall reduction in spending for services provided by the state's health care programs.

In regard to major social services programs, General Fund support will increase for CalWORKs (4 percent) and SSI/SSP (2.9 percent) even after the Governor's BBRs (discussed later). Conversely, the budget proposes to reduce General Fund support for Child Welfare Services/Foster Care (-7.7 percent) and Child Support Services (-14 percent), primarily as a result of BBRs. Overall, the budget proposes to hold General Fund spending on social services programs constant at about \$9.5 billion.

MAJOR BUDGET CHANGES

Figures 5 (see page 13) and 6 (see page 14) illustrate the major budget changes proposed for health and social services programs in 2008-09. (We include the federal Temporary Assistance for Needy Families [TANF] funds for CalWORKs because, as a block grant, they are essentially interchangeable with state funds within the program.) Most of the major changes can be grouped into five categories: (1) funding caseload changes, (2) suspending certain cost-of-living adjustments (COLAs), (3) rate reductions, (4) across-the-board reductions, and (5) other policy changes.

Caseload Changes. The budget reflects caseload changes in the major health and social services programs. For example, the budget reduces resources for the Medi-Cal caseload in 2008-09 because of the expected caseload decline resulting from elimination of continuous eligibility for children and restoration of quarterly status reports for children and parents. General Fund support for regional centers (RCs) that serve the

Figure 4**Major Health and Social Services Programs
Budget Summary^a***(Dollars in Millions)*

	Actual 2006-07	Estimated ^b 2007-08	Proposed 2008-09	Change From 2007-08	
				Amount	Percent
Medi-Cal					
General Fund	\$13,628.3	\$14,063.9	\$13,591.8	-\$472.1	-3.4%
All funds	35,402.1	36,997.1	36,034.7	-962.4	-2.6
CalWORKs					
General Fund	\$2,017.8	\$1,481.0	\$1,547.2	\$66.2	4.5%
All funds	N/A	5,176.5	4,798.2	-378.4	-7.3
Foster Care/Child Welfare Services					
General Fund	N/A	\$1,235.7	\$1,140.5	-\$95.2	-7.7%
All funds	N/A	4,365.8	4,179.3	-186.5	-4.3
SSI/SSP					
General Fund	\$3,427.3	\$3,640.8	\$3,747.9	\$107.1	2.9%
All funds	N/A	9,153.7	9,510.2	356.4	3.9
In-Home Supportive Services					
General Fund	\$1,474.0	\$1,629.8	\$1,632.6	\$2.8	0.2%
All funds	N/A	4,863.2	4,846.9	-16.3	-0.3
Regional Centers/Community Services					
General Fund	\$2,106.8	\$2,222.4	\$2,342.2	\$119.8	5.4%
All funds	3,288.2	3,656.8	3,798.3	141.5	3.9
Community Mental Health Services					
General Fund	\$755.1	\$756.3	\$815.0	\$58.7	7.8%
All funds	2,188.4	3,492.6	3,562.4	69.8	2.0
Mental Hospitals/Long-Term Care Services					
General Fund	\$959.2	\$1,128.3	\$1,206.2	\$77.9	6.9%
All funds	1,034.1	1,234.4	1,312.9	78.5	6.4
Healthy Families Program					
General Fund	\$347.7	\$393.6	\$387.8	-\$5.7	-1.5%
All funds	969.6	1,090.1	1,072.4	-17.7	-1.6
Child Support Services					
General Fund	\$525.6	\$351.5	\$300.8	-\$50.7	-14.4%
All funds	1,116.5	1,036.6	858.9	-177.7	-17.1

^a Excludes administrative headquarters support.

^b Includes Governor's budget-balancing reduction proposals.

N/A=not available.

Figure 5

Health Services Programs Proposed Major Changes for 2008-09 General Fund

Medi-Cal (Local Assistance)	Requested: \$13.6 Billion
	Decrease: \$472.1 Million (-3.4%)

- + \$295 million for increases in costs and utilization of prescription drugs and inpatient hospital services
 - + \$93 million for increased payments to Medi-Cal managed care plans
 - + \$59 million from increased costs for premiums paid by Medi-Cal on behalf of beneficiaries who are also enrolled in the federal Medicare Program
-
- \$602 million from reducing provider rates for physicians and other medical and service providers
 - \$134 million by eliminating certain optional benefits for adults who are not in a nursing facility such as dental and chiropractic services
 - \$92 million from reductions in caseload due to the elimination of continuous eligibility for children and restoration of quarterly status reports for children and parents
 - \$87 million from reducing rates paid to long-term care facilities and certain hospitals

Department of Developmental Services (Local Assistance)	Requested: \$2.3 Billion
	Increase: \$119.8 Million (+5.4%)

- + \$62 million primarily for increases in regional center caseloads
-
- \$215 million continuation of regional center cost containment measures

developmentally disabled would continue to grow due mainly to caseload growth. Funding would be adjusted upward in the budget year for HFP to reflect anticipated caseload growth.

Figure 6

Social Services Programs Proposed Major Changes for 2008-09 General Fund

CalWORKs	Requested:	\$1.5 Billion	
	Increase:	\$66 Million	(+4.5%)

- + \$258 million to backfill reduced Temporary Assistance for Needy Families (TANF) balances
 - + \$131 million for the 4.25 percent cost-of-living adjustment
 - + \$87 million for restoring the TANF reserve
 - + \$83 million for child care and services for families who comply with work requirements in response to the graduated full-family sanction
-
- \$57 million for caseload decrease
 - \$486 million from grant savings associated with new time limits and the graduated full-family sanction

SSI/SSP	Requested:	\$3.7 Billion	
	Increase:	\$107 Million	(+2.9%)

- + \$103 million for caseload increase

In-Home Supportive Services	Requested:	\$1.6 Billion	
	Increase:	\$3 Million	(+0.2%)

- + \$79 million for caseload increase
 - + \$52 million for new computer system
-
- \$10 million from reducing county administration by 10 percent
 - \$109 million from reducing domestic service hours by 18 percent

Suspended COLAs. Pursuant to current law, the budget provides \$131 million to fund the July 2008 CalWORKs COLA. The budget proposes to delete both the June 2008 and June 2009 SSI/SSP COLAs, resulting in total savings of \$23 million in 2007-08 and \$300 million in 2008-09. The

budget does not provide the discretionary Foster Care COLA, nor does it provide the inflationary adjustment for payments to counties for administration of the Medi-Cal Program resulting in General Fund savings of \$22.4 million in 2008-09.

Rate Reductions. The Governor proposes rate reductions in Medi-Cal, HFP, Foster Care, Developmental Services, Rehabilitation, Alcohol and Drug Programs, and to other health care services. These rate reductions are generally in the range of 10 percent and taken together result in General Fund savings of about \$800 million.

Across-the-Board Reductions. The budget proposes to apply across-the-board reductions to many programs after they were first adjusted on a workload basis. Typically, the reduction is in the range of 10 percent of the adjusted base. Impacted programs include child welfare services allocation to counties (\$83.7 million), food stamps administration (\$14.4 million), IHSS administration (\$10.2 million), public health (\$31.7 million), the mental health managed care program (\$23.8 million), developmental services programs (\$22.5 million), and alcohol and drug programs (\$6.2 million).

Other Policy Changes

Increasing CalWORKs Sanctions. Currently, when an able-bodied adult does not comply with CalWORKs participation requirements, the family's grant is reduced by the adult portion, resulting in a "child-only" grant. The Governor proposes to increase this sanction to 50 percent of the remaining child-only grant after six months in sanction status, and completely eliminate the family's grant after another six months elapses, unless the adult comes into compliance. In response to this increased sanction, the budget estimates that many families will enter employment, resulting in child care and employment services costs of \$83 million. In cases where families do not comply, the budget estimates grant and administrative savings of \$62 million, so the net cost of this proposal is about \$21 million in 2008-09.

Time Limits for Aided Children. Currently, after five years of assistance, a family's grant is reduced by the adult portion, and the children continue to receive a child-only grant in the safety net program. The budget proposes to eliminate the safety net grant for children whose parents fail to comply with the federal work participation requirements (20 hours per week for families with a child under age 6 or 30 hours per week for families where all children are at least age 6). The budget also proposes to limit assistance to five years for most other child-only cases (such as those with parents who are undocumented or ineligible due to a previous felony drug conviction). These time-limit policies are estimated to result in savings of about \$500 million in 2008-09.

Reducing Domestic Service Hours for IHSS Recipients. Currently social workers assess each IHSS client to determine the number of hours of service that the recipient will need to remain safely in their own home. Services include personal care services (such as bathing, toileting, ambulation, and medication management), as well as domestic services (meal preparation, cleaning, and errands). The budget proposes to reduce domestic services hours by 18 percent, resulting in savings of \$109 million in 2008-09.

Medi-Cal Benefit Reductions. The budget proposes to eliminate certain Medi-Cal optional benefits provided to adults not residing in nursing facilities including dental, incontinence creams and washes, acupuncture, and chiropractic services for savings of \$134 million General Fund in 2008-09. Most of the savings (\$115 million) results from the elimination of dental services.

Continue RC Cost Containment Measures. The budget plan proposes to make permanent in 2008-09 cost containment measures that have been in place since 2003-04, for savings of almost \$215 million General Fund. The cost containment measures include rate freezes to certain providers and a freeze on funding for the startup of new programs.

Changes to Early and Periodic Screening Diagnosis and Treatment (EPSDT). The budget plan proposes to achieve savings of about \$46 million General Fund in the budget year through changes to the EPSDT program. A prior authorization requirement would be imposed on requests for day treatment services exceeding six months in duration. Savings would also be achieved through rate reductions to providers.

HFP Benefit Limits and Co-Payments. The budget proposes to establish a \$1,000 annual benefit limit for dental coverage for HFP participants and increase co-payments for nonpreventative services and premiums for children in families with incomes over 150 percent of the federal poverty level. These changes are estimated to result in \$20.8 million in annual General Fund savings. According to the Managed Risk Medical Insurance Board, these changes must be negotiated with the health plans by March 1, 2008 in order to be effective for the budget year.

Proposition 36 Funding Reduction. The budget proposes a net reduction of \$12 million General Fund for Proposition 36 drug rehabilitation programs. This would be achieved by reducing funding by \$10 million for the Substance Abuse and Treatment Trust Fund, established by Proposition 36. Funding for the Substance Abuse Offender Treatment Program—established to improve the outcomes of Proposition 36 Programs—would decrease by \$2 million.

DEPARTMENTAL ISSUES

Health and Social Services

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS (4200)

The Department of Alcohol and Drug Programs (DADP) directs and coordinates the state's efforts to prevent or minimize the effects of alcohol-related problems, narcotic addiction, drug abuse, and gambling. As the state's alcohol and drug addiction authority, the department is responsible for ensuring the collaboration of other departments, local public and private agencies, providers, advocacy groups, and beneficiaries in maintaining and improving the statewide service delivery system. The DADP operates data systems to collect statewide data on drug treatment and prevention and administers programs in the following areas: (1) substance abuse prevention services, (2) substance abuse treatment and recovery services, (3) licensing adult alcoholism or drug abuse recovery or treatment facilities, (4) criminal justice, and (5) problem gambling.

Governor's Budget Proposal. The Governor's budget proposes \$662.5 million from all funds for support of DADP programs in 2008-09, which is an increase of \$5 million, or almost 1 percent, above the revised estimate of current-year expenditures mainly due to a fund shift from the California Department of Corrections and Rehabilitation (CDCR). The budget proposes \$286.9 million from the General Fund, which is an increase of \$10.3 million, or 3.7 percent, above the revised estimate of current-year expenditures. The budget plan includes the following proposed spending:

- ***Fund Shift From CDCR.*** The Governor's budget includes a \$25 million General Fund increase in funding for the Substance Abuse Services Coordinating Agencies contract which passes through DADP to CDCR. This is in addition to the existing \$8.9 million General Fund that passes through to CDCR, which was exempt from the Governor's budget balancing solutions. The department is using these pass-through funds to keep their overall spending high enough to satisfy maintenance of effort requirements for federal Substance Abuse Prevention and Treatment block grant funds.
- ***Reduced Drug Medi-Cal Provider Rates.*** The budget plan proposes \$133 million (\$64.9 million General Fund) for the Drug Medi-Cal Program. This is a \$12.6 million General Fund reduction in 2008-09 compared to current year revised funding due mainly to a 10 percent across-the-board reduction in provider rates.
- ***Reduction of Proposition 36 Funding.*** The spending plan proposes to reduce funding for the Substance Abuse and Treatment Trust Fund by \$3.3 million General Fund in the current year and \$10 million General Fund in the budget year. Additionally, the spending plan includes General Fund reductions of \$667,000 in the current year and \$2 million in the budget year for the Offender Treatment Program. We describe the potential fiscal impacts of these proposals in more detail below.
- ***Reduced County Funding for Drug Court Programs.*** The spending plan proposes a 10 percent reduction of current county funding for all drug court programs including the Comprehensive Drug Court Implementation Act (CDCI), Drug Court Partnership (DCP), and dependency drug courts (DDCs). This reduction would result in General Fund savings of \$1 million in the current year and \$3.1 million in the budget year. We discuss the fiscal impacts of these proposals in more detail below.
- ***California Methamphetamine Initiative (CMI) Continuation.*** The Governor's Budget proposes a General Fund reduction of \$360,000 to the \$10 million provided in the *2007-08 Budget Act* and \$1 million in the budget year for CMI social campaign efforts. The budget year is the last of a three-year multimedia methamphetamine prevention campaign that provided roughly \$10 million in funding each year.

Reductions to Drug Diversion Programs Likely to Result in Increased State Costs

The Governor's proposal to reduce Proposition 36 and drug court programs funding in both the current and budget year is likely to result in offsetting increases in state criminal justice system and child welfare services costs, including state prison expenditures. Based on the demonstrated cost-effectiveness of Proposition 36 and drug court programs, we recommend rejecting these funding reductions and instead funding these programs at 2007-08 Budget Act spending levels. In a subsequent issue, we identify funds that could be used to backfill the Governor's proposed reductions in Proposition 36 and drug court programs. (Increase Item 4200-105-0001 by \$3.3 million in the current year and \$10 million in the budget year and Item 4200-101-0001 by \$1.7 million in the current year and \$5.1 million in the budget year.)

Background

The DADP funds drug diversion programs intended to provide treatment in the community generally to nonviolent drug offenders in two primary ways—Proposition 36 and county-operated drug court programs.

Proposition 36 Approved by Voters in November 2000. The Substance Abuse and Crime Prevention Act, or Proposition 36, passed in 2000 and changed state law so that certain adult offenders who use or possess illegal drugs are sentenced to participate in drug treatment and supervision in the community rather than being sentenced to prison or jail, supervised on probation, or going without treatment. Proposition 36 programs are funded through the Substance Abuse Treatment Trust Fund, established by the measure, and the Substance Abuse Offender Treatment Program (OTP) established by Chapter 75, Statutes of 2006 (AB 1808, Committee on Budget). (For additional background information, see page C-78 of the *Analysis of the 2006-07 Budget Bill* and page C-29 of the *Analysis of the 2007-08 Budget Bill*.)

County Administered Drug Court Programs. Generally, drug court programs combine judicial monitoring with intensive treatment services over a period of about 18 months. Individuals who usually qualify are nonviolent drug offenders but often have more serious offenses than those who are eligible for Proposition 36 programs. The department funds many types of drug courts that are supported in part through two programs: (1) the DCP program created in 1998 that supports adult drug courts in 33 counties and (2) the CDCI program created in 1999 that supports adult, juvenile, family, and DDCs in 54 counties. The DDCs provide intensive substance abuse treatment along with close court supervision to parent(s)

identified with a substance abuse problem referred through child protective services. This drug court model also provides parent(s) with skills and treatment necessary to prevent their children's potential placement in the foster care system and allows them instead to remain safely at home.

Governor's Budget Proposes 10 Percent Reductions

The Governor's budget plan proposes to reduce General Fund support for both Proposition 36 programs and drug court programs in the current and budget years as shown in Figure 1. For the current year, the Governor proposes to reduce Proposition 36 program funding by \$4 million from the appropriation amount of \$120 million to \$116 million. The budget proposes to further reduce Proposition 36 program funding by 10 percent in 2008-09.

As regards the drug court programs, the Governor's spending plan proposes a \$1 million reduction in the current year and a \$3.1 million reduction (10 percent) in the budget year.

Figure 1
Proposition 36 and Drug Court Funding
Governor's 2008-09 Budget Compared to
Current Year and 2007-08 Budget Act

(In Millions)

Program	General Fund		
	2007-08 Budget Act	2007-08 Revised	2008-09 Proposed ^a
Proposition 36 programs			
SATTF	\$100.0	\$96.7	\$86.7
OTP	20.0	19.3	17.3
Totals	\$120.0	\$116.0	\$104.0
Drug Court programs			
CDCI	\$18.0	\$17.4	\$16.0
DCPA	8.0	7.6	7.0
DDCs	5.0	4.9	4.0
Totals	\$31.0	\$29.9	\$27.0

^a Assumes current-year reductions.
 SATTF = Substance Abuse Treatment Trust Fund.
 OTP = Substance Abuse Offender Treatment Program.
 CDCI = Comprehensive Drug Court Implementation program.
 DCPA = Drug Court Partnership program.
 DDCs = Dependency Drug Courts.

Proposition 36 Programs And Drug Courts Reduce State Costs

A number of evaluations of Proposition 36 and drug court programs show that these drug treatment programs result in net savings to the state primarily through the diversion of drug offenders from prison.

Proposition 36 Programs Shown to Reduce State Costs. A recent benefit-cost analysis of Proposition 36 indicates that costs are \$2,861 lower per offender for *all* Proposition 36 participants (a benefit-cost ratio of \$2.50 saved for every \$1 spent) and costs are \$5,601 lower per offender for those that *complete* the program (a benefit-cost ratio of \$4 to \$1). Based on our review of this report, and our own prior analysis (see page C-32 of the *Analysis of the 2007-08 Budget Bill*), we conclude that Proposition 36 results in net savings to the state, primarily because of diversion of offenders from state prisons.

Adult Drug Court Program Evaluations Indicate Criminal Justice Savings. According to departmental studies, adult felony drug court programs result in savings to the state. The department indicates that in 2006-07, the most current year for which data are available, the CDCI program saved \$35.5 million by avoiding days in prison for those who successfully complete the drug treatment program. The estimated benefit-cost ratio is \$4.64 to \$1. Similarly, adult drug felons who successfully completed treatment in the DCP program saved \$26.9 million in avoided prison costs (a benefit-cost ratio of \$3.50 to \$1) in 2006-07. Differences in savings between these two drug court programs may be due to variation in county implementation.

The DDCs Help Avoid Costs. Evaluations of the DDC model have determined that working with parents with substance abuse problems reduces the amount of time required to unify them with their children, increases reunification rates, and increases participation in substance abuse treatment programs. These programs help the state avoid cost increases in Child Welfare Services (CWS) programs, including Foster Care.

Reductions in Drug Diversion Programs Increase Other State Costs. The current- and budget-year reductions proposed for drug diversion programs funded by DADP are likely to result in increased costs to other state programs such as CDCR, Department of Justice, and CWS. For example, if funding for drug courts is reduced, a judge presiding over an adult drug felon case is less likely to propose a drug court program for that individual if there are no resources for treatment and supervision. Alternatively, the judge may be more likely to send that individual to prison so as not to risk public safety. Such a decision would result in an increase in state prison costs. If the person had participated in a drug court

program, prison costs would not have been incurred. The cost of serving an individual in the drug court program is generally less than the cost of prison, as discussed earlier.

Analyst's Recommendations

In order to ensure that the state continues to achieve net savings, primarily from the diversion of drug offenders from state prison, we recommend the Legislature fund Proposition 36 and drug court programs at the 2007-08 *Budget Act* appropriation levels. Accordingly, we recommend the Legislature fund Proposition 36 programs at \$120 million General Fund and all drug court programs at \$31 million General Fund in 2008-09.

As we discuss in the next issue, we believe that the Governor's proposed reduction in Proposition 36 programs and drug courts can be back-filled by redirecting funds from two separate funding sources.

Reductions Could Be Offset With Other Funds

The Governor proposes to cut funding for Proposition 36 and drug court programs that have been shown to reduce overall state costs. We recommend the Legislature consider alternative funding sources for these substance abuse treatment services as follows: (1) redirecting advertising funds from the California Methamphetamine Initiative (CMI) and (2) using a portion of proceeds from state and federal narcotic asset forfeitures. These alternative funding sources could help maintain current spending levels for cost-effective substance abuse treatment services.

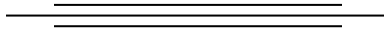
Advertising Funding Could Be Redirected. The CMI funds multi-media advertising and outreach education intended to prevent the use of methamphetamine by Californians. The Governor's spending plan proposes about \$8.6 million for support of CMI activities in 2008-09. This amount reflects a \$1 million reduction in the budget year from the Governor's workload budget amount of \$9.6 million. (The Governor is also proposing a \$360,000 reduction in the current year.)

Given that many of the state's drug treatment services including Proposition 36 and drug courts have proven to reduce costs in other state programs such as CDCR, we believe cuts to these programs are not cost-effective. To offset the proposed cuts, the Legislature could redirect up to \$9.6 million General Fund from CMI to drug treatment programs to minimize the cuts proposed for the budget year. This redirection would be on a one-time basis because, under current law, funding for CMI was appropriated for three years only beginning in 2006-07 through 2008-09.

Use of Forfeiture Proceeds Could Be Shifted. We recommended in our 2002-03 *Analysis of the Budget Bill* (see page C-55) that the Legislature consider modifying state law to redirect asset forfeiture proceeds to support drug treatment programs. The state receives proceeds from seizures of assets found to have been used in illegal drug-trafficking activities. The majority of these forfeiture monies currently fund local law enforcement agencies. Based on our prior analysis, the state could shift between \$4.5 million and \$10 million of the approximately \$50 million in state and federal asset forfeiture proceeds to support substance abuse treatment programs.

Analyst's Recommendation. In order to continue the current level of funding for Proposition 36 and drug court programs which have proven to be cost-effective, we recommend the Legislature consider:

- Redirecting \$9.6 million (compared to the workload budget) in methamphetamine prevention advertising funds from CMI to these substance abuse treatment services, which have proven to be cost-effective.
- Modifying state law to redirect a portion of asset forfeiture monies (between \$4.5 million and \$10 million) to support drug treatment programs. We have assumed savings of \$10 million from asset forfeitures in our LAO budget alternative discussed in *The 2008-09 Budget: Perspective and Issues*.



DEPARTMENT OF HEALTH CARE SERVICES (4260)

The 2007-08 *Budget Act* implemented Chapter 241, Statutes of 2006 (SB 162, Ortiz), which created a new state Department of Public Health and renamed the then Department of Health Services as the Department of Health Care Services (DHCS). The DHCS is responsible for protecting and improving the health of all Californians.

The department finances and administers three health care services programs: (1) the California Medical Assistance Program (Medi-Cal), which is the state's federal Medicaid Program; (2) Children's Medical Services, which coordinates and directs the delivery of health care services to low-income and seriously ill children; and (3) Primary and Rural Health Care, which coordinates and directs the delivery of health care to Californians in rural areas and to underserved populations. Most of the DHCS budget is allocated to the provision of benefits under the Medi-Cal Program.

MEDI-CAL

The Medi-Cal Program provides health care services to welfare recipients and other qualified low-income persons (primarily families with children and the aged, blind, or disabled). Expenditures for medical benefits are shared about equally by the General Fund and by federal funds. The Medi-Cal budget also includes federal funds for (1) disproportionate share hospital (DSH) payments and other supplemental payments, which provide additional funds to certain hospitals that serve Medi-Cal or other low-income patients; and (2) matching funds for state and local funds in other related programs.

OVERVIEW OF MEDI-CAL BUDGET PROPOSAL

Since the release of the Governor's budget on January 10, the administration has made technical adjustments to the estimated level of savings

in the Medi-Cal Program generated by various budget-balancing proposals resulting in an overall reduction in the level of savings proposed for both the current and budget year. As a result, of these changes, the dollar amounts in our *Analysis* may not match the numbers in the Governor’s January 10 budget document.

The budget proposes Medi-Cal expenditures totaling \$36.4 billion from all funds for state operations and local assistance in 2008-09. Figure 1 displays a summary of Medi-Cal General Fund expenditures in the DHCS budget for the past, current, and budget years. The General Fund portion of the spending for local assistance (\$13.7 billion) decreases by about \$402 million, or 2.9 percent, compared with estimated General Fund spending in the current year. The largest decreases are from proposals to reduce payments for certain providers which total \$649 million in the budget year and a reduction of \$143.5 million from the discontinuation of some optional Medi-Cal benefits. These decreases are partially offset by increases in other areas.

Figure 1
Medi-Cal General Fund Budget Summary^a
Department of Health Care Services

(Dollars in Millions)

	Expenditures			Change From 2007-08	
	Actual 2006-07	Estimated 2007-08	Proposed 2008-09	Amount	Percent
Local Assistance					
Benefits	\$12,649	\$13,184	\$12,829	-\$354	-2.8%
County administration (eligibility)	673	786	734	-52	-7.1
Fiscal intermediaries (claims processing)	84	101	105	4	3.8
Totals, Local Assistance	\$13,406	\$14,071	\$13,668	-\$402	-2.9%
Support (state operations)	\$115	\$129	\$132	\$3	2.3%
Caseload (thousands)	6,544	6,638	6,564	-74	-1.1%

^a Excludes General Fund Medi-Cal budgeted in other departments.
Detail may not total due to rounding.

The remaining expenditures for the program are mostly federal funds, which are budgeted at \$21.7 billion, or 2 percent, less than estimated for the current year. In addition, the spending total for the Medi-Cal budget includes an estimated \$596 million in local government funds for certain payments to hospitals. About \$5.9 billion of total Medi-Cal spending consists of funds budgeted for programs operated by other departments, counties, and the University of California.

Key Changes in Current-Year Spending

The Governor's budget projects that actual current-year spending will be \$201.1 million General Fund below the level appropriated in the *2007-08 Budget Act*, despite expected growth in current-year caseload over the budgeted amount. This decrease is due to the budget-balancing reductions (BBRs) proposed to begin in the current year. As mentioned previously, technical adjustments to some of the BBRs since the release of the Governor's budget reduce the overall level of General Fund savings proposed in the current year by \$5.5 million.

Current-Year Caseload Slightly Higher Than Forecasted. The Governor's budget projects that the 2007-08 caseload will grow in the current year by 51,600 beneficiaries, almost 1 percent, over the budgeted amount. This is estimated to increase program costs by approximately \$130 million General Fund. The group of individuals who are estimated to experience the greatest growth are those in the 100 percent Federal Poverty Level (FPL) category. This Medi-Cal group, which consists of children from the ages of 6 to 19 years whose family income is at or below 100 percent of FPL, is estimated to increase by 13,000 beneficiaries, or 14.4 percent. Slightly higher-than-anticipated growth also is expected in other beneficiary categories. Program costs as a result of this caseload growth are offset by lower-than-expected costs in other areas.

Budget-Balancing Reductions. In addition to the regular programmatic changes affecting expenditures, the Governor's budget proposes many current-year budget reductions that, if adopted, would decrease current-year spending by a total of \$42 million General Fund. They include the following:

- ***Rate Reductions (\$26 Million Savings).*** The Governor's plan proposes a 10 percent provider rate reduction affecting physicians, managed care plans, and other providers that is estimated to reduce state costs by \$26 million General Fund in the current year.
- ***Elimination of Optional Benefits (\$16 Million Savings).*** The budget plan also proposes the elimination of many benefits that

are optional for the state to provide under federal Medicaid rules, including the provision of certain adult dental services. The Medi-Cal Program would also stop paying Medicare Part B premiums for beneficiaries in Medi-Cal's share of cost programs. The elimination of these benefits would result in savings of \$16 million General Fund.

The Governor's 2008-09 Budget Proposal

Medi-Cal Local Assistance

The Governor's proposed budget estimates that total General Fund spending for Medi-Cal local assistance will be \$13.7 billion, a net decrease of approximately \$402 million, or 2.9 percent, below the estimated spending for the current year. Technical adjustments to some of the BBRs provided to us by the administration decrease the overall amount of savings proposed in the Governor's budget by \$76.4 million. As summarized in the "Health and Social Services Overview" of this chapter of the *Analysis*, the spending plan proposes a number of significant adjustments and policy changes that are reflected in the budget-year totals.

Most Medi-Cal expenditure reductions proposed by the 2008-09 budget result from the continuation of various current-year proposals included in the Governor's budget to reduce local assistance funding for benefits provided to Medi-Cal beneficiaries. Savings increase in the budget year because of the continuation of the proposed reductions and the effect of full-year implementation. General Fund spending for the provision of Medi-Cal benefits would decrease by \$353.5 million, or 2.8 percent, from the current year. Figure 2 (see next page) shows the major components of the Governor's budget reductions, which we discuss below.

Rate Reductions (\$561 Million Savings). The spending plan takes into account the estimated ongoing effect of several significant budget reductions proposed for the current fiscal year. For example, the Governor's budget proposes a 10 percent provider rate reduction in the current year that would continue in the budget year, resulting in \$504 million General Fund savings. Rate reductions for certain long-term care providers would also go into effect in the budget year, producing additional savings of \$57 million General Fund. Skilled nursing facilities (SNFs) and Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) are exempt from the rate reductions because they are subject to quality assurance fees, which generate state revenues. These rate reduction proposals are discussed in more detail later.

Figure 2**Medi-Cal Local Assistance
Major General Fund Spending Changes
2008-09 Governor's Budget***(In Millions)***Savings From Cuts in Rates and Services**

10 percent rate reductions	-\$561
Reduction in hospital payments	-88
Elimination of various optional services	-139
Discontinuation of payment of Medicare Part B premiums for Medi-Cal share of cost beneficiaries	-67

Caseload Reduction Proposals

Reinstatement of quarterly status reports for parents	-\$9
Reinstatement of quarterly status reports for parents and cessation of continuous eligibility	-84

Caseload Increases

Implementation of SB 437	\$13
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Reductions in County Administration Funding

Elimination of 2008-09 cost-of-living increase	-\$22
Reduction of funding for eligible growth	-33
Reduction in county administration base funding	-15

Increased Cost of Services

Increased cost for payment of Medicare premiums	\$59
Increased cost for Medicare Part D "clawback"	49

Some numbers may not match text due to rounding.

Elimination of Certain Optional Benefits (\$206 Million Savings).

The budget plan proposes, beginning in the current year, to eliminate various optional services for adults who are not in long-term care, with the ongoing effect of this proposal generating savings of \$139 million General Fund in the budget year. The majority of these savings result from the elimination of optional dental services for adults, which is expected to result in General Fund savings of \$120 million. The budget plan also includes savings of \$67 million General Fund for the continuation of the current-year proposal to stop paying the Medicare Part B premium for beneficiaries who owe a share of cost.

Tightening Eligibility Rules (\$92 Million Savings). The budget plan includes proposals to tighten eligibility rules beginning July 1, 2008 to

reduce the total Medi-Cal caseload and associated costs. The proposals call for reinstatement of a quarterly reporting requirement for parents and children, which would require Medi-Cal beneficiaries to report changes in income and assets. The quarterly status reporting requirement was eliminated in January 2001 by Chapter 945, Statutes of 2000 (AB 2900, Gallegos). Additionally, the proposal calls for elimination of continuous eligibility for children whose families exceed the income and asset requirements, which began in 2001. The department estimates that these proposals combined will reduce the average monthly caseload by 172,000 individuals for General Fund savings of \$92 million in 2008-09.

Reductions in Hospital Inpatient Payments (\$88 Million Savings).

The budget proposes to reduce some payments to hospitals for inpatient services to generate savings of \$88 million General Fund, or 2 percent, of Medi-Cal inpatient General Fund spending. This total consists of the following specific proposals:

- A reduction of 10 percent, or \$34 million, in federal "Safety Net Care Pool" funds for public hospitals. These funds would be redirected to offset General Fund spending for four other DHCS health care programs: the California Children's Services Program, the Genetically Handicapped Persons Program, the Breast and Cervical Cancer Treatment Program, and the Medically Indigent Adult-Long-Term Care Program.
- A decrease of 10 percent, or \$30 million, General Fund in reimbursements to hospitals that provide Medi-Cal services without state contracts.
- A reduction of 10 percent, or \$24 million, General Fund in supplemental payments to private hospitals and small public hospitals, who currently receive these funds as DSH payments or "DSH replacement" payments.

Reductions in County Administration Funding (\$70 Million Savings). The 2008-09 budget proposes to reduce funding to counties for the determinations of Medi-Cal eligibility by \$70 million General Fund. This proposal would reduce the counties' base payment for eligibility determination processing (\$15 million savings), eliminate funding for anticipated growth in caseload determinations (\$33 million savings), and eliminate the 2008-09 cost-of-living increase (\$22 million savings).

Medicare Premiums (\$59 Million Cost). The Medi-Cal Program pays the premiums for Medi-Cal beneficiaries who also are eligible for Medicare, thereby obtaining 100 percent federal funding for those services covered by Medicare. (This arrangement is favorable to the state because it generally has the net effect of reducing state costs for Medi-Cal.) The

budget estimates that the General Fund cost of these so-called “buy-in” payments will increase by \$59 million General Fund, mainly as a result of increased premium costs.

Medicare Part D (\$49 Million Cost). Medi-Cal payments for the Medicare prescription drug benefit program, known as Medicare Part D, continue to rise, mainly as a result of growth in the number of beneficiaries who qualify for the benefit and the rising cost of pharmaceuticals. Under the Medicare Part D program, the state no longer pays the cost for drugs for beneficiaries who are eligible for both Medi-Cal and Medicare. These costs are paid for by the federal government. However, the federal government requires that the states pay back much of the savings on dual eligible drug coverage, a payment known as the “clawback.” The Governor’s budget estimates that the state’s clawback payment will be \$1.2 billion in the budget year, an increase of \$49 million over the prior year’s payment.

Implementation of New Pilot Program Allowing Self-Certification of Assets (\$13 Million Cost). The Governor’s budget assumes implementation of Chapter 328, Statutes of 2006 (SB 437, Escutia), which authorized a pilot program allowing applicants and beneficiaries to self-certify their income and assets. The 2008-09 budget includes a General Fund increase of \$11.4 million for increased caseload growth of 17,000 individuals, \$900,000 for counties to administer Chapter 328, and \$700,000 for an evaluation of the program’s implementation and necessary computer systems’ changes.

DHCS State Operations

Reductions in State Staffing Levels Proposed (\$7 Million Savings). The Governor’s budget proposes \$143 million General Fund for state operations. This includes savings of nearly \$7 million General Fund in the budget year, mostly due to the elimination of 113 positions and other associated funding.

BUDGET FORECASTS DECLINE IN CASELOAD

The budget’s overall estimate for the Medi-Cal caseload is reasonable and we will monitor caseload trends and recommend appropriate adjustments at the time of the May Revision. However, we believe that implementation of a pilot program allowing for self-certification of income and assets is inconsistent with the Governor’s other proposals to reduce caseload and recommend delaying implementation. (Decrease Item 4260-001-0001 by \$13 million and Item 4260-001-0890 by \$13 million.)

