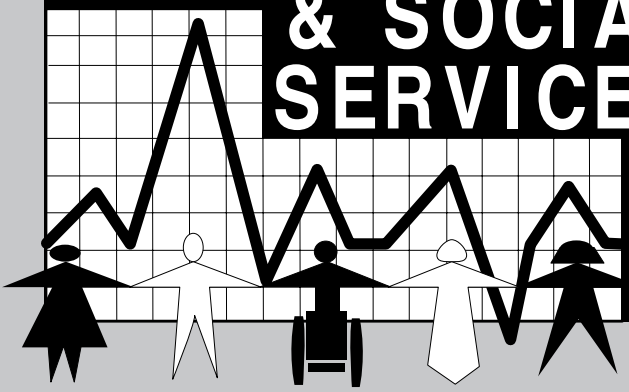
HEALTH & SOCIAL SERVICES



LAO

60 YEARS OF SERVICE

2002-03 Analysis

MAJOR ISSUES

Health and Social Services

☑ **Tobacco Securitization: Is It Good Financial And Budget Policy?**

- The administration's proposal to "securitize" a portion of the state's future tobacco settlement revenues is in general a feasible and reasonable step for the Legislature to consider as part of a comprehensive solution to the state's budget problems. However, we recommend that the Legislature consider such a transaction only if presented a more detailed proposal demonstrating that the net financial outcome would be beneficial to the state (see page C-27).

☑ **Assessing the Proposed Medi-Cal Budget Reductions**

- We recommend that the Legislature not adopt an administration proposal to reduce provider rates because of its potential negative impact on patient access to Medi-Cal services. We suggest a different approach to establishing copayments that would avoid imposing charges on essential medical services (see page C-74).

☑ **Hospitals Facing Financial Headaches**

- Our analysis finds that hospitals face significant financial pressures in the next several years, particularly from recent federal regulations limiting the amount of federal funds that can be paid to public hospitals participating in Medi-Cal. We present options the Legislature could take, even in difficult fiscal times, to deal with these problems (see page C-38).

☑ **Regional Center Mission and Funding Are Misaligned**

- Our analysis finds that Regional Center funding has more than doubled since 1995-96, yet Regional Centers are

experiencing financial problems. We propose some initial steps the Legislature could take to reduce state spending or reinvest in the system (see page C-126).

☑ Guidance on CalWORKs Five-Year Time Limit Needed

- By June 2003, about 100,000 adult recipients (20 percent of caseload) will lose their cash aid because of the CalWORKs five-year time limit. The CalWORKs statute does not provide counties with clear guidance on the number of recipients that should be exempted from the time limit or the circumstances under which employment services should continue to be provided after an individual reaches the time limit. We (1) present options for establishing guidelines for counties in providing exemptions and (2) and recommend enactment of legislation providing transportation assistance to former recipients who are working at least 20 hours per week (see page C-190).

☑ Welfare-to-Work Component of CalWORKs Underfunded in 11 Counties

- County welfare-to-work block grants in 11 counties are not sufficient to provide all recipients with the services they require to become self-sufficient prior to reaching their five-year time limit. In developing a long-term budget plan for CalWORKs, the Legislature faces difficult choices. We suggest that the Legislature consider (1) whether to increase funding above the minimum federal requirement, (2) the relative importance of grant payments versus welfare-to-work services, and (3) reallocating block grant funds among counties (see page C-203).

☑ California Currently Falls Below Federal Standards For Foster Care

- Preliminary analysis of the most recent federal Foster Care performance data (1998) indicates that California may fail to meet national standards on a number of performance measures, which could result in the loss of federal funds. We review California's record compared to other large states and make recommendations for improving California's performance (see page.C-226).

TABLE OF CONTENTS

Health and Social Services

OVERVIEW

Health and Social Services

General Fund expenditures for health and social services programs are proposed to increase by 3.3 percent in the budget year. This net increase in spending is due primarily to a variety of caseload and cost increases partially offset by suspension of cost-of-living adjustments in social services programs and certain health program reductions.

EXPENDITURE PROPOSAL AND TRENDS

The budget proposes General Fund expenditures of $22.4 billion for health and social services programs in 2002-03, which is 28 percent of total proposed General Fund expenditures. Figure 1 (see next page) shows health and social services spending from 1995-96 through 2002-03. Although the health and social services share of the budget is proposed to be less in 2002-03 than it was in 1995-96, it does increase slightly in both the current and budget years. The budget proposal represents an increase of $719 million, or 3.3 percent, over the revised estimated expenditures in the current year.

Figure 1 shows that General Fund expenditures (current dollars) for health and social services programs are projected to increase by $8.2 billion, or 57 percent, from 1995-96 through 2002-03. This represents an average annual increase of 6.7 percent.