Administration’s Caseload Projections

The budget projects that the average monthly caseload of individuals enrolled in Medi-Cal will grow slightly over anticipated levels in the current year and decline in the budget year. As regards the current year, the caseload is estimated to be 51,600 individuals over the caseload assumed in the 2007-08 Budget Act, resulting in minimal caseload growth of 1.4 percent from 2006-07 to 2007-08. The budget plan projects a decrease of nearly 74,000 individuals, or a decrease in the caseload of 1.1 percent, largely as a result of the budget proposals discussed above. Without these reduction proposals, the Governor anticipates that caseload would grow by 1.4 percent, which is somewhat above the forecasted growth rate for the overall state population.

Tightening of Eligibility Rules Decreases Non-Welfare Families Caseload. Figure 3 shows the budget’s forecast for the Medi-Cal caseload in the current year and 2008-09. As shown in the figure, the families and children caseload is expected to decline by 122,000 individuals or 2.6 percent. The majority of this decline occurs within the nonwelfare families

Figure 3

Budget Forecasts Increased Caseload Growth in Current Year, Decreased Growth in Budget Year

(Eligibles in Thousands)

	2006-07	2007-08	Change From 2006-07		2008-09	Change From 2007-08	
			Amount	Percent		Amount	percent
Families/Children	4,773	4,821	48	1.0%	4,699	-122	-2.6%
CalWORKs ^a	1,196	1,179	-17	-1.4	1,179	—	—
Nonwelfare families	2,954	2,981	27	0.9	2,871	-110	-3.8
Pregnant Women	197	214	17	7.9	220	6	2.7
Children	426	447	21	4.7	429	-18	-4.2
Aged/Disabled	1,701	1,744	43	2.5	1,790	46	2.6
Aged	654	671	17	2.5	691	20	2.9
Disabled (includes blind)	1,047	1,073	26	2.4	1,099	26	2.4
Undocumented Persons^b	71	71	—	—	73	2	2.7
Totals^c	6,545	6,636	182	1.4%	6,562	-74	-1.1%

^a California Work Opportunity and Responsibility to Kids.

^b Persons placed into a dedicated undocumented aid category. Other caseload groups also include undocumented persons. Services available to undocumented immigrants are generally limited to prenatal care, long-term care, and emergency care.

^c Detail may not total due to rounding.

caseload as a result of the reinstatement of quarterly status reports and the cessation of continuous eligibility for children in the budget year. The nonwelfare families caseload is expected to grow by 0.9 percent in the current year and decline by 3.8 percent in the budget year. The nonwelfare families caseload would be expected to grow by 142,000 individuals, or 4 percent, without the decreases in caseload resulting from this tightening of eligibility rules.

Caseload for the California Work Opportunity and Responsibility to Kids families is expected to decrease slightly, by 1.4 percent in the current year, and remain largely unchanged in the budget year.

Moderate Growth in Medically Needy Aged and Disabled. Consistent with current population trends, caseloads for the aged, blind, and disabled are expected to grow by about 43,000 beneficiaries, or roughly 2.5 percent in the current year, and by an additional 46,000 beneficiaries, or 2.6 percent in the budget year.

Caseload increases for the aged, blind, and disabled are driven primarily by those aged and disabled individuals who qualify as medically needy. (The medically needy category includes those who do not qualify for, or choose not to participate in the Supplemental Security Income/State Supplementary Program, such as low-income individuals who must pay a certain amount of medical costs themselves before Medi-Cal begins to pay for their care.) The budget estimates that in 2008-09 this caseload for the medically needy aged will grow by about 14,700 individuals, or 6.7 percent, and that the medically needy disabled caseload will grow by about 7,700 individuals or 6.5 percent.

The public assistance and long-term care eligibility categories project modest growth of less than 1.6 percent for the aged, blind, and disabled in 2008-09. This growth is consistent with previous trends.

Evaluation of the Governor's Caseload Proposals

Tightening of Eligibility Requirements May Not Achieve Proposed Level of Savings. As discussed in the prior section, the Governor's budget proposes reinstatement of quarterly status reporting for parents and children and the elimination of continuous eligibility for children. Though the Governor's proposals will likely result in a decrease in the number of Medi-Cal beneficiaries, the extent to which caseload will decline is uncertain because some individuals disenrolled by this process due to their failure to return the required paperwork might be eligible for reenrollment when medical services are needed.

Savings From Reduction in County Administration Funding May Erode. The Governor's budget includes reductions of \$70 million for the county administration function. The counties are responsible for processing new Medi-Cal applications and for the redetermination of eligibility status for existing Medi-Cal beneficiaries, currently performed on a biannual basis for adults and on an annual basis for children. The Governor proposes to reinstate quarterly status reports, which will increase the counties' workload as they will have to perform redeterminations on a more frequent basis. The Governor's proposal does not include funding to perform the extra redeterminations because the assumed decrease in overall caseload resulting from the additional reporting requirements would act as an offset.

If the total reduction in funding to the counties impedes their ability to handle the workload, counties may prioritize the processing of new Medi-Cal applications and delay completion of redeterminations. This may cause some Medi-Cal beneficiaries to receive benefits for a longer period than assumed in the Governor's budget and erode the level of savings estimated from tightening eligibility requirements.

Implementation of Self-Certification Inconsistent With Other Proposals. The proposal to implement Chapter 328, which would increase the Medi-Cal caseload, is inconsistent with the BBRs intended to reduce the Medi-Cal caseload. Given the projected operating budgetary shortfall, delaying implementation of this pilot program would allow the Legislature to redirect these resources (totaling \$13 million) to other areas.

The Economy Represents a Major Uncertainty. Continuing softness in the economy could potentially have a significant effect on Medi-Cal caseload trends. It is possible that a number of individuals who may have recently become unemployed are already enrolled in Medi-Cal. Although such individuals and their families would shift between Medi-Cal eligibility categories, their impact on overall Medi-Cal caseload and costs would be minimal. However, if the economic sluggishness continues, causing more people to become unemployed, Medi-Cal caseloads could rise above the forecasted levels.

Federal Changes in Eligibility Requirements. The federal Deficit Reduction Act of 2005 (DRA) mandated evidence of citizenship and identity as a condition of Medicaid eligibility. The number of undocumented persons receiving full-scope Medi-Cal benefits is unknown, though DHCS has indicated that it is not a large number. Although the effects of DRA on the Medi-Cal caseload are unknown, other states have indicated that they have experienced a decline in caseload, which they attribute to the citizenship and identity requirements.

Analyst's Recommendations

Our analysis indicates that the Governor's caseload estimate is reasonable overall, but we believe that both upside and downside risks to the estimate exist. This is due to a number of factors, including the BBRs and the effect of the economic downturn. Given the fiscal situation and because the Governor's proposal to implement Chapter 328 is inconsistent with other proposals to reduce the Medi-Cal caseload, we recommend the Legislature delay implementation to achieve savings of \$13 million General Fund.

In addition, the data available at the time of the May Revision will provide updated information for the Legislature to assess the proposed Medi-Cal caseload prior to making any adjustments. We will continue to monitor Medi-Cal caseload trends and will recommend any appropriate adjustments to the budget estimate at the May Revision.

SOME PROPOSED REDUCTIONS TO PROVIDER REIMBURSEMENT COULD FURTHER LIMIT ACCESS TO CARE

The Governor's budget proposes to reduce provider reimbursements by \$668 million General Fund for 2008-09. We review the potential effects of this proposal and generally find that the proposed reductions might reduce patient access to care or cause patients to obtain care through other, more costly access points such as emergency rooms. We recommend that the Legislature reject the proposed reductions for all providers except hospitals. We also recommend additional actions to generate savings in certain areas.

Background

Medi-Cal. The Medi-Cal Program provides services through two basic arrangements, managed care and "fee-for-service" (FFS). In the traditional FFS portion of the program, providers are paid for each examination, procedure, or other service that they furnish. The Medi-Cal Program is estimated to spend \$19.3 billion (\$8.4 billion in state funds) in 2007-08 for FFS care, including \$1.2 billion (\$600 million General Fund) for physician services and \$7.7 billion (\$3 billion in state funds) for hospital inpatient services. Medi-Cal also pays for the services provided by various other types of providers, including nursing facilities and pharmacy under FFS.

Under Medi-Cal managed care, DHCS contracts with health care plans to provide health care coverage for Medi-Cal beneficiaries residing in certain counties. The plans are reimbursed on a "capitated" basis with a predetermined amount per person per month regardless of the num-

ber of services an individual receives. Most of the estimated \$5.8 billion (\$2.9 billion General Fund) in premiums that Medi-Cal pays health plans for beneficiaries enrolled in managed care indirectly pays for services that physicians that contract with the health plans provide to patients. About one-half of Medi-Cal's beneficiaries are enrolled in managed care health plans while the remainder receive services under the FFS portion of the program.

Other Health Programs. The DHCS operates several other health care programs besides Medi-Cal. Two of these programs, California Children Services (CCS) and the Genetically Handicapped Persons Program (GHPP), provide health care services to low-income persons with qualifying medical conditions. Additional programs, including the Expanded Access to Primary Care (EAPC) Program, provide funds to support clinics that serve certain populations. Expenditures for these programs in 2007-08 are budgeted at \$347 million (\$163 million General Fund). Counties are also expected to contribute an additional \$106 million for CCS in 2007-08 that is not included in the state budget.

Savings From Rate Reduction Overstated

Governor's Proposal. The 2008-09 budget proposes to reduce almost all Medi-Cal provider rates. Rates for physicians and many other providers would be reduced by 10 percent. The overall reductions for hospital inpatient care would total about 2 percent of total Medi-Cal spending for inpatient services. This would be achieved through a 10 percent reduction to certain types of hospital payments. A portion of the hospital payment reduction consists of federal funds that would be redirected to backfill General Fund spending for CCS and GHPP. Figure 4 (see next page) lists the affected providers and the amount of the proposed decrease by provider type. The only providers not affected would be SNFs and ICF-DD. These facilities are excluded from the rate reductions because they are subject to quality assurance fees that generate state revenue. Collectively, the proposed reductions are expected to save the state \$668 million General Fund. The dollar amount of the savings generated by the rate reductions shown in Figure 4 do not match the numbers provided in the Governor's budget because of technical adjustments provided to us by the administration after the budget was issued on January 10, 2008.

Savings Estimate Double Counts Dental Reduction. The DHCS' estimate of savings from a 10 percent reduction in the rates of dental providers does not take into account another Governor's proposal which would eliminate optional dental services provided to adults who are not living in long-term care facilities. Therefore, the department overstates the total savings that would be available if dental rates were reduced. We estimate

Figure 4	
Governor's Budget Proposes to Reduce Provider Reimbursement	
<i>(2008-09 General Fund Effect, Dollars in Millions)</i>	
Rate Reductions	
Medi-Cal Service Category	
Managed care plans	\$223
Pharmacy	86
Long-term care facilities	57
Hospitals	54
Physicians	49
Other medical	34
Dental ^a	29
Other services	29
Outpatient services	28
Other programs ^b	14
Home health	8
Medical transportation	6
California Children's Services	11
Genetically Handicapped Persons Program	4
Other	
Shift of federal hospital payments ^c	34
Reductions to funding for clinics	4
Total	\$668
<p>^a Dental reductions do not incorporate the estimated impact of a reduction in provided benefits and therefore are overstated.</p> <p>^b Other programs include Early Periodic Screening, Diagnosis, and Treatment; Family PACT; and Breast and Cervical Cancer Treatment Program.</p> <p>^c Shift will backfill General Fund.</p> <p>Note: Total may not match text or sum due to rounding.</p>	

that the savings shown in Figure 4 from the proposal to reduce rates to providers of dental services by 10 percent is overstated by \$10.6 million General Fund in 2008-09.

Rate Reductions Could Reduce Access to Care

Rate reductions have the potential to negatively impact the operation of the Medi-Cal Program and the services provided to beneficiaries by

limiting access to providers and services. The Legislature may wish to take into account the following factors when making a decision regarding the proposed rate reductions.

Physicians Have Not Received Rate Increases in Recent Years. In general, FFS physician rates have not changed since the Legislature granted rate increases in the 2000-01 budget year, though medical costs continue to rise. A recent study that compared the rates Medi-Cal pays to its FFS providers to rates paid by Medicare found that, on average, Medi-Cal rates are about 61 percent of what Medicare pays to its service providers. A 10 percent rate reduction will reduce the rates to approximately 57 percent of what Medicare would pay.

Hospitals and Some Other Providers Have Received Recent Rate Increases. In contrast to physicians, Medi-Cal adjusts on an annual basis the reimbursement rates for certain other types of providers. For example, the rates for some long-term care providers, including nursing homes, are recalculated on a yearly basis to account for changes in costs.

Funding for hospitals has also increased recently. Between 2000 (the last year that physicians received a Medi-Cal rate increase) and 2006, rates increased by an average of 4.7 percent annually for hospitals that contract to provide Medi-Cal services. In 2005-06, the state also negotiated an agreement (known as a Medi-Cal "waiver") with the federal government that is estimated to provide increased payments of hundreds of millions of dollars annually to the largest public hospitals in the state. Also in 2005-06, the state stopped collecting an "administration fee" from public hospitals related to the DSH Program. This fee, which offset General Fund costs, had been set at over \$200 million annually in some previous years.

Studies Link Rates and Access to Timely Health Care. Though the effect of reimbursement rates on access to care and quality of care is complicated and influenced by a number of factors, some evidence exists that the rates paid to providers can positively affect access to care. A recent national survey has suggested that Medicaid rates not only seem to have an effect on access, but also on the perception of the quality of care that beneficiaries receive. Beneficiaries in this study uniformly had higher levels of satisfaction with their care when Medicaid reimbursements were higher. Other studies have shown that physician fee levels affect both access and outcomes for Medicaid patients.

Medi-Cal reimbursements may particularly impact the participation of specialist providers in the program. A recent study of otolaryngologists (ear, nose, and throat specialists) in Southern California found that fewer than 50 percent of the practicing physicians would accept appointments with children enrolled in FFS Medi-Cal. Of the physicians who would not accept new appointments, 90 percent cited low reimbursement rates

as a reason. If the cost of practicing medicine in California continues to grow while Medi-Cal rates remain stagnant, the relatively low Medi-Cal reimbursement rate for many primary care doctors and specialists may limit the number of physicians willing to see new Medi-Cal patients or continue treatment of existing patients.

Lack of Primary Care Access May Cause a Shift to More Expensive Forms of Care. Research indicates that access to effective primary care services can reduce the inappropriate use of the emergency room. Generally, the cost of services is more expensive if provided in an emergency room than in a primary care doctor's office. Many Medi-Cal managed care plans, as well as commercial health care plans, reward physicians for providing after-hours service and being available on weekends in order to increase their availability to beneficiaries, reducing the unnecessary use of the emergency room and thereby helping to control costs.

A recent nationwide report indicates that the number of doctors accepting new Medicaid patients has declined and that the percentage of doctors with no Medicaid patients has increased. In addition, the report found that a relatively small percentage of physicians provide most of the care to the Medicaid population. The most recent estimate available specifically for Medi-Cal physician services, provided by a 2001 survey by the California Health Care Foundation, concluded that only 55 percent of primary care physicians and less than 50 percent of specialists were willing to accept Medi-Cal patients following the rate increase that year. If the proposed physician rate reductions were to result in a decrease in the number of physicians willing to serve the Medi-Cal population, it would be more difficult for beneficiaries to find physicians or schedule appointments. If physicians are unavailable, these beneficiaries may seek care in expensive emergency room settings.

Other Options to Achieve Savings Are Available

Rate Reductions Could Be Implemented in Alternate Ways. If the Legislature decides to reduce the rates paid to Medi-Cal providers, it may wish to consider alternatives to the administration's approach. Rather than reducing rates by 10 percent across the board for almost all providers, the Legislature may wish to consider ways to implement rate reductions that would least disrupt the provision of services. We provide some options for ways in which the Legislature might modify application of a rate reduction:

- ***Reduction in Overall Proposed Rate Reduction:*** The Legislature may wish to moderate the overall size of the rate reduction by reducing the proposed percentage.

- ***Application of Reduction to Certain Providers:*** The Legislature may wish to consider whether a provider has received a recent rate increase. As stated above, DHCS adjusts certain providers' rates on a yearly basis, while other providers do not receive yearly adjustments.
- ***Consideration of Potential Cost Shifts Towards More Expensive Services:*** The Legislature may wish to consider whether a reduction of rates to certain providers would cause a cost-shift towards more expensive provider types. For example, if rate reductions force Adult Day Health Care Centers to close, beneficiaries who rely on services provided by the centers to stay in their homes may be forced to enter into relatively more costly nursing homes or other assisted living facilities.

Analyst's Recommendations

Reject Reductions for Most Provider Types. We recommend the Legislature reject the Governor's proposal to reduce payments for all providers except hospitals. The rate reductions proposed by the Governor, in our view, could further limit access to primary care in Medi-Cal and the other DHCS programs. Furthermore, these rate reductions may cause a shift to the utilization of costlier sources of care, diminishing the net savings to the state.

Approve and Increase Reductions for Hospitals. Our review indicates that hospitals have received significant rate increases relative to other provider types in recent years, and hospitals are generally among the most expensive settings to provide care. As such, we recommend that the Legislature take the following actions:

- Approve the Governor's proposed payment reductions for hospitals, as well as the proposed shift of federal hospital payments to other state-funded programs. These actions would result in savings of \$88 million General Fund in 2008-09 and \$108 million annually.
- Shift additional federal funds from public hospital payments to offset General Fund spending for the following programs: EAPC, CCS, GHPP, the Medically Indigent Adult Long-Term Care Program, and certain clinic grant programs. We estimate that this shift would result in additional savings of \$91 million General Fund in 2008-09 while maintaining the primary care services funded by these programs.

Consider Alternate Approaches. However, if the Legislature were to enact rate reductions for nonhospital providers, we recommend the pri-

oritization of the reductions, as described above, to minimize the impact upon these programs. Any of these approaches would eliminate or, at least, diminish somewhat the level of savings proposed by the administration from rate reductions. Recognizing the magnitude of the state's fiscal problem, our office has identified a number of options and recommendations for reducing state costs or increasing state revenues in "Part V" of our companion publication, *The 2008-09 Budget: Perspectives and Issues*.

PAY-FOR-PERFORMANCE COULD REDUCE MEDI-CAL COSTS AND IMPROVE PATIENT CARE

As health care costs continue to face upward cost pressures, many federal, state and private health care programs have turned to pay-for-performance programs as a way of both ensuring the practice of effective and efficient medicine and of controlling costs. Our analysis indicates that the implementation of a pay-for-performance program in Medi-Cal could eventually reduce General Fund costs by as much as tens of millions of dollars annually and significantly improve care for patients.

What Is Pay-for-Performance?

Pay-for-Performance (P4P) is a program that links fiscal incentives for medical service providers to measures of access, quality, and efficiency, thereby giving providers an incentive to provide efficient, effective, and appropriate medical care. The fiscal incentives generally take the form of increased reimbursements to providers.

Goals of P4P Programs

Through the use of appropriate incentives, P4P programs target the following broad goals: (1) improving patient outcomes, (2) improving access to care and quality of care, and (3) lowering costs. The success that providers have meeting these goals is evaluated using a number of different performance measures. Based on our review of available studies and discussions with managers of P4P programs, performance measurements vary among P4P programs depending on each P4P program's goals. Typically they focus on the evaluation of three areas: a doctor's clinical practice, the patient experience, and an office's use of information technology (IT).

Clinical Practice. The most common goal of P4P programs is to improve a doctor's practice of medicine. To this end, many programs will structure their incentives around measures that reward physicians for

ensuring that their practice meets certain standards for care. For example, many programs reward physicians for ensuring that parents bring their newborns in for well-baby visits and for ensuring that these babies receive their immunizations.

Patient Experience. The P4P programs are also structured to reward physicians for providing their patients with a satisfactory experience when they visit. Accordingly, many P4P programs structure incentives around measures of patient satisfaction and access to care.

Health IT and Data Submission. Health IT can improve patient outcomes by reducing medical errors, such as mistakes in the administration of prescriptions. However, health IT often requires a significant up front investment for providers. Therefore, many P4P programs provide fiscal incentives to providers to encourage them to adopt health IT, such as electronic prescriptions.

Components of Successful P4P Programs

Based on our review of the available literature and the experiences of managed care plans that have implemented P4P programs within their own provider networks, we have learned that successful programs generally combine the following key components: (1) well-designed performance measures, (2) fiscal incentives that are carefully aligned with performance measures, and (3) reliable and robust data sources. A more detailed explanation of these key components is provided below.

Well-Designed Performance Measures. Performance measures should be designed to affect a targeted group of patients and achieve a specific outcome. For example, a performance measure could measure the reduction in the number of emergency room visits for nonemergency illnesses achieved by improving access to primary care providers and preventative care.

Fiscal Incentives and Performance Measures Should Be Aligned. The available data show that the P4P programs that carefully align their incentives with their goals achieve better results than programs that do not. When incentive payments can significantly affect a physician's profitability, the physician is much more likely to try to earn the incentives.

Reliable Data Sources. The collection of reliable, accurate data is integral to an incentive program's success. Data must be robust enough that they paint an accurate picture of an individual physician's or physician group's practice as well as showing actionable areas for improvement. The data must also be complete enough to allow for uniform evaluation of a physician's performance based on several different measures and across multiple health plans.

Current Status of P4P

As health care costs continue to rise, health care insurers have started to turn towards P4P programs as a means of providing better health care while controlling the growth in costs. Although commercial providers were generally the first adopters of P4P programs, many state Medicaid programs, as well as the federal Medicare program have started to implement P4P programs.

Federal Medicare Program Is Experimenting With P4P Programs

The federal Center for Medicare and Medicaid Services (CMS) has started to explore the concept of incorporating performance into the rates paid to physician groups. In an initial demonstration project, ten physician groups participated in a P4P program that allowed the participating groups to share in any savings resulting from the practice of high quality, efficient medicine. All groups showed improvement in patient outcomes, though only two of the groups qualified to share in the savings. The CMS estimates that, during the initial year, the program saved an estimated \$10 million. At the time this analysis was prepared, CMS had not yet calculated overall savings for the program. However, the physician groups participating in the program estimate that the first two years have likely saved Medicare about \$21 million.

Some State Medicaid Programs Now Operate P4P Programs

The implementation of P4P programs has become a national trend in state Medicaid programs. Currently over one-half of state Medicaid programs operate at least one P4P program, with nearly 85 percent expected to begin a program within the next five years. Many states have operated their programs for over five years. Some states, such as New York, have focused their programs on encouraging participation in health IT. New York issues grants to physician groups that perform well based on New York's P4P criteria thereby funding the up-front costs of purchasing health technology systems. Other states have focused on other goals.

Alabama's FFS Medicaid Program has operated a P4P program for the past decade called Patient 1st that tracks doctors' generic drug prescription rates, number of office visits, and emergency room visits. Doctors can also receive per member per month bonuses by meeting certain accessibility standards. State officials estimate the program saves the state roughly \$12 million annually, with doctors and the state sharing the savings.

Many P4P Programs Already Operate Within California

Many Medi-Cal Managed Care Plans Have Implemented Incentive Programs Internally. Some, but not all, of the state's Medi-Cal managed care plans currently have implemented some type of internal P4P program. By operating their own *internal* P4P programs, plans are trying to control costs and improve outcomes for their members. The nearby box identifies the three types of Medi-Cal managed care systems that operate in California.

In an effort that has been under way for several years, Medi-Cal managed care plans are attempting to create a statewide P4P program that will include a core set of performance measures agreed upon by all the plans. The uniformity of performance measures adopted by health care plans for physicians is a key component of any statewide P4P program. If each health plan adopts a different set of performance measures, physicians who contract with multiple health plans may be faced with multiple reporting requirements and competing objectives. Most plans choose to measure performance using the nationally accepted Health Effectiveness Data and Information Set (HEDIS) measures. These measures represent a set of generally accepted benchmarks that provide an indicator of the quality of care patients receive. The plans hope that by creating a statewide program, they will lessen the administrative burden on participating physicians and reduce confusion when a physician contracts with more

Three Major Types of Managed Care Plans

- *County Organized Health System (COHS).* Under this model, there is one health plan run by a public agency and governed by an independent board that includes local representatives. The COHS are different from the other managed care systems because nearly all Medi-Cal enrollees residing in the county are required to receive care from this system.
- *Geographic Managed Care (GMC).* The GMC system allows Medi-Cal beneficiaries to choose to enroll in one of many commercial health maintenance organizations (HMOs) operating in a county.
- *Two-Plan Model.* The Two-Plan Model consists of counties where the department contracts with only two managed care plans. One plan generally must be locally developed and operated. The second plan is a commercial HMO, selected through a competitive bidding process.

than one Medi-Cal managed care plan (as in a two-plan or geographic managed care [GMC] county).

A statewide program would also have several advantages for most managed care plans. Especially in the GMC and two-plan counties, the opportunity for data aggregation would make all data on physicians more robust, presenting a better overall picture of a physician's practice.

The DHCS Operates a Program Similar to P4P in Two-Plan and GMC Counties. The DHCS has already started to implement some P4P principles in select Medi-Cal managed care counties. In two-plan and GMC counties, DHCS measures the performance of these plans using various predetermined quality measures. The DHCS then assigns higher-performing plans a larger percentage of new Medi-Cal beneficiaries that do not select a plan in which to be enrolled.

Benefits of a Statewide P4P Program in California

As described below, a statewide P4P program in California would promote desirable changes in how physicians practice medicine and reward physicians and health care plans that achieve measurable performance outcomes.

P4P Programs Promote Change

Many insurers use their internal P4P plans to encourage desired change among their providers. Santa Barbara Regional Health Authority, a Medi-Cal County Organized Health System, has used its incentives program to encourage the submission of data from its providers. The providers that submit data electronically receive a higher payment rate than those who submit paper claims. Recently, the plan has also created incentives to encourage providers to remain available during weekend and evening hours as a way of decreasing emergency room and urgent care usage.

A recent study of five Medi-Cal managed care health plans and their efforts in implementing a P4P program documented that most of the studied plans experienced some success in raising HEDIS scores. Of the different measures, improvement across all the plans was seen in at least one measure, the well-baby visit. Other plans saw varying levels of improvement in other measures. The study suggests that P4P plans in Medi-Cal have the potential to create improvement, but will require careful design and implementation.

A Way to Selectively Reward the Best Doctors and Plans

The DHCS has recently implemented a new actuarially based methodology for calculating rates for Medi-Cal managed care health plans, resulting in rate increases for many of the plans. Broader implementation of a P4P program would give DHCS a way to selectively reward the plans providing the highest quality of care and practicing the most efficient medicine without raising rates to all plans.

Moving California Towards P4P

We recommend the enactment of legislation to guide the implementation and evaluation of a pay-for-performance (P4P) program for Medi-Cal managed care plans. We also recommend the adoption of supplemental report language directing the Department of Health Care Services to examine the feasibility of implementing P4P in the Medi-Cal fee-for-service program. We estimate that the implementation of statewide P4P program would eventually result in net savings to the General Fund of up to tens of millions of dollars annually.

The DHCS currently does not operate a *statewide* P4P program in its Medi-Cal managed care or FFS program. Below we discuss how P4P could be implemented statewide in both managed care and FFS.

P4P Program Structure Must Take Into Account How Providers Are Reimbursed. Medi-Cal provides health care coverage through two basic types of arrangements—FFS and managed care. Under an FFS health care delivery system, a health care provider receives an individual payment from DHCS for each medical service delivered to a Medi-Cal beneficiary. Beneficiaries generally may obtain services from any provider who has agreed to accept Medi-Cal payments.

Because FFS providers are spread throughout the state, implementation of a P4P program presents several logistical challenges not present when creating a P4P program for managed care plans that typically operate in densely populated regions. However, as previously described, other states and the federal Medicare Program have managed to create successful P4P programs in an FFS system.

In contrast to FFS, under Medi-Cal managed care, DHCS contracts with health care plans, also known as HMOs, to provide health care coverage for Medi-Cal beneficiaries residing in certain counties. The health plans are reimbursed on a capitated basis with a predetermined amount per person, per month regardless of the number of services an individual receives. As we discuss above, managed care plans have taken steps independent of the state to implement internal P4P programs.

Program Can Be Structured in Many Ways. A statewide program in California could be structured in a variety of ways and with varying means of computing financial incentives. A financial incentive model links monetary rewards with the achievement of certain outcomes, adherence to certain processes or protocols, demonstration of improved performance or for participation in a desired activity. Though financial incentive models are often created with a separate pool of funds that is paid to providers in addition to regular compensation, not all financial incentive models require additional funds. For example, Michigan's Medicaid managed care program withholds a small amount of each approved capitation payment from each of their contractors until a predetermined amount for the pool is met. Awards are then made to contractors from this pool based on established performance criteria.

Program Could Be Implemented at Little Cost. Using a similar structure to that used by Michigan, a P4P program could be implemented in California in a way that would result in little additional state costs. This would be accomplished by withholding a small amount of each plan's capitation payment to create the initial incentive pool.

General Fund Savings Potential. While the majority of P4P programs focus on improving the quality of care delivered to patients, the potential exists for such a plan to generate cost savings. However, it is difficult to provide a precise estimate of potential savings that would result from the implementation of a P4P program because the level of savings would depend upon the performance measures the program would target and the population these measures affect.

Our FFS savings estimate assumes that a P4P program would result in better preventive care for all Medi-Cal beneficiaries, leading to a decrease in the overall rate of hospital admissions. The total cost of hospital admissions in Medi-Cal during calendar year 2006 was almost \$3.5 billion, with the average cost per beneficiary over \$6,000 for all claims paid. Our savings estimate assumes that some portion of these hospital days could be avoided through the practice of timely and appropriate outpatient medical care that would be incentivized through P4P.

Figure 5 shows for illustrative purposes the potential General Fund savings the state could achieve from full-scale implementation of an FFS P4P program. We estimate the state could save in the range of \$18 million to \$88 million General Fund annually, the equivalent of between 1 percent to 5 percent of the total yearly Medi-Cal cost for inpatient hospitalizations. However, we note that some of these savings would likely be offset by increased costs from higher utilization of primary care.

These estimates are in line with national and statewide studies that show that up to 10 percent of hospital admissions are potentially avoidable. The actual level of savings that Medi-Cal could possibly achieve would vary significantly depending upon program implementation and the target population.

Figure 5

Potential General Fund Savings From Implementation of Pay-for-Performance in Fee-for-Service Medi-Cal Alternative Scenarios

(Dollars in Millions)

	1%	2.5%	5%
Percent net savings ^a	1%	2.5%	5%
Total funds ^b	\$35	\$88	\$175
General Fund ^b	18	44	88

^a Represents a percent reduction in the total number of claimed inpatient hospital days.

^b These amounts would be offset to an unknown extent by increases in primary care utilization.

Implementation of P4P could also reduce costs in Medi-Cal managed care. For example, managed care plans would likely have lower overall costs as a result of providing more preventive care in order to earn P4P incentives. In turn, the cost-based rates that the state calculates for managed care plans would reflect these lower overall costs.

Savings Unlikely in Budget Year. One important consideration for the Legislature is that any potential savings will likely not occur until after the budget year has passed. The implementation of a P4P program will require some up front personnel resources to develop the performance measures and some funding for the incentives. However, the implementation of a program may reap significant savings in the long term by reducing avoidable hospitalizations and other expensive medical services. Given the projected growth in Medi-Cal costs, such an investment makes sense.

Analyst’s Recommendations. As noted above, our analysis indicates that the implementation of a P4P program, if carefully designed and structured, could eventually result in significant net General Fund savings to the state. However, a full-scale implementation of a P4P program for the FFS providers may not be feasible at this time because DHCS has not yet examined how best to implement an incentive program for Medi-Cal’s FFS

physicians. Also, the state's current budget shortfall may make it difficult to provide the funding necessary to create an incentive pool large enough to significantly motivate FFS physicians. Given these circumstances, we believe that DHCS should take some modest first steps to support current efforts under way to implement a statewide P4P program for managed care, while assessing the potential of expanding P4P programs to FFS in the future.

We therefore recommend the Legislature enact legislation directing DHCS to create a statewide P4P program for Medi-Cal managed care plans. This plan-based program would act to support the current project under way in the state to create a uniform performance incentive program applicable to all Medi-Cal managed care plans. We recommend that the legislation include the following provisions.

- A requirement to create an incentive pool to be used to provide fiscal incentives for health care providers participating in a statewide P4P program.
- A requirement that the P4P program, in addition to standard and commonly used measures, include measures designed to promote the use of health IT and data submission among providers in managed care plans and measures designed to reduce the rate of avoidable hospitalizations and emergency room visits.
- A requirement that DHCS work with DMHC in creating a Medi-Cal managed care report card rating each of the plans on quality, similar to the report card established for commercial HMOs.
- A requirement that DHCS evaluate the impact on the quality of care and the fiscal effects of the P4P program and report these results back to the Legislature by December 1, 2011.

The incentive pool could initially be implemented with funds withheld from each plan's capitation payment. Withholding a small percentage of payments (up to 3 percent) to fund an incentive pool would help to ensure budget neutrality. We recommend DHCS report at budget hearings on the necessary staff needed to implement such a program.

We further recommend the Legislature adopt supplemental report language directing DHCS to report on the feasibility of implementing a P4P program in FFS Medi-Cal. The following language is consistent with this recommendation:

It is the intent of the Legislature that the Department of Health Care Services (DHCS) shall submit a report to the Legislature evaluating the feasibility of implementing a pay-for-performance P4P program for fee-for-service (FFS) Medi-Cal. The report shall at a minimum address the following: (1) ways in which a P4P program may be implemented for FFS Medi-Cal; (2)

appropriate performance measures and their targeted outcomes; and (3) estimated costs and savings to the state of implementation of P4P. This report is due to the legislative fiscal committees and the Joint Legislative Budget Committee by January 1, 2010.

Our recommendations would provide the Legislature with a relatively low-cost approach to evaluate the benefits of P4P for the Medi-Cal Program.

Providing HIV/AIDS Medications Should Be a Priority

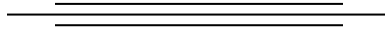
The 2008-09 budget proposes nearly \$3 million General Fund for the continuation of an HIV/AIDS Pharmacy Pilot Program that helps to ensure that patients comply with their medication regimen. While coordinating care is important, we believe that the continued provision of direct services is a higher priority than continuing to fund a pilot program beyond the time period set by the Legislature. We recommend allowing the HIV/AIDS Pharmacy Pilot Program to sunset and redirecting these funds to the AIDS Drug Assistance Program. (Decrease Item 4260-001-0001 by \$2,655,000 and Increase Item 4264-111-0001 by \$2,655,000).

Governor's Proposal. The Governor proposes about \$2.7 million General Fund to fund continuation of an HIV/AIDS Pharmacy Pilot Program, which was created by Chapter 850, Statutes of 2004 (AB 1367, Steinberg). This program was scheduled to sunset January 1, 2008, but was extended until June 30, 2008 by the 2007-08 Budget Act. The Governor's budget proposes to extend this program an additional year, until June 30, 2009. The pilot was designed to test the effectiveness on patient outcomes of having pharmacists coordinate and monitor HIV/AIDS patients' therapeutic drug regimens.

The Governor's budget also proposes to reduce approximately \$7 million General Fund to the AIDS Drug Assistance Program (ADAP). The ADAP provides drugs to low-income HIV and AIDS patients, who would be otherwise unable to afford treatment. This reduction would reduce the formulary by excluding some of the drugs used to treat side effects and related conditions of HIV/AIDS. Patients who receive drugs through ADAP are generally not eligible to receive drugs from other state programs. A Department of Public Health study found that patients in ADAP had a lower rate of death than similar Medi-Cal beneficiaries and patients in commercial insurance plans.

Analyst's Recommendation. Consistent with legislative intent, we recommend the Legislature allow the HIV/AIDS Pharmacy Pilot Program to sunset June 30, 2008. We further recommend the funding from this program be redirected to the ADAP program in 2008-09 to continue

funding for HIV/AIDS patients' medications that treat side effects and related conditions. While we recognize the merits of having pharmacists coordinate HIV/AIDS patients' therapeutic drug regimens, we believe that the provision of direct services is a higher priority than continuing to fund a pilot program beyond the time period set by the Legislature.



DEPARTMENT OF PUBLIC HEALTH (4265)

The Department of Public Health (DPH) delivers a broad range of public health programs. Some of these programs complement and support the activities of local health agencies in controlling environmental hazards, preventing and controlling disease, and providing health services to populations who have special needs. Others are solely state-operated programs, such as those that license health care facilities.

The Governor's budget proposes about \$2.6 billion from all funds for state operations and local assistance for DPH in the budget year, this is a decrease of about \$208 million, or 7.3 percent, from the revised level of spending proposed for 2007-08. Total proposed local assistance expenditures are about \$2.4 billion, of which \$257.9 million is from the General Fund. The General Fund amount is 7.3 percent less (\$20.1 million) than the revised current-year level of spending. This decrease is due to the proposed budget-balancing reductions (as discussed below).

KEY BUDGET PROPOSALS

The Governor's proposed budget for public health programs includes the following significant changes:

- ***Budget-Balancing Reductions.*** The Governor's budget plan includes a reduction of \$31.7 million General Fund and 51.2 positions in 2008-09. A 10 percent reduction against the base workload budget for 2008-09 was applied to each program area funded by the General Fund except for programs related to food-borne illness and lease-revenue bond payments for the Richmond Laboratory. Of the 51.2 positions proposed to be eliminated, 19 were vacant as of January 10, 2008.
- ***Additional Funding for Licensing and Certification.*** The budget proposes \$8.8 million in special funds and 68 positions to implement Chapter 896, Statutes of 2006 (SB 1312, Alquist), which

requires DPH to inspect all long-term care health facilities to ensure compliance with state laws and regulations.

- **Upgrade of Richmond Laboratory.** The budget includes \$2.5 million General Fund to fund construction of enhancements to the Richmond Laboratory necessary to meet newly established federal standards.
- **Implementation of Infections Control Program.** The budget includes \$1.7 million (\$1.3 million General Fund) and 12 positions to implement an infection surveillance and prevention program pursuant to Chapter 526, Statutes of 2006 (SB 739, Speier). The Governor vetoed funding for this program in the *2007-08 Budget Act* indicating in his veto message that his intent was to delay implementation by one year.

REFORMING CATEGORICAL FUNDING FOR PUBLIC HEALTH PROGRAMS

The state's current process for administration and funding of over 30 public health programs at the local level is fragmented, inflexible, and fails to hold local health jurisdictions (LHJs) accountable for achieving results. This reduces the effectiveness of these programs because these services are not coordinated or integrated and LHJs cannot focus on meeting the overall goal of improving the public's health. We recommend (1) the consolidation of certain public health programs into a block grant and (2) the enactment of legislation that would direct the Department of Public Health (DPH) to develop a model consolidated contract for these and other public health programs (which are not consolidated into the block grant). In addition, we recommend that outcome measures for these programs be developed and that DPH work with counties in using a consolidated contract.

Background

The DPH's 2008-09 budget includes about \$2.4 billion (\$258 million General Fund, \$1.3 billion federal funds, and \$635 million special funds) in local assistance for public health programs. This funding is allocated primarily to local health jurisdictions (LHJs) for a variety of purposes, such as emergency preparedness, infectious disease programs, chronic disease programs, county health services, and environmental health. (There are 61 LHJs, composed of the 58 counties and the cities of Berkeley, Long Beach, and Pasadena.) Community based organizations and universities also receive state local assistance funds for public health programs and

research. Figure 1 (see next page) lists the numerous categorical public health programs that provide state and federal support to LHJs.

Public Health Programs Are Funded By the State in Two Primary Ways

The state funds public health programs in two primary ways—through categorical public health programs and the state’s realignment program. Categorical public health programs provide most of the funding, \$2.4 billion in 2008-09 as mentioned above, while realignment provides an estimated \$660 million to \$825 million (an estimate we discuss in further detail below).

Many Categorical Public Health Programs. The state provides a combination of state and federal funds to LHJs for over 30 categorical programs. In general, these programs are targeted to specific populations with particular health needs. Funding for these programs is allocated in a variety of ways including on a formula basis and via a grant application process. The LHJs receiving these funds must comply with many and varied administrative requirements. For example, some programs require annual status reports, while others must submit data on a monthly basis. Generally, LHJs have little discretion over how the categorical funds can be used.

Realignment. The state enacted a major change, known as realignment, in the relationship between state and local governments in 1991. Realignment shifted responsibility for certain health programs from the state to LHJs and provided LHJs with a dedicated tax revenue from the sales tax and vehicle license fee to pay for these changes. In 2007-08, LHJs received \$1.6 billion in realignment funds for health programs. It is unclear how much realignment funding LHJs use for public health purposes because LHJs are not required to report how these funds are spent. However, based on discussions with county associations it is generally estimated that between \$660 million and \$825 million (about 40 percent to 50 percent) of realignment funds are spent on public health programs and that the remainder is spent on inpatient and outpatient services for persons who are uninsured and are not eligible for other health care coverage, such as Medi-Cal and Healthy Families.

Categorical Funding for Public Health Programs Creates Problems

As previously discussed, LHJs have discretion over the use of realignment funds and are not required to report to the state how the funds are spent. In contrast, one of the primary purposes of categorical programs is to assure on a statewide basis that LHJs allocate resources for specific activities and services. However, this method of funding and administering

each public health concern individually often leads to a public health system that is fragmented, inflexible, and not responsive to the overall health status of the community. Figure 2 (see page 56) summarizes the problems with California's system of categorical public health programs.

Numerous Categorical Programs Promote Fragmentation. The current system of numerous categorical programs targeted to different populations promotes fragmentation of services at the local level. This fragmentation manifests itself in LHJs administering each program separately from other programs rather than in a coordinated or integrated fashion. County officials indicate that there is often limited communication among staff assigned to separate programs and limited ability to work together, even when the programs serve the same families and deal with related issues. This lack of coordination shifts the LHJ's focus from one of improving the overall community's health to focusing on a specific health concern.

State Rules Restrict Local Flexibility Needed to Be Effective and Efficient. The complex and detailed program requirements in categorical programs restrict the flexibility needed by LHJs to maximize the use of available funds. A recent evaluation of LHJs by the Health

Figure 1

Public Health Categorical Programs

Chronic Disease Prevention

- Children's Dental Disease Prevention Program
- Fatal Child Abuse and Neglect Surveillance Program
- Kids' Plates Program
- Preventative Health Care for Aging
- Tobacco Control Section

Communicable/Infectious Diseases

- Immunization
- Sexually Transmitted Diseases
- Tuberculosis Control

County Health Services

- Emergency Medical Services Appropriation (EMSA) for California Healthcare for Indigents Program Counties
- EMSA for Rural Health Services Counties
- Refugee Programs
- State Public Health Subvention
- Vital Records

Continued

Officers Association of California, for example, indicated that categorical program funding restricts the ability of employees, especially public health nurses, to participate in education, training, and exercises aimed at building LHJs’ capacity to respond to a large disease outbreak. This is because staff must allocate their time according to the specific activity funded by a categorical program. In this case, categorical funding limits LHJs’ ability to adequately prepare for an emergency response situation.

Similarly, categorical funding can prevent LHJs from delivering services in the most effective manner. For example, one LHJ may have a disproportionate share of persons infected with certain sexually transmitted diseases (STDs) and a very low percentage of human immunodeficiency virus (HIV) cases. However, the state’s separate allocation of funding for HIV and STD programs does not take this into consideration. Furthermore, a LHJ might find that STD testing is an effective means to prevent the spread of HIV because it addresses risky behavior that also leads to the spread of HIV. However, state HIV prevention funds cannot be used for such activities.

Emergency Preparedness
<ul style="list-style-type: none"> • Bioterrorism Preparedness • Hospital Preparedness
Environmental Health
<ul style="list-style-type: none"> • Beach Water Sanitation • Childhood Lead Poisoning Prevention Program
Family Health
<ul style="list-style-type: none"> • Adolescent Family Life Program • Battered Women Shelter Program • Black Infant Health • Maternal, Child, and Adolescent Program • Women, Infants, and Children Supplemental Nutrition Program
HIV/AIDS Programs
<ul style="list-style-type: none"> • AIDS Drug Assistance Program • Bridge II-Minority AIDS Initiative • Care Services Program • Early Intervention Program • HIV Counseling and Testing • HIV Education and Prevention • HIV Resistance Testing and Viral Load • HIV/AIDS Case Management Program • HIV/AIDS Surveillance and Special Epidemiology Studies • Housing Opportunities for People With AIDS Program • Neighborhood Interventions Geared to High-Risk Testing

Figure 2**Problems With California's System of Categorical Public Health Programs**

- **Numerous Categorical Programs Promotes Fragmentation.** Process requirements of the categorical programs often shape local responses rather than the needs of the community.
- **State Rules Restrict Needed Local Flexibility.** Complex and detailed program requirements in some programs reduce the flexibility needed by local health jurisdictions (LHJs) to maximize the impact of funds on improving the public's health.
- **Accountability Fails to Focus on Outcomes.** Current oversight efforts are intended to ensure accountability for how funds are spent and how programs are structured. Few programs are required to routinely collect good outcome data and measure performance.
- **Administrative Burden.** State public health programs separately enter into agreements with local health jurisdictions. These agreements have different definitions, formats, and requirements. Locals must enter into agreements with each state program.

Categorical funding can also promote inefficiency. For example, five different health educators from five different programs may meet separately with individual pediatricians in a LHJ to discuss each program. However, it would be more efficient if LHJs had the flexibility to allow the health educators to coordinate their messages and visits to maximize the time available to both the educators and health care providers for delivering direct services.

Accountability Fails to Focus on Outcomes. Most categorical programs are bound by various state and/or federal restrictions on how the program must be structured or how funds may be used. For example, legislation enacted with the passage of Proposition 99 in November 1988 has very specific requirements for how LHJs must implement their tobacco cessation programs and has a specific percentage of funding that must be allocated to each LHJ. Consequently, current oversight efforts intended to ensure accountability focus on what activities LHJs fund and how services are delivered, instead of what the funding accomplishes (outcomes). Few programs are required to routinely collect outcome data and measure performance. This emphasis encourages local administrators to design programs that ensure compliance, rather than providing LHJs the freedom to assess the needs of the community and develop programs that would achieve desired results.

Categorical Programs Are an Administrative Burden. As shown in Figure 3 (see page 60), most state public health programs must separately enter into an agreement with each LHJ. Each program must (1) develop a contract or allocation agreement, (2) develop a budget, (3) define its scope of work, (4) include invoice requirements, (5) follow reporting requirements, (6) outline policies and procedures, and (7) develop a data collection system. Furthermore, each of these programs generally has different definitions of fiscal terms (such as what constitutes indirect costs, operating expenses, and travel) and accounting formats. Consequently, program staff at both the state and local level devote a significant amount of time to administrative activities, rather than the delivery of public health services.

Benefits of Reforming Public Health Funding

As discussed above, the current approach to funding and administering distinct public health concerns leads to fragmentation and does not provide LHJs needed flexibility to address the overall health needs of the community. We find that there are benefits to reforming this system.

Local Flexibility Increases Effectiveness of LHJs. Various studies, including some by the Rand Corporation and the U.S. Government Accountability Office (GAO), indicate that increasing local flexibility over funding allocations, administrative requirements, and program details allows LHJs to use funds in ways that meet community needs more efficiently and effectively. Providing local flexibility recognizes that health needs vary greatly from place to place, depending on geographic location, local industry (such as agriculture versus manufacturing), and the population served. Generally, public health professionals closest to the communities are in the best position to make detailed program decisions.

For example, a recent GAO study cited a flexible-funding demonstration project (conducted under a waiver with the federal government) by the State of Ohio's child welfare department. Under this project, participating counties received a monthly allotment to fund child services free of any eligibility and allocation restrictions. During the first six years of the project, 11 of the 14 counties operated at below average costs, resulting in a total savings of \$33 million.

In California, Placer County is piloting a program that integrates health and human services programs and allows the county to have an integrated contract with the state that consolidates the administrative requirements for 16 state and federally funded health programs. (See box on next page for more information on Placer County's pilot program.)

Placer County's Consolidated Health Contract Pilot Program

Chapter 899, Statutes of 1996 (SB 1846, Leslie) and Chapter 268, Statutes of 2006 (AB 1859, Leslie) authorized Placer County, with the assistance of the appropriate state departments, to implement a pilot program for funding the delivery of health services through an integrated and comprehensive county health and human services system. The integrated program has been operational for five years and consolidates the administrative requirements for 16 state and federally funded health programs. These health programs include:

- California Children's Services
- Child Health and Disability Prevention Program
- Health Care Program for Children in Foster Care
- Childhood Lead Poisoning Prevention Program
- Immunization Outreach and Education
- Maternal and Child Health
- Adolescent Family Life Program
- Adolescent Sibling Pregnancy Prevention Program
- HIV/AIDS Counseling and Testing
- HIV/AIDS Education and Prevention
- HIV/AIDS Surveillance
- Oral Health, Miles of Smiles
- Preventative Health Care for the Aging
- Sexually Transmitted Disease Control
- Tobacco Control Program
- Women, Infants and Children Supplemental Nutrition Program

Prior to the pilot, these services were administered by separate programs within the county and each program had a separate contract with the state. In contrast, as shown in the figure, Placer County now has one consolidated contract with the state that includes a single scope of work, and a single, streamlined accounting, contracting, claiming, and reporting process for 16 public health programs administered

by the state Department of Health Services. The goals of this consolidated contract were to (1) create a simplified administrative framework for managing categorical funding for public health programs, (2) maximize the use of public health funds and staffing by reducing staff administrative duties and deploying staff more flexibly, (3) improve administrative efficiencies for reporting and accountability, and (4) track program outcomes more effectively.

These programs remain categorical in nature because the funding for these programs is not pooled or comingled. Consequently, funds allocated for any one of the programs cannot be expended for other purposes or programs.

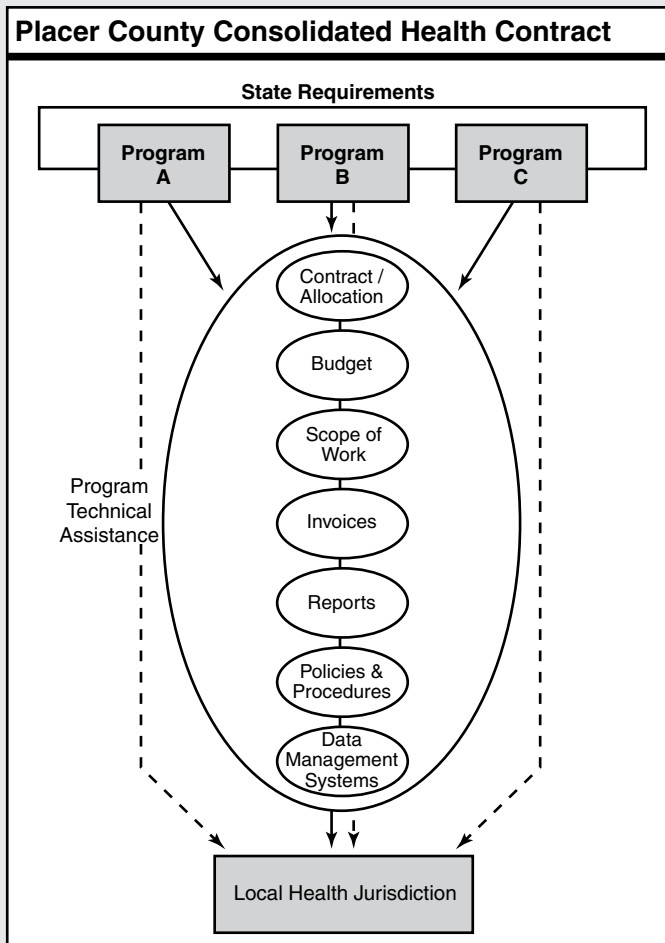
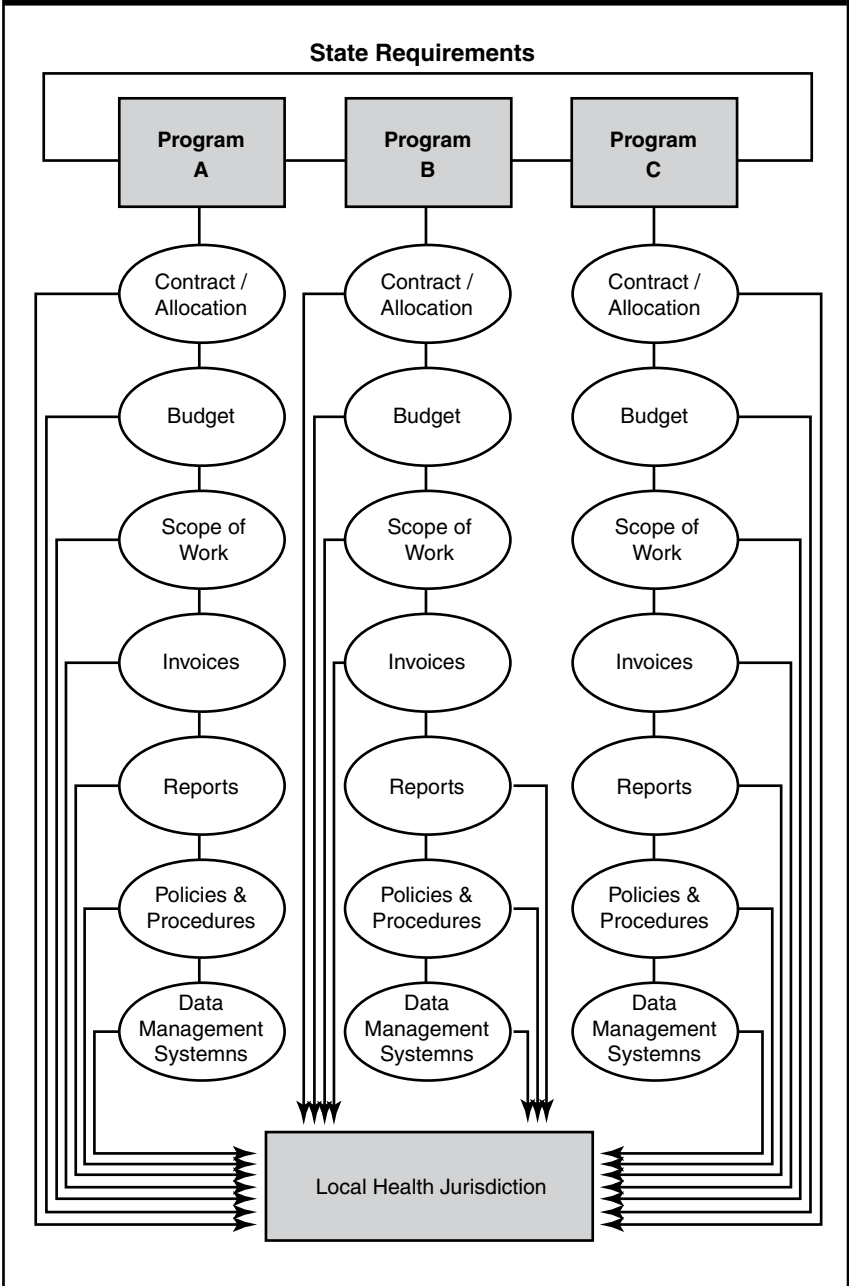


Figure 3

Public Health Funding System with Local Health Jurisdictions



An independent evaluation of the Placer County pilot found that having a consolidated contract increased staff's flexibility to provide services to their clients. Under the pilot, a single health educator can work with a high-risk teenager on HIV prevention, nutrition, tobacco, dental health, and other issues, whereas, prior to the pilot, this teenager would be seen by multiple health educators even though the educators were teaching the same prevention strategies.

In addition, Placer County staff found that the consolidated contract permits greater county flexibility in meeting state and federal requirements because it reduces the administrative burden associated with administering 16 contracts and shifts the focus from being accountable for carrying out a series of individual categorical programs to being accountable for the overall health of the community. In addition, Placer County has achieved significant savings in accounting, reporting, and contracting costs. Specifically, Placer County estimates that it has reduced its accounting, reporting, and contracting workload by 1,600 hours annually. County staff also have more flexibility to provide better coordinated services to the community.

Other Counties Interested in Using a Consolidated Contract. Other LHJs are interested in using a consolidated contract for certain public health programs. For example, Alameda County was working with the Department of Health Services (DHS) on consolidating its health contracts prior to the split of DHS into DPH and the Department of Health Care Services. However, since the split there has been no movement on DPH's part to engage again in these discussions. (Chapter 655, Statutes of 2004 [AB 1881, Berg], gave Alameda, Humboldt, and Mendocino Counties the authority to integrate their health and human services systems.)

Block Grants Can Unify Program Objectives, Freeing Locals to Achieve Goals

As just discussed, Placer County has taken steps to simplify and consolidate aspects of its administration of public health programs. We find that in addition to consolidating the administrative requirements of these programs, the state could do more to consolidate programs and funding by using block grants.

Block grants consolidate funding for multiple categorical programs into one allocation. Reforming categorical public health programs by consolidating them into block grants with a single program structure and funding stream provides flexibility to deliver services in a way that best fits local needs.

What Are Block Grants? Block grants consolidate funding for multiple categorical programs into one allocation. A block grant tends to have fewer restrictions on how money is spent, in contrast to disparate funding streams each with different sets of requirements.

Block Grants Promote Integration of Services. Proponents of block grants argue that since block grants remove many specific requirements about how local governments must spend their money, they simplify the funding system and provide flexibility to deliver and integrate services in a way that best fits local needs. A unified set of goals and objectives put forth by a single agency frees LHJs to focus on the health care needs of the community. For example, a block grant that promotes disease prevention would allow LHJs to integrate disease prevention services that target similar at-risk populations.

Integration of Services Leads to Better Results. Integration of services can lead to better outcomes. For example, the California Department of Education's Healthy Start Program provided grants to integrate service delivery for children and families. These services may include academic, youth development, family support, medical care, mental health care, and employment. (Prior to the implementation of this program, these services were not coordinated or integrated for a child or family.) One of the goals of this program is to streamline and integrate these services—from the child and family's perspective—to provide more efficient and effective support to these families. The evaluations of this program indicate it was successful at arranging health care services for persons who might not have gotten them otherwise and that school violence decreased at schools with a Healthy Start Program.

Another example of how the integration of services leads to better outcomes is a demonstration project the state Office of AIDS (OA) at DPH is conducting for hepatitis C virus (HCV) and HIV testing. The OA found that HIV testing rates among injection drug users nearly doubled and the number of individuals returning to receive test results increased by 21 percent when an HIV test was offered in conjunction with an HCV test. This is because those individuals being tested were more interested in learning their HCV status than their HIV status. These results indicate that the integration of HIV testing with other services geared towards high-risk clients is likely to help prevent the spread of HIV and/or other diseases. As a result of this demonstration project, OA will distribute funds to LHJs to provide HCV tests as part of the HIV testing program.

Integration of Certain Prevention Services Can Improve Results. The Governor's budget includes a total of about \$40 million General Fund local assistance spread over a number of programs to prevent the spread of HIV, STDs, hepatitis, and tuberculosis (TB). Each of these programs separately

allocates funding to LHJs. However, all of these prevention programs share the same general goal of preventing the spread of disease by educating persons about risky behaviors that lead to contraction of the disease. As illustrated in the example above, a person dealing with one of these issues is often engaged in risky behaviors that make them susceptible to multiple infections. Therefore, these programs often work with the same people, but currently there is little integration of the services they receive. As we discuss later, we find that the consolidation of these programs could lead to better outcomes.

Limitations to Consolidation. Given that a majority of the state's public health programs are funded with a combination of federal and state special funds, there are limitations currently on the extent to which programs can be consolidated. This is because of federal funding requirements and restrictions on the use of state special funds. We note, however, that at the federal level, the Centers for Disease Control and Prevention are taking significant steps to increase the integration of categorical funding and programs. Nevertheless, steps can be taken to encourage the integration of certain programs and to reduce the administrative burden on LHJs that can interfere with achieving program objectives.

Reforming the Public Health Funding System

We recommend the enactment of legislation that would create a block grant for certain health prevention services. Specifically, we find that consolidating funding for disease prevention programs would provide flexibility to Local Health Jurisdictions (LHJs) to deliver services that best meet the needs of their communities and provide an integrated approach to disease prevention. We also recommend the enactment of legislation that would direct the Department of Public Health to develop a model consolidated contract and outcome measures and work with LHJs that are interested in consolidation. This would lead to administrative efficiencies at the state and local level.

In order to reform the funding of public health programs we make two recommendations. First, we recommend the consolidation of certain disease prevention program funding into a block grant. Second, we recommend the consolidation of contracts with LHJs for public health programs. These recommendations are discussed in more detail below.

Consolidate Funding for Certain Prevention Services Into a Block Grant. We recommend that the Legislature create a disease prevention block grant. This grant would include about \$40 million in General Fund support that is allocated for the prevention of HIV, STDs, hepatitis prevention (nonperinatal), and TB. Consolidating these programs would maximize local control for LHJs in order to best meet community needs,

and if structured well, shifts the focus from process to results. The LHJs would be allowed to shift funding among these prevention programs in response to the needs of a particular community. We find that combining these prevention-funding streams has the potential to lead to better program integration and as a result, a reduction in the spread of disease and the improvement of the overall health of the community. Furthermore, to help evaluate the effectiveness of this funding, the block grant would require the tracking of specific outcome measures to evaluate the LHJs efforts in preventing these diseases.

Direct DPH to Develop a Model Consolidated Contract and Outcome Measures. We recommend the enactment of legislation that would direct DPH to develop a consolidated contract model building on its work with Placer County. The department should also be required to work with LHJs who are interested in using a consolidated contract. A consolidated contract could lead to long-term administrative efficiencies at both the state and local level and a significant reduction in costs associated with accounting, reporting, and contracting. These administrative savings would more than offset the short-term state cost to refine the contract model and work with LHJs. In addition, to help ensure that the focus is on achieving positive outcomes, the state would design specific outcome measures to evaluate the effectiveness of LHJs. Based on the experience of those counties choosing to consolidate their contracts, the Legislature may wish to consider requiring all LHJs to use a consolidated contract in the future.

Conclusion

The state's process of administering and funding categorical public health programs leads to a system that is fragmented, inflexible, and not accountable to the overall health status of the state. We recommend the creation of a prevention block grant and the enactment of legislation that would direct DPH to develop a model consolidated contract, outcome measures, and work with counties interested in using this approach.

FAILURE TO PROMULGATE REGULATIONS LEADS TO STATE LAWS NOT BEING ENFORCED

The Legislature relies on departments to promulgate regulations to implement laws. The Department of Public Health is slow to promulgate such regulations and consequently, state laws are not being enforced or applied consistently across the state. We recommend the department report at budget hearings on the status of the development and promulgation of unissued regulations.

Every year the Legislature passes new laws. For many of these laws, the administering department must promulgate regulations in order to implement the new law's requirements. Regulations often provide the details necessary to implement the law so that it can be applied consistently across the state.

Department Behind in Promulgating Regulations. Our review found that DPH is behind in its development and promulgation of regulations. This often means that state laws are not being implemented or enforced. For example, a superior court judge recently tossed out a lawsuit alleging understaffing in numerous Sacramento-area nursing homes because the state had failed to promulgate regulations relating to minimum-staffing requirements thereby failing to provide a standard the courts could use to determine if the nursing homes complied with state law.

Department Unresponsive to Requests for Information. Our office requested a list of pending regulations from DPH in March 2007. We continued to follow-up on this request and almost a year later have not received any information from the department. For example, we specifically asked the department about the status of regulations to implement Chapter 742, Statutes of 1997 (AB 186, V. Brown), a law that has been on the books for over ten years. This law requires the Department of Health Services (now DPH) to adopt written standards to establish sterilization, sanitation, and safety procedures for persons engaged in the business of tattooing, body piercing, or permanent cosmetics. The state's failure to promulgate regulations on this issue has led to individual local health departments passing their own ordinances. This can result in a state law being implemented differently across the state or not being implemented and enforced at all.

Analyst's Recommendation. We recommend that the department report at budget hearings on the status of regulations which it is required to promulgate in order to carry out laws passed by the Legislature. Specifically, the department should identify what regulations are under development, what steps the department is taking to promulgate the regulations, and how the issues are being regulated in the interim. With this information, the Legislature will be aware of what laws have not been implemented and it can direct the department's priorities in promulgating regulations to ensure the public's health and safety are protected.

BUDGET REDUCES DIRECT SEXUAL HEALTH RELATED SERVICES

The 2008-09 budget plan proposes \$127,000 General Fund and one position to ensure that the state's sexual health education programs are comprehensive and not based on abstinence-only. Since this is a new activity and the program has not yet begun, we believe that these funds would be best used to offset the cuts the Governor is proposing to ongoing programs that provide direct services for sexual health needs. Accordingly, we recommend the Legislature delay implementation of Chapter 602, Statutes of 2007 (AB 629, Brownley), and redirect the proposed increase in funding to offset budget-balancing reductions for teen pregnancy and sexual health direct services. (Decrease Item 4265-011-0001 by \$127,000. Increase Item 4265-111-0001 by \$127,000.)

Governor's Proposal. The budget includes \$127,000 General Fund and one position to implement Chapter 602, Statutes of 2007 (AB 629, Brownley), which requires that sexual health education programs funded or administered by the state be comprehensive and not based on abstinence-only. This position would monitor the state's sexual health education programs to ensure that they meet the requirements of Chapter 602.

The Governor's budget also includes a reduction of about \$365,000 General Fund for direct teen pregnancy prevention and sexual health services. The administration estimates that because of this reduction approximately 38,000 teens would not receive pregnancy prevention and sexual health services.

Analyst's Recommendation. We recommend the Legislature delay implementation of Chapter 602 and redirect proposed funding for staff to offset budget-balancing reductions the Governor proposes for direct teen pregnancy and sexual health services. Since this is a new program and has not yet started, we believe that providing direct services to 38,000 teens is more likely to be cost-beneficial.

MANAGED RISK MEDICAL INSURANCE BOARD (4280)

The Managed Risk Medical Insurance Board (MRMIB) administers several programs designed to provide health care coverage to adults and children. The Major Risk Medical Insurance Program provides health insurance to California residents unable to obtain it for themselves or their families because of preexisting medical conditions. The Access for Infants and Mothers (AIM) program currently provides coverage for pregnant women and their infants whose family incomes are between 200 percent and 300 percent of the federal poverty level (FPL). The Healthy Families Program (HFP) provides health coverage for uninsured children in families with incomes up to 250 percent of the FPL who are not eligible for Medi-Cal and provides health coverage for certain uninsured infants born to AIM mothers.

The MRMIB also administers the County Health Initiative Matching Fund (CHIM), a program established as a component of Healthy Families pursuant to Chapter 648, Statutes of 2001 (AB 495, Diaz). Under CHIM, counties, County Organized Health System managed care health plans, and certain other locally established health programs are authorized to use county funds as a match to draw down federal funding to purchase health coverage for children in families with incomes between 250 percent and 300 percent of the FPL. No state funds are used to support CHIM.

Budget Proposal. The budget proposes \$1.3 billion from all fund sources (\$390 million from the General Fund) for support of MRMIB programs in 2008-09, which is a decrease of about \$3 million from all fund sources over estimated current-year expenditures. This decrease is attributable to the proposed budget-balancing reductions that we discuss below.

The Governor's budget plan includes the implementation of Chapter 328, Statutes of 2006 (SB 437, Escutia), which, among other things, allows HFP subscribers to self-certify income at the time of annual eligibility review. The Governor vetoed funding for SB 437 in the 2007-08 *Budget*

Act indicating that his intent was to delay the program for one year. The budget includes \$5 million in total funds (\$1.8 million General Fund) for SB 437 to reflect the impact of increased enrollment due to income self-certification and about \$930,000 in implementation costs, including three new staff positions.

HEALTHY FAMILIES PROGRAM

Background

Expanded Health Coverage for Low-Income Children. The federal government authorizes states to expand health care coverage for children under the State Children's Health Insurance Program (SCHIP) and provides states with an enhanced federal match as a financial incentive to cover children in families with incomes above the previous limits of their Medicaid programs. Funding for SCHIP generally is available to states on a two-to-one federal/state matching basis.

California utilizes its SCHIP funding to support HFP. Through this program, children in families earning up to 250 percent (and in select cases up to 300 percent) of FPL receive comprehensive health care coverage that includes dental, vision, and basic mental health care benefits. Families pay a relatively low monthly premium and can choose from a selection of managed care plans for their children. This program is administered by MRMIB.

The Budget Proposal. As shown in Figure 1, the Governor's budget proposes \$1.1 billion (all funds) in HFP expenditures for 2008-09. This is a decrease of about 1.5 percent over estimated current-year expenditures. The budget proposes about \$390 million in General Fund support for HFP, a \$5.6 million decrease below the revised current-year level. The decrease in General Fund expenditures is due to the budget-balancing reductions proposed in HFP discussed earlier.

Withhold Recommendation on Budget-Balancing Reductions

We withhold recommendation on the proposed budget-balancing reductions pending completion of rate and contract negotiations with the health plans.

The budget proposes reductions of \$41.9 million General Fund and \$76.1 million federal funds to HFP. These budget-balancing reductions include:

Figure 1				
Managed Risk Medical Insurance Board				
Healthy Families Program Expenditures				
<i>(Dollars in Millions)</i>				
	2007-08		2008-09	
	Budget Act	Revised	January Budget	Percentage Change From Revised
Local assistance	\$1,109.4	\$1,090.0	\$1,072.4	-1.6%
State operations	9.2	9.4	9.7	3.1
Totals^a	\$1,118.6	\$1,099.4	\$1,082.1	1.5%
General Fund	\$401.1	\$396.1	\$390.4	1.4%
Federal funds	\$707.1	\$693.6	\$682.7	-1.5%
Reimbursements	\$10.4	\$9.7	\$8	-17.4%

^a Detail may not total due to rounding.