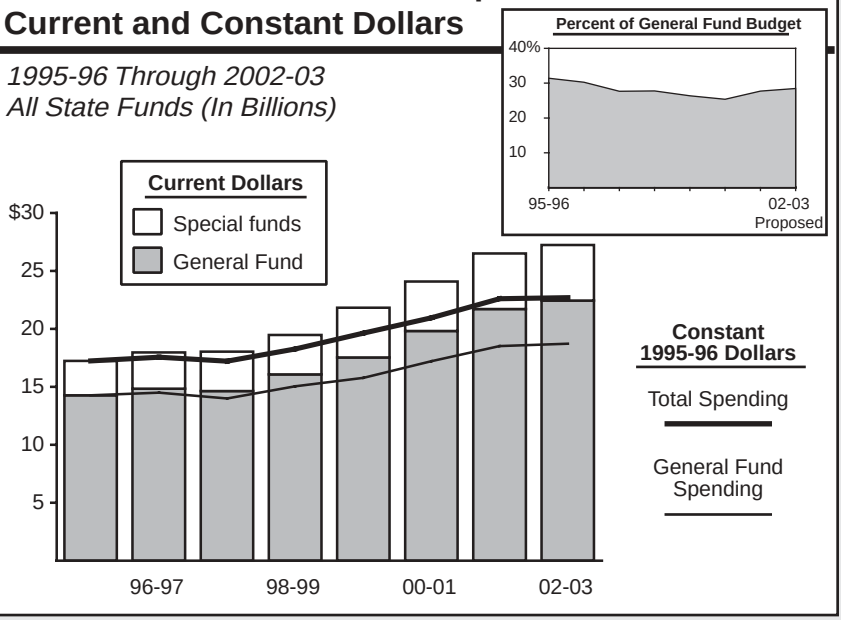
The figure also shows that General Fund spending (in current dollars) has increased each year since 1995-96, except for a slight reduction in 1997-98 due primarily to a decline in California Work Opportunity and Responsibility to Kids (CalWORKs, formerly Aid to Families with Dependent Children [AFDC]) program caseloads.

Special funds expenditures are estimated to remain level in the budget year. Under the Governor's spending plan, expenditures from a special new trust fund (tobacco settlement funds) for certain health services programs would remain about the same as in the current year. This is because, under the Governor's proposal, a portion of the tobacco settle

Figure 1

Health and Social Services Expenditures
Current and Constant Dollars

1995-96 Through 2002-03
All State Funds (In Billions)



ment funds that were originally intended to support growth in health programs will instead be used to pay debt service on money the state would borrow using future settlement proceeds as security. We discuss this proposal later in this chapter of the *Analysis*. The line-up of health programs supported with tobacco settlement funds in 2002-03 would also change significantly under the Governor's budget plan from the allocation provided in the *2001-02 Budget Act*. Some programs would be shifted to General Fund support while others previously supported from the General Fund would be shifted to the new special fund.

Combined General Fund and special funds spending is projected to increase by about $10 billion, or about 58 percent, from 1995-96 through 2002-03. This represents an average annual increase of 6.7 percent.

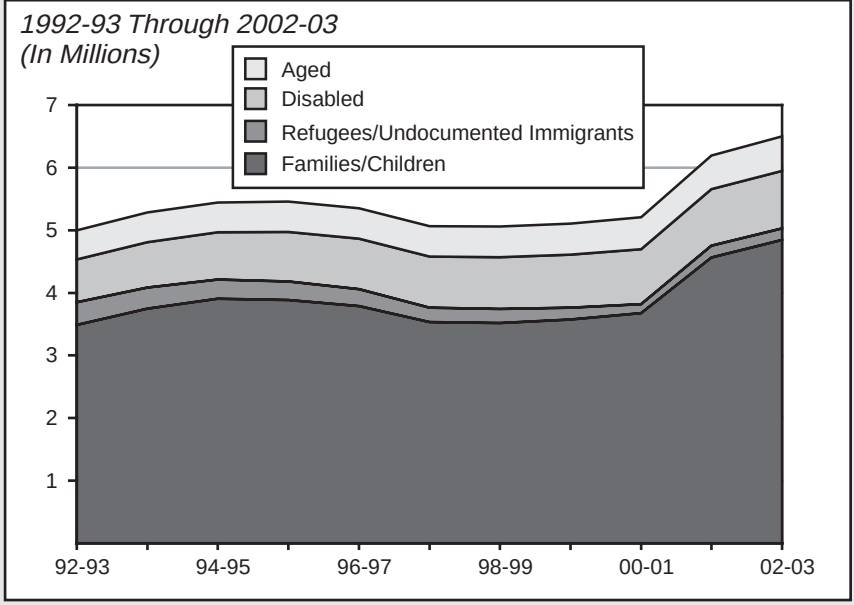
Figure 1 also displays the spending for these programs adjusted for inflation (constant dollars). On this basis, General Fund expenditures are estimated to increase by 31 percent from 1995-96 through 2002-03, an average annual rate of 4 percent. Combined General Fund and special funds expenditures are also estimated to increase by 31 percent during the same period.

CASELOAD TRENDS

Figures 2 and 3 illustrate the caseload trends for the largest health and social services programs. Figure 2 shows Medi-Cal caseload trends over the last decade, divided into three groups: families and children (primarily recipients of CalWORKs—formerly AFDC), refugees and undocumented persons, and disabled and aged persons (who are primarily recipients of Supplemental Security Income / State Supplementary Program [SSI / SSP]). Figure 3 (see next page) shows the caseloads for CalWORKs and SSI / SSP.

Figure 2

Continued Increase Forecast in Medi-Cal Caseloads



Medi-Cal Caseloads. As shown in Figure 2, the Governor's budget plan assumes that significant caseload growth will occur during the budget year in the Medi-Cal program. Specifically, the overall caseload is anticipated to increase by about 300,000 eligibles, or 4.9 percent, during 2002-03 compared to the estimated current-year caseload.