- Reduction of HFP Plan Rates by 5 Percent.** The budget includes a HFP plan rate reduction of 5 percent from the 2007-08 rates for health, dental, and vision plans. This rate reduction will result in savings of \$22.4 million General Fund and \$40.7 million federal funds.
- Increase in Premiums for HFP Subscribers Over 150 Percent of FPL.** The Governor's budget proposes to increase subscriber premiums for certain families. Specifically, premiums for families with incomes between 150 percent and 200 percent of FPL will increase from \$9 per child per month to \$16 per child per month and from a maximum of \$27 per family per month to a monthly maximum of \$48 per family. Additionally, premiums for families with incomes above 200 percent of FPL will increase from \$15 to \$19 per child per month and from a per month maximum of \$45 to \$57 per family monthly. Premiums will not increase for families with incomes below 150 percent of FPL. These premium increases will result in savings of \$11.1 million General Fund and \$20.2 million federal funds.
- Implementation of HFP Annual Dental Benefit Limit.** The budget proposes to establish an annual benefit limit for dental coverage of \$1,000 per child. Currently there is no limit on dental benefits in HFP. It is estimated that 5 percent of HFP subscribers will reach

this benefit limit. This proposal will result in savings of \$6.3 million General Fund and \$11.4 million federal funds.

- ***Increase in Co-Payments for Nonpreventative Services for Certain Subscribers.*** The budget includes an increase in co-payments from \$5 to \$7.50 for nonpreventative services for families with incomes over 150 percent of FPL. This increase in co-payments will result in savings of \$3.4 million General Fund and \$6.2 million federal funds.

The above changes to the HFP benefits and plans must occur in time for MRMIB to communicate each plan's package of benefits to subscribers prior to the 2008 open enrollment period (April 15 through May 31). Consequently, MRMIB indicates that legislation would need to be enacted by March 2008 in order to achieve these savings in 2008-09.

Withhold Recommendation Pending Results of Rate Negotiations. We withhold recommendation on the proposed budget-balancing reductions pending completion of rate and contract negotiations with the health plans. Currently, MRMIB does not anticipate any benefit reductions or reductions in access to services, but until the contracts have been negotiated we are unable to evaluate the impacts of this proposal.

Federal Funding Expires in Budget Year

Federal funding for the Healthy Families Program (HFP) expires in March 2009. In light of this funding uncertainty, we recommend the enactment legislation that directs how the Managed Risk Medical Insurance Board should manage HFP enrollment at a level that is consistent with available funding.

Federal Funding Level Temporarily Sufficient

Sufficient Funding for HFP in 2007-08. As a result of state program expansions and underlying growth in HFP caseload, the current level of SCHIP funds being spent each year now exceeds the federal SCHIP funds allocated annually to California. As a result, in federal fiscal year 2008 (October 1, 2007 through September 30, 2008), which overlaps with the state's 2007-08 fiscal year, California became a "shortfall state" because its annual federal allocation plus its carryover funds from previous years are not sufficient to support its existing caseload. California's projected shortfall for federal fiscal year 2008 is over \$200 million.

Initially, the state faced a funding shortfall in 2007-08 because SCHIP funding was only authorized until September 2007 and then reauthorized on a month-to-month basis until the recent federal legislation was passed

in December. This legislation included sufficient funds for California to maintain projected enrollment levels through March 2009. However, at the time this analysis was written, the federal process for funding shortfall states and the allocations to each state had not been announced.

Emergency Regulations Adopted in Current Year to Address Potential Shortfall. In light of the current year funding uncertainty, in November 2007, MRMIB approved the adoption of emergency regulations to establish a wait list for the program and require some current recipients to no longer receive services (referred to as “disenrollment”). These actions were designed to manage enrollment at a level consistent with available funding. However, since federal funding was ultimately extended, MRMIB never had to exercise this authority.

Level of Federal Funding Uncertain in Budget Year

Since SCHIP funding has only been extended through March 2009, the state is not assured that (1) it will receive the same amount of funding as it did in the current year nor (2) the funding necessary to meet the projected caseload growth for state fiscal year 2008-09 will be available. This uncertainty in federal support could have a significant impact on HFP caseload and the level of spending for this program.

Options for Managing Enrollment Consistent With Available Funding

Given the uncertainty of funding levels for the budget year, we recommend the enactment of legislation that directs how MRMIB should address potential funding shortfalls. The MRMIB has the authority to establish a wait list for the program and require disenrollments. (Because HFP plans and benefits are negotiated prior to the start of the budget year the state could not change its contracts with the health care plans and address the funding shortfall to achieve savings.) We recommend the changes below in order to better prioritize who receives these benefits. Specifically, the legislation should:

- ***Prioritize Waiting List to Reflect Need.*** Although MRMIB already has the authority to establish wait-lists, the Legislature should require MRMIB to modify its first-come, first-served approach to prioritize coverage for the poorest eligible children, and/or those with the most significant medical needs. See *Analysis of the 2004-05 Budget Bill*, page C-149, for further discussion on issues related to a HFP waiting list.
- ***Modify CHIM Program Income Eligibility Requirements.*** The CHIM program allows counties, County Organized Health System managed care health plans, and certain other locally established

health programs to use local funds as a match to draw down federal funding to purchase health coverage for children in families with incomes between 250 percent and 300 percent of FPL. The CHIM counties may continue to provide coverage using only local funds if there were a reduction in federal funds. If counties were to do so, the CHIM program should be modified to allow counties to provide coverage to children otherwise eligible for HFP but placed on a waiting list. This would address the inequity by which CHIM children in families could receive coverage while those in families with lower incomes (who are eligible for HFP) would remain on a waiting list.

We bring this to the Legislature's attention because we find that these changes would better enable MRMIB to target services to children in the most need of medical care.

DEVELOPMENTAL SERVICES (4300)

A developmental disability is defined as a severe and chronic disability, attributable to a mental or physical impairment that originates before a person's eighteenth birthday, and is expected to continue indefinitely. Developmental disabilities include, but are not limited to, mental retardation, cerebral palsy, epilepsy, autism, and disabling conditions closely related to mental retardation. The Lanterman Developmental Disabilities Services Act of 1969 forms the basis of the state's commitment to provide developmentally disabled individuals with a variety of services, which are overseen by the state Department of Developmental Services (DDS). Unlike most other public social services or medical services programs, services are generally provided to the developmentally disabled at state expense without any requirements that recipients demonstrate that they do not have the financial means to pay.

The Lanterman Act establishes the state's responsibility for ensuring that persons with developmental disabilities, regardless of age or degree of disability, have access to services that sufficiently meet their needs and goals in the least restrictive setting. Individuals with developmental disabilities have a number of residential options. Almost 99 percent receive community-based services and live with their parents or other relatives, in their own houses or apartments, or in group homes that are designed to meet their medical and behavioral needs. Slightly more than 1 percent live in state-operated, 24-hour facilities.

Community Services Program. This program provides community-based services to clients through 21 nonprofit corporations known as regional centers (RCs) that are located throughout the state. The RCs are responsible for eligibility determinations and client assessment, the development of an individual program plan, and case management. They generally pay for services only if an individual does not have private insurance or they cannot refer an individual to so-called "generic" services that are provided at the local level by counties, cities, school districts, and other agencies. The RCs also purchase services, such as transportation, health care, respite, day programs, and residential care provided by community

care facilities. The department contracts with RCs to provide services to more than 220,000 clients each year.

Developmental Centers (DC) Program. The department operates five DCs, and two smaller leased facilities, which provide 24-hour care and supervision to approximately 2,600 clients. All the facilities provide residential and day programs as well as health care and assistance with daily activities, training, education, and employment. More than 7,300 permanent and temporary staff serve the current population at all seven facilities.

Overall Budget Proposal. The budget proposes \$4.5 billion (all funds) for support of DDS programs in 2008-09, which is a 1.2 percent increase over estimated current-year expenditures. General Fund expenditures for 2008-09 are proposed at \$2.7 billion, an increase of almost \$61 million, or 2.3 percent, above the revised estimate of current-year expenditures.

Community Services Budget Proposal. The budget proposes \$3.8 billion from all funds (\$2.3 billion General Fund) for the support of the Community Services Program in 2008-09. This represents almost a \$120 million General Fund increase, or 5.4 percent, over the revised estimate of current-year spending. The increase is a net result of caseload growth and other program changes. Of the total \$3.8 billion in funding proposed for RC programs in 2008-09, about \$525 million is for RC operations and \$3.3 billion is for the purchase of services. The 2008-09 community services budget plan includes the following major proposals:

- ***Purchase of Services Cost Containment Measures.*** The administration proposes to make permanent some cost containment measures that would otherwise sunset at the end of the current year for a savings of about \$215 million General Fund in 2008-09. These measures include the following savings: (1) \$128 million from freezing rates for contracted services, (2) \$34 million from freezing service levels and eliminating a specified pass-through of federal funds for community care facilities, (3) \$33 million from freezing funding for startup of certain new types of programs, (4) \$11 million from freezing rates for day, work activity and in-home respite programs, (5) \$9.4 million from freezing rates for habilitation services.
- ***RC Operations Cost Containment Measures.*** The administration proposes to extend cost containment measures to reduce RC operations costs for savings of about \$20 million General Fund in 2008-09.
- ***Freeze Negotiated Rates.*** The administration proposes to place an upper limit on the rates RCs can negotiate with new providers

in certain service categories for savings of \$14 million General Fund.

- **Rate Reduction for Supported Employment Programs (SEP).** The administration proposes to reduce rates for SEP by 10 percent to achieve savings of \$7.7 million.
- **Redesign Family Cost Participation Program (FCPP).** The FCPP requires families to pay a share of the cost for respite, child day care and camping services if their child is 3 to 17 years old, lives at home, and is ineligible for Medi-Cal. The administration proposes to expand FCPP and thereby reduce RC costs by \$773,000 General Fund.

Developmental Centers Budget Proposal. The budget proposes \$670 million from all fund sources (\$358 million General Fund) for the support of DCs in 2008-09. This represents a net decrease of almost \$57 million General Fund, almost 14 percent below the revised estimate of current-year expenditures. The DC budget plan includes the following major proposals:

- **Agnews DC Closure.** The Governor's budget plan includes a decrease of \$62 million total funds (\$38.7 million General Fund) to account for the scheduled closure of Agnews DC on June 30, 2008. The plan also includes almost \$4 million (\$192,000 General Fund) and 24 positions to provide medical, dental, and other professional services through a primary care clinic at Agnews to individuals residing in the community and to facilitate the transition of Agnews residents to community health care providers. The reimbursements for the primary care clinic will mostly come from RCs.
- **Suspend Activation of 96 Secure Treatment Beds at Porterville DC.** A 96 bed expansion of the Secure Treatment Program at Porterville DC is currently under construction and is scheduled for completion in October 2008. The administration estimates savings of \$11.7 million General Fund in the budget year from reduced staffing and operation costs because the new beds will not be activated.

Headquarters Budget Proposal. The budget proposes almost \$38 million from all funds (\$24 million General Fund) for support of headquarters. About 62 percent of headquarters funding is for support of the community services program, with the remainder for support of the DC program.

REGIONAL CENTER SYSTEM: SPENDING GROWTH CONTINUES

In this analysis we describe the major features of the Governor's budget proposal, assess the Governor's caseload projections, and identify a potential underfunding in regional center (RC) purchase of services of as much as \$113 million General Fund in the budget year. The underfunding appears to be driven by increases in utilization and costs in the RC program. We recommend the department report at budget hearings on the specific causes for increased utilization and costs in the RC program.

Background

How Do RCs Provide Services for Their Clients?

The RCs provide services to clients through two mechanisms. First, RCs purchase services directly from vendors. These services are commonly referred to as "purchase of services." Secondly, RCs assist their clients in obtaining services from public agencies. These services are commonly referred to as "generic services." We discuss both types of services further below.

Purchase of Services. The budget for purchase of services consists of ten main service categories as follows: (1) community care facilities, (2) medical facilities, (3) day programs, (4) habilitation services, (5) transportation, (6) support services, (7) in-home respite, (8) out-of-home respite, (9) health care, and (10) miscellaneous. (A more detailed description of these categories is provided on page C-162 of our *Analysis of the 2005-06 Budget Bill*.)

Generic Services. Under state law, generic services are defined as those being provided by federal, state, and local agencies which have a legal responsibility to serve all members of the general public and that receive public funds for providing such services. There are more than a dozen different generic services that are regularly accessed by RC clients. For example, medical services for an eligible developmentally disabled person might be provided through the Medi-Cal health care program. City or county park and recreation programs also provide generic services for developmentally disabled clients. State law requires that RCs access generic services first and purchase services only when generic services are unavailable.

Some Purchase of Services Provided Under a Federal Waiver. Under the federal Home and Community-Based Services (HCBS) waiver, federal funds can be drawn down to pay for about one-half the costs of certain community-based services for individuals at risk of institutionalization.

The 2008-09 budget plan assumes that RC programs will draw down \$824 million in federal funds under the HCBS waiver.

RC Caseload. Between 2001-02 and 2008-09, the RC caseload is projected to grow from almost 173,000 to about 232,000, an average annual growth rate of about 4.3 percent. The caseload trend is shown in Figure 1.

Figure 1			
Regional Center Caseload Growth Trend			
Average Annual Population		Increase From Prior Year	
Fiscal Year	Caseload	Amount	Percent
2001-02	172,714	9,101	5.6%
2002-03	182,175	9,461	5.5
2003-04	190,030	7,855	4.3
2004-05	197,355	7,325	3.9
2005-06	203,823	6,468	3.3
2006-07	211,180	7,357	3.6
2007-08 ^a	221,655	10,475	4.9
2008-09 ^a	232,125	10,470	4.7

^a Administration caseload estimate.

Several key factors appear to be contributing to ongoing growth in the RC caseload. Medical professionals are identifying persons with a developmental disability at an early age and referring more persons to DDS programs. Improved medical care and technology have increased life expectancies for individuals with developmental disabilities. The RC caseload growth also reflects a significant increase in the diagnosed cases of autism, the causes of which are not fully understood.

Governor's Budget Proposal

In accordance with past practice, the 2008-09 budget plan reflects DDS' updated projections for the number of RC clients for the current and budget years. The budget plan indicates that the actual caseload in the RC system in 2007-08 is tracking at a higher level than the originally budgeted level in the 2007-08 *Budget Act*. Specifically, the average annual caseload for the current year is estimated at 221,655, or 2,425 clients more than the estimate of 219,230 that was the basis for the RC system's appropriations in

the 2007-08 Budget Act. The budget plan further estimates that the average annual RC caseload will grow to 232,125 in 2008-09, a year-to-year increase of 10,470 clients, or 4.7 percent.

For 2008-09, the Governor's budget proposes to increase spending for the RC system by about \$142 million, including an increase of about \$120 million from the General Fund. This increase reflects estimated growth in caseloads but not increases in costs and utilization.

Recent Data Suggest Caseload Estimate Is on Target. Recent data through December 2007 indicate that the average annual caseload is likely to be about 100 below the revised level that DDS has estimated in the current year (221,655 clients) and at about the level that DDS has estimated in the budget year.

Estimate Fails to Take Into Account Cost and Utilization Growth. Increased costs for RC purchase of services are driven by three major factors: (1) increases in caseload, (2) increases in the costs of the services provided, and (3) increases in utilization of services by RC clients. The estimating methodology that the administration uses to forecast growth in RC purchase of services indicates that caseload growth is being outstripped by increased costs and utilization of services. The administration indicates that until it has a better understanding of what is causing the growth in costs and utilization, only caseload growth will be funded (on an average cost-per-client basis). Therefore, the administration does not propose to fund projected growth due to estimated cost and utilization, totaling about \$113 million General Fund the budget year.

Analyst's Recommendation

We recommend the Legislature take into account that the RCs are likely underbudgeted by as much as \$113 million General Fund in the budget year. We further recommend the Legislature require the department to report at budget hearings on the specific causes for increased utilization and costs. In our view, without accurate information about what is causing increased utilization and costs, the Legislature lacks the information it needs to assess the causes of the rapid growth in the RC program and determine which policies would be most effective to contain these costs.

We note that in our *Analysis of the 2006-07 Budget Bill*, (page C-156) we recommended that the Legislature direct the Department of Finance's Office of State Audits and Evaluations to conduct an audit to evaluate the accuracy and the consistency of the purchase of services data now being reported by RCs. Because the accuracy and consistency of these data are now uncertain, the state lacks tools that are needed to exercise strong fiscal oversight over RC spending. An improvement in the way expenditure

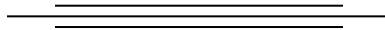
data are reported has additional potential benefits. It could improve the quality of the data used by DDS for budget forecasts, so that its budget request to the Legislature could more closely match the actual funding required to support community services programs.

The administration has indicated that it will provide updated information on the overall RC caseload trend, change in the mix of RC clients, and trends in the cost and utilization of services at the time of the May Revision. We will continue to monitor caseload trends and will recommend appropriate adjustments, if necessary, in May when DDS' updated budget request is presented to the Legislature.

Report on Potential RC Savings Measures Overdue

Chapter 188, Statutes of 2007 (AB 203, Committee on Budget) requires DDS to develop a plan of options for consideration by the administration and the Legislature to better control RC costs of operating and providing services. The plan is required to include a wide range of options with an analysis of the advantages and disadvantages of each. The plan was due to the Legislature on October 1, 2007. At the time this analysis was prepared, the report was five months overdue.

Analyst's Recommendation. We recommend the Legislature require the administration to report at budget hearings on the status of the overdue plan to control RC costs.



DEPARTMENT OF MENTAL HEALTH (4440)

The Department of Mental Health (DMH) directs and coordinates statewide efforts for the treatment of mental disabilities. The department's primary responsibilities are to (1) provide for the delivery of mental health services through a state-county partnership, (2) operate five state hospitals, (3) manage state prison treatment services at the California Medical Facility at Vacaville and at Salinas Valley State Prison, and (4) administer various community programs directed at specific populations.

The state hospitals provide inpatient treatment services for mentally disabled county clients, judicially committed clients, clients civilly committed as sexually violent predators (SVPs), mentally disordered offenders, and mentally disabled clients transferred from the California Department of Corrections and Rehabilitation.

Budget Proposal Increases DMH's Overall Budget. The budget proposes \$5 billion from all fund sources for support of DMH programs in 2008-09, an increase of \$144.4 million, or 3 percent, above the revised estimate of current-year expenditures. The proposal includes about \$2.1 billion General Fund, which is an increase of \$143.8 million General Fund, or 7.4 percent, from the revised current-year budget. The major spending proposals are discussed below.

State Mental Hospitals/Long-Term Care Services. The Governor's spending plan proposes \$1.3 billion (\$1.2 billion General Fund) in 2008-09, an increase of \$78.6 million (\$78 million General Fund) from the adjusted 2007-08 budget. The Governor's budget exempts state hospitals and related programs from across-the-board reductions because of the risk to public safety by releasing dangerous individuals.

The proposed increase is due primarily to employee compensation adjustments required by the *Coleman* court, the continued activation of Coalinga State Hospital, and compliance with the Civil Rights for Institutionalized Persons Act (CRIPA) consent decree requirements. Additionally, the Governor has proposed about \$3 million General Fund for

SVP evaluations for full implementation of Proposition 83, also known as Jessica's Law, and Chapter 337, Statutes of 2006 (SB 1128, Alquist). The increase also includes \$1.8 million General Fund for a 4 percent increase for clinical care costs and the expected participation of four SVPs in the Conditional Release Program. We discuss proposals affecting the state hospital system and SVPs in more detail below.

Community Services Budget Proposal. The Governor's spending plan proposes \$3.7 billion from all funds (\$884.7 million General Fund) for support of the community services programs, an increase of \$65.9 million General Fund compared to the revised 2007-08 budget.

The community services budget plan includes the following proposals:

- **Funding for Mental Health Services to Special Education Pupils (AB 3632).** The budget proposes a \$52 million General Fund increase to fund prior-year obligations for mental health services provided to children enrolled in special education as directed under the AB 3632 mandate and as required by the federal Individuals with Disabilities Education Act.
- **Increased Early and Periodic Screening Diagnosis and Treatment (EPSDT) Program Funding.** The Governor's spending plan proposes \$924 million (\$455.5 million General Fund) for support of EPSDT services, a net increase of 2.9 percent, or \$11.8 million, over current-year revised estimates due to increases in caseload, utilization, and costs of services as well as adjustments to Mental Health Services Act (MHSA)-EPSDT related services. The net increase incorporates the Governor's 10 percent budget-balancing reductions totaling \$6.7 million General Fund in the current year and \$46.3 million General Fund in the budget year. The Governor's budget-balancing reductions are achieved through proposals to: (1) impose a prior authorization requirement on all requests for EPSDT day treatment services that exceed six months, (2) eliminate the annual cost-of-living adjustment (COLA) increase to provider rates, and (3) reduce the non-inpatient provider rates by 5 percent.
- **Healthy Families Funding Net Increase.** The budget proposes \$31.1 million (\$640,000 General Fund), an increase of \$6 million (\$134,000 General Fund) to provide supplemental mental health services to children enrolled in the Healthy Families program. The net increase includes the effect of the 10 percent budget-balancing reductions.
- **Reduced Mental Health Managed Care Provider Rates.** The budget plan proposes a total of \$421.5 million (\$214.4 million Gen-

eral Fund) for 2008-09, a decrease of \$22.6 million (\$11.6 million General Fund) over the current year mostly due to elimination of an annual COLA and other rate reductions.

- **Early Mental Health Initiative Program Reduction.** The budget plan proposes about a 10 percent reduction or \$1.6 million General Fund in 2008-09 for mental health intervention and prevention services for children in grades K-3.
- **Implementation of Foster Children Specialty Mental Health Services.** The Governor's spending plan proposes \$188,000 (\$94,000 General Fund) for implementation of Chapter 469, Statutes of 2007 (SB 785, Alquist), to provide foster children with specialty mental health services.

THE SVP CASELOAD LIKELY TO BE BELOW PROJECTED LEVELS

Updated caseload data indicate that the amount of General Fund support needed for the state hospital system is likely to be overstated in both the current and budget year. We recommend the Legislature recognize current-year savings of \$12.6 million and budget-year savings of \$13.8 million General Fund to adjust for overbudgeting of the sexually violent predator caseload. (Reduce Item 4440-011-0001 by \$12.6 million in the current year and \$13.8 million in the budget year.)

New SVP Laws Increase Demands on Department Resources. Chapter 337 was approved by the Legislature and signed by the Governor in September 2006. Chapter 337 made changes in law that generally increase criminal penalties for sex offenses and strengthen state oversight of sex offenders. Additionally, the voters in the November 2006 statewide election approved Proposition 83. This measure increases penalties for violent and habitual sex offenders and expands the definition for a SVP commitment.

State hospitals, operated by DMH, hold sex offenders who have been committed as SVPs. State mental hospitals also hold some sex offenders who have completed their prison sentences, but are still undergoing SVP evaluations for commitment proceedings. The new SVP laws have increased the demands on the department by requiring increased screenings and evaluations. (For additional background, see page C-99 of the *Analysis of the 2007-08 Budget Bill*.)

Governor's State Hospital Budget Proposal. The Governor's spending plan for state hospitals proposes \$1.2 billion (nearly all General Fund) in 2008-09, an increase of \$79.4 million (\$78.8 million General Fund) from the adjusted 2007-08 budget. The proposed increase is due primarily to a

projected increase in SVP caseload, continued activation of Coalinga State Hospital, and compliance with CRIPA consent decree requirements.

SVP Caseload Likely to Be Below Projected Level. At the end of January 2008, the total SVP caseload was 689, an increase of 38 SVPs during the first seven months of 2007-08. The department estimates that the number of SVPs in state hospitals will approach 867 patients by the end of the current year, an increase of 178 patients, or about 26 percent above the caseload as of January 2008. Additionally, the department estimates that the SVP population will reach 1,227 patients by the end of the budget year, an increase of 360 patients.

Given that the SVP population in the past seven months grew by 38 patients, it seems unlikely that in the next five months the caseload will grow by 178 patients and that the caseload will increase by another 360 patients in the budget year. Based on our analysis, we believe that it is more likely that the SVP caseload will grow by as much as 50 SVPs in the remaining five months of the current year and 220 in the budget year.

Analyst's Recommendation. We recommend that the Legislature recognize General Fund savings of \$12.6 million in the current year and \$13.8 million in the budget year to adjust for overbudgeting of the SVP caseload.

MENTAL HEALTH MANAGED CARE CASELOAD POSSIBLY OVERSTATED

Our analysis of the Medi-Cal caseload shows that the Governor's mental health managed care budget proposal is likely overstated in the budget year. Based on a reduction of 172,000 eligible mental health managed care beneficiaries, we recommend a corresponding reduction of \$2.5 million in the budget year. We will monitor caseload trends and recommend any needed adjustments at the May Revision. (Reduce Item 4440-103-0001 by \$2.5 million.)

Administration's Caseload Projections. The budget projects an overall increase in the mental health managed care caseload, including psychiatric inpatient services, and requests about \$3.5 million General Fund for this caseload growth. Specifically, the DMH projects an increase of about 98,100, or 1.5 percent, in Medi-Cal eligibles for psychiatric inpatient services.

Medi-Cal Caseload Declining in the Budget Year. The Department of Health Care Services (DHCS) operates the Medi-Cal Program and estimates the program's caseload. Several other departments use this information for

their caseload projections. Our analysis indicates that DMH's estimate of the number of Medi-Cal beneficiaries using mental health managed care services is inconsistent with DHCS' estimate.

The DHCS projects that the overall Medi-Cal caseload will decline in the budget year, generally due to budget-balancing reductions that tighten eligibility restrictions. In particular, the DHCS projects a *reduction* of 73,900 beneficiaries for Medi-Cal mental health services, or 1.1 percent, in the budget year compared to the current year. On the other hand, DMH projects an *increase* in these beneficiaries of 98,000. Thus, compared to DHCS estimates, it appears that DMH overstated its caseload by 172,000 individuals, or about 2.6 percent. This caseload discrepancy may be explained by DMH excluding overall Medi-Cal eligibility budget-balancing reductions in its estimates.

Analyst's Recommendation. The DMH mental health managed care caseload projection is likely overstated in the budget year and is inconsistent with Medi-Cal caseload data available at this time. Based on a reduction of 172,000 eligible beneficiaries, we recommend a corresponding reduction of \$2.5 million to mental health managed care in the budget year. More updated caseload information will be available at the May Revision, at which time the Legislature can assess the level of funding proposed for mental health managed care services. We will continue to monitor Medi-Cal caseload trends related to mental health managed care and recommend appropriate adjustments to the budget estimate at the May Revision.

EXPANDED EFFORTS COULD FURTHER REDUCE COST OF MENTAL HEALTH DRUGS

The cost of mental health drugs in the Medi-Cal Program continues to grow. We estimate the state can save about \$5 million General Fund annually by reducing inappropriate prescribing practices. Accordingly, we recommend the Legislature consider the following two options: (1) encourage county participation in the California Mental Health Care Management (CalMEND) Program and (2) expand the use of fixed annual allocations to counties that include the cost of prescription drugs. We further recommend the Legislature approve the Governor's CalMEND proposal to support three limited-term positions and expand program activities.

Background

Who Provides Mental Health Services? The DMH directs and coordinates statewide efforts for the treatment of mental health disabilities. The DMH, in some cases, only provides part of the services that beneficiaries receive to address their mental health needs. For example, some individuals are dually diagnosed as being mentally ill and having a drug dependency problem or as being mentally ill and being developmentally disabled. In the case of a dual diagnosis, a beneficiary may also access programs managed by, for example, the Department of Alcohol and Drug Programs and the Department of Developmental Services. Services for mental health problems often include a combination of counseling and therapeutic medications.

There is a difference between who provides specialty mental health services and general mental health care needs. For example, a psychiatrist usually treats individuals with severe mental health problems such as schizophrenia or bipolar disorder. In contrast, a general medical practitioner can treat patients who have less severe mental health problems such as mild depression. The Medi-Cal Program provides general mental health care services for Medi-Cal beneficiaries. Specialty mental health services are “carved out” from general Medi-Cal services and are provided by specialists in county Mental Health Plans (MHPs).

The cost of prescription drugs provided to Medi-Cal beneficiaries receiving specialty mental health services are not paid through MHPs. Instead, the Medi-Cal Program pays on a fee-for-service basis for drugs prescribed through MHPs to Medi-Cal beneficiaries. The exception to this is a pilot program in San Mateo County that includes the costs of mental health drugs and related laboratory services. Specifically, the state pays an additional fixed annual allocation to cover these expenses.

Cost of Mental Health Drugs Continues to Grow

Significant Growth in Medi-Cal Spending for Mental Health Drugs. State spending for all prescription drugs in the Medi-Cal Program grew by about \$1.9 billion General Fund, or 336 percent, between 1994-95 and 2004-05. (Drug costs cited in this analysis do not include state or federal drug rebates because this information is proprietary.) Of this increase, \$535 million General Fund, or nearly 30 percent, was due to increased spending on mental health drugs. The average annual growth rate of mental health drug expenditures during this ten-year period was about 25 percent. Our analysis does not include data from the more recent years because implementation of the federal drug benefit known as Medicare

Part D distorts the data. See text box for more information about Medicare Part D impacts.

Antipsychotic Medications are Generally the Most Expensive. Antipsychotic medications are generally the most costly mental health drugs paid for by Medi-Cal and are primarily used by psychiatrists to treat patients suffering from schizophrenia. State spending on antipsychotic medications accounts for over one-half of the cost of all mental health fee-for-service prescription drugs in the Medi-Cal Program. The average monthly cost for an antipsychotic prescription was about \$319 in 2006-07. This amounts to an average annual total drug cost of \$3,828 per person. In contrast, the average cost for a monthly prescription for an antidepressant was \$79, or \$948 annually in 2006-07.

Inappropriate Prescribing Increases State Costs

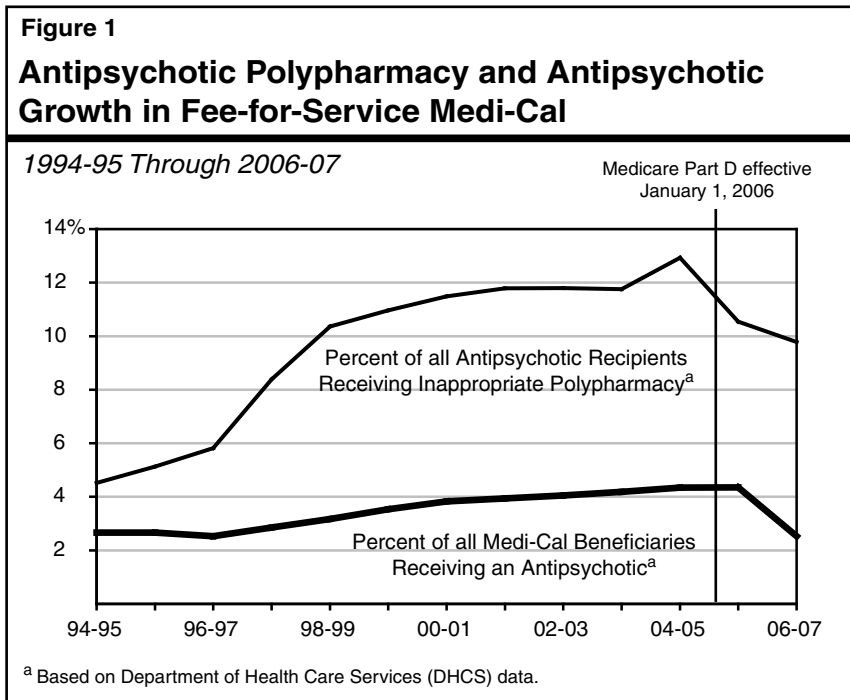
Polypharmacy generally refers to the use of multiple medications of the same type by a patient. According to the academic health literature, polypharmacy use involving antipsychotic medications is particularly common. In some cases, polypharmacy can be appropriate for antipsychotic medications. For example, clinical guidelines recommend polypharmacy for a short duration (not more than two months) when switching or transitioning from one antipsychotic to another. Clinical guidelines generally do not support the use of two or more antipsychotic drugs beyond these transition periods and, therefore, experts consider polypharmacy beyond two months *inappropriate*. Additionally, the costs of polypharmacy can be twice as much as treatment with one medication. Nonetheless, polyphar-

Medicare Part D

Medicare Part D Reduces State Drug Costs. The federal Medicare Prescription Drug, Improvement and Modernization Act provides a Medicare drug benefit component, known as Part D, that went into effect January 1, 2006. Prior to Medicare Part D, individuals who are entitled to Medicare benefits and who are also eligible for some form of Medi-Cal benefit received most of their prescription drugs through Medi-Cal. Since the implementation of Medicare Part D, these individuals now receive most of their prescription drugs through the Medicare Program. As a result, Medicare Part D now covers about one-half of the previous Medi-Cal mental health prescription drug volume according to Department of Health Care Services.

macy, while appropriate in some situations, can in other situations result in unnecessary costs and potentially harmful side effects.

As shown in Figure 1, based on DHCS data, the prevalence of inappropriate polypharmacy among Medi-Cal beneficiaries receiving an antipsychotic medication grew significantly in the decade prior to 2005-06, peaking at about 13 percent between 2004-05 and 2005-06. In 2006-07, the most recent year data are available, nearly 10 percent of Medi-Cal beneficiaries taking an antipsychotic were polypharmacy patients. This is a slightly reduced prevalence rate compared to prior years, mostly due to the impact of Medicare Part D. The risks of such prescribing practices are increased costs to the state and potentially negative impacts on the health of the person taking the drugs.



State Is Taking Some Steps to Reduce Costs and Improve Care

There are a couple of efforts underway in California which may help control the rising cost of mental health drugs in the Medi-Cal Program.

CalMEND Program Expands Efforts to Improve Care and Reduce Costs

Overview. The 2006-07 Budget Act appropriated initial funding for the California Mental Health Care Management (CalMEND) program in an effort to address rising drug costs and a lack of coordination in California's mental health delivery system. The CalMEND program is an interdepartmental, coordinated effort to help improve the cost-effectiveness of providing community mental health services in California. The program consists of multiple agencies, including DHCS, DMH, county MHPs, other state departments, and contracted entities.

The CalMEND began its efforts with a project directed at reducing the use of inappropriate polypharmacy for antipsychotic medications. In 2007-08, participating counties are implementing various best practices to decrease inappropriate antipsychotic prescribing. One of these practices is the use of medication algorithms which provide a "decision making tree" model that helps a health care practitioner determine the best drug course for a patient. These algorithms also include educational components and clinical assessment tools. At least five counties including Orange, Alameda, Fresno, Marin, and Stanislaus have been participating during the current year and results of the initial implementation efforts, including savings associated with this pilot, will be available within the next six months. A variety of other pilots and outreach projects are also in development or are underway such as the creation of standardized pharmacy utilization reports to promote quality improvement and a pilot for medication management therapy using pharmacists to better manage medications.