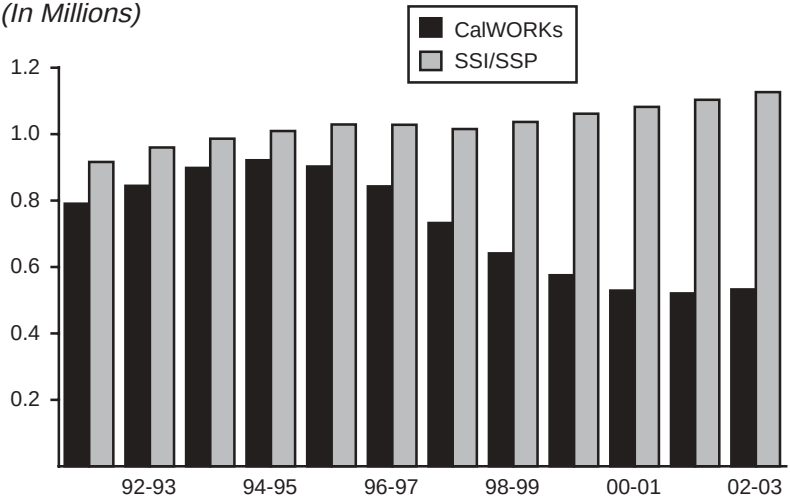
This projected trend reflects the estimated impact of a number of policy changes to the Medi-Cal program approved during the past few years. The changes resulting in the largest projected caseload increases are (1) the

expansion of health coverage for two-parent families earning up to 100 percent of the federal poverty level (FPL), (2) changes in program rules intended to make it easier for families and children to remain eligible for Medi-Cal coverage or to be enrolled in the program, and (3) a caseload shift to Medi-Cal that would result from the Governor's proposal to eliminate the Child Health and Disability Prevention program.

Figure 3

CalWORKs Caseloads Starting to Grow; SSI/SSP Caseloads Increasing Moderately

1991-92 Through 2002-03
(In Millions)



These increases in caseload would be partly offset by a projected decline in the number of CalWORKs families who are eligible for Medi-Cal benefits. Following the enactment of welfare reform laws, the number of CalWORKs families and children has declined, along with the number of persons who are on Medi-Cal due to their receipt of CalWORKs public assistance. While this decrease in the CalWORKs-related caseload would continue to be significant, the Governor's budget proposal assumes it will not be sufficient to offset the other factors discussed above that are increasing the Medi-Cal caseload.

Healthy Families Caseload. The Governor's budget plan assumes that the caseload for the Healthy Families Program will continue the rapid growth experienced since it began enrolling children in July 1998. The budget provides for the enrollment of 85,000 additional children, a 15 per-

cent increase in caseload, by the end of 2002-03 as a result of ongoing outreach efforts to increase program participation and several changes in eligibility rules. The Governor's January budget plan also delays until 2003-04 a proposed major expansion of the program to parents in families earning up to 250 percent of the FPL because of delays in obtaining federal approval for the change as well as the state's fiscal problems. The federal government announced its approval in January 2002 of a waiver initially allowing the program to serve parents in families earning up to 200 percent of the FPL. Subsequently, the Governor indicated that he was interested in going forward with the expansion provided funding were available to allow this to occur.

The CalWORKs and SSI/SSP Caseloads. Figure 3 shows the caseload trend for CalWORKs and SSI/SSP. While the number of *cases* in SSI/SSP is greater than in the CalWORKs program, there are more *persons* in the CalWORKs program—about 1.5 million compared to about 1.1 million for SSI/SSP. (The SSI/SSP cases are reported as individual persons, while CalWORKs cases are primarily families.)

To the extent that caseloads increased in these two programs, it has been due, in part, to the growth of the eligible target populations. As Figure 3 shows, the CalWORKs caseloads increased through the early 1990s due to the recession, peaking in 1994-95. Then the caseloads declined steadily for several years, bottoming out in 2001-02, and are projected to increase slightly in 2002-03.

As discussed in our annual *California's Fiscal Outlook* reports, the caseload declines are due to various factors, including the improving economy, lower birth rates for young women, a decline in legal immigration to California, changes in grant levels, behavioral changes in anticipation of federal and state welfare reform, and, since 1999-00, the impact of the CalWORKs program interventions (including additional employment services). The projected caseload increase in 2002-03 can be attributed to (1) the downturn in the economy, (2) growth in the child-only component of the caseload, and (3) the likelihood that the remaining caseload with adults probably faces substantial barriers to employment.

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. This component accounts for about one-third of the total caseload. The larger component—the disabled caseload—grew significantly faster than the rate of increase in the eligible population group (primarily ages 18 to 64) in the early 1990s. This was due to several factors, including (1) the increasing incidence of AIDS-related disabilities, (2) changes in federal policy that broadened the criteria for establishing a disability, (3) a decline in the rate

at which recipients leave the program (perhaps due to increases in life expectancy), and (4) expanded state and federal outreach efforts in the program. In recent years, however, the growth of the disabled caseload has slowed.

In the mid-to-late 1990s, the total SSI/SSP caseload leveled off and actually declined in 1997-98, in part because of federal changes that restricted eligibility. Since March 1998, however, the caseload has been growing moderately, about 2.3 percent each year.

SPENDING BY MAJOR PROGRAM

Figure 4 shows expenditures for the major health and social services programs in 2000-01 and 2001-02, and as proposed for 2002-03. As shown in the figure, the three major benefit payment programs—Medi-Cal, CalWORKs, and SSI/SSP—account for a large share of total spending in the health and social services area.