Governor's Budget Increases Spending for CalMEND. The CalMEND program is funded by matching MHSA funds with federal funds obtained through the Medi-Cal Program. (Voters in the November 2004 election approved MHSA, or Proposition 63, which imposes an additional 1 percent rate on the portion of incomes in excess of \$1 million, for a total marginal rate of 10.3 percent for affected taxpayers.) For 2008-09, the Governor's spending plan proposes \$1.4 million, an increase of \$421,000 above the current year, for CalMEND. The DHCS, along with other partners, primarily intends to use these additional funds to implement and expand various pilots, including the project targeting inappropriate antipsychotic use. Additionally, the funding will be used for increased data evaluation and to provide three limited-term positions for Medi-Cal's Pharmacy Benefits Division for maintenance and management of the program.

San Mateo's Capitated Rate for Mental Health Services

San Mateo County's Program. The San Mateo MHP, unlike other counties, receives what is effectively a capitated rate from DMH for the

provision of all mental health services, including prescription drugs. Essentially, the cost of mental health prescription drugs is “carved into” the county’s allocation. By “carving in” the cost of prescription drugs into the county’s allocation it provides the county an incentive to aggressively manage drug costs in order to ensure that the funds it receives are adequate to cover the cost of care for all services.

Evaluation Due in March 2008. The program has been operating for more than ten years under the assumption that it was cost-effective; however, no formal evaluation of its cost-effectiveness has been completed. An evaluation of the program’s cost-effectiveness is due to the Legislature in March 2008 as required by Chapter 188, Statutes of 2007 (AB 203, Committee on Budget). Specifically, this report will: (1) articulate best practices learned from the San Mateo program and whether these best practices should be replicated statewide, (2) offer suggestions to improve the program, and (3) clarify the program’s relationship to other local and statewide efforts related to pharmaceutical usage and purchasing, such as those conducted through the Health Plan of San Mateo and the CalMEND project, as well as others.

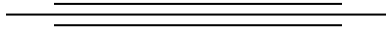
State May Be Able to Further Reduce Costs for Mental Health Drugs

Potential Savings Based on Improved Care Management. The state may be able to achieve a greater level of savings for the cost of mental health drugs by encouraging county mental health plans to adopt strategies that help to ensure they use the most appropriate clinical practices such as those supported by CalMEND. Specifically, county participation in CalMEND could help reduce the rate of inappropriate polypharmacy. Based on our review of polypharmacy trends, we estimate prescription drug costs in the Medi-Cal Program could be reduced by about \$5 million General Fund annually depending on the length and overall reduction rates of antipsychotic polypharmacy.

One option to encourage more counties to participate in CalMEND would be to create a “set aside” award for counties. This set aside for counties could be a direct share of the savings to the state or a financial incentive from other fund sources such as MHSA monies. This additional incentive could help accelerate county implementation of clinical best practices that are likely to improve care and coordination while also reducing costs.

Analyst’s Recommendation. Given the potential for savings, we recommend the Legislature consider options to encourage county participation in CalMEND. We also recommend the Legislature consider expanding, for county MHPs, the use of fixed allocations that include the

cost of prescription drugs. The Legislature will be further informed on this issue when the results from an evaluation of the state's only model for such an approach are available in March 2008. Finally, we recommend approval of the Governor's CalMEND proposal to support three-limited term positions and expand the program's pilot activities.



DEPARTMENT OF CHILD SUPPORT SERVICES (5175)

The Department of Child Support Services (DCSS), created on January 1, 2000, administers California's child support program by overseeing 52 local child support offices (some small counties have joined together to form local child support agencies). The primary purpose of the program is to collect from absent parents support payments for custodial parents and their children. Local child support offices provide services such as locating absent parents; establishing paternity; obtaining, enforcing, and modifying child support orders; and collecting and distributing payments.

The Governor's budget proposes expenditures totaling \$858.9 million from all funds for support of DCSS in the budget year. The budget proposes \$300.8 million from the General Fund for 2008-09 which is a decrease of \$50.7 million (14 percent) compared to 2007-08. This decrease is primarily due to the Governor's budget balancing reduction proposals and decreased costs for automation systems.

Increasing the Child Support Pass-Through

The Federal Deficit Reduction Act of 2005 increases federal participation in the amount of child support passed through to families who currently receive welfare assistance. The Governor's budget proposes to increase the monthly pass-through from \$50 to \$100 in January 2009. We recommend delaying this proposal until July 2010, thereby saving \$5.6 million in General Fund revenue in 2008-09 and \$11.2 million in 2009-10.

Background. In general, child support which is collected from absent parents whose families are receiving cash grants through the California Work Opportunity and Responsibility to Kids (CalWORKs) program are deposited in the General Fund as a partial offset to the state's costs for the cash grants. Since the enactment of the 1996 federal welfare reform legislation, federal law lets states decide whether to pass through to the

custodial parent on welfare any child support collected from the absent parent. However, any amount of child support that the state decides to pass through to the custodial parent reduces dollar for dollar the amount of collections deposited in the General Fund. Currently, California elects to pass through the first \$50 per month collected from the noncustodial parent to welfare families at a cost of about \$25 million General Fund annually.

Pursuant to the Deficit Reduction Act, beginning in October 2008 the federal government will share in the cost of the child support that is passed through to CalWORKs recipients up to specified limits. Specifically, the federal government will participate in 50 percent of the pass-through of up to \$100 for families with one child, and up to \$200 for families with two or more children.

Governor's Proposal to Increase the Pass-Through. The Governor's budget proposes to increase the monthly child support pass-through from the current \$50 to \$100 for all welfare families beginning January 2009. As shown in Figure 1, this policy change results in lost General Fund revenue of about \$5.6 million in 2008-09 and \$11.2 million in 2009-10. This is because, as mentioned above, child support not passed through to families would otherwise be retained by the state as General Fund revenue, partially offsetting the cost of the grant provided to CalWORKs families. The lost revenue is greater in 2009-10 than in 2008-09 because the budget proposal is effective for only six months in 2008-09, and for a full year in 2009-10.

Although federal participation in the child support pass-through begins in October 2008, the Governor's budget delays the increase in the pass-through until January 2009, two months after the anticipated completion of the single statewide automation system.

Figure 1

General Fund Revenue Loss for Increasing Child Support Pass-Through

(In Millions)

	General Fund Impact	
	2008-09	2009-10
\$50 Pass-through (current law)	\$15.8	\$12.6
\$100 Pass-through (Governor's proposal)	21.4	23.8
Net Cost From Governor's Proposal	\$5.6	\$11.2

Analyst's Recommendation. Without prejudice to the proposed policy change, we recommend postponing the increase in the pass-through from \$50 to \$100 until July 2010. This recommendation, if adopted, would retain the current pass-through of \$50, and therefore, there would be no reduction in the income support for welfare families receiving child support. Adopting this proposal will increase General Fund revenues by \$5.6 million in 2008-09 and \$11.2 million in 2009-10.

Revenue Losses Exceed Savings for Certain Proposals

The Governor's budget includes budget balancing reductions that would result in General Fund revenue losses that are greater than the associated General Fund expenditure savings. We review these proposals and recommend their rejection.

Governor's Reduction Proposals. The Governor's budget includes two budget reduction proposals where the estimated General Fund revenue loss exceeds estimated General Fund savings. In total, these particular reductions result in General Fund savings of about \$1.7 million, while creating General Fund revenue losses of about \$3.2 million. Additionally, the budget includes other reductions that we believe may potentially have a negative impact on General Fund revenues. We discuss these proposals in more detail below.

Reducing the Judicial Council Contract. The Governor's plan reduces the contract between the Judicial Council and DCSS by \$1.5 million General Fund in 2008-09. This contract provides for court commissioners, family law facilitators, support staff, and the court expenses necessary to establish child support orders. By assuming that the reduction will result in less court commissioners, and therefore less hearings and order establishments, DCSS estimates that this proposal will result in \$1.8 million in lost General Fund revenues.

Reducing the Locate and Intercept Contracts. The Governor's budget also reduces DCSS locate and intercept contracts by \$175,000 General Fund in 2008-09. The DCSS has several contracts with various state agencies to locate noncustodial parents and intercept their assets for purposes of paying their child support obligations. The locate and intercept contracts are responsible for an estimated \$160.5 million in child support collections per year. By reducing these contracts by \$175,000 General Fund (about 8.8 percent), DCSS estimates that locate and intercept collections will decline by \$1.4 million (about 8.8 percent) in 2008-09.

Other Potential Revenue Losses. The Governor's budget proposes to make several reductions to DCSS state operations. One proposal includes a reduction of 11 employees responsible for pursuing, through various

means, the recovery of funds from noncustodial parents. Reducing these positions could result in delayed recovery of child support collections for the state General Fund and for families. The DCSS indicates that this reduction proposal is being revised.

Analyst's Recommendation. At the time this analysis was prepared, DCSS indicated that it is in the process of pursuing strategies to mitigate the General Fund revenue loss associated with the Judicial Council contract and locate and intercept reduction proposals. However, at this time additional proposals have not been identified by the administration. Because the difference between General Fund savings and lost General Fund revenue is so large for the locate and intercept reduction proposal, lost revenues are likely to exceed General Fund savings despite mitigation strategies. As a result, we recommend rejecting the reduction proposals that reduce Judicial Council and locate and intercept contracts. Finally, we withhold recommendation on the 11 positions proposed for reduction, pending the receipt of information demonstrating that the reduction does not result in more lost General Fund revenue than it saves in General Fund costs.

Fiscal Risks of Delayed Single System Implementation

In September 2006, the Department of Child Support Services applied for federal certification of the California Child Support Automated System. We review system implementation, federal certification, and the General Fund risks associated with delayed project certification.

Automation Components. The California Child Support Automation System (CCSAS) consists of two major components, the State Disbursement Unit (SDU) and Child Support Enforcement (CSE). The SDU was fully implemented in May 2006, and collects, processes, and distributes child support payments. The CSE component of the project provides a central database and case management system to support child support enforcement activities in all Local Child Support Agencies. The CSE portion of CCSAS is being implemented in two phases. The first phase of CSE is Version 1, which created a centralized database and reporting system for two preexisting systems (referred to as legacy systems). The second phase is Version 2 which will consolidate the two preexisting legacy systems and create increased child support capabilities. Within certain limitations discussed more fully below, the state share of the project costs is 34 percent and the federal share is 66 percent.

Two Certifications. Because California is implementing its single statewide system in two phases, there will be two federal certifications. The first certification will be of Version 1. As indicated below, this certification process is currently underway. Upon certification of Version 1,

the state will receive a reimbursement for a federal penalty incurred for failing to have a single statewide system in place. The second certification is of Version 2. Counties began to transition from Version 1 to Version 2 in waves beginning in May 2006. The earliest Version 2 will be certified is November of 2008. After Version 2 is implemented, a federal funding cap placed on project costs will be lifted. Below we discuss each certification and how it impacts state funds.

Penalty Relief and Reimbursement. Since 1998, California has paid a total of nearly \$1.2 billion in federal penalties for failing to have a single statewide system. The 2006-07 budget included \$215 million to pay the federal penalty for federal fiscal year 2006 (October 2005 through September 2006).

As previously mentioned, the state is in the process of implementing a single statewide automation system in two phases. The first phase (Version 1) is known as the alternative system configuration (ASC). Once Version 1 and the SDU were fully operational in September 2006, the state applied for certification of this alternative system. After the state applied for certification federal penalties were held in abeyance pending federal certification. When the system is certified, the federal government will reimburse the state 90 percent (\$193 million) of the final penalty paid in 2006-07. The budget assumes that the federal government will certify the ASC, and reflects this reimbursement as revenue in 2007-08. At the time this analysis was prepared, 37 federal certification findings must be corrected before the ASC can be certified. Therefore, it is more likely that the reimbursement revenue will occur in 2008-09.

Version 2 County Implementation Experiences. Counties began to transition from CSE Version 1 to Version 2 in waves beginning in May of 2007. As of January 2008, 24 counties (representing about 13 percent of the caseload) had converted to Version 2. We have visited six counties after their conversion. The first three counties experienced difficulties because of system defects, design flaws, and forms printing incorrectly. The state and vendor worked closely with counties to correct many of these problems before additional counties were converted. Subsequent county conversions have resulted in fewer complications. In February 2008, Orange County is expected to convert to Version 2. Orange County has three times the caseload of any county converted thus far (Orange County's caseload is about 98,000). We will continue to monitor the county conversions to ensure the Legislature is advised of the status on a timely basis.

Federal Cap on Alternative System Configuration. When DCSS requested federal approval of the two phase approach to implementing a single statewide system, federal funding for the project was locked-in, or capped, at the cost estimates as of that date. This federal funding cap

ensures that a state does not spend more in developing an ASC than it would spend building a single statewide system. The federal cap will be lifted when California's single statewide system is completed and obtains federal certification. Los Angeles, currently scheduled to convert in November 2008, will be the last county to convert to Version 2. Thus, November 2008 is the earliest possible date for Version 2 certification.

Delayed Certification May Create General Fund Costs. Because the state is currently operating under a federal fund cap, any additional development costs above the cap must be covered solely by the General Fund. If the state is not certified in 2008-09, and CCSAS project costs remain at the currently estimated amounts, DCSS indicates that there would be an additional General Fund cost of approximately \$11.4 million in 2009-10 to absorb the federal portion of the planned project costs for that year. This is because, at that point, DCSS estimates that project costs will exceed the amount approved under the federal cap. It is important to note that this estimated \$11.4 million in additional General Fund costs in 2009-10 is not a firm number, but a point-in-time estimate. If project costs are higher than anticipated, General Fund costs, because of the federal cap could occur in 2008-09.

CALIFORNIA WORK OPPORTUNITY AND RESPONSIBILITY TO KIDS (5180)

In response to federal welfare reform legislation, the Legislature created the California Work Opportunity and Responsibility to Kids (CalWORKs) program, enacted by Chapter 270, Statutes of 1997 (AB 1542, Ducheny, Ashburn, Thompson, and Maddy). Like its predecessor, Aid to Families with Dependent Children, the new program provides cash grants and welfare-to-work services to families whose incomes are not adequate to meet their basic needs. A family is eligible for the one-parent component of the program if it includes a child who is financially needy due to the death, incapacity, or continued absence of one or both parents. A family is eligible for the two-parent component if it includes a child who is financially needy due to the unemployment of one or both parents.

The budget proposes an appropriation of \$4.8 billion (\$1.5 billion General Fund, \$107 million county funds, \$35 million from the Employment Training Fund, and \$3.1 billion federal funds) to the Department of Social Services (DSS) for the CalWORKs program in 2008-09. In total funds, this is a decrease of \$378 million, or 7.3 percent, compared to estimated spending of \$5.2 billion in 2007-08. This decrease is primarily attributable to estimated savings from the Governor's proposed policy changes to establish time limits for children whose parents cannot or will not comply with participation requirements.

General Fund spending for 2008-09 is proposed to be \$59 million, 4 percent, more than estimated spending for 2007-08. This General Fund increase is due to a higher federal maintenance-of-effort (MOE) requirement, partially offset by using more countable MOE funds from other departments.

BUDGET UNDERESTIMATES COST OF CALWORKS COLA

The Governor's budget provides \$131 million to fund the California Work Opportunity and Responsibility to Kids (CalWORKs) cost-of-living adjustment (COLA) based on an estimated California Necessities Index (CNI) of 4.25 percent. Our review of the actual data indicate the CNI will be 5.26 percent, which raises the cost of the CalWORKs COLA by \$31 million, to a total of \$162 million.

Actual CNI Exceeds Governor's Estimate. Current law requires that the CalWORKs grant be adjusted in July 2008 based on the change in the CNI from December 2006 through December 2007. The Governor's budget, which is prepared prior to the release of the actual data from December 2007, estimates that the CNI will be 4.25 percent. Our review of the actual data, however, indicates that the CNI will be 5.26 percent.

Higher State Cost to Provide COLA. Based on its estimate of CNI, the Governor's budget provides \$131 million to fund the CalWORKs cost-of-living adjustment (COLA) beginning in July 2008. Based on the actual CNI of 5.26 percent, we estimate the cost of providing the CalWORKs COLA to be \$162 million, an increase of \$31 million compared to the Governor's budget.

Grant Levels Compared to Poverty. Figure 1 shows the combined cash and food stamps in 2007-08 and in 2008-09 after the July COLA has been provided. As the figure shows, maximum monthly cash grants increase by \$38 in high-cost counties, and \$36 in low-cost counties. These increases are in part offset by a \$17 monthly reduction in food stamps benefits. The figure also compares the combined grant and food stamps benefit to the federal poverty guideline for 2008. As the figure shows, combined benefits will be about 75 percent of the guideline in high-cost counties and 74 percent of the guideline in low-cost counties.

MAINTENANCE-OF-EFFORT AND CASELOAD REDUCTION CREDIT (CRC)

Pursuant to federal law, any spending above the federally required maintenance-of-effort (MOE) level results in a caseload reduction credit (CRC) which reduces California's work participation requirement in the California Work Opportunity and Responsibility to Kids program. Recent federal changes are likely to reduce the amount of countable MOE spending and CRC available to California. We review the MOE requirement, the impact of the recent federal changes, and forecast the CRC through 2010-11.

Figure 1**CalWORKs Maximum Monthly Grant and Food Stamps
2007-08 and 2008-09
Family of Three**

	2007-08	2008-09 ^a	Change	
			Amount	Percent
High-Cost Counties				
Grant	\$723	\$761	\$38	5.0%
Food stamps	361	344	-17	-4.9
Totals	\$1,084	\$1,105	\$21	1.9%
<i>Percent of poverty^b</i>	<i>73.9%</i>	<i>75.3%</i>		
Low-Cost Counties				
Grant	\$689	\$725	\$36	5.0%
Food stamps	377	360	-17	-4.7
Totals	\$1,066	\$1,085	\$19	1.8%
<i>Percent of poverty^b</i>	<i>72.7%</i>	<i>74.0%</i>		

^a Based on a grant COLA of 5.26 percent resulting from the actual change in the California Necessities Index.

^b Federal fiscal year 2008 federal poverty guidelines.

Temporary Assistance for Needy Families (TANF) MOE Requirement. To receive the federal TANF block grant, states must meet a MOE requirement that state spending on assistance for needy families be at least 75 percent of the federal fiscal year (FFY) 1994 level, which is \$2.7 billion for California. (The requirement increases to 80 percent if the state fails to comply with federal work participation requirements.) Because California is likely to fail the work participation requirement for FFY 2007, the required spending level rises to 80 percent beginning in the 2008-09 budget. Although the MOE requirement is primarily met through state and county spending on CalWORKs and other programs administered by DSS, state spending in other departments is also counted toward satisfying the requirement.

Expanded Definition of MOE Spending. The federal Deficit Reduction Act (DRA) of 2005 expanded the definition of what types of state spending may be used to meet the MOE requirement. Previously, countable state spending had to be for aided families or for families who were otherwise eligible for assistance. The DRA allows state expenditures designed to prevent out-of-wedlock pregnancies or promote the formation of two-

parent families to count toward the MOE requirement, even if the program participants are not otherwise eligible for aid. Essentially, the act removes the requirement that countable spending for these purposes be on behalf of low-income families with children.

Because of this change, California now counts some existing spending on higher education tuition assistance (CalGrants and community college fee waivers) and after school programs toward the MOE requirement. The rationale for tuition assistance is that higher education is generally associated with better employment and life outcomes, which in turn may result in fewer out-of-wedlock births. Similarly, after school programs are associated with better school attendance and achievement, which in turn improves employment and life outcomes, potentially resulting in fewer teen pregnancies.

Excess MOE Spending Results in CRC. As discussed more fully in the next section, pursuant to DRA, states must meet federal work participation rates (50 percent for all families) less a CRC based on the decline in their caseloads since FFY 2005. Current federal regulations allow states that spend above their required MOE level to subtract out cases funded with excess MOE for the purpose of calculating CRC. Based on the amount of excess MOE spending during FFY 2006, California increased its CRC from 3.5 percent to a total of 14.4 percent. Pursuant to federal rules, the CRC percentage that is due to excess MOE spending during FFY 2006 is subtracted from the federal work participation requirement for the subsequent year (FFY 2007).

New Federal Regulations

On February 5, 2008, the federal Administration for Children and Families published new regulations regarding the implementation of DRA. Although these regulations make many modifications to the prior rules, the most significant changes are to (1) the method by which CRC from excess MOE is calculated and (2) which types of expenditures may be counted as MOE. The new rules take effect on October 1, 2008.

Change in Calculation of the MOE CRC. Many states have claimed excess MOE spending and have submitted federal reports which calculate CRC based on their amount of excess spending. The new regulations limit the amount of countable excess MOE spending to that portion of the excess MOE spending that represents "assistance." Because California's assistance spending is about one-half of its total MOE expenditures, imposition of this calculation methodology will significantly reduce California's credit by about 50 percent compared to the existing California calculation method.

To date, the federal government has not yet notified California that its credit will be reduced, but such notification is expected in the near future.

Limits on Spending Which May Be Counted as MOE. As described earlier, DRA allowed states to count spending on individuals and families that were not eligible for TANF so long as the spending was reasonably calculated to reduce out-of-wedlock births or promote marriage. The new regulations only allow expenditures on specified programs that support marriage (such as mentoring programs, and marriage education) to be counted as MOE. States will no longer be able to count tuition assistance and other programs for families and individuals not otherwise eligible for TANF. Because these regulations go into effect on October 1, 2008, they impact how state spending is counted during FFY 2009 (October 2008 through September 2009), and impact the FFY 2010 CRC.

Given this recent federal change, further analysis of California's spending which is outside of the regular CalWORKs program, and used to satisfy either the MOE requirement and/or create excess MOE CRC, is needed. On a preliminary basis, we are concerned that these regulations would substantially reduce countable excess MOE spending, most likely eliminating the excess MOE CRC beginning in FFY 2010. Moreover, the ability to meet the base MOE requirement under the Governor's budget may be jeopardized. This problem is compounded by recent information suggesting that Proposition 49 after school funds may not be countable toward MOE because they are in part used to obtain federal education funds. On the other hand, it may be possible to create TANF fund shifts to restore some of the excess MOE funds. After we have more carefully reviewed the regulations we will provide the Legislature with options for potentially mitigating this loss of MOE funds.

From FFY 2007 through FFY 2010, Figure 2 (see next page) shows estimated excess MOE spending under both the Governor's budget and under current law. For comparison purposes, the current law version backs out the savings from the Governor's reforms discussed later in this chapter. The only difference is the credit for FFY 2009, which is based on spending in FFY 2008. The Governor's proposals reduce spending during 2007-08 and 2008-09, and approximately \$75 million of this savings impacts the FFY 2009 CRC. For FFY 2010, the figure shows no excess MOE spending because of the impact of the new federal regulations. Depending on the level of spending within the regular CalWORKs program, it may be possible, through fund shifts, to restore some of the excess MOE CRC in FFY 2010.

Figure 2**Excess MOE Caseload Reduction Credit
Current Law and Governor's Budget***Federal Fiscal Year 2007 through 2010
(Dollars in Millions)*

	2007	2008 ^a	2009 ^a	2010
Governor's Budget				
Excess MOE spending ^b	\$408.5	\$749.2	\$485.1	—
Caseload reduction credit	-6.3%	-10.9%	-7.4%	—
Current Law				
Excess MOE spending ^b	\$408.5	\$749.2	\$558.8	—
Caseload reduction credit	-6.3%	-10.9%	-8.4%	—
^a Amounts for 2008 and 2009 would be lower if Proposition 49 after school funds cannot be counted as MOE.				
^b The excess MOE spending is actually from the year prior to the credit shown, because credits are based on prior-year spending.				

CURRENT WORK PARTICIPATION REQUIREMENT AND STATUS

Federal law requires that states meet a work participation rate of 50 percent for all families and 90 percent for two-parent families, less a caseload reduction credit (CRC). The Deficit Reduction Act of 2005 and associated regulations significantly changed the calculation of the participation rate and CRC. We estimate California's work participation rate under these federal changes, and find that absent policy changes, California is out of compliance with federal requirements.

Background

Required Hours of Work for Adults. To comply with federal work participation rates, adults must meet an hourly participation requirement each week. For single-parent families with a child under age six, the weekly participation requirement is 20 hours. The requirement goes up to 30 hours for single parents in which the youngest child is at least age six. For two-parent families the requirement is 35 hours per week. The participation hours can be met through unsubsidized employment, subsidized employment, certain types of training and education related to work, and job search (for a limited time period).

Work Participation Penalties for States. If a state fails to meet the work participation rates, it is subject to a penalty equal to a 5 percent reduction of its federal TANF block grant. For each successive year of noncompliance, the penalty increases by 2 percent to a maximum of 21 percent. For California, the 5 percent penalty would be approximately \$149 million annually, potentially growing by up to \$70 million per year. Penalties are based on the degree of noncompliance. For example, if a state is in compliance with the all-families rate, but is out of compliance for the two-parent rate, the penalty would be prorated down based on the percentage of cases that are two-parent cases. Pursuant to current state law, the state and counties would share in any federal penalty.

State Impact of Penalties. States that fail to meet their work participation requirements are required to (1) backfill their federal penalty with state expenditures and (2) increase their MOE spending by 5 percent. States out of compliance may enter into corrective action plans which can reduce or eliminate penalties, depending on state progress in meeting the negotiated goals of the corrective plan. Given past practice and regulations, if California were notified in late 2008 that it was out of compliance with work participation in FFY 2007, California would have until FFY 2010 to meet the goals of a corrective action plan.

Deficit Reduction Act Effectively Increases Participation Requirements for States

The DRA increased participation requirements on states in three different ways. First, it moved the base period for calculating CRC from 1995 to 2005. Because California's caseload decline mostly occurred before 2005, this substantially reduces the state's CRC, from about 46 percent to about 3.5 percent for FFY 2007 and an estimated 6.8 percent in FFY 2008. Second, it made families served in separate state programs subject to federal participation rates. Thus, beginning with FFY 2007, California is subject to the 90 percent federal work participation rate for two-parent families. In the past, these families were not subject to federal work participation requirements. Third, it provided the Secretary of Health and Human Services with broad authority to adopt federal regulations to (1) narrow the definition of work and participation and (2) expand the number of families who are included in work participation calculations. (For a complete description of how the DRA and the regulations changed the work participation calculations see Figure 3 on page C-123 of the *Analysis of the 2007-08 Budget Bill*.)

Current Participation Rate

The most recent data on California's work participation rate are from FFY 2006. The DRA provisions, which became effective in FFY 2007, increase the number of families required to participate and also expand the definition of which families are meeting the rate. Based on data from FFY 2006, Figure 3 estimates California's work participation for 2007 under DRA. As the figure shows, DRA changes have the effect of reducing the participation rate from 25 percent to 21 percent. Most of this loss is attributable to changes requiring that families sanctioned for more than three months and families in the safety net program (who have been on aid for five years) be included in the work participation rate.

Figure 3

Work Participation Status—All Families^a Under Prior and Current Law

	Prior Law and Regulations	Current Law/DRA Regulations	Change From Prior Law
Families meeting requirements ^b	49,473	59,742	10,269
Families subject to participation ^c	201,076	281,925	80,849
	=	=	
Participation rate	24.6%	21.2%	-3.4%

a Most recent data are from FFY 2006.
 b This is the numerator of the participation rate calculation.
 c This is the denominator of the participation rate calculation.

Estimated Impact of Recently Enacted State Reforms. Through enactment of Chapter 68, Statutes of 2005 (SB 68, Committee on Budget and Fiscal Review) and Chapter 75, Statutes of 2006 (AB 1808, Committee on Budget), the Legislature has made significant program changes that should increase work participation among CalWORKs families. Last year, DSS estimated that these measures would increase participation by 4 percentage points in FFY 2007 and 10 percentage points in FFY 2008. Now DSS is forecasting that these changes will have almost the same impact, but one year later. In other words, the 4 percent increase is projected to occur in FFY 2008 with an additional 6 percent in FFY 2009. Thus, given the current participation rate of 21 percent, DSS estimates that participation will be 25 percent in FFY 2008 and 31 percent in FFY 2009.

Projected Participation Shortfalls

In order to assess where California stands with respect to meeting the federal work participation requirements, we have projected future participation and future CRCs based on the assumptions described above. Figure 4 projects that California will fall substantially below (19 percent) the required work participation rate in FFY 2007. However, in FFY 2008 the shortfall is reduced to 7 percent, falling to just under 4 percent in FFY 2009. In FFY 2010 the shortfall goes up to 12 percent, assuming the new federal rules regarding countable MOE spending cannot be mitigated by state changes. We note that the shortfall in 2009 would rise to about 12 percent if it turns out Proposition 49 funds for after school programs cannot be counted.

Figure 4

Estimated Work Participation Shortfalls Current Law

	Federal Fiscal Year (FFY)				
	2007	2008	2009	2010	2011
Federal Participation Requirement	50.0%	50.0%	50.0%	50.0%	50.0%
Caseload Reduction Credits					
"Natural" caseload decline ^a	-3.5%	-6.8%	-6.5%	-7.3%	-7.3%
Excess MOE reduction	-6.3	-10.9	-8.4	—	—
Total Credit	-9.8%	-17.8%	-14.9%	-7.3%	-7.3%
Net Participation Requirement	40.2%	32.2%	35.1%	42.8%	42.8%
Work participation rate	21.2%	25.2%	31.2%	31.2%	31.2%
Participation Shortfall	-19.0%	-7.0%^b	-3.9%^b	-11.6%	-11.6%

^a Since FFY 2005.
^b Shortfalls increase if Proposition 49 after school funds cannot be counted as MOE.

GOVERNOR'S REFORMS ADDRESS PARTICIPATION SHORTFALL AND ACHIEVE BUDGETARY SAVINGS

In order to increase work participation and achieve budgetary savings, the Governor proposes a series policy changes for the California Work Opportunity and Responsibility to Kids program. These are (1) a

graduated full-family sanction that increases to 100 percent of the grant after one year in sanction status, (2) a five-year time limit on children whose parents cannot meet federal work participation requirements, (3) a nutritional supplement for working poor families, and (4) a five-year time limit for other child-only cases. We review the Governor's proposals and comment on them.

Overview of Governor's Proposal

The Governor's budget proposes four major policy changes which would significantly alter the CalWORKs program. As a package, these proposals result in net savings of \$471 million in 2008-09, and are estimated to increase work participation by 9.7 percent in FFY 2009 and 19.8 percent in FFY 2010. Figure 5 summarizes the estimated fiscal and work participation impacts of each component. We discuss each aspect of the Governor's proposal below.

LAO Bottom Line. The Governor's CalWORKs proposals would increase the work participation rate and result in substantial budgetary savings because many children would lose access to cash assistance. The proposals raise significant policy and budget issues. Later in this chapter we present alternative policy approaches which increase work participation but provide much less budgetary savings. In order to address federal work participation requirements, the Legislature will need to set its own priorities with respect to the policies and budget for CalWORKs.

Graduated Full-Family Sanction

Policy Description. Currently, when an able-bodied adult does not comply with CalWORKs participation requirements, the family's grant is reduced by the adult portion, resulting in a "child-only" grant. The Governor proposes to increase this sanction to 50 percent of the remaining child-only grant after six months in sanction status, and completely eliminate the family's grant after another six months elapses, unless the adult comes into compliance. Families would be able to end the sanction and restore their grants by complying with program requirements.

Proposed trailer bill language "strongly encourages" counties to contact noncompliant cases by phone, letters, or home visits, before imposing the increased sanction. However, the budget does not include any additional funds for these activities (meaning that counties would have to absorb these contact costs within their existing block grants).

The Governor proposes that this policy be enacted through special session legislation. Clients would be notified in March about this sanction,

and would begin experiencing the increased sanction in June 2007 unless they complied with program rules.

Impact on Families. Here we describe the financial impact of this proposal using a family of three in a high-cost county for purposes of example. Currently, the maximum grant for a family of three is \$723 per month plus \$361 in food stamps, for a total of \$1,084 per month. When a family moves into sanction status, the adult is removed, the grant drops to \$584 and the food stamps increase to \$416, for a total of \$1,000 per month. Under the Governor's proposal, after six months in sanction status, the grant for the noncomplying family would drop by 50 percent to \$292 plus \$426 in food stamps (for a combined benefit package of \$718). After an additional six months, the grant would be completely eliminated and the family would retain its food stamps benefits of \$426 per month.

Figure 5

**Governor's CalWORKs Package
Summary of Fiscal and Work-Related Impacts**

(Dollars in Millions)

Component	2008-09			Change in WPR ^a	
	Grants/ Administration	Child Care/ Services	Net Fiscal Impact	FFY 2009	FFY 2010
Graduated full-family sanction	-\$61.7	\$82.7	\$21.1	3.7%	5.7%
Modified safety net (5-year time limit)	-256.7	-2.5	-259.2	5.1	5.1
Work Incentive Nutritional Supplement (WINS) ^b	8.4	—	8.4	0.9	9.0
Child-only time limit	-241.5	—	-241.5	—	—
Totals	-\$551.5	\$80.2	-\$471.3	9.7%	19.8%

^a WPR = Work Participation Rate.

^b In 2008-09, \$8.4 million for automation, rising to about \$24 million in 2010-11.

Behavioral Impacts on Families. For 2007-08, the estimated number of families in sanction status is 41,700 (with an average of 1.9 children per family). The Governor's budget assumes that 13,000 families (31 percent) will participate sufficiently to come into compliance and avoid further sanction. The remaining 28,700 would receive a 50 percent reduction in their grant. Of this remaining group, the budget assumes that 5,800 families (20 percent) would comply with program requirements and avoid

the full-family sanction. The remaining 23,000 families are estimated to experience the full-family sanction. This represents about 44,000 children. The budget further estimates that about 6,300 families experiencing the full-family sanction would subsequently comply with program requirements and return to aid within six months.

Impact on Work Participation. There are two impacts on the state's work participation rate from this policy. First, some families will work sufficient hours to meet federal participation requirements. Specifically, the budget estimates there will be about 1,200 newly participating families in FFY 2008, rising to 8,400 in FFY 2009, and 11,500 in FFY 2010. This increases the numerator, thus raising the work participation rate. Second, the families which experience the full-family sanction exit the program and reduce the denominator. Together, the budget estimates that these changes will increase the work participation rate by about 0.44 percent in FFY 2008, rising to 3.7 percent in FFY 2009, and 5.7 percent in FFY 2010. We note that regardless of the success rate of this policy in encouraging families to work, the policy will increase the work participation rate, because families who experience the full-family sanction will go off aid and therefore be excluded from the denominator. The only question is the number who would leave aid and be excluded.