Special note should be taken of the budget-year growth rate shown for Medi-Cal benefits (3.8 percent) because it potentially understates the growth in this program (as well as other health programs supported with federal Medicaid funds). This is the result of a key assumption in the Governor's budget proposal. Specifically, the Governor's spending plan includes a proposed budget adjustment (separate from Medi-Cal and the other state health program budget items) assuming that the state will receive $400 million in federal funding in the current fiscal year. The budget assumes that these federal funds will offset General Fund money already allocated to Medi-Cal and other health programs.

The Governor's budget plan does not indicate how the $400 million would be allocated among the different health programs in the current year. Nevertheless, by lowering current-year expenditures, it would clearly result in larger year-to-year increases in such expenditures. For example, if $174 million of such federal relief were allocated to the Medi-Cal Program (the fiscal impact of the decline in federal share of costs estimated by DHS), the year-to-year growth in General Fund Medi-Cal expenditures overall would be $540 million, or 5.7 percent, rather than the smaller increase shown in Figure 4 for the Medi-Cal Program budget item.

The budget plan indicates that this funding would come from an economic stimulus package that was pending in Congress at the time this analysis was prepared. This money was expected to provide fiscal relief offsetting a formula-driven decline in the share of costs borne by the federal government. The budget does not assume that this fiscal relief continues in the budget year.

Figure 4

Major Health and Social Services Programs Budget Summary[a]

(Dollars in Millions)

	Actual 2000-01	Estimated 2001-02	Proposed 2002-03	Change From 2001-02	
				Amount	Percent
Medi-Cal					
General Fund[b]	$9,167.6	$9,704.7	$10,071.8	$367.1	3.8%
All funds	22,589.7	25,053.7	25,237.1	183.4	0.7
CalWORKs					
General Fund	1,965.9	2,014.8	2,150.9	136.2	6.8
All funds	5,396.7	5,551.0	5,943.4	392.4	7.1
AFDC-Foster Care					
General Fund	388.2	416.4	426.1	9.8	2.3
All funds	1,455.8	1,532.8	1,538.1	5.2	0.3
SSI/SSP					
General Fund	2,555.0	2,821.4	3,049.1	227.8	8.1
All funds	6,690.4	7,250.3	7,665.8	415.5	5.7
In-Home Supportive Services					
General Fund	689.3	902.8	1,008.4	105.6	11.7
All funds	1,875.1	2,378.5	2,636.2	257.7	10.8
Regional Centers/Community Services					
General Fund[b]	936.0	1,497.1	1,642.4	145.3	9.7
All funds[c]	1,888.3	2,075.5	2,215.5	140.0	6.7
Developmental Centers					
General Fund[b]	163.5	349.2	346.3	-2.9	-0.8
All funds[c]	642.6	624.7	624.8	0.1	—
Child Welfare Services					
General Fund	513.8	586.3	589.8	3.5	0.6
All funds	1,646.7	1,862.5	1,867.8	5.3	0.3
Healthy Families					
General Fund[d]	139.9	146.3	—	-146.3	-100.0
All funds	389.5	549.6	651.5	101.9	18.5
Children and Families First Commissions[e]					
General Fund	—	—	—	—	—
All funds	585.6	906.5	667.3	-239.2	-26.4
Child Support Services					
General Fund	318.5	419.6	257.8	-161.8	-38.6
All funds	458.2	1091.8	889.7	-201.1	-18.5

a Excludes departmental support.

b Beginning in 2001-02, some General Fund spending for Medi-Cal services is displayed in the Department of Developmental Services budget instead of the Department of Health Services budget.

c Includes state's share of federal Medicaid reimbursements (costs budgeted in Medi-Cal).

d In 2002-03, all General Fund costs shifted to the Tobacco Settlement Fund.

e Includes state and county commissions.

The budget for the Department of Developmental Services (regional centers and community services) would grow significantly under the Governor's budget plan even without taking into account any federal financial relief. The proposed General Fund budget for the support the state's system of Regional Centers for the developmentally disabled would grow by about $145 million, or 9.7 percent, in 2002-03 compared to the proposed current-year spending level—a rate of growth that is larger than most other major health and social services caseload programs.

Figure 4 also indicates that General Fund support expenditures for local assistance provided under the Healthy Families Program would be eliminated in the budget year. However, this change reflects a shift of some program support to the new tobacco settlement fund. There are also significant increases in expenditures of federal funds. Thus, as the figure indicates, overall spending on the Healthy Families Program would increase almost 19 percent under the Governor's spending plan.

MAJOR BUDGET CHANGES

Figures 5 and 6 (see page C-16) illustrate the major budget changes proposed for health and social services programs in 2002-03. (We include the federal 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 four categories: (1) funding caseload growth, (2) suspending cost-of-living adjustments (COLAs), (3) assuming federal penalty relief, and (4) adopting policy changes.

Caseload Growth. The budget funds caseload growth in SSI/SSP, Medi-Cal, the Healthy Families Program, and CalWORKs. The budget reflects projected caseload increases of 2.1 percent in SSI/SSP, 2.3 percent in the CalWORKs program, 4.9 percent in the Medi-Cal program, and 15 percent in the Healthy Families Program.

Cost-of-Living Adjustment Suspensions. The budget proposes to suspend statutory COLAs for CalWORKs, SSI/SSP, and does not provide the discretionary COLA for Foster Care and related programs. Similarly, the budget proposes no inflation adjustment for county administration of CalWORKs, Foster Care, Food Stamps, and Medi-Cal.