Fiscal Impact. Because of the estimated increase in compliance and work participation, the budget estimates increased child care and welfare-to-work services costs of about \$83 million in 2008-09. These costs would be offset by grant savings (\$62 million) from the families that experience the full-family sanction. Thus, the Governor's budget estimates these net costs to be about \$21 million in 2008-09.

LAO Assessment of Graduated Full-Family Sanction

Assumptions Concerning Impacts Reasonable. It is difficult to assess the behavioral impacts of sanction policies because there is no consensus in the research community on whether stronger sanctions correlate with better employment outcomes for families. This is mostly because there have been no rigorous studies that compare the impacts of randomly assigned participants to weaker and stronger sanctions. (There is research on the characteristics of sanctioned cases and what happens to them. We summarized this research in the CalWORKs section of the *Analysis of the 2007-08 Budget Bill*.)

Last year, the administration assumed that 70 percent of cases experiencing a full-family sanction would not only come into compliance and end their sanction, but would actually participate sufficient hours to meet federal participation requirements. As described in the *Analysis of*

the 2007-08 Budget Bill, we concluded that these assumptions were overly optimistic.

This year, the budget distinguishes between cases that will comply with program requirements (attend orientation, and participate in required activities for example) and end their sanction and cases that will actually participate enough to meet the federal hourly requirements. The administration assumes that about 28 percent of the sanctioned parents will meet federal participation requirements while 55 percent will experience the full-family sanction. We believe these assumptions are reasonable.

Graduated Sanction Policy Could Be Pilot Tested. The graduated full-family sanction is a high risk and high reward strategy. On the one hand, it is likely to substantially increase work participation by 5.7 percent when fully implemented in 2010. The graduated aspect of the policy gives sanctioned cases more time to come into compliance than last year's immediate sanction proposal. On the other hand, it could result in hardship for children whose parents cannot or will not cooperate with work participation requirements. Given the lack of research on the behavioral impacts of sanction policies, the Legislature could consider pilot testing this policy in several counties. After seeing the results of these pilots, the Legislature could decide whether to end or expand the sanction policy pilot.

Five-Year Time Limit for Children in Safety Net

Policy Description. Currently, after five years of assistance, a family's grant is reduced by the adult portion, and the children continue to receive a child-only grant in the safety net program. The budget proposes to eliminate the safety net grant for children whose parents fail to comply with the federal work participation requirements as of June 1, 2008. Families currently on the safety net would be given 90 days to increase their work hours to remain eligible. Families unable to meet federal requirements would be removed from aid.

Working Families Could Reenter Safety Net. In contrast to last year's proposal, families who are removed from aid under this policy would be able to return to the safety net under certain conditions. Specifically, the proposed trailer bill legislation allows former safety net children of adults who work sufficient hours to meet federal participation requirements to rejoin the safety net. This is because for the first six months after being removed from aid, the proposed trailer bill applies the income limits for recipients (about \$1,670 per month for a family of three) to this population, rather than the much lower income limits for applicants (about \$800 per month for a similar family). The income limits for recipients are higher than

those for applicants because recipients have the first \$225, and one-half of all earnings above \$225, “disregarded” when calculating their grant.

Impacts on Families. The budget estimates that there would be approximately 47,500 safety net cases in June 2008, rising to 48,500 cases during 2008-09. The budget assumes that in 2008-09, 26 percent of these families—about 12,400 cases—will work sufficient hours to maintain eligibility for the safety net. The DSS bases this 26 percent rate on data indicating that currently about 19 percent of safety net cases are meeting the federal participation requirements, and that when faced with complete benefit termination, an additional 7 percent who are working part time would increase their hours so as to remain eligible. The budget estimates that the other 35,100 cases, with approximately 67,000 children, would lose aid because of this policy.

Fiscal Impacts. The budget estimates that the safety net time limit will result in savings of \$18 million in June 2008, rising to \$259 million in 2008-09.

Impact on Work Participation. The safety net time limit would increase participation in two ways. First, it modestly increases the number of families working enough hours to meet federal requirements (the 7 percent of families on the safety net who are working part-time and are assumed to reach the federally required levels in response to potential benefit termination). Second, those unable to meet federal participation would have their benefits terminated. By removing these cases from assistance, it reduces the denominator, thus increasing the participation rate. The budget estimates that these combined impacts will raise the work participation rate by 1.6 percent in FFY 2008, and 5 percent in FFY 2009. These estimates appear reasonable.

Work Incentive Nutritional Supplement (WINS)

Policy Description. Beginning on July 1, 2009, the budget proposes to provide a \$40 per month nutritional supplement to working families who are not in the CalWORKs program but are working sufficient hours to meet the federal work participation requirements. The benefits would be provided in the form of additional food stamps, which are usually made available to recipients through the use of electronic benefit transfer cards. The budget estimates that approximately 40,000 families will be eligible for this supplement. For 2008-09, the budget proposes \$8.4 million to make necessary automation changes. The administration estimates that during 2009-10, the cost of providing benefits under this program would be \$18.6 million, rising to \$24 million each year thereafter.

Impact on Work Participation. Besides increasing food benefits for the working poor, the primary advantage of this proposal is adding about 40,000 working families to the numerator for purposes of calculating the federal work participation rate. The administration estimates that this proposal will increase the work participation rate by 0.9 percent in FFY 2009, 9 percent in FFY 2010, and 10 percent in FFY 2011.

Because this proposal adds to the CalWORKs caseload, in isolation it reduces the natural caseload reduction credit of 7.3 percent in FFY 2010 and FFY 2011 as shown in Figure 4. This is because the cases receiving WINS would be new CalWORKs cases, creating a caseload increase, which would reverse the 7.3 percent reduction. However, federal rules allow caseload increases from eligibility changes such as this to be offset against eligibility changes that reduce the caseload. The Governor's full-family sanction is an example of such an eligibility change which could be offset against the increase of WINS, thus preserving the full work participation impact of WINS discussed above.

LAO Assessment. We believe that the WINS proposal is a cost-effective way of raising work participation, and we previously recommended adoption of a program like this in the *2007-08 Analysis*. This WINS proposal is incorporated into the LAO CalWORKs reform package presented below.

Child-Only Time Limit

Fiscal Impacts. Effective June 1, 2008, the budget proposes to limit assistance to five years for most child-only cases (such as those with parents who are undocumented or ineligible due to a previous felony drug conviction). There are approximately 37,000 cases which have been aided for five years and would lose assistance under this proposal. Removing these families from assistance results in General Fund savings of \$18 million in June 2008, rising to \$242 million in 2008-09. There are about 70,300 children in these families.

No Impact on Work Participation. Limiting benefits to other child-only cases to five years (where the parents are ineligible because they are drug felons or undocumented) has no impact on work participation. This is because they are already excluded from the work participation calculation.

Governor's Proposals Address Participation

As discussed above, the Governor's proposals substantially increase work participation. Figure 6 (see next page) compares the estimated work participation rates assuming adoption of the Governor's proposals against

the estimated federal requirements. The figure shows that the Governor's proposal would result in participation surpluses beginning in FFY 2009. However, if Proposition 49 after school funds cannot be counted as MOE, then there would be a 2.7 percent shortfall in FFY 2009, with surpluses beginning in FFY 2010.

Figure 6

Governor's CalWORKs Reforms Estimated Participation Shortfall(-)/Surplus

	Federal Fiscal Year			
	2008	2009	2010	2011
Federal Participation Requirement	50.0%	50.0%	50.0%	50.0%
Caseload Reduction Credits				
"Natural" caseload decline ^a	-6.8%	-6.5%	-7.3%	-7.3%
Excess MOE reduction	-10.9	-7.4	—	—
Total Credit	-17.8%	-13.8%	-7.3%	-7.3%
Net Participation Requirement	32.2%	36.2%	42.8%	42.8%
Current-Law Work Participation	25.2%	31.2%	31.2%	31.2%
Policy Changes				
Graduated full-family sanction	0.4%	3.7%	5.7%	5.7%
Modified safety net	1.6	5.1	5.1	5.1
Work Incentive Nutritional Supplement	—	0.9	9.0	10.4
Participation Rate^b	27.2%	40.9%	51.0%	52.4%
Participation Shortfall(-)/Surplus	-5.0%^c	4.7%^c	8.2%	9.6%

^a Since FFY 2005.

^b Includes estimated affect of policy changes on participation rate.

^c Shortfalls increase or emerge, respectively if Proposition 49 after school funds cannot be counted as MOE.

Governor's Proposals Likely to Result in MOE Shortfall

One potential problem with the Governor's proposal is that there may not be sufficient countable MOE expenditures from outside of CalWORKs to meet the base MOE requirement of \$2.9 billion. This is because the Governor's proposals result in savings of about \$471 million, and the new federal regulations substantially reduce the amount of countable

MOE spending. This most likely creates an MOE shortfall beginning in FFY 2009. If Proposition 49 after school funds cannot be counted as MOE, the problem would begin in FFY 2008. To address this MOE shortfall, the Legislature could (1) reject some or all of the Governor's proposals which result in savings, (2) identify alternative sources of countable MOE spending from other departments, (3) shift TANF funds, or (4) some other combination of these solutions.

ALTERNATIVES TO THE GOVERNOR'S PROPOSALS

We have identified two alternatives to the Governor's proposals which would increase work participation but with less budgetary savings. The two alternatives are a pre-assistance program which prepares incoming recipients to enter the labor force within four months of their application and a community service requirement for adults who have received five years of assistance. We discuss these alternatives, estimate their impacts, and present an alternative package of California Work Opportunity and Responsibility to Kids reforms which includes the Governor's Work Incentive Nutritional Supplement proposal. This package might meet federal requirements in FFY 2009 and would very likely meet these requirements in FFY 2010 and thereafter.

Pre-Assistance Program for Entering CalWORKs Recipients

Federal Flexibility for up to Four Months. When states provide assistance to TANF recipients, all TANF rules concerning work participation, child support assignment, and federal time limits apply. Assistance typically means *ongoing* cash assistance. Federal regulations specifically allow states to provide up to four months of aid without it being counted as assistance because four months is considered short term rather than ongoing. One potential use of this flexibility is that when recipients receive "non-assistance" they are removed from the federal work participation calculation for up to the first four months of aid. States such as Washington, Pennsylvania, and Minnesota, have adopted pre-assistance programs using this federal flexibility.

Currently, there are about 12,000 new families with adults entering CalWORKs each month. In general, able-bodied adults attend orientation and then proceed to a job club/job search program where many recipients find employment. Those unable to find employment are usually assessed for their job skills and barriers to employment. They then sign a welfare-to-work plan with the county indicating what steps the client will take toward becoming self-sufficient. Plans might include substance

abuse treatment, English as a second language, vocational training, work experience, attending community college, or a combination of activities. Below we present a four-month pre-assistance program for these newly entering families.

Pre-Assistance Employment Readiness System (PAERS). Under this option, each approved family (meeting current eligibility requirements) entering aid would be placed in PAERS for up to 120 days. The goal of PAERS is to help recipients either become employed or to sign a welfare-to-work plan. The main change under this option is that in order for the family to continue receiving aid after PAERS by entering the CalWORKs program, they must become employed for sufficient hours to meet federal work participation requirements, or sign the welfare-to-work plan, unless they can establish that they are exempt or have good cause under current law for nonparticipation. Failure to meet at least one of these requirements would mean that the family does not enter CalWORKs. Families could immediately have aid restored upon agreeing to sign their plan. There would be no sanction or conciliation process during PAERS. Noncompliant families would be reminded of the requirement that they sign their plan or become employed with 120 days of entering PAERS.

Advantages of PAERS. One advantage of PAERS is the potential that it will improve the work participation rate by more directly focusing clients on quickly obtaining employment or establishing a self-sufficiency plan. Currently some families fail to attend orientation and eventually slip into sanction status where it may take months before a family becomes reengaged with program activities. The 120-day PAERS time limit helps ensure that engagement occurs promptly.

A second advantage of PAERS is that it delays entry into the federal work participation calculation for those unable to find employment. This is because pursuant to the federal flexibility discussed above, PAERS families are not counted in the work participation rate because they are for federal purposes in non-assistance status for 120 days (although they continue to receive cash grants). As soon as families obtain employment they would transfer to the CalWORKs program where their presence would help satisfy the work participation rate. Preliminarily, we estimate that adopting a PAERS would increase the work participation rate by 1.9 percent (when fully implemented) and result in annual net savings of about \$10 million per year.

Interaction With Other Policy Changes. As noted in the discussion of the Governor's proposals, the WINS program results in a caseload increase which, in isolation, would reduce CRC by 7.3 percentage points. The PAERS described above would reduce the TANF caseload because PAERS cases are not receiving assistance pursuant to federal rules and

thus are outside of the TANF program. This caseload reduction attributable to PEARS could be used to offset the caseload increase associated with WINS, thereby eliminating the loss of 7.3 CRC percentage points that would occur if WINS were implemented in isolation.

Community Service Requirement After Five Years of Assistance

Background. The current safety net provides cash grants to the children of approximately 48,000 families where the adult has been on aid for five years. The safety net caseload includes many situations. About 29 percent of the safety net adults are working at least 17 hours per week. Another 16 percent have some level of participation either in employment or other activities. About 55 percent are not participating at all. These non-participants (about 26,000 families) can be further subdivided into three groups: (1) adults unable to work because of substantial barriers to employment, (2) adults who are working but not reporting their income, and (3) adults who are choosing not to work or participate. However, it is difficult to know which cases are in each category. We believe a community service job requirement after five years of assistance could help sort out who is choosing not to participate from who is truly unable to participate.

Required Community Service Job. Under this option, after five years of assistance, each safety net adult would be required to work in non-subsidized employment for 20 hours per week, participate for sufficient hours to meet federal participation requirements, or accept a subsidized employment or community service job for 20 hours per week arranged by his/her county.

Counties would have discretion in how to set up the community service position and/or whether to offer a subsidized employment opportunity. Adults who refuse to accept the county community service or subsidized job assignment, would have their families removed from aid. Before any such removal, there would be a required county home visit. At the home visit, county staff would attempt to determine if the client has barriers to employment that could be remedied through assistance, whether the client qualifies for an exemption from program participation requirements, or is determined to be incapable of participating pursuant to current law.

Periodic Test of the Labor Market. After every three months of community service or subsidized employment, each client would be placed in a job club/job search program for one month. Some would find non-subsidized employment and thus meet their participation requirement. Those unable to find employment would be required to return to community service for at least 20 hours per week. After three community service/job club cycles have been completed, at the one-year mark, counties would

have the option of exempting the client from the community service job requirement while continuing aid to the children.

Clients found to be out compliance with the 20-hour requirement for community service would have the same process that exists in current law with respect to the sanction for nonparticipation. This approach would strengthen the message that in order to receive government paid income assistance, clients must meet an obligation to work or participate in community service if they are able.

Impacts. The exact impacts of this proposal are difficult to estimate. We believe that most clients who are unable to participate would be identified by the county home visit. Most families who are employed but not reporting their income would either leave the program or begin reporting their income and thus retain eligibility by working sufficient hours. As with the Governor's proposal, we estimate that the 5,600 current safety net cases working at least 17 hours per week would choose to increase their participation level so as to meet federal requirements (20 or 30 hours per week depending on the age of the child), thereby retaining their family's grant (less the adult portion). Those who refuse to participate would also exit the program. Preliminarily, we estimate that adoption of this program would increase the work participation rate by 2.9 percent and result in net annual savings of about \$30 million.

LAO CalWORKs Reform Package

In order to meet the work participation requirement, we suggest the following package.

- Adopt the Governor's Work Incentive Nutritional Supplement which increases work participation by an eventual 10 percent.
- Adopt the Pre-Assistance Employment Readiness System which increases work participation by 1.9 percent.
- Adopt the requirement that safety net adults either work sufficient hours to meet federal participation or accept a community service job, which raises work participation by 2.9 percent.

This package results in net General Fund savings of about \$16 million per year compared to the Governor's workload budget. (Savings of about \$40 million from the community service job requirement and PAERS are partially offset by WINS costs of \$24 million.)

Figure 7 shows the estimated work participation rates compared to the requirements. In FFY 2009, we estimate that adopting this combination would probably meet work participation requirements if the Proposition 49 after school funding is countable toward the MOE. In FFY 2010 and

FFY 2011, when the program changes are completely phased in, we estimate that California would likely exceed the estimated requirements.

Figure 7
LAO CalWORKs Package
Estimated Participation Shortfall(-)/Surplus

	Federal Fiscal Year (FFY)		
	2009	2010 ^a	2011
Federal Participation Requirement	50.0%	50.0%	50.0%
Caseload Reduction Credits			
“Natural” caseload decline since FFY 2005	-6.5%	-7.3%	-7.3%
Excess MOE reduction	-8.4%	—	—
Total Credit	-14.9%	-7.3%	-7.3%
Net Participation Requirement	35.1%	42.8%	42.8%
Current-Law Work Participation	31.2%	31.2%	31.2%
Policy Changes			
Work Incentive Nutritional Supplement	0.9	9.0	10.4
Pre-Assistance Employment Readiness system	1.6	1.9	1.9
Community service requirement for safety net	1.5	2.9	2.9
Participation Rate^b	35.2%	45.0%	46.4%
Participation Shortfall(-)/Surplus	—^c	2.2%	3.6%

^a Assumes zero CRC from excess MOE beginning in FFY 2010 pursuant to February 2008 federal regulations.

^b Includes estimated affect of policy changes on participation rate.

^c Drops to -7 percent if Proposition 49 after school funds cannot be counted as MOE.

The LAO alternative budget (presented in “Part V” of *The 2008-09 Budget: Perspectives and Issues*) does not include this CalWORKs reform package. The alternative budget reflects the current law “workload” funding level without policy changes. In order to address federal work participation requirements, the Legislature will need to set its own budget policy and priorities for CalWORKs.

CHILD WELFARE SERVICES

California's state-supervised, county-administered Child Welfare Services (CWS) program provides services to abused and neglected children, children in foster care, and their families. The CWS program provides (1) immediate social worker response to allegations of child abuse and neglect; (2) ongoing services to children and their families who have been identified as victims, or potential victims, of abuse and neglect; and (3) services to children in foster care who have been temporarily or permanently removed from their family because of abuse or neglect.

In 2008-09, the Governor's budget provides a separate CWS General Fund appropriation (Item 5180-153-0001) for the two counties (Los Angeles and Alameda) participating in the Title IV-E Child Welfare Waiver Demonstration Capped Allocation Project. The remaining 56 counties are budgeted in Item 5180-151-0001. Including the waiver counties, the Governor's budget proposes \$2.5 billion from all funds and \$695 million from the General Fund for the child welfare system. This represents a decrease of 3.5 percent in total funds and a decrease of 7.4 percent in General Fund from the most recent estimates of current-year expenditures. This decrease in funding primarily results from the Governor's budget-balancing reduction proposal to reduce CWS allocations (excluding automation, Adoptions, and Child Abuse Prevention) to counties by 11.4 percent.

BUDGET PROPOSES REDUCTION IN CWS ALLOCATIONS TO COUNTIES

The Governor's budget proposes to reduce the total General Fund allocation to counties for Child Welfare Services (CWS) by \$83.7 million. Counties will have the discretion to apportion their reduced allocation among various program components. We describe the potential impact of this proposed reduction on social worker caseloads and possible subsequent policy consequences resulting from fewer resources. We also provide three alternatives to the Governor's proposal that more narrowly target reductions in CWS expenditures.

Background

There has been an ongoing effort in CWS to determine how many child welfare cases a social worker can carry and still effectively do his or her job. In 1984, the Department of Social Services (DSS) and the County Welfare Directors Association (CWDA) established an agreed-upon level of cases for each program component of CWS. These 1984 workload standards are still used by DSS to calculate the base level of funding for each county. In 2000, however, the Child Welfare Services Workload Study, which was required by Chapter 785, Statutes of 1998 (SB 2030, Costa), determined that the 1984 caseload standards were too high and that social workers had too many cases to effectively ensure the safety and well-being of the children for which they were responsible. The SB 2030 Study, as it is commonly called, proposed revised minimum and optimum caseload standards for social workers. Figure 1 compares the 1984 standards to the minimal and optimal standards developed in the SB 2030 Study.

Figure 1
Child Welfare Services Workload Standards
Cases Per Social Worker

	Emergency Response Assessment	Emergency Response	Family Maintenance	Family Reunification	Permanent Placement
1984 Workload Standards	322.5	15.8	35.0	27.0	54.0
SB 2030 Standards:					
Minimal	116.1	13.0	14.2	15.6	23.7
Optimal	68.7	9.9	10.2	11.9	16.4

Concerned about large social worker caseloads, over the years the Legislature has added additional funds known as the “augmentation” and the Outcome Improvement Project (OIP). The Governor’s workload budget proposes \$152.7 million (\$96.4 million General Fund) for these funding streams in 2008-09. These monies, in combination with the hold harmless budgeting methodology (which we discuss below), have enabled counties to hire more caseworkers and move toward standards established by the SB 2030 Study.

Governor’s Proposal

The Governor’s budget proposes to reduce CWS expenditures by \$83.7 million General Fund. This represents a reduction of 11.4 percent to

the total General Fund allocation for CWS, excluding funds for the Child Welfare Services Case Management System (CWS/CMS), the Adoptions Program, and the Child Abuse Prevention Program. Counties will have the flexibility to choose how to apportion the reduction to various CWS program expenditures. According to DSS, the department will work with CWDA to develop an allocation process for apportioning this proposed reduction. At the time this analysis was prepared, DSS could not provide further details on the implementation of the CWS reduction to county allocations and the potential program impacts.

Staffing Level Impacts of Proposed Reduction to CWS

The impact of the proposed reduction is difficult to measure because counties have multiple ways of responding to reduced funding. County options include reducing payments to service providers for preventive services, reducing transitional services for emancipated foster youth, reducing overhead expenses, and/or hiring fewer social workers. Nevertheless, because social workers and their support costs represent the majority of the CWS budget, counties are likely to substantially reduce the number of social workers.

Increase in Social Worker Caseloads. One potential program impact of the proposed reduction is an increase in county social worker caseloads because of a decrease in the number of funded full-time equivalent (FTE) social workers. The proposed reduction represents approximately 87 percent of the CWS augmentation and OIP monies. As a result, there may be a reversal of some of the progress made by counties in meeting or exceeding SB 2030 minimum standards.

In order to estimate existing staffing levels and the potential impact of the proposed reduction, we used the most recent caseload and budget data available from DSS and made a series of assumptions and adjustments related to non-case carrying social workers, the amount of OIP augmentation funds directed to hiring more social workers, and inflationary adjustments known as the cost-of-doing-business.

As Figure 2 shows, we estimate that in 2007-08, 20 counties, which have 9 percent of the total CWS caseload, are funded for enough FTE social workers to either exceed the SB 2030 minimum standards, or be within 10 percent of the standards. Additionally, 14 counties, which have approximately 43 percent of CWS cases, are between 80 and 89 percent of meeting the minimum standards.

As a result of the proposed reduction, we estimate an increase in the number of counties that are further away from meeting the minimum standards in the budget year. For example, we estimate that the

number of counties that would be between 80 and 89 percent of meeting the minimum standards would decrease from 14 counties in 2007-08 to 6 counties in 2008-09. In addition, the number of counties below 80 percent of the standard would increase from 24 (representing 48 percent of the CWS caseload) to 38 (representing 90 percent of the CWS caseload) in the budget year.

Figure 2
Child Welfare Services (CWS)
Number of Counties and Percent of Caseload
Meeting SB 2030 Minimum Standards

	2007-08		Proposed 2008-09 ^a	
	Number of Counties	Percentage of Cases	Number of Counties	Percentage of Cases
Exceeds standards	10	1.9%	9	2.2% ^b
From 90%-99% of standards	10	7.1	5	3.3
From 80%-89% of standards	14	42.7	6	4.8
From 70%-79% of standards	15	34.0	18	49.6
Less than 70% of standards	9	14.3	20	40.2

^a Based on Governor's proposals. LAO analysis assuming increases in county social worker caseloads.
^b This counter-intuitive result is because Butte County's funding is increasing for technical reasons, despite the proposed reduction.

From a statewide perspective, we estimate that the proposed reduction would result in an overall decrease of 522 FTE social workers. As a result, while the total number of funded FTE social workers in the state is at approximately 79 percent of meeting the minimum standards for 2007-08, for 2008-09 that figure would decline to 73 percent.

Potential Consequences of Fewer Resources

While counties will take different approaches to responding to reduced funding, there are several potential policy consequences from their actions:

- Counties that choose to reduce the number of social workers may decide to open fewer CWS cases or close cases earlier than they would otherwise because of limited resources. This could lead to leaving children in more marginally risky situations.

- Counties that choose to reduce spending on preventive services could see an increase in foster care cases. Rather than provide intensive and time-consuming family case-management services to cases in which the child remains in the home, counties with fewer social workers and limited resources may choose to change their policy to removing children from the home more frequently and placing them in foster care.
- Counties that choose to reduce spending in transitional services for emancipated foster youth could see an increase in unstable housing situations for this population.

Alternatives to the Governor's Proposal

Below we present three alternatives to the Governor's proposal which offer less budgetary savings, but are less likely to negatively impact services for children.

Suspend Hold Harmless. In preparing the budget for CWS, DSS adjusts proposed funding upwards when the caseload increases, but does *not* adjust funding downward when the caseload actually decreases. The practice of not adjusting the budget to reflect caseload decline is known as the "hold harmless" approach, though DSS technically refers to this as the "base funding adjustment." Because of the way the hold harmless provision works, the number of social workers funded for the counties remains unchanged despite workload decreases. In other words, if an individual county's caseload is declining, its number of caseworkers is held at the prior-year level. At the same time, if another county's caseload is increasing, the state provides that county with funds to hire additional caseworkers. Therefore, on a statewide basis, despite an overall caseload decline, the funding for CWS continues to grow.

One alternative to the Governor's proposal is to suspend the hold harmless budgeting methodology for 2008-09. For 2008-09, DSS reviewed estimated caseloads per CWS component and included \$17.6 million (\$6 million General Fund) in the budget for 29 counties with declining caseloads, pursuant to the hold harmless funding provision.

Under this option, the CWS case-management funding per child would remain at its 2007-08 level for these 29 counties. This would result in a General Fund savings of \$6 million, while not reducing the level of care and service provided to the children and families in the child welfare system in the budget year. While the Governor's proposed reduction would impact every county, suspending hold harmless would target CWS expenditure reductions to those counties with declining caseloads and would not reduce existing social worker caseload ratios.

Cap Social Worker Costs. Another option is to cap the total cost per social worker at \$155,000, which would result in a General Fund savings of approximately \$5.1 million. The average statewide “fully loaded” cost of a social worker, which is currently frozen at the level of funding provided in 2001-02, is \$129,074. The fully loaded cost represents the social worker’s salary and benefits, in addition to the allocated cost of supervisors, data processing, departmental overhead, and other general expenses related to providing services.

The fully loaded social worker cost per county ranges from \$72,788 to \$176,930. This range in cost per county partially reflects cost-of-living differences, but there are also significant differences in costs between bordering counties. For example, while Sacramento County’s fully loaded social worker cost is \$162,866, Yolo County’s cost is \$101,468. Therefore, in some cases, the fully loaded funding for social workers in counties with similar cost-of-living rates are substantially different.

By capping the total cost per social worker at \$155,000, which is the 2001-02 average statewide fully-loaded cost of a social worker adjusted for the California Consumer Price Index since that time, seven counties would experience a reduction in funding because their fully loaded social worker cost exceeds the proposed cap. Capping social worker costs is another alternative that targets a reduction in CWS expenditures to specific counties that have larger funding allocations per case, rather than an across-the-board reduction for all counties.

A Combined Approach. The Legislature could also choose a combination of a smaller across-the-board reduction to CWS county allocations, in conjunction with the hold harmless and social worker cost cap alternatives discussed above. For example, a 3 percent reduction to CWS county allocations, in combination with suspending the hold harmless provision and capping the fully loaded social worker cost at \$155,000, results in an estimated General Fund savings of \$33.1 million.

Conclusion

The Governor’s proposal to reduce CWS allocations to counties by 11.4 percent results in General Fund savings of \$83.7 million. In deciding whether to adopt this proposal, the Legislature should weigh the budgetary savings against the potential for increased social worker caseloads as a result of fewer FTE social workers, as well as possible subsequent policy consequences resulting from fewer resources in CWS. Although the specific alternatives to reduce CWS expenditures that are outlined above save considerably less than the Governor’s proposal, these options set priorities and target the reductions which would lessen their statewide impact.

RETHINKING THE FUTURE OF CWS AUTOMATION

The Governor's budget proposes to spend \$247 million (\$112 million General Fund) over the next seven years to continue with the development of a new Child Welfare computer system (referred to as the New System). Our review indicates that the current Child Welfare Services Case Management System (CWS/CMS) can be updated to meet federal and county functionality requirements. Accordingly, we recommend cancelling the New System project and updating the CWS/CMS, resulting in savings (all funds) of \$184 million over the next seven years.

Current System

The CWS/CMS is a statewide computer system deployed in all 58 counties to support the administration of CWS. From 1992 until 1995, state and county staff participated with the vendor to develop system requirements and design. Statewide system implementation began in 1995, and by 1997 the CWS/CMS was in use in all 58 counties.

Federal Statewide Automated Child Welfare Information System (SACWIS)

Federal Funding. In 1993, the federal government offered "incentive funding" to states that would develop a SACWIS that met federal requirements. These systems would receive 75 percent federal funding for the first three years of system development and 50 percent thereafter. California received the 75 percent funding through 1997 when it implemented CWS/CMS and has received 50 percent federal funding since that time.

SACWIS Compliance. In 1999, a federal review raised concerns about the extent to which CWS/CMS complied with the requirements of SACWIS. In 2003, the federal government notified the state that CWS/CMS did not meet all SACWIS functional requirements. The missing functions included Adoptions case management, Foster Care eligibility, financial management, and automated interfaces to the Child Support and human services systems. In 2004, the state submitted a plan (referred to as the Go Forward Plan) to the Department of Finance (DOF) and the federal government for achieving SACWIS compliance and for meeting additional county business requirements. The counties had two business requirements beyond the SACWIS requirements: (1) a simplified data entry process and (2) the ability to access CWS/CMS from locations other than their office (remote access). The plan proposed to conduct a study to determine the technical viability of the current system to provide the additional functionality and a technical analysis of alternatives. The federal government approved the plan.

Technical Architecture Analysis Alternatives (TAAA)

In 2005, the state Office of Systems Integration (OSI) hired Eclipse Solutions and Gartner Group to conduct a technical analysis that would provide alternatives for meeting the following requirements:

- Achieve SACWIS compliance.
- Meet county requirements for simplified data entry and remote access.

In addition to these requirements, OSI instructed the consultants to propose solutions for making the system accessible from the web by abandoning the existing mainframe platform and moving it onto servers.

TAAA Report Did Not Consider All Possible Alternatives

State Instructions Constrained Analysis. The consultants conducted their analysis as they were instructed by OSI. The instruction that the system should be moved off the large, mainframe computer and onto servers represented a major constraint on the consultants' analysis. It prevented them from considering all possible technical solutions for achieving SACWIS and county requirements.

Only Two Alternatives Were Examined. Because of the constraint placed on the consultants, only two alternatives were examined.

- The first alternative would move the current system, a piece at a time, off the mainframe and onto web servers. In the process of moving the system, software changes would be incorporated to meet the county requirements and the missing SACWIS components would also be added. This alternative would take eight years to accomplish.
- The second alternative was to develop a new system. This alternative would build in all the federal and county requirements. The new system would take three years to develop.

Third Alternative Was Not Considered. A third alternative was not considered by TAAA consultants because the state had specified that it wanted to eliminate use of the mainframe. This alternative would update the current system and leave it on the mainframe. In fact, a 2003 study also conducted by Gartner Group recommended this as a solution for making CWS/CMS accessible from the web in order to provide counties with a simplified data entry process and remote access.

Decision to Procure New System

Of the two alternatives provided in the 2005 TAAA Report, the state chose to develop a new system. A feasibility report was approved by DOF in April 2006. Since that time, DSS, OSI, and the counties have been working to document the detailed business requirements for a vendor bid to build a new Child Welfare system. The proposed technological solution is currently referred to as the "New System."

Proposed New System Adds Risk and Cost. When replacement systems are built, the data from the old system must be moved to the new system. This is referred to as "data conversion." In order to convert data, programmers must write software programs to locate and move the data from the old database to the new database. Data conversion efforts can be complex, time-consuming, expensive, and high risk. The high risk is attributable to the possibility that data can be accidentally altered or even lost during the conversion process. Both the alternatives considered by the TAAA require this costly and risky data conversion process. In order to avoid these cost and risk factors, many companies are choosing to retain their legacy database and modernize their systems by adding a software layer that allows the system to be accessed from the web. This software layer is referred to as an "enterprise service bus." Adding an enterprise service bus enables application changes that can provide remote access and simplify data entry.

LAO Alternative

Update Current System. The CWS/CMS is built on software products currently under vendor support. That is, the vendors continue to maintain, upgrade, and market the software. Therefore, there is no reason to abandon CWS/CMS if it can play a role in meeting the additional SACWIS and county requirements. County requirements not met by the current system can be accommodated by making the system more modular and accessible from the web. This can be accomplished by adding an enterprise service bus as described above. This approach is increasingly being used by organizations to leverage their existing databases in order to minimize both the risk of data conversion and the cost of building a new system. Thus, the LAO alternative is to (1) update the current system and (2) add the missing SACWIS components. This will meet the federal and county business requirements.

Budget and Contract Availability. The CWS/CMS has been in use for more than ten years. There is \$10 million in the baseline budget to keep the system current for changes in regulations and legislation. During the first five years that CWS/CMS was in operation, this baseline amount was being spent, most of it to adjust the system for changing business processes

as social workers transitioned from a manual operation to an automated one. Over the past five years, approximately one-third has been spent of the \$50 million budgeted. This reduced spending pattern is typical for new systems as they stabilize and attain user acceptance. The current vendor contract is effective through 2013 and allows up to \$10 million annually for system changes. We estimate that \$8 million could be made available each year from the existing baseline budget to update the system to make it accessible from the web and to add the missing SACWIS components. The remaining \$2 million would be available to incorporate any regulatory and legislative changes.

Comparing New System to LAO Alternative

Figure 3 shows the total project cost for the New System and the LAO alternative. As the figure shows, the new system is estimated to cost \$247 million (all funds), \$184 more than the LAO alternative.

Figure 3						
Cost Comparison for CWS Automation Projects						
<i>(Total Funds in Millions)</i>						
	2008-09	2009-10	2010-11	2011-12	2012-13 Through 2014-15	Totals ^a
New system	\$6.8	\$8.2	\$11.2	\$39.5	\$181.5	\$247.2
LAO alternative	14.8	16.2	16.2	16.2	—	63.4

^a Does not include \$7.4 million expended from 2006-07 through 2007-08.

Cost of New System Was Understated. Over the past two years the state has spent \$7 million for New System project planning. In November 2007, the administration estimated that it would take seven more years to procure a vendor and complete the system at a cost of \$247 million. During the final three years of New System development, after the contract has been awarded, there will be a reduction in federal funding for the current system.