Federal Penalty Relief. Although not shown in Figure 6, the budget assumes that Congress will enact legislation eliminating the federal penalty on California for its failure to automate the statewide child support collection system. As discussed later in this *Analysis*, the penalty for 2002-03 is estimated to be $181 million, so this assumption represents substantial budget risk.

Figure 5

Health Services Programs
Proposed Major Changes for 2002-03
General Fund

Medi-Cal	**Requested:**	**$10.1 billion**	
	Increase:	**$367 million**	**(+3.8%)**

+ $230 million due to higher costs for prescription drugs, partly offset by a $61 million increase in rebates
+ $174 million to backfill a decreased federal share of support
+ $85 million for increased costs for mental health services
+ $57 million for increased premium costs for Medicare and Medicare HMOs
+ $56 million due to simplified eligibility rules and making it easier to enroll new beneficiaries
+ $42 million for continued expansion of eligibility for the working poor and the aged, blind, and disabled
+ $34 million for services provided under the Multipurpose Senior Services Program and the Adult Day Health Care Program
+ $30 million for a caseload shift due to the proposed elimination of the Child Health and Disability Prevention program

---

– $100 million in savings from changing the way drugs are purchased and provided
– $78 million due to reductions in provider rates
– $55 million from increasing the state "takeout" from a fund for Disproportionate Share Hospitals
– $31 million from the establishment of copayments for outpatient services

Healthy Families	**Requested:**	**—**
	Decrease:	**$146 million**

– $146 million from shifting all General Fund support except $1.8 million for administration to the Tobacco Settlement Fund

Figure 6

Social Services Programs
Proposed Major Changes for 2002-03
General Fund

CalWORKs	**Requested:**	**$2.2 billion**	
	Increase:	**$136 million**	**(+6.8%)**

+ $341 million to replace TANF carryover funds with General Fund
+ $158 million to backfill for reductions in countable maintenance-of-effort expenditures outside of CalWORKs
+ $96 million for a caseload increase

– $220 million due to families reaching their five-year time limit
– $189 million from redirecting county performance incentive funds to support basic program costs
– $117 million for suspending the October 2002 cost-of-living adjustment (COLA)
– $50 million from child care eligibility reforms
– $25 million for deferring state matching expenditures for federal Welfare-to-Work funds

SSI/SSP	**Requested:**	**$3 billion**	
	Increase:	**$228 million**	**(+8.1%)**

+ $162 million for the full-year cost of the January 2002 COLA
+ $51 million for caseload increase

– $133 million due to suspension of the January 2003 COLA

In-Home Supportive Services	**Requested:**	**$1 billion**	
	Increase:	**$106 million**	**(+12%)**

+ $54 million for caseload increase
+ $31 million due to the full-year cost of the January 2002 minimum wage increase
+ $26 million for higher wages for certain providers

– $27 million due to suspension of state participation in a $1 per hour wage increase for providers working in public authorities

Policy Changes

Medi-Cal. The budget provides an additional $230 million during 2002-03 above projected current-year General Fund expenditure levels due to increases in the cost of prescription drugs for Medi-Cal beneficiaries. These additional costs would be partly offset by a projected $61 million increase in the rebates the state receives on drugs for Medi-Cal patients, and an additional $100 million in projected savings from changing the way drugs are purchased and provided for patients.

About $57 million was added to the Medi-Cal budget to help pay increases in premium costs for Medi-Cal eligibles who are also enrolled in the Medicare program and Medicare Health Maintenance Organizationss. The budget plan also provides $85 million General Fund increase for costs for Medi-Cal mental health services administered by the Department of Mental Health as well as $34 million more from the General Fund for two programs to provide care for the elderly run by the Department of Aging.

Several significant spending reductions are proposed in the Medi-Cal budget, including a $78 million General Fund cut in the rates paid to physicians and certain other medical providers. The budget plan also assumes a $31 million savings to the General Fund from charging certain Medi-Cal beneficiaries copayments for specified outpatient medical services.

Healthy Families. The proposal by the Governor to postpone expansion of the Healthy Families Program to parents until 2003-04 is estimated to save $54 million in state tobacco settlement funds in the current year and more than $160 million in the budget year. As noted earlier, the Governor has since indicated his interest in going forward with this expansion in the budget year if funding can be identified for this purpose.

Other Health Programs. Other state-supported health programs would be reduced. The budget assumes net savings of more than $50 million by eliminating the Child Health and Disability Prevention (CHDP) program, which provides screening and immunization services to children, and shifting the caseload to Medi-Cal, Healthy Families, and the Expanded Access to Primary Care (EAPC) community clinic program. A $25 million augmentation provided in the current fiscal year to assist trauma care centers would lapse in 2002-03. A cancer research program would be reduced $7 million in the current fiscal year, with all $25 million for the program eliminated in the budget year. General Fund support for local assistance for drug and alcohol programs would drop by about $50 million while local assistance for mental health services would decrease by about $60 million compared to current-year spending levels. While Regional Center programs would increase overall, they would face an unspecified $52 million reduction in the purchase of services for consumers.

However, the Governor's budget plan contains a number of significant augmentations for public health programs, including an additional $16 million from the tobacco settlement fund to continue implementation of the new Breast and Cervical Cancer Treatment program and a $20 million increase in grants for youth antitobacco efforts from that same source. A proposed $10 million reduction in the EAPC program would be restored in both the current year and budget year, with an additional $17.5 million provided in 2002-03 to handle caseload shifted to the program from CHDP. The AIDS Drug Assistance Program budget would increase by $20 million General Fund, while an additional $7 million in special funds would be used to bolster the Childhood Lead Poisoning Prevention Program.