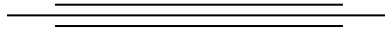
LAO Alternative Reduces Schedule, Cost, and Risk. As shown in Figure 3 above, the total cost of the LAO alternative is \$63 million. The current contract provides adequate resources to perform the work necessary to update the current system to meet SACWIS and county requirements. Although there are separate costs for state and county staff to design and test the system, such costs are significantly less than they would be for

the New System. This alternative also eliminates the risk and cost of data conversion, which is necessary under the other alternatives. In addition, federal funding levels for the current system will be retained if it is updated to meet SACWIS and county requirements.

Funding the LAO Alternative. The LAO alternative could be funded by applying \$8 million of the existing CWS/CMS baseline budget to cover the system programming. In addition, the increased state and county staff needed to help design and test the system changes could be covered by redirecting funding from the New System for 2008-09 (\$6.8 million) and 2009-10 (\$8.2 million). Thus, through these redirections, there would be no net new cost under the LAO alternative for these years.

Analyst's Recommendation

We recommend canceling the Child Welfare New System Project and updating the current system. This will result in reduced time, cost, and risk. This proposal is budget neutral in 2008-09 and 2009-10. Over the life of the project, total savings would be \$184 million (all funds).



FOSTER CARE

Foster Care is an entitlement program funded by federal, state, and local governments. Children are eligible for foster care grants if they are living with a foster care provider under a court order or a voluntary agreement between the child's parent and a county welfare department. The California Department of Social Services (DSS) provides oversight for the county-administered Foster Care system. County welfare departments make decisions regarding the health and safety of children and have the discretion to place children in one of the following: (1) a foster family home, (2) a foster family agency home, or (3) a group home. Seriously emotionally disturbed (SED) children are identified by the California Department of Education (CDE) and are typically placed in group homes to facilitate a greater degree of supervision and treatment.

The 2008-09 Governor's Budget provides a separate Foster Care General Fund appropriation (Item 5180-153-0001) for the two counties (Los Angeles and Alameda) participating in the Title IV-E Child Welfare Waiver Demonstration Capped Allocation Project. The remaining 56 counties are budgeted in Item 5180-101-0001. Including the waiver counties, the Governor's budget proposes expenditures of \$1.6 billion (\$425 million General Fund) for the Foster Care program in 2008-09. This represents an 8.6 percent decrease in General Fund expenditures from current-year estimated expenditures. Most of this decrease is attributable to the Governor's budget-balancing reduction proposal to reduce Foster Care, Adoption Assistance, and Kinship Guardianship Assistance Payment (Kin-GAP) payment rates by 10 percent.

BUDGET PROPOSES TO REDUCE FOSTER CARE RATES

The Governor's budget proposes to reduce most Foster Care, Adoption Assistance, and Kinship Guardianship Assistance Payment rates by 10 percent, effective June 1, 2008. This proposed reduction will save an estimated \$15.9 million in total funds (\$6.8 million General Fund) in the current year and \$190.3 million in total funds (\$81.5 million Gen-

eral Fund) in 2008-09. We provide background information on existing rates and describe potential impacts of the proposed reductions on the supply of care providers. In addition, we present two alternatives to the Governor's proposal.

Background

Foster Care Placement Types. If there is reason to believe that an allegation of child abuse or neglect is true, county welfare departments can place a child in one of the following: (1) a foster family home (FFH), (2) a foster family agency (FFA) home, or (3) a group home (GH). The FFAs are nonprofit agencies licensed to recruit, certify, train, and support foster parents for hard-to-place children who would otherwise require GH care. The FFA rates are based on the FFH rate, plus a set increment for the special needs of the child and an increment for the support services offered by the FFA.

Children who are identified by the CDE as SED are usually placed in GHs with psychiatric peer group settings. However, some SED children are placed in FFHs and FFA homes.

Permanent Placement Types. The Kin-GAP program provides monthly cash grants for children who are permanently placed with a relative who assumes guardianship. The Adoption Assistance program (AAP) provides monthly cash grants to parents who adopt foster children. Both Kin-GAP and AAP grants are tied to the foster care payment the child would have received if the child remained in a foster care placement.

Existing Rates. Foster care basic grant rates for FFH, FFA, and GH (including SED children) were designed to fund the basic costs of raising a child. For some foster care payment recipients, as a supplement to the basic grant, a specialized care increment (SCI) may be paid for the additional care and supervision needs of a child with health and/or behavioral issues. This could include, for example, a wheelchair ramp for a disabled child. A clothing allowance may also be paid in addition to the basic grant.

For 2007-08, the Legislature approved a 5 percent increase to the basic and SCI rates for FFHs and Kin-GAP recipients, effective January 1, 2008. The 5 percent increase also applies to GHs, excluding the rates for SED children, and new AAP cases entering the program after January 1, 2008. The Legislature did not approve a rate increase for FFA recipients as the average FFA grant is currently significantly higher than the average FFH grant. In addition, there is some evidence that rather than becoming the lower-cost alternatives to GHs, FFA homes have instead become higher-cost alternatives to FFHs. The last foster care rate increase was provided in 2001-02.

Governor’s Proposal. The Governor’s budget proposes to reduce the basic care, SCI, clothing allowance, and SED rates for children in FFHs and GHs by 10 percent. The proposal also reflects a corresponding 10 percent decrease for Kin-GAP and AAP recipients. In addition, the budget proposes to reduce FFA rates by 5 percent rather than 10 percent, as FFA recipients did not receive the recent 5 percent rate increase. The budget assumes enactment of legislation during the special session so that the rate reductions would go into effect June 1, 2008. This would save an estimated \$6.8 million General Fund in the current year and \$81.5 million General Fund in 2008-09. Figure 1 compares the average monthly foster care, Kin-GAP, and AAP payments prior to the 5 percent increase, after the rate increase, and with the Governor’s proposed reduction.

Figure 1
Foster Care and Related Programs
Average Monthly Payments by Placement

	Prior Law (2007)	Current Law ^a (January 2008)	Governor’s Proposal (June 2008)	
			Amount	Percent Reduction
Foster Family Home	\$693	\$728	\$655	-9.9%
Foster Family Agency	1,850	1,850	1,758	-5.0
Group Home	5,058	5,311	4,780	-10.0
Seriously Emotionally Disturbed	5,614	5,614	5,053	-10.0
Adoption Assistance	785	824	706	-14.4
Kin-GAP	552	580	522	-10.0

^a Reflects 5 percent rate increase except for rates for foster family agency and seriously emotionally disturbed children which received no adjustment.

Potential Impacts of Rate Reductions

While the impact of the proposed reduction on existing and potential care providers is difficult to measure, one possible program impact is a decrease in the supply of care providers for both foster care and permanent placements. This change in the supply of care providers could ultimately lead to increased foster care expenditures depending on which types of placements experience the most significant supply effects. On the one hand, reduced foster care rates could result in a decrease in the number of FFH providers, which could then lead to increased placements in the

more expensive FFA homes and GHs. On the other hand, a decrease in the number of GH providers could lead to increased placements in the less expensive FFHs and FFA homes.

In addition, reduced grants for Kin-GAP and AAP recipients could decrease the number of permanent placement providers, which could also lead to longer stays in foster care. This could raise Child Welfare Services costs as these cases remain open with social worker intervention. This could also increase Medi-Cal costs and utilization because recipients are eligible for these health services by virtue of their foster care status.

Alternatives to the Governor's Proposal

Below we present alternatives to the Governor's proposal which offer less budgetary savings, but reduce the financial impact on foster care, Kin-GAP, and AAP recipients.

Rescind Recent 5 Percent Rate Increase. One alternative to the Governor's proposal is to rescind the recent 5 percent rate increase for FFH, GH, Kin-GAP, and new AAP recipients in the budget year. This option would generate an estimated savings of \$17 million General Fund in 2008-09. By only rescinding the 5 percent rate increase, and not reducing rates by an additional 5 percent, foster care and permanent care providers would be no worse off financially than they were one year ago.

As part of this alternative, the Legislature should consider reducing the FFA rate by 5 percent in 2008-09, to keep the differential between the FFA rate and other foster care rates established by the Legislature. The Legislature did not provide the recent rate increase to FFAs in part because of a concern that FFA homes have become a higher-cost alternative to FFHs rather than a lower-cost alternative to GHs, which was the original intent of FFAs. The caseload trend for FFAs, which has been consistently increasing while other placement types have been decreasing or holding steady, supports this finding. Reducing FFA rates by 5 percent would generate an additional estimated savings of \$6.6 million General Fund in 2008-09.

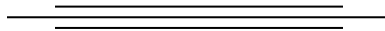
Cap the SCI Rate in Certain Counties. Another alternative is reforming the current SCI rate structure. As Figure 2 shows, the SCIs range from zero in three small counties to over \$2,000 per month in other counties. The SCIs reflect historical rate structures which vary by county. One reform option for the SCI rate structure is to cap the maximum rate at \$1,000 beginning in 2008-09. This option could save an estimated \$1 million General Fund in the budget year. This cap would impact seven counties representing approximately 20 percent of the caseload. We note that currently 51 counties are able to serve children within this proposed cap.

Figure 2**Foster Care
Distribution of Maximum Specialized Care Increments**

Maximum Increment	Number of Counties	Percentage of Cases
\$1,001 to \$2,097	7	19.5%
\$500 to \$1,000	28	74.3
\$1 to \$499	20	6.1
None	3	0.1

Conclusion

The Governor's proposal to reduce most foster care, Kin-GAP, and AAP rates by 10 percent results in General Fund savings of \$6.8 million in the current year and \$81.5 million in 2008-09. In deciding whether to adopt this proposal, the Legislature should weigh the budgetary savings against the potential for a decrease in foster and permanent care providers, which could lead to increased foster care expenditures as children may move into more expensive placements or remain in care for longer periods. Although the LAO alternatives to reduce foster care expenditures save considerably less than the Governor's proposal, these options would lessen the financial impact on foster care, Kin-GAP, and AAP recipients, and reduce the chance for placement shifts.



SUPPLEMENTAL SECURITY INCOME/ STATE SUPPLEMENTARY PROGRAM

The Supplemental Security Income/State Supplementary Program (SSI/SSP) provides cash assistance to eligible aged, blind, and disabled persons. The budget proposes an appropriation of nearly \$3.8 billion from the General Fund for the state's share of SSI/SSP in 2008-09. This is an increase of \$107 million, or 2.9 percent, over estimated current-year expenditures. This increase in funding is primarily due to increases in the SSI/SSP caseload.

In 2008-09, it is estimated that there will be an average of about 366,500 aged, 21,600 blind, and 859,500 disabled recipients. In addition to these federally eligible recipients, the state-only Cash Assistance Program for Immigrants is estimated to provide benefits to an average of 11,419 legal immigrants in 2008-09, for whom federal financial participation is not available.

BUDGET DELETES STATE COST-OF-LIVING ADJUSTMENTS

The Governor's budget proposes to delete the June 2008 and 2009 state statutory cost-of-living adjustments (COLAs), while passing through the federal COLAs. The budget estimates that this proposal will save \$23.3 million in the current year, and \$300.3 million in 2008-09. Due to revisions of the California Necessities Index and the Consumer Price Index, we estimate that the Governor's budget understates the savings from deleting the state COLA by \$5.3 million in 2008-09.

Background

The SSI/SSP payment is funded with federal and state funds, with the SSI component supported with federal funds and the SSP portion funded with state funds. Under current law, both the federal and state components of the SSI/SSP grant are adjusted annually for inflation. In the past, the

federal and state cost-of-living adjustments (COLAs) were both applied to the SSI/SSP grant each January (with the exception of several years when the state COLA was deleted and the federal COLA was not passed through). Chapter 171, Statutes of 2007 (SB 77, Ducheny) permanently rescheduled from January to June the annual SSP state COLA.

The state COLA is based on the California Necessities Index (CNI) and is applied to the combined SSI/SSP grant. It is funded by both the federal and state governments. The federal COLA, which is applied each January, (based on the Consumer Price Index for Urban Wage Earners and Clerical Workers, or the CPI-W) is applied annually to the SSI (federal) portion of the grant. The remaining amount needed to cover the state COLA is funded with state monies. Based on its assumptions concerning both the CNI and CPI-W, the budget estimates the General Fund cost of providing these COLAs to be \$23.3 million in 2007-08 and \$300.3 million (\$271 million from the June 2008 COLA, and \$29.3 million from the June 2009 COLA) in 2008-09.

Deleting the June 2008 COLA

The Governor's budget proposes to delete the June 2008 COLA, and includes the pass-through of the federal COLA. Because the state COLA has been permanently rescheduled from January to June, deleting the June 2008 COLA results in a one month General Fund savings of \$23.3 million in 2007-08, and annualized savings of \$271 million in 2008-09. Given the lead-time required to notify the Social Security Administration about grant changes, the June 2008 COLA deletion issue must be addressed prior to March 1.

Deleting the June 2009 COLA

The Governor proposes to delete the June 2009 state COLA, while passing through the January 2009 federal COLA. The Governor's budget estimates that deleting the June 2009 COLA will result in a one month General Fund savings of \$29.3 million in 2008-09. However, our review of the actual CNI and our estimate of the CPI-W indicates that this proposal understates the General Fund savings in the budget year.

The CNI Revised. The June 2009 COLA is based on the change in the CNI from December 2006 to December 2007. The Governor's budget, which is prepared prior to the release of the December 2007 CNI figures, estimates that the CNI will be 4.25 percent, based on partial data. Our review of the actual data indicates that the June 2009 CNI will be 5.27 percent.

The January 2009 CPI Underestimated. The January 2009 federal SSI COLA will be based on the change in the CPI-W from the third quarter

(July to September) of calendar 2007 to the third quarter of calendar 2008. The Governor's budget estimates that the change in the CPI-W for this period will be 1.7 percent. Our estimate of the CPI-W, based on additional data, is 2.41 percent. Figure 1 compares our estimates of the CNI and the CPI-W to the Governor's budget estimates.

Figure 1		
June 2009 COLA Assumptions		
	Governor's Budget	LAO Estimate
CPI-W	1.70%	2.41%
CNI	4.25	5.26
CPI-W = U.S. Consumer Price Index for Urban Wage Earners and Clerical Workers.		
CNI = California Necessities Index.		

Combined COLA Deletion Savings

Taken together, the changes in the CNI and the CPI-W (in relation to the Governor's budget) increase the 2008-09 savings associated with deleting the June 2009 state COLA by \$5.3 million, to a total savings of \$34.6 million. As shown in Figure 2, in total, we estimate that the Governor's proposals to delete the state COLAs in 2008 and 2009 result in General Fund savings of \$23.3 million in the current year, and \$305.6 million in the budget year.

Figure 2		
LAO Estimate of General Fund Savings From Governor's SSI/SSP COLA Suspension Proposal		
<i>(In Millions)</i>		
Proposal	2007-08	2008-09
Suspend June 2008 State COLA	\$23.3	\$271.0
Suspend June 2009 State COLA	—	34.6
Total Savings	\$23.3	\$305.6

SSI/SSP Grant Levels

Figure 3 (see next page) shows SSI/SSP average grant levels for individuals and couples under both current law and the Governor's budget proposal. The 2009 grant levels have been adjusted to reflect the actual CPI, and our best estimate of the CPI-W. As the figure indicates, under the Governor's proposal, grants for individuals are expected to rise due to the pass-through of the federal COLA from \$870 (100 percent of poverty) in January 2008 to \$885 (102 percent of poverty) in June 2009. Absent the Governor's proposal, grants for individuals would increase from \$870 in January 2008 to \$935 in June 2009 (108 percent of poverty).

Under the Governor's spending plan, grants for couples would increase from \$1,524 (131 percent of poverty) in January 2008 to \$1,547 (133 percent of poverty) in June 2009 due to the federal COLAs. Under current law, grants for couples are estimated to increase from \$1,524 in January 2008 to \$1,640 (141 percent of poverty) in June 2009.

Inclusion in LAO Alternative Budget. As part of the LAO alternative budget package presented in *The 2008-09 Budget: Perspectives and Issues*, we recommend the deletion of the June 2008 and 2009 state statutory COLAs. This is because prior pass-throughs of the federal COLA has kept both individuals and couples above the federal poverty guideline. Moreover, the alternative continues to pass-through the federal COLA in 2009, thus ensuring that SSI/SSP recipients remain above poverty.

Additional Savings Included in the LAO Alternative Budget. Also, as part of the LAO alternative budget package, we recommend reducing SSI/SSP couples grants to 125 percent of the 2008 federal poverty guideline. This results in General Fund savings of about \$89.5 million in 2008-09. As seen in Figure 3, couples grants are currently at 131 percent of poverty, while grants for individuals are at 100 percent of the 2008 federal poverty guideline. Even with this reduction, SSI/SSP couples will remain further above the poverty guideline than individuals. This proposal would reduce the SSP grant for couples by \$66, from \$568 to \$502, well above the current federal maintenance of effort requirement (\$396). This proposal does not result in any federal funds loss, since it only affects the SSP portion of the grant. Couples would continue to receive the federal COLA in January 2009, and would be entitled to future federal and state COLAs when they are provided. The SSP grant of \$502, when combined with the federal SSI grant, would total \$1,458 per month for a couple.

Figure 3**SSI/SSP Maximum Monthly Grants
Current Law and Governor's Proposal**

	January 2008	June 2008	January 2009	June 2009
Individuals				
Current Law				
SSI	\$637	\$637	\$652	\$652
SSP	233	251	251	283
Totals	\$870	\$888	\$903	\$935
Percent of Poverty^a	100%	102%	104%	108%
Governor's Budget				
SSI	\$637	\$637	\$652	\$652
SSP	233	233	233	233
Totals	\$870	\$870	\$885	\$885
Percent of Poverty^a	100%	100%	102%	102%
Change From Current Law				
SSI	—	—	—	—
SSP	—	\$18	\$18	\$50
Totals	—	\$18	\$18	\$50
Couples				
Current Law				
SSI	\$956	\$956	\$979	\$979
SSP	568	602	602	661
Totals	\$1,524	\$1,558	\$1,581	\$1,640
Percent of Poverty^a	131%	134%	136%	141%
Governor's Budget				
SSI	\$956	\$956	\$979	\$979
SSP	568	568	568	568
Totals	\$1,524	\$1,524	\$1,547	\$1,547
Percent of Poverty^a	131%	131%	133%	133%
Change From Current Law				
SSI	—	—	—	—
SSP	—	\$34	\$34	\$93
Totals	—	\$34	\$34	\$93

^a 2008 U.S. Department of Health and Human Services Poverty Guidelines. The guidelines are adjusted annually for inflation.

IN-HOME SUPPORTIVE SERVICES

The In-Home Supportive Services (IHSS) program provides various services to eligible aged, blind, and disabled persons who are unable to remain safely in their homes without such assistance. An individual is eligible for IHSS if he or she lives in his or her home—or is capable of safely doing so if IHSS is provided—and meets specific criteria related to eligibility for the Supplemental Security Income/State Supplementary Program. In August 2004, the U.S. Department of Health and Human Services approved a Medicaid Section 1115 demonstration waiver that made about 93 percent of IHSS recipients eligible for federal financial participation. Prior to the waiver, about 25 percent of the caseload were not eligible for federal funding and were served in the state-only “residual” program.

The budget proposes about \$1.6 billion from the General Fund for support of the IHSS program in 2008-09, an increase of \$2.8 million (0.2 percent) compared to estimated expenditures in the current year. This slight increase is attributable to increases in the IHSS caseload and provider wages, which is largely offset by the Governor’s proposal to reduce IHSS domestic and related care service hours.

REDUCING DOMESTIC AND RELATED CARE HOURS FOR IHSS RECIPIENTS

The Governor’s budget proposes to reduce the hours of domestic and related services provided to the In-Home Supportive Services recipients by 18 percent, resulting in estimated General Fund savings of about \$110 million in 2008-09. Additionally, the budget includes a proposal to reduce county administrative funding and workload by 10 percent, resulting in estimated General Fund savings of about \$10 million in the budget year. We provide background on domestic care service hours, highlight key features of the Governor’s proposals, present some concerns with the estimated savings, and provide alternatives for achieving savings.

Background

After the needs of an IHSS recipient are assessed by a social worker, the recipient is authorized to receive a specific number of hours of care each month for a variety of services. This care is allocated among certain tasks to create a package of services to assist recipients in remaining in their own homes thereby potentially avoiding being placed in a residential care or nursing facility. Figure 1 provides a list of the tasks for which IHSS recipients may receive service hours.

Who Receives Domestic Services? As shown in Figure 1, domestic and related services include general housekeeping activities, meal preparation, meal clean-up, shopping for food, and errands. For 2008-09, the IHSS caseload is estimated to be about 408,000 persons. Over 95 percent of these recipients are estimated to receive some level of domestic and related care service. Currently, the average number of hours authorized for IHSS domestic services is 37 hours per month, and the average number of hours for all other tasks is about 50 hours per month. In other words, for an average IHSS recipient, domestic and related services make up about 43 percent of their total care hours each month.

The Current Assessment Process. The IHSS program relies on county social workers to conduct individualized assessments to determine the number of hours of each type of IHSS service that a recipient needs in order to remain in his/her home. Recently, social workers have received training in order to implement a standardized assessment process throughout the state.

Reassessment Process. Current law requires social workers to reassess most recipients' need for service every 12 months. The length of time between assessments can be extended for an additional 6 months (to a total of 18 months between assessments) if recipients meet certain criteria relating to their health and living conditions.

IHSS Appeals. Currently, if IHSS recipients disagree with the hours authorized by the social worker, they have a right to request a reassessment, and if still not satisfied, they can appeal their hour allotment by submitting a request for a state hearing to the Department of Social Services (DSS).

Governor's Proposals

County Administration Proposal

The Governor's budget proposes to reduce county administrative funding by about \$10 million General Fund (about 10 percent) in 2008-09. He

also proposes to reduce the workload for county social workers by extending the interval between IHSS recipient assessments from 12 months to 18 months. The Governor's proposal allows for assessments more frequently than 18 months if recipients meet certain criteria relating to their condition or at any time that a recipient requests an assessment.

Figure 1**In-Home Supportive Services Task Categories**

Task	Examples
Domestic and Related Services:	
Domestic Services	Cleaning; dusting; picking up; changing linens; changing light bulbs; taking out garbage
Laundry	Sorting; washing; hanging; folding; mending; and ironing
Shopping and Errands	Purchasing groceries, putting them away; picking up prescriptions; buying clothing
Meal Preparation	Planning menus; preparing food; setting the table
Meal Cleanup	Washing dishes and putting them away
All Other Services:	
Feeding	Feeding
Ambulation	Assisting recipient with walking or moving in home or to car
Bathing, Oral Hygiene, Grooming	Cleaning the body; getting in or out of the shower; hair care; shaving; grooming
Routine Bed Baths	Cleaning the body
Dressing	Putting on/taking off clothing
Medications and Assistance With Prosthetic Devices	Medication administration assistance; taking off/putting on, maintaining, and cleaning prosthetic devices
Bowel and Bladder	Bedpan/ bedside commode care; application of diapers; assisting with getting on/off commode or toilet
Menstrual Care	External application of sanitary napkins
Transfer	Assistance with standing/ sitting
Repositioning/ Rubbing Skin	Circulation promotion; skin care
Respiration	Assistance with oxygen and oxygen equipment
Protective Supervision	Ensuring recipients are not harming themselves

Domestic and Related Care Reduction

The Governor's budget proposes to reduce the number of hours provided for IHSS domestic and related services by 18 percent in 2008-09. This reduction is estimated to save \$110 million General Fund in the budget year. Because most recipients receive domestic care services, this reduction will have an effect on nearly all IHSS recipients and providers. As seen in Figure 2, the average IHSS recipient will go from having 37 hours of domestic and related services to 30.4 hours per month, and their total services will be reduced from 86.6 hours to 80 hours per month.

Figure 2

Domestic and Related Services Reduction Impact of the 18 Percent Reduction Average Monthly Hours

	Current Level	Governor's Proposal	Change	
			Amount	Percent
Domestic and related care service hours	37.0	30.4	-6.6	-18%
All other hours	49.6	49.6	—	—
Totals	86.6	80.0	-6.6	-8%

Implementing the Reduction. The Governor's proposal assumes that the reduction in domestic and related care hours would become effective on July 1, 2008. This assumes enactment by the Legislature of the necessary statutory changes by March 1, 2008. Currently, information regarding recipient hour authorizations is stored in the state operated Case Management Information and Payrolling System (CMIPS). The Governor's proposal does not include any administrative or reprogramming costs to enable the reduction. The DSS states that CMIPS will be reprogrammed to automatically apply the 18 percent reduction to existing hour assignments for domestic and related services. At the time this analysis was prepared, it was not clear if CMIPS could make this change within its existing resources or whether additional costs will be incurred for computer reprogramming.

The Assessment Process. The DSS states that there will be no change in the assessment process at the county level. Social workers will continue to use their training and existing guidelines to perform an individualized

assessment and determine the amount of care that they believe a recipient should receive to avoid institutionalization.

Pursuant to the proposed trailer bill language, after their hours are reduced by 18 percent, all IHSS recipients will receive a notice in the mail with information about (1) the amount of hours the recipient received prior to the reduction and the number of hours the recipient will receive as a result of the reduction, (2) the reason for the reduction, (3) when the reduction will be effective, and (4) how all or part of the reduction may be restored if the recipient believes he/she will be at serious risk of out-of-home placement if the care is not restored.

Changes to the Appeals Process. Current law states that IHSS recipients do not have the right for a state hearing if they are appealing a reduction in hours that occurred as a result of a change in federal or state law. However, when describing how all or part of the 18 percent reduction in domestic and related care service hours may be restored, the trailer bill language implementing the Governor's proposal refers to a section in current law that allows IHSS recipients to apply to have their hours restored through an IHSS care supplement, which is designed to provide additional hours of service. If the recipient disagrees with the county's determination regarding the need for a care supplement, the recipient may then request a hearing on that determination. Additionally, under the Governor's proposal, recipients retain the right to request a social worker reassessment and to appeal their reassessment if not satisfied.

Projected Savings May Not Be Achieved

Although it is likely that this proposal will lead to some General Fund savings, we are concerned that the estimated savings in the Governor's budget may be overstated. The Governor's budget assumes that by increasing the allowable time between social worker assessments, county workloads will decrease by 10 percent. Additionally, the Governor's plan assumes that *all* IHSS domestic and related care hours will be reduced by 18 percent for *all* recipients in 2008-09. Below we present our concerns with the estimated savings included in the Governor's budget.

Administrative Cost Reduction May Not Lead to Equivalent Workload Reduction. Although the proposal to reduce funding for county administration by 10 percent results in savings, there is the potential that it will not result in a 10 percent reduction to county workload. Although the proposal extends the allowable time between reassessments, it does not change the recipient's ability to request a reassessment at any time. As more time passes between assessments, recipients may experience changes in their conditions and request a social worker reassessment. This

may require social workers to perform more assessments than would be budgeted under the Governor's proposal.

Implementing Hour Reduction Proposal. Although the 18 percent reduction in domestic and related care service hours will be applied automatically by CMIPS, it is not clear whether there will be administrative or reprogramming costs to enable the reduction. The Governor's budget does not include any administrative or reprogramming costs that may be required for CMIPS to apply the reduction. To the extent that these costs exist, some of the savings in this proposal will erode.

Appeals for Additional Hours. As recipients become aware of the 18 percent reduction in domestic and related services, there will likely be an increase in the number of recipient requests for hour restorations (whether through reassessments or requests for an IHSS care supplement). This is because the proposal does not change the ability of the recipient to request these reevaluations, and the notice they receive will inform them of their ability to restore hours if they believe that they are at serious risk of out-of-home placement. If these reassessments or appeals result in restored domestic and related care services for recipients, the savings due to this proposal will be less than estimated in the Governor's budget.

Additionally, increased reassessments and appeals would raise administrative costs. This is because it will take a social worker time to process the increase in the requests and appeals.

Social Worker Incentives May Reduce Savings. As social workers become aware of the 18 percent reduction, there may be an incentive to increase the hours in nondomestic categories of care, or inflate the assessed hours for domestic care, to make up for the lost hours. Social workers might do this in order to avoid requests for reassessments and appeals which take additional social worker time. It should be noted that these additional hours could be assigned to domestic or nondomestic services. This is because IHSS recipients typically use their hours as if they are a block grant. Although social workers assign a certain number of hours for each task, recipients often reallocate hours among tasks. (For a more complete discussion of how recipients treat their hours as a block grant, see "Enhancing Program Integrity" in the "IHSS" section of the *Analysis of the 2007-08 Budget Bill*.)

State Plan Amendment May Be Required for Both Proposals. The DSS indicates that a Medi-Cal state plan amendment, approved by the federal Centers for Medicare and Medicaid Services, may be needed in order to implement the extension of time between recipient assessments and the 18 percent reduction in domestic and related care hours. If it is determined that a state plan amendment is required, and the amendment is

not approved prior to July 1, 2008, the implementation date will be delayed and the proposed savings will be reduced.

Other Means of Achieving Savings

The administration's proposals reduce service hours without changing the underlying statutory or regulatory criteria for assigning hours. Based on our review, we conclude that some of the estimated savings are likely to be offset by increased appeals and hour restorations, reassessments, and potential administrative costs.

In order to make meaningful changes to service hours, the Legislature could consider changes in statute to the standards for authorizing hours in the program, rather than reduce the hours once they have already been assessed, as the Governor's budget proposes. Below we present some options to consider.

Cap Hours for Certain IHSS Services. Although the Governor's proposal reduces the number of hours assessed by social workers by 18 percent, it does not limit the number of hours which may be assessed. In order to achieve meaningful savings by reducing IHSS hours, the underlying criteria for providing hours could be changed. To achieve this, the Legislature could place caps on the hours authorized for certain IHSS services. Such caps, with exceptions, currently exist for services provided in the IHSS program. For example, the maximum number of hours that recipients can receive for certain domestic services is limited to 6 hours per month, unless there is an exception because the needs of the recipient require additional time. Thus, as an alternative approach, the Legislature could cap the hours for this service at five hours and not allow exceptions.

We believe that it is reasonable to place caps, without exceptions, on certain domestic services where the condition of the recipient is not likely to lead to a variance in the need for service hours. The savings associated with this proposal would depend upon the number of services that are capped without exceptions and the number of hours at which they are capped.

Consider Living Situation When Assessing Hours. The Legislature could also establish differential hours based on the recipient's living situation. In other words, the Legislature could cap the number of domestic hours available to a recipient who lives with their family at a level that is lower than for someone living independently. For example, the current maximum number of hours that recipients may receive for food shopping is one hour per week. The Legislature could consider continuing to allow one hour per week for recipients who live on their own, but authorize only one-half hour per week for recipients who live with relatives.

When assessing hours for certain domestic services, it seems appropriate to consider the living situation of the recipient. As part of the current assessment process, social workers do consider whether the recipient has access to voluntary assistance and other resources. However, there is no formal distinction made between the maximum authorized hours for those who live with family members and those who live independently. Recipients living with relatives may need less hours for domestic services than individuals living independently. This is because family members would likely be performing domestic tasks, such as food shopping, regardless of whether or not they were living with a recipient of IHSS. In such a situation, it would not be necessary to provide the same number of IHSS service hours for recipients living with relatives as are provided for those living independently. The savings attributable to this type of reduction would depend upon the number of services selected for the establishment of differential hour caps, and the amount of the hour differential.

State Plan Amendment. Similar to the Governor's proposal, prior to implementing these types of IHSS hour reforms, a Medi-Cal state plan amendment (with federal approval) may be necessary.

Conclusion

We believe that the Governor's proposal to reduce domestic and related care hours will result in some savings in the budget year. However, due to the concerns mentioned above, it is likely that the savings will be less than estimated by the Governor's budget. To the extent that the Legislature wants to achieve savings by reducing service hours, the preferred approach is to change the statute regarding actual standards for assigning hours, rather than reduce the hours after the need has been assessed.

IMPROVING THE IHSS WORKFORCE THROUGH TIERED STATE PARTICIPATION IN WAGES

Although the In-Home Support Services (IHSS) wages represent a significant cost to the state, current law grants local county boards of supervisors the authority to set wage levels and the conditions under which potential providers may list themselves as available to recipients. In order to improve the IHSS labor force, and control growing wage costs, we recommend enactment of legislation, before 2010-11, which modifies the structure for state participation in wages to reflect the training and tenure of IHSS providers.

Background

IHSS Recipients and Providers. In 2008-09, the IHSS program is estimated to provide in-home care to approximately 408,000 recipients. The IHSS care is primarily delivered by an average of 325,000 individual providers located throughout the state. About 58 percent of IHSS providers are related to the IHSS recipient for which they provide care.

Recipient Control. In the IHSS program, the recipient is considered to be the employer, and has the responsibility to hire, supervise, and fire their provider. Although the recipient is the employer, they do not set IHSS wages, which are collectively bargained between counties (generally represented by “public authorities” discussed below) and employer representatives. As the employer, IHSS recipients have few restrictions on who they are permitted to hire. Specifically, the only restrictions on IHSS recipients is that they may not hire individuals who in the last ten years have been convicted of Medi-Cal fraud, child abuse, or elder abuse.

The Role of Public Authorities. For purposes of collective bargaining over IHSS provider wages and terms of employment, all but two counties in the state have established public authorities (other counties have established different entities for this purpose). The public authorities essentially represent the county in provider wage negotiations. Besides collective bargaining, the primary responsibilities of public authorities include (1) establishing a registry of IHSS providers who have met various qualification requirements, (2) investigating the background of potential providers, (3) establishing a system to refer IHSS providers to recipients, and (4) providing training for providers and recipients.

Funding for Provider Wages and Benefits. The federal, state, and local governments share in the cost of IHSS wages. Specifically, the federal government funds 50 percent of the cost, and the remaining, nonfederal share of costs is funded 65 percent by the state and 35 percent by the counties.

Funding Criminal Background Investigations. Among other things, Chapter 447, Statutes of 2007 (SB 868, Ridley-Thomas), provides, if funds are appropriated, for state participation in the cost of performing criminal background investigations (CBIs) on registry and nonregistry IHSS providers. Prior to enactment of this legislation, the state did not share in the cost of CBIs. Pursuant to Chapter 447, if over 50 percent of those on a public authorities registry have received a CBI, the county is eligible for state reimbursement of 65 percent of the nonfederal cost. Additionally, if funds are appropriated in the annual budget act, recipients may request a CBI be conducted on their provider at no cost to the recipient or provider. No such appropriation was made in 2007-08, and the Governor’s budget does not include funding for 2008-09. Thus under current practice, there is no state participation in the cost for CBIs.

Flexibility Leads to County Variance

Local county boards of supervisors have used their discretion to implement public authority registry requirements and wage structures that vary throughout the state, as discussed below.