California Work Opportunity and Responsibility to Kids. In order to hold General Fund spending on CalWORKs at the federally required minimum, the budget proposes several changes to reduce cost pressures. These include (1) redirecting $189 million in county performance incentives and $50 million in funds formerly appropriated to the California Community Colleges to fund basic employment services and grants, (2) suspending the statutory COLA, and (3) reforming child care eligibility rules and reimbursement rates.

CROSSCUTTING ISSUES

Health and Social Services

FEDERAL FUNDS RISK

Legislature Needs More Information on Federal Funds Maximization Proposal

The Governor's budget for Health and Human Services assumes savings of $50 million from unspecified proposals to maximize federal funds. Because no details are available concerning these proposals, this assumption represents a budget risk. We recommend that the Health and Human Services Agency provide details on its plan for achieving these savings prior to budget hearings.

Schedule 9 of the Governor's budget summary includes a "Miscellaneous Adjustment" of $50 million in additional federal funds that offset General Fund costs. Because no details concerning this proposal were available at the time this analysis was prepared, there is no way to assess the likelihood that California will receive these federal funds. Accordingly, assuming their receipt creates substantial budget risk. In order for the Legislature to exercise its budget review responsibilities, we recommend that the Health and Human Services Agency provide details of its plan for achieving these savings prior to budget hearings.

We note that the budget for Health and Human Services assumes other savings (totaling $616 million) that are dependent on federal action and, thus, represent substantial additional budget risk. These savings assumptions are summarized in Figure 1 (see next page) and are discussed later in the relevant sections of this *Analysis.*

Figure 1

Savings Assumptions Contingent on Federal Action

(In Millions)

Department/Proposal	2001-02	2002-03	Total
Health and Human Services Agency			
Unspecified proposals to maximum federal funds	—	$50	$50
Health Services			
Offset for reduced Medicaid cost-sharing	$400	—	$400
Social Services			
Restoration of federal Food Stamp eligibility	—	$35	$35
Child Support Services			
Automation penalty relief	—	$181	$181
Totals	**$400**	**$266**	**$666**

WORKFORCE DEVELOPMENT

GOVERNOR PROPOSES TO RESTRUCTURE THE WORKFORCE DEVELOPMENT SYSTEM

The Governor' budget summary outlines a proposal to reorganize the state's job training programs into a new labor agency and to restructure the state's workforce development system. The restructuring proposal includes (1) the potential consolidation of up to 34 separate job training programs, (2) providing more funds in block grants to local agencies, (3) increasing standards of accountability, and (4) shifting the focus of workforce development toward economic development. We review and comment on the Governor's proposal.

Summary of the Governor's Proposal

The Governor's budget summary presents a broad outline intended to improve California's workforce development system. The outline essentially consists of two proposals: (1) a specific proposal to create a new labor agency and (2) a more general strategy for improving the state's $4.6 billion ($2 billion General Fund) workforce development system. Workforce development refers to a myriad of state programs that provide training for workers or help match job seekers with employers.

Creating a Labor Agency. The proposed labor agency would be comprised of the Employment Development Department (EDD), the Department of Industrial Relations (DIR), the Workforce Investment Board (WIB), and the Agricultural Relations Board (ALRB). All apprenticeship programs currently operated by the Department of Education (SDE), and the California Community Colleges (CCC) would be consolidated under DIR.

Strategy for Improving the Workforce Development System. The Governor provides a general plan for reforming the workforce development system in order to (1) promote access to services and accountability,

(2) eliminate program duplication, and (3) achieve cost-effectiveness. The four primary elements of this plan are:

- Streamlining the existing system which is composed of 34 separate programs divided among 14 different state departments.
- Increasing local flexibility by placing all existing funding streams into block grants.
- Applying standards of accountability to state and local job training programs (including job retention after placement, wage gain, academic achievement, and return on public investment).
- Shifting the focus of workforce development toward economic development.

Process for Reforming the Workforce Development System

Creation of the proposed labor agency and reform of the workforce development system will proceed on two separate tracks. With respect to creation of the proposed labor agency, the process for reorganizing state government is specifically prescribed in the State Constitution and in statute. As discussed below, the administration plans to begin this process in the near future. Conversely, the administration has no specific plan for exactly which programs will be consolidated as part of the workforce development reform effort, or when these reforms would take place. The administration had indicated, however, that a task force will be established to consult with stakeholders and develop specific policy options for reforming the workforce development system by the time of the May Revision.

Process For Reorganizing State Government. The State Constitution (Article 5, Section 6) grants the Governor the authority to reorganize functions among executive officers and agencies through legislation. State law (Section 8523 of the Government Code) requires that the Governor submit any reorganization plan to the Milton Marks "Little Hoover" Commission on California State Government and Organization and Economy 30 days prior to submitting any such plan to the Legislature. The Little Hoover Commission then must report its findings on the proposed reorganization within 30 days to the Governor and the Legislature. The Legislature then has 60 days to reject or accept the reorganization plan submitted by the Governor. The administration indicates that it intends to start this process so that it can be completed prior to the start of the 2002-03 fiscal year.

Criteria for Evaluating the Reform Proposals

The current workforce development system includes a total of 34 programs with a combined budget totaling $4.6 billion in 2002-03 ($2 billion General Fund). Fourteen separate departments or boards currently oversee these programs. Given the magnitude of the resources involved and the degree of fragmentation in existing programs, the Governor's proposals for streamlining the system, increasing local flexibility through block grants, increasing accountability, and fostering economic development are reasonable. Reforming this fragmented system presents an opportunity for the Legislature to improve the delivery of workforce development services in California. In their deliberations on reforming the workforce development system, we suggest that the Legislature and the task force use the following criteria as they consider the proposals.

- Does the change in organizational structure result in an overall increase in program efficiency and effectiveness? Do the benefits of the change outweigh the negative impacts of any program disruptions?
- Does the change correct an existing problem that impedes delivery of workforce development services?
- Does the change in organizational structure need to occur now, or can it occur later and/or be phased in over time? Are there incremental changes that can be made to reduce any program disruptions but still allow for program improvement?

Comments on the Reform Proposals

In order to assist the Legislature and task force in improving the workforce development system, we comment on various aspects of the Governor's proposal.

The Proposed Labor Agency

Although the Governor identifies a total of 34 training programs currently overseen by 14 different departments or boards, the administration has not decided which of these programs will be consolidated into the proposed labor agency. At the time this analysis was prepared, the labor agency was to be comprised of the EDD, DIR, WIB, and ALRB.

Comments on the Labor Agency. We note that the ALRB does not provide job training. Rather, the ALRB (1) conducts union certification elections to determine collective bargaining representation and (2) investi-

gates and resolves unfair labor practice disputes. The Public Employee Relations Board performs virtually identical functions for public employees. Similarly, the Department of Fair Employment and Housing and the Fair Employment and Housing Commission enforce laws against discrimination in employment, housing, and public accommodations. The Legislature may wish to consolidate some of these union certification, dispute resolution, and discrimination prevention functions under one board and / or department within the proposed labor agency. This approach could increase efficiency by avoiding duplication of effort.

Apprenticeship Consolidation Proposal

The Governor proposes that all apprenticeship programs currently operated by the SDE, and the CCC would be consolidated under DIR.

Comments on Apprenticeship Consolidation. The DIR does not currently administer apprenticeship programs. The DIR does have a Division of Apprenticeship Standards (DAS) which sets standards for certification of apprenticeship programs. Although DAS's certification functions could be consolidated with other departments (like SDE or CCC) which operate apprenticeship programs, we believe the lead department should be one that has demonstrated its expertise directing apprenticeship programs.

Vocational and Adult Education Consolidation Proposal

All vocational and adult education programs would be consolidated under CCC. According to the Governor's budget summary, community colleges currently receive approximately $459 million (Proposition 98 General Fund) for vocational education and related job development services. The budget proposes to move approximately $1.3 billion ($1.1 billion Proposition 98 General Fund and $138 million other funds) worth of additional adult and vocational programs to CCC from the SDE and the Secretary for Education.

Comments on the Vocational and Adult Education Proposal. We believe that, in principle, consolidating vocational and adult education programs under one state agency, such as CCC, has merit. It is possible that consolidation could reduce administrative costs, increase coordination of services, and preserve access. However, the administration has not been able to provide the Legislature with sufficient information to evaluate whether the consolidation envisioned by the administration is an appropriate one.

Increasing Local Flexibility Through Block Grants

To the extent permitted by federal law, the Governor proposes to place all existing job training programs into block grants. Specifically, the Governor has identified (1) $2.9 billion in funding ($459 million General Fund) for employment services, economic development, and job training services; and (2) $1.7 billion in funding ($1.6 billion General Fund) for adult and vocational education programs. The Governor proposes that these funding streams be consolidated into block grants.

Comments on the Block Grant Proposal. We concur with the concept of increasing local flexibility through block grants. However, the Governor's budget does not identify the local entity or entities that would receive the proposed block grant. Currently, there are a number of local entities involved in workforce development including county welfare departments, community college districts, and local WIBs. Under current state and federal law, the local WIBs receive approximately $500 million in federal Workforce Investment Act funds. In theory, these local WIBs have board members representing these other entities. Thus, the local WIBs potentially could be the recipient of the proposed block grant. We note that any shift in funding to the local WIBs would require a similar shift in responsibility.

Increasing Accountability

The administration proposes to hold state and local job training programs to the same standards of accountability that were enacted as part of K-12 education reforms in 1999-00. Although Chapter 771, Statutes of 1995 (SB 645, Johnston), established a job training report card in 1996, implementation of this program has been hampered by lack of funding and concerns involving federal confidentiality laws. To inform policymakers, service providers, and the public, the Governor proposes specific outcome measures including (1) job placement and duration of job retention after placement, (2) wage increase, (3) academic achievement, and (4) the return on public investment. The administration proposes to redirect existing funds to support the accountability system started by Chapter 771.

Comments on the Accountability Proposal. We concur with the accountability goals outlined in the Governor's proposal. Nevertheless, the Legislature needs more information about how much funding will be redirected to the accountability system, and what specific steps the administration proposes in order to restart the job training report card program created by Chapter 771.

Shifting the Focus to Economic Development

The administration believes that the workforce development system should focus on long-term economic development rather than short-term job training. To this end, the Governor proposes that job training programs (1) be responsive to labor market and industry demands and growth opportunities, (2) provide opportunities to move up in the workforce, and (3) reflect the needs of larger regional markets rather than the needs of a single small community.