Wages Vary Among Counties. Pursuant to Chapter 108, Statutes of 2000 (AB 2876, Aroner), the state participates in combined wage and benefit levels of up to \$12.10 per hour for IHSS providers. Although the state participates in wages of up to \$12.10 per hour, as seen in Figure 3, county combined wages and benefits range from \$8 per hour to \$14.43 per hour. A county, such as Santa Clara, with an established wage over the state participation cap of \$12.10 per hour, shares the cost of the portion of the wage that is over the \$12.10 with the federal government. In other words, the additional \$2.33 above the \$12.10 is shared 50 percent by the federal government and 50 percent by Santa Clara County.

Currently, the average statewide IHSS wage and benefit level is about \$9.98 per hour. County decisions to raise wages to this level have resulted in state costs of \$281 million more than they would have been if counties had continued paying minimum wage (\$8 per hour as of January 2008). If all counties decide to raise wages and benefits to the authorized maximum (\$12.10 per hour), state costs would increase by about \$316 million annually.

Registry Requirements Vary. Each public authority maintains a registry of IHSS providers who have met various background and qualification requirements implemented by the counties. The names of providers listed on the registry are distributed to IHSS recipients to aid them in the hiring process. The IHSS recipients are not required to hire their providers from the registry. Current law grants broad discretion to counties when establishing criteria for providers to qualify for IHSS registry placement. Failure to meet registry requirements does not prohibit a person from working as an IHSS provider, but instead renders them ineligible from being placed on the registry. Below we list some of the requirements that some counties have implemented in order for a person to be placed on the registry.

- Attend provider training,
- Pass a drug screening test,
- Pass a criminal background investigation,
- Provide personal and professional references,
- Participate in an interview with the public authority,
- Provide employment history.

Figure 3

IHSS Hourly Wages and Benefits by County Approved as of January 2008

Alpine	\$8.00	San Bernardino	\$9.43
Colusa	8.00	Stanislaus	9.44
Humboldt	8.00	Los Angeles	9.51
Inyo	8.00	Yuba	9.57
Lake	8.00	El Dorado	9.60
Lassen	8.00	Kern	9.60
Madera	8.00	Placer	9.60
Mariposa	8.00	San Diego	9.71
Modoc	8.00	Statewide Average	9.98
Mono	8.00	San Joaquin	10.02
Shasta	8.00	Mendocino	10.05
Siskiyou	8.00	San Luis Obispo	10.10
Trinity	8.00	Ventura	10.10
Tuolumne	8.00	Riverside	10.35
Glenn	8.15	Fresno	10.45
Imperial	8.25	San Benito	10.60
Kings	8.60	Santa Barbara	10.60
Tehama	8.60	Monterey	11.10
Butte	8.75	Napa	11.10
Del Norte	8.85	Sacramento	11.10
Sutter	8.85	Solano	11.10
Calaveras	8.98	Sonoma	11.10
Orange	9.00	Marin	11.19
Amador	9.10	Alameda	11.49
Merced	9.10	Contra Costa	11.83
Tulare	9.10	Santa Cruz	12.10
Nevada	9.16	San Mateo	12.10
Plumas	9.16	Yolo	12.80
Sierra	9.16	San Francisco	13.39
		Santa Clara	14.43

The requirements established for qualification for the provider registry vary by county. Not all counties have implemented all of the registry requirements listed above, and some counties have implemented requirements that are not included. Additionally, counties with similar requirements may implement them in a variety of ways. For example, two counties

may require that registry providers attend training, but one county may require more hours of training than another county.

County Experience With Tiered Wages

Although there is wide variation among county registry requirements, with very few exceptions, IHSS workers within each county are paid the same hourly wage. However, at least two counties have used their authority to consider or implement variable wage rates within their counties. Below we discuss a differential wage approach in Los Angeles County and a proposal for tiered wages in Lake County.

The Los Angeles County Back-Up Attendant Program. Los Angeles County has utilized the flexibility in current law to implement a back-up attendant program. The Back-Up Attendant program was set up to ensure that IHSS recipients in Los Angeles County receive their authorized care even if their regular provider is not available. The program provides a wage of \$12 per hour for providers who are willing to be listed on the registry as back-up providers, and \$9 per hour for all other providers. The back-up providers are used when eligible IHSS recipients have an urgent but temporary need for assistance, and their regular provider is unable to provide that assistance. The requirements to become a back-up provider are the same as the requirements to be listed on the registry, but in addition to those requirements, back-up providers must complete a 12-hour training course or pass a proficiency test to evaluate their skills. The DSS concurred that counties have the authority to set wage levels and approved this differential wage structure, as it was implemented at no additional cost to the state. The Los Angeles Back-Up Attendant program provides an example of how counties have used their authority to make differential wage decisions.

Lake County Two-Tier Wage Proposal. Recently, Lake County proposed to implement a two-tiered wage structure that would pay higher wages to IHSS providers who were willing and able to qualify for the Lake County Public Authority registry. Individuals who did not wish to sign up for the registry, or did not qualify for the registry, could still be hired as an IHSS provider, but would be paid a lower wage. The Lake County Board of Supervisors indicated that the purpose of this tiered wage proposal was to use a monetary incentive to encourage a heightened standard for IHSS providers. They maintain that a tiered wage structure would provide IHSS recipients with the opportunity to make more informed decisions when searching for a provider. To qualify for the registry in Lake County, a provider would have to pass a criminal background investigation, pass a drug screening, and participate in first-aid training. The DSS has concluded that current law permits counties to negotiate tiered wage structures as

long as it is done at no cost to the state. Lake County is currently in the process of providing DSS with the details of how it plans to implement a tiered wage structure at no additional state cost.

Tiered Wage Automation Considerations. Both the Los Angeles County Back-Up Attendant Program and the Lake County tiered wage proposal require a payroll system that is able to accommodate multiple wages within a county. Each county's payroll claim is processed by the state's CMIPS. Currently, CMIPS is only capable of accommodating a single wage for all workers in a given county. Thus, Los Angeles County must use "work arounds" and manual inputs by county workers to operationalize the wage differential for the Back-up Attendant program. Similarly, DSS is requiring Lake County to address the data entry issue at no state cost. However, a new payroll processing system, CMIPS II, is currently being developed, and this new system will be able to accommodate multiple wage levels within a single county. The system should be fully operational by summer of 2011.

Opportunity for the Legislature to Condition State Participation in Wages

Because multiple wages within a county are permissible under current law, and CMIPS II will be able to accommodate multiple wages within a county, more counties may begin to propose differential wage structures. This will provide the Legislature with the opportunity to consider whether it wishes to link the level of state participation in wages to the skills, training, and experience of IHSS providers. Differential wage structures are common in the public and private sectors. Valuing the experience and training of IHSS providers should improve the IHSS labor force and thus the quality of services for recipients. Below we present several alternatives for creating pay differentials among workers.

Higher State Participation in Wages for Experienced Providers. Currently, with very few exceptions, virtually all IHSS providers within a county are paid the same amount in wages and benefits regardless of experience. Typically, wage structures in the public and private sectors are designed to pay those with more experience at a higher level than those new to the job. The Legislature could consider implementing a "training wage" for new IHSS providers, and therefore participate in higher wages for IHSS providers with more experience. In other words, *new* IHSS providers would receive less state participation than providers with at least six months of experience. This would reward skilled providers, and result in some savings to the state with potential county costs or savings. Whether counties will experience savings is dependent upon county behavior. If counties decide to reduce wages to the level of state participation, they will also receive some savings from the training wage. However, those

counties that maintain wages despite decreased state participation will experience additional costs.

Higher State Participation for Trained Workers. Similarly, the Legislature could authorize state participation in higher wages for providers who obtain training. For example, the Los Angeles City College currently offers a free IHSS provider training course. This particular training course is designed to provide IHSS providers with the skills needed to be an effective in-home care provider. Upon completion of the course, participants receive a certificate of completion.

Blending Training and Experience Rules. Another alternative for the Legislature to consider would be to allow IHSS providers to substitute successful completion of a training course for up to six months of on-the-job training. The Legislature would specify the number of hours of training needed to substitute training for experience, as well as require provider documentation of course completion in order to receive state participation in the higher wage.

The Legislature would ultimately determine the details of the training wage. For purposes of illustration, if the Legislature creates a wage differential whereby the state participates in \$0.50 cents less for a six month training wage for new providers, this would result in General Fund savings of about \$1 million annually.

Higher State Participation in Wages for Providers Who Complete a Criminal Background Investigation. The Legislature could provide greater state participation for providers who are willing to have a CBI conducted. Under this approach, workers desiring the higher wage level would apply to the Department of Justice (DOJ) for a CBI. The results of the CBI would be provided to the IHSS recipients and the county. The information in the CBI would assist recipients in making informed decisions during the hiring process. Unless the CBI reveals that the provider was convicted of fraud or abuse as previously described, the state would participate in a higher wage level for providers who complete a criminal background investigation and are hired by an IHSS recipient.

Implementing this criteria would result in some savings to the state, as it is unlikely that all IHSS providers would participate in the CBI. For example, if 10 percent of all providers opt not to participate in a CBI within the timeframe established, and the Legislature decides to participate in \$0.50 cents less per hour for those providers, the state would save about \$5.7 million annually.

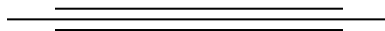
Other Considerations. The options described above would improve the IHSS labor force. Additionally, encouraging training and increasing the recipient's knowledge of the provider through a CBI, may result in

reduced fraud in the IHSS program. These options would not prevent counties from maintaining or increasing current wages, as it only affects state participation in those wages. Failure to comply with the criteria established in these differential wage options would not prevent an individual from becoming an IHSS provider.

Analyst's Recommendation

In order to improve the IHSS labor force, we recommend enactment of legislation that conditions state participation in IHSS wages on the provider's experience, training, and willingness to have a criminal background investigation conducted. Because the current version of CMIPS is only able to accommodate one wage level per county, we recommend that variable state participation in wages only become operational when CMIPS II is fully implemented (in 2010-11).

The precise policy mix of state participation in wages would be up to the Legislature. Variants to the options mentioned above could include increases or decreases to the amount of the wage differentiation and the length of time new providers receive the training wage. In other words, the Legislature may decide to participate in \$1 less per hour for providers who have not completed a CBI, rather than the \$0.50 differential we used in our example, or they may decide to participate in a training wage for three months rather than six months. All of these decisions will influence the amount of savings associated with tiered wages. Adopting all of the options described above (\$0.50 wage differentials and six months of the training wage) would result in annual General Fund savings of about \$6.7 million. In addition, we believe linking pay to experience and training will improve the IHSS labor force and services for recipients.



COUNTY ADMINISTRATION AND AUTOMATION PROJECTS

The budget appropriates funds for the state and federal share of the costs incurred by the counties for administering the following programs: Food Stamps, California Food Assistance Program, Foster Care, and Refugee Cash Assistance. In addition, the budget provides funds for the ongoing maintenance and development of county welfare automation systems.

For 2008-09, the budget proposes an appropriation of \$429 million from the General Fund for county administration and automation systems. This represents a reduction of \$20.8 million, primarily attributable to proposed budget balancing reductions which (1) cancel the Interim Statewide Automated Welfare System (ISAWS) Migration Project and (2) reduce Food Stamps administrative funding by 10 percent.

THE FUTURE OF COUNTY WELFARE AUTOMATION CONSORTIA

Each county uses one of four automated systems to administer California's human services programs. To reduce costs and increase efficiency, we recommend enactment of legislation establishing a goal of standardizing the state's human services programs on no more than two automated systems. In addition, we recommend increasing legislative oversight of information technology consortia contracts that support these systems.

Background

The Department of Social Services oversees the administration of California's social services programs. The actual delivery of services at the local level is carried out by 58 separate county welfare departments. Since the 1970s, the state has made various efforts to develop a single, statewide automated welfare system.

Establishment of the County Consortia Structure

In the 1990s, the state was working with certain counties to develop an automation system which came to be known as ISAWS. At the same time, Los Angeles County was pursuing its own system called the Los Angeles Eligibility Automated Determination, Evaluation, and Reporting System (LEADER). Meanwhile other counties came together to pursue their own automated systems. Each group was attempting to demonstrate that its system could be the one statewide system.

There was active discussion about this in the 1995 budget hearings and the Legislature ultimately decided that one statewide system was not feasible. The *1995 Budget Act* instructed the Health and Welfare Data Center (which is now called the Office of System Integration [OSI]) to collaborate with the County Welfare Directors' Association (CWDA) on a consortia strategy for statewide welfare automation. Specifically, the Legislature required that there be "...no more than four county consortia, including ISAWS and LEADER."

During the fall of 1995, OSI worked with CWDA and the counties to develop an agreement on the consortia systems and their member counties. They decided there would be two more consortia in addition to ISAWS and LEADER. An existing system, which included Bay Area counties, would be renamed CalWIN and the Merced County system would be renamed Consortium IV (C-IV). The remaining, unaligned counties selected the consortium they each wanted to join and the four county consortia were formed. Figure 1 shows the relative size of each consortium.

Figure 1
California Welfare Automation Consortia

Consortium	Number of Counties	2007 Estimated Caseload ^a	
		Cases	Percentage
CalWIN Counties	18	363,532	36%
C-IV Counties	4	146,774	14
ISAWS Counties	35	166,097	16
LEADER (Los Angeles)	1	346,958	34
Totals	58	1,023,361	100%

^a Although certain consortia systems process many programs, this estimate is limited to CalWORKs and Food Stamps cases which are processed by all consortia.
ISAWS = Interim Statewide Automated Welfare System
LEADER = Los Angeles Eligibility Automated Determination, Evaluating, and Reporting System.

Consortia Systems Technology

The technology used to develop large automated systems has evolved rapidly over the past 20 years. Several evolutionary cycles have greatly changed the way these systems function. Systems of the size and complexity of the consortia take years to complete and cannot be redesigned midstream in order to take advantage of evolving technology. Therefore, the technology employed to develop each consortia system reflects the time period during which the system was designed. The older systems do not have the ease of function and support commonly available with more current technology. Below we summarize the technology status of each consortium.

ISAWS. The ISAWS was designed in the late 1980s and uses hardware and software that is nearing the end of vendor support. The programmers needed to support the software are not readily available because the programming language is not commonly used today. Therefore, programmers must be trained specifically for this purpose. In addition, the software must reside on hardware that is available from only one vendor and so it cannot be competitively replaced. The state enters into “sole source” contracts for this ISAWS support.

LEADER. The Los Angeles County LEADER system uses the same technology as the ISAWS system. Over the years, Los Angeles County has entered into a number of sole source contracts to maintain and update its system.

CalWIN. The technology used to develop CalWIN is referred to as client/server. With this technology, the data is stored in a database on a large mainframe. This data interacts with an application on the desktop personal computer (PC). For client/server systems, as the amount of software on the PC grows, the PC must also grow. Therefore, the PC’s capacity must be increased periodically via an upgrade or replacement. This drives up the cost of maintaining client/server systems.

C-IV. As use of the Internet increased, vendors began to develop applications that could be accessed over the web, referred to as “web enabled.” Web enabled applications do not require special software on a PC to access the application like client/server applications. At the time C-IV was being formulated, vendors also changed the way they develop large systems. Now a series of smaller applications are developed and each performs a discreet function or “service.” This is referred to as “service-oriented architecture” and it allows for system changes to be accomplished more quickly. The C-IV system takes advantage of these more current technologies. This makes it easier to maintain and less expensive to adapt the C-IV system to process and regulatory changes.

Recent Re-Procurement Decisions

ISAWS Migration to C-IV. With respect to the 35 ISAWS counties, the Legislature concluded that it was more efficient to consolidate ISAWS counties into the existing C-IV system, rather than procure a new system. This consolidation, approved by the Legislature in 2006, is known as the ISAWS Migration Project and has an estimated cost of \$245 million over four years. In light of California's budget deficit, the *2008-09 Governor's Budget* proposes to cancel the ISAWS Migration Project. The administration has stated that it plans to resume this project when it can be accommodated within the state budget. The outcome of this budget proposal is unknown at this time.

LEADER: A New Procurement. As LEADER was approaching the end of its useful life, the initial (2005) procurement strategy was for Los Angeles to receive a replacement system based on either C-IV or CalWIN. In 2007 the county and the administration changed this approach to open the procurement to all viable vendor proposals. The Legislature approved this change, thus allowing Los Angeles to procure a new system.

Where We Stand Today. California has four disparate welfare automation systems. We view the proposed cancellation of the ISAWS migration to C-IV as a temporary delay on a path toward potentially three systems. Each of these systems processes caseload using different business processes, even though they each adhere to the same laws and program regulations. In addition, the consortia systems don't talk to each other; meaning they do not share data, and caseload information cannot be transferred among consortia systems. These siloed business operations have further divided county human services operations across the state.

How Many Consortia Systems in the Future?

The *1995-96 Budget Act* stated that there would be "no more than four consortia." With the decision to move ISAWS to C-IV, the Legislature previously expressed a preference for reducing the number to three: C-IV, CalWIN, and Los Angeles.

Benefits of Further Consolidation. Reducing the number of consortia reduces maintenance costs that are incurred because there are fewer systems that must be modified for regulatory and legislative changes. In addition, there are other administrative savings. Currently, when a client moves to another county with a different system, client information must be recreated. This increases workload and the opportunity for fraud. Having fewer systems reduces the frequency of this occurrence. While it is difficult to quantify total savings, reducing the number of consortia will result in ongoing annual savings for system changes that are currently costing between \$10 million and \$20 million per system.

Setting a Consolidation Goal. By setting a goal for reducing the number of consortia systems, the Legislature would provide clear guidance for future consortia system proposals. The administration could then make the appropriate plans for current consortia systems as they come to the end of their useful life. This could reduce the cost of future consortia planning activities.

Legislative Oversight of Consortia Contracts

Under Budget Control Section 11.00, state-managed information technology (IT) projects must provide legislative notification 30 days prior to entering into a contract that will increase the project budget by 10 percent, or \$500,000, whichever is less. This provides the Legislature an opportunity to review proposed contract terms and conditions. For some state IT projects, vendor contract terms have been renegotiated because of concerns expressed by the Legislature under Control Section 11.00 reviews. However, consortia procurements are conducted at the county level and, while the resulting contracts undergo OSI review, they can be entered into without any legislative notification and review. These county consortia contracts can exceed \$100 million and have very limited legislative oversight. Given the substantial state investment in these consortia systems, we believe the Legislature should increase its oversight of consortia contracts.

Analyst's Recommendation

Establish a Goal of Only Two Welfare Consortia Systems. We recommend enactment of legislation which sets a goal to further standardize California's welfare operations by ultimately reducing the number of consortia to two systems. As we discuss above, further consolidation can produce efficiencies and reduce system support costs. By moving in this direction, one-time development costs of \$80 million (based on recent state experience) could be saved for each consortia system that is consolidated rather than replaced. Similarly, for each system that is consolidated, there are annual savings in the tens of millions of dollars for ongoing application maintenance.

Enhance Legislative Oversight of County Consortia. Legislative review of consortia contracts should be consistent with Control Section 11.00 requirements to provide 30-day legislative notification prior to contract signature. County consortia contracts are funded, in total, with state and federal funds. Accordingly, the Legislature should be afforded the opportunity to review the contractual arrangements that obligate those funds, consistent with state IT contracting procedures. Specifically we recommend amending Control Section 11.00 notification requirements to include county welfare consortia contracts.

COMMUNITY CARE LICENSING

The Community Care Licensing (CCL) Division of the Department of Social Services (DSS) develops and enforces regulations designed to protect the health and safety of individuals in 24-hour residential care facilities and day care. The CCL oversees the licensing of about 86,000 facilities, including child care centers, family child care homes, foster family and group homes; adult residential facilities; and residential facilities for the elderly. Counties who have opted to perform their own licensing operations monitor approximately 11,000 of these facilities.

The Governor's budget proposes total expenditures of \$118.2 million (\$37.3 million General Fund) for CCL in 2008-09. This is an increase of \$1.7 million (\$1.3 million General Fund) from the current year. These amounts include state operations and local assistance for the five counties that perform their own licensing operations. Most of the increase is due to the extension of limited-term staff to complete a backlog of facility inspections.

Proposed Reduction in Random Inspections Could Impact Compliance With Existing Statute

The Governor's budget proposes to reduce the Community Care Licensing (CCL) random visits from 30 percent to 14 percent of facilities, resulting in estimated General Fund savings of \$2.3 million in 2008-09. Under this proposal, the majority of facilities would receive an inspection approximately once every seven years. We provide background information on existing inspection statutes, describe the potential impact of the proposed reduction on CCL's ability to meet current law, and provide the Legislature with two alternatives.

Current Law. The CCL Division of DSS performs different types of inspection visits to licensed facilities. Facilities with complaints filed against them or those with new applications receive prompt inspections. Those facilities that require close monitoring, due to their compliance history or because they care for developmentally disabled clients, receive

annual inspections. Approximately 10 percent of community care facilities require these annual visits.

The remaining 90 percent of community care facilities are subject to a routine unannounced inspection only if selected as part of a 30 percent random sample of facilities. This equates to about 21,300 facilities per year. In practice, this sampling procedure means that most of the licensed facilities in California would receive a routine visit once every three years. In addition to the 30 percent random inspection protocol, there is a separate statutory requirement that a community care facility be visited at least once every five years.

Governor's Proposal. The Governor's budget proposes to reduce the current 30 percent random inspection protocol to 14 percent of facilities. This would result in a reduction of 33 positions and an estimated General Fund savings of \$2.3 million in 2008-09, increasing to an annualized savings of \$4.7 million General Fund and 66 positions in the following year (these amounts include local assistance). Under this proposal, facilities with complaints would continue to receive prompt attention and those 10 percent of facilities that require close monitoring would continue to receive annual inspections. The remaining 90 percent of facilities would receive inspections at a substantially reduced frequency, as part of a 14 percent random sample of facilities. This proposal will require a change in statute, reducing the current random sample of unannounced visits from 30 percent to 14 percent of facilities. The Governor proposes to retain the existing statutory requirement to visit a facility at least once every five years.

Reduced Random Inspections May Impact Compliance With Existing Statute. Based on our review of CCL's workload and staffing levels, we believe the proposed reduction in random inspections would result in a maximum of 70 percent of facilities receiving a visit at least once every five years. In other words, this proposed staffing level is sufficient to support one facility visit every seven years. Thus, this proposal would be in conflict with the existing statutory requirement to visit every facility at least once every five years.

Alternatives for Legislative Consideration. The proposed reduction to random inspections to community care facilities means that CCL would be unable to comply with the existing statute to visit a facility at least once every five years. To meet the current law standard, CCL would most likely ask for additional resources as it approaches 2013 (five years from now). The Legislature has two options for resolving this issue. First, the Legislature could reduce the current 30 percent random inspection level to 14 percent and amend the existing five-year statute to a minimum requirement of at least one facility visit every seven years. Second, the Legislature could raise

the random inspection level from the Governor's proposed 14 percent to 20 percent, to fund CCL at a level that corresponds with the existing five-year statute. This second alternative would reduce General Fund savings from \$2.3 million to approximately \$1.4 million.

FINDINGS AND RECOMMENDATIONS

Health and Social Services

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Department of Alcohol and Drug Programs

- C-19 ■ **Reductions to Drug Diversion Programs Likely to Result in Increased State Costs.** Increase Item 4200-105-0001 by \$3.3 Million in the Current Year and \$10 million in the Budget Year. Increase Item 4200-101-0001 by \$1.7 Million in the Current Year and \$5.1 Million in the Budget Year. The Governor's proposal to reduce Proposition 36 and drug court programs funding in the current and budget years is likely to result in offsetting increases in state criminal justice system and child welfare services costs, including state prison expenditures. Based on the demonstrated cost-effectiveness of these programs to the state, we recommend funding these programs at 2007-08 Budget Act spending levels.
- C-22 ■ **Reductions to Proposition 36 and Drug Court Programs Could Be Offset With Other Funds.** The Governor proposes to cut funding for Proposition 36 and drug court programs that have been shown to reduce overall state costs. We recommend the Legislature consider alternative funding sources for these substance abuse treatment services as follows: (1) redirecting advertising funds from the California Methamphetamine Initiative and (2) using a portion of proceeds from state and federal narcotic asset forfeitures. These alternative funding sources could help maintain current spending levels for cost-effective substance abuse treatment services.

Department of Health Care Services (DHCS)

- C-30 ■ **Overall Caseload Estimate Is Reasonable. Reduce Item 4260-001-0001 by \$12,980,000 and Reduce Item 4260-001-0890 by \$12,980,000.** We find that the budget's caseload estimate for the Medi-Cal Program is reasonable, but there are both upside and downside risk factors to the forecast that could result in the projection being overestimated or underestimated. We recommend delaying the implementation of a pilot program allowing Medi-Cal applicants to self-certify their income and assets for savings of \$13 million General Fund.

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- C-34 ■ **Proposed Rate Reductions Could Reduce Access to Care.** Recommend that the Legislature not adopt the proposed reductions to any providers except hospitals, as these reductions may limit enrollees' access to care in Medi-Cal and other health programs. Recommend that the Legislature shift federal funds for certain hospital payments to backfill General Fund spending for various other health programs.
- C-40 ■ **Pay-for-Performance (P4P) Could Reduce Medical Costs and Improve Patient Care.** Recommend the enactment of legislation directing DHCS to implement a statewide P4P program for Medi-Cal managed care. Further recommend the Legislature adopt supplemental report language directing DHCS to explore the feasibility of implementing P4P in fee-for-service Medi-Cal.
- C-49 ■ **Providing HIV/AIDS Medications Should Be a Priority. Decrease Item 4260-001-0001 by \$2,655,000 and Increase Item 4264-111-0001 by \$2,655,000.** Recommend that the Legislature allow the HIV/AIDS Pharmacy Pilot to sunset June 30, 2008, and redirect the funds to the AIDS Drug Assistance Program.

Department of Public Health (DPH)

- C-52 ■ **Reforming Public Health Funding.** The state's existing system for administering and funding over 30 public health programs at the local level is fragmented, inflexible, and fails to hold local health jurisdictions (LHJs) accountable for achieving outcomes. This reduces the effectiveness of these programs because these services are not coordinated or integrated and LHJs cannot focus on meeting the overall goal of improving the public's health. Recommend the consolidation of certain programs into a block grant and the enactment of legislation that would direct DPH to develop a model consolidated contract and outcomes and work with counties interested in using this approach.
- C-64 ■ **Failure to Promulgate Regulations Leads to State Laws Not Being Enforced.** The Legislature relies on departments to promulgate regulations to implement laws. The DPH is behind in its promulgation of regulations and; consequently, state laws are not being enforced or applied consistently across the state. Recommend the department report at budget hearings on its status in developing and promulgating regulations.
- C-66 ■ **Direct Sexual Health Services Should Be Priority. Reduce Item 4265-001-0001 by \$127,000. Increase Item 4265-111-0001 by \$127,000.** The 2008-09 budget plan proposes \$127,000 General Fund and one position to ensure that the state's sexual health education programs are comprehensive and not based on abstinence-only. Recommend the delay of this proposal and redirect the proposed increase in funding

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to offset budget-balancing reductions for teen pregnancy and sexual health services.

Managed Risk Medical Insurance Board (MRMIB)

- C-68 ■ **Withhold Recommendation on Budget-Balancing Reductions.** Withhold recommendation on the proposed budget-balancing reductions pending completion of rate and contract negotiations with the health plans.
- C-70 ■ **Federal Funding for the Healthy Families Program (HFP) Expires in Budget Year.** Federal funding for HFP expires in March 2009. In light of this funding uncertainty, recommend the Legislature enact legislation that directs how MRMIB should maintain HFP enrollment at a level that is consistent with funding.

Developmental Services

- C-78 ■ **Regional Center (RC) Estimate Fails to Take Into Account Increases in Costs and Utilization.** Recommend the Legislature take into account that in the budget year RCs are likely underbudgeted by as much as \$113 million General Fund.

Department of Mental Health

- C-82 ■ **Sexually Violent Predator (SVP) Caseload Likely to Be Below Projected Levels. Reduce Item 4440-011-0001 by \$12.6 in the Current Year and \$13.8 Million in the Budget Year.** Updated caseload data indicate that the amount of General Fund needed for support of the state hospital system is likely to be overstated in both the current year and budget year. We recommend the Legislature recognize current-year savings of \$12.6 million and budget-year savings of \$13.8 million General Fund to reflect that the SVP caseload is unlikely to grow as fast as projected.
- C-83 ■ **Mental Health Managed Care Caseload Possibly Overstated. Reduce Item 4440-103-0001 by \$2.5 Million.** Our analysis of the Medi-Cal caseload shows that the Governor's mental health managed care budget proposal is likely overstated in the budget year. Based on a reduction of 172,000 eligible mental health managed care beneficiaries, we recommend a corresponding reduction of \$2.5 million in the budget year. We will monitor caseload trends and recommend any needed adjustments at the May Revision.
- C-84 ■ **Expanded Efforts Could Reduce Cost of Mental Health Drugs.** The cost of mental health drugs in the Medi-Cal Program continues to grow. We estimate the state can save about \$5 million General Fund

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annually by reducing inappropriate prescribing practices. Accordingly, we recommend the Legislature consider the following two options: (1) encourage county participation in the California Mental Health Care Management (CalMEND) Program and (2) expand the use of fixed annual allocations to counties that include the cost of prescription drugs. We further recommend the Legislature approve the Governor's CalMEND proposal to support three limited-term positions and expand program activities.

Department of Child Support Services (DCSS)

- C-91 ■ **Increasing the Child Support Pass-Through.** We recommend delaying the Governor's proposal to increase the child support pass-through from \$50 to \$100 until July of 2010. This saves \$5.6 million in General Fund Revenue in 2008-09 and \$11.2 million in 2009-10.
- C-93 ■ **Revenue Losses Exceed Savings for Some Proposals.** We recommend the rejection of the Governor's budget balancing reductions where estimated General Fund revenue loss exceeds estimated savings.
- C-94 ■ **Fiscal Risks of Delayed Single System Implementation.** The DCSS applied for certification of a single statewide automation system. We review system implementation, certification, and the risks associated with a delay in federal certification.

California Work Opportunity and Responsibility to Kids (CalWORKs)

- C-98 ■ **Budget Underestimates Cost of CalWORKs Grant COLA.** The Governor's budget provides \$131 million to fund the CalWORKs cost-of-living adjustment (COLA) based on an estimated California Necessities Index (CNI) of 4.25 percent. Our review of the actual data indicate the CNI will be 5.26 percent, which raises the cost of the CalWORKs COLA by \$31 million, to a total of \$162 million.
- C-98 ■ **Maintenance-of-Effort (MOE) and Caseload Reduction Credit (CRC).** Pursuant to federal law, any spending above the federally required MOE level results in a CRC which reduces California's work participation requirement in the CalWORKs program. We review the MOE requirement, the impact of the recent federal guidance concerning the calculation of the credit, and forecast CRC through 2010-11.
- C-102 ■ **Current Work Participation Requirement and Status.** Federal law requires that states meet a work participation rate of 50 percent for all families and 90 percent for two-parent families, less a CRC. We estimate California's work participation rate and find that absent policy changes, California is out of compliance with federal requirements.

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- C-105 ■ **Governor's Reforms Address Participation Shortfall and Achieve Budgetary Savings.** In order to increase work participation and achieve budgetary savings, the Governor proposes a series policy changes for the CalWORKs program. These are (1) a graduated full-family sanction that increases to 100 percent of the grant after one year in sanction status, (2) a five-year time limit on children whose parents cannot meet federal work participation requirements, (3) a nutritional supplement for working poor families, and (4) a five-year time limit for other child-only cases. We review the Governor's proposals and comment on them.
- C-113 ■ **Alternatives to the Governors Proposal.** Pre-assistance programs focusing on preparing recipients to enter the labor force within four months and a community service requirement for adults who have received five years of assistance are two policies which would increase participation with less budgetary savings than the Governor. We discuss these alternatives, estimate their impacts, and present an alternative package of CalWORKs reforms which meet the anticipated work participation shortfall.

Child Welfare Services (CWS)

- C-118 ■ **Reduction in CWS Allocations to Counties.** The budget proposes to reduce CWS county allocations, resulting in General Fund savings of \$83.7 million in 2008-09. We describe the potential impact of this proposed reduction on social worker caseloads and possible subsequent policy consequences resulting from fewer resources. We provide three alternatives to the Governor's proposal that more narrowly target the reductions in CWS expenditures.
- C-124 ■ **Rethinking the Future of CWS Automation.** The Governor's budget proposes to spend another \$247 million over the next seven years to procure a new Child Welfare computer system to meet additional business requirements. Our review indicates that the requirements can be met by updating the current system. We recommend cancelling the New System project and updating the current system, resulting in total (all funds) savings of \$184 million over the next seven years.

Foster Care

- C-129 ■ **Reduction to Foster Care Rates.** The budget proposes to reduce most Foster Care, Adoption Assistance, and Kinship Guardianship Assistance Payment (Kin-GAP) rates by 10 percent, effective June 1, 2008. This proposed reduction will save an estimated \$6.8 million General Fund in the current year and \$81.5 million General Fund in 2008-09. We provide background information on existing rates and describe potential impacts of the proposed reductions on the supply of care providers. In addition, we present two alternatives to the Governor's proposal.

Analysis**Page****Supplemental Security Income/State Supplementary Program**

- C-134 ■ **Budget Deletes State Cost-of-Living Adjustments (COLAs).** The Governor's budget proposes to delete the June 2008 and 2009 state statutory COLAs and pass-through the federal COLAs. The Governor estimates that the deletion of these COLAs will result in savings of \$23.3 million in 2007-08, and \$300.3 million in 2008-09. Based on more recent data, we estimate savings in 2008-09 will increase by \$5.3 million to a total of \$305.6 million in the budget year.

In-Home Supportive Services (IHSS)

- C-139 ■ **Reducing Domestic and Related Care Service Hours for IHSS Recipients.** The Governor's budget includes General Fund savings of about \$120 million by proposing to reduce the hours of IHSS domestic and related care services by 18 percent, and reduce county administrative funding and workload. We highlight the key features of the Governor's proposal, present some concerns, and provide alternatives for achieving savings.
- C-146 ■ **Improving IHSS Workforce Through Tiered Wages.** Although IHSS wages represent a significant cost to the state, current law grants local county boards the flexibility to establish IHSS wage levels and requirements for providers who choose to be listed on county registries. In order to improve the IHSS labor force and services to recipients, we recommend, prior to 2010-11, enactment of legislation to modify the structure for state participation in wages to reflect the training and tenure of IHSS providers.

County Administration and Automation Projects

- C-154 ■ **The Future of County Welfare Automation Consortia.** To reduce costs and increase efficiency, we recommend enactment of legislation establishing a goal of standardizing the state's human services programs on no more than two automated systems. In addition, we recommend increasing legislative oversight of information technology consortia contracts that support these systems.

Community Care Licensing (CCL)

- C-159 ■ **Reduction in Random Inspections.** The budget proposes to reduce CCL random visits from 30 percent to 14 percent of facilities, resulting in estimated General Fund savings of \$2.3 million in 2008-09. We provide background information on existing inspection statutes, describe the potential impact of the proposed reduction on CCL's ability to meet current law, and provide the Legislature with two alternatives.