Comments on the Shift to Economic Development. We generally concur with the Governor's goals of using employment training to foster economic development that makes sense on a regional, rather than local level. We note that certain job training programs, such as those designed to move California Work and Responsibility to Kids recipients into employment, will need to retain their focus of quickly moving individuals into jobs. As the administration develops more specific proposals for redirecting job training programs toward economic development, the Legislature will need to weigh the relative importance of such economic development against the short-term job training needs of certain individuals.

Conclusion

The current workforce development system is fragmented among many departments. Generally, we concur with Governor's goals for streamlining the system, increasing local flexibility through block grants, increasing accountability, and fostering economic development. However, in order for the Legislature to exercise its oversight and policy review responsibilities with respect to improving workforce development, the administration needs to provide specific proposals that are designed to achieve the goals presented by the Governor. In presenting more specific proposals, the administration should identify the problems that it intends to solve and how the proposed reform measures will solve the identified problems.

TOBACCO SETTLEMENT FUND

BACKGROUND

In 1998, the attorneys general of most states and the major United States tobacco companies agreed to settle more than 40 pending lawsuits brought by states against the tobacco industry. These lawsuits sought reimbursement for the expenses states had incurred for smoking-related health costs. As part of the agreement, the tobacco companies are required to make annual payments to the states in perpetuity. California's share of these receipts over 25 years is expected to total about $21 billion, with about one-half of that amount ($10.5 billion) going to the state government and the remainder going to local governments.

From 1998-99 through 2000-01, the revenues the state received from the settlement were deposited into the General Fund. Last year, however, the Legislature adopted budget bill language (Chapter 171, Statutes of 2001 [AB 430, Aroner]), that established a new special fund—the Tobacco Settlement Fund (TSF)—to support a variety of health care programs administered by the Department of Health Services and the Managed Risk Medical Insurance Board with revenues from the settlement of the case.

Chapter 171 specifies that appropriations from the TSF shall be used for health programs, including:

- Health care expansions in the Medi-Cal, Healthy Families, and other state programs.
- Health care education and outreach, including efforts to help reduce the use of tobacco products.
- Smoking cessation services.
- Enforcement of tobacco-related statutes.
- Expansions of primary care and other state-funded clinics that serve low-income, uninsured, or underinsured Californians.

Summary of Governor's Budget Proposals. The Governor proposes to spend about $476 million in 2002-03 from the TSF for health programs. He further proposes to change state law so that an additional $62 million in revenues anticipated from the legal settlement—money that would otherwise also be dedicated to health programs—could instead be used in 2002-03 to pay the debt service resulting from a plan to address the state's fiscal problems by selling future TSF proceeds for $2.4 billion in cash.

The Governor's budget also reflects a significant decrease in anticipated spending from the TSF in the current fiscal year. The 2001-02 budget allocated about $73 million from the legal settlement to the General Fund and the remaining $402 million to the TSF for various health programs. The Governor's revised budget plan assumes that the expenditures made from the TSF for health programs during the current fiscal year will actually be about $338 million, or $64 million below the level specified in the *2001-02 Budget Act*.

This projected decrease in current-year spending is due primarily to the administration's plan to initially postpone implementation of an expansion of the Healthy Families Program to parents until 2003-04 because of federal delays in approving this expansion and the state's current fiscal problems. (Following the recent federal approval of the waiver, however, the Governor has indicated his intention to revise his budget plan to enable the program expansion to proceed.) Consistent with the legislation creating the special fund, this $64 million in unspent TSF funds would be carried over to the budget year and, thus, be available for expenditure in 2002-03 for the support of health programs.

The Governor's budget also proposes to significantly change the lineup of health programs that would be supported from the TSF. Some programs would be shifted to General Fund support while others previously supported from the General Fund would be shifted to the TSF.

We discuss the Governor's major proposals relating to the TSF in more detail below.

SECURITIZATION OF TOBACCO SETTLEMENT REVENUES

The administration's proposal to sell, through securitization, its rights to a portion of the state's tobacco settlement revenues for $2.4 billion is, in general, a feasible and reasonable step for the Legislature to consider as part of a comprehensive solution to the state's budget problems. In considering this specific proposal, the Legislature will have to weigh the potentially adverse implications of securitization for future funding of health programs against its contribution in the short term to

addressing the state's budget problem. We recommend that the Legislature consider such a transaction only if the administration presents a more detailed proposal and an analysis demonstrating that the net financial outcome would be beneficial to the state.

The Governor's Budget Proposal

Future Revenues Would Be Sold for Cash. As part of his plan to deal with California's budget shortfall, the Governor proposes to "securitize" future tobacco settlement revenues (TSRs) to obtain $2.4 billion that would be used to help balance the 2002-03 budget and to meet the state's short-term cash flow needs. The term "securitization" simply means that the state would sell part of its long-term TSR stream for cash that would be obtained in the short term—in this case, the current fiscal year. The conversion of the future TSRs into cash would be accomplished through the issuance of a $2.4 billion revenue bond issue secured by the state's future TSRs. (This $2.4 billion is equivalent to roughly 45 percent of the present value of the TSR stream expected over the bonds' lifetime.)

The administration's rationale for this proposal is that, absent the receipt of the $2.4 billion in bond proceeds, it would be forced to make further reductions in health or other state-supported programs to keep the state budget in balance. The administration has also indicated that these funds could be needed to ensure there is sufficient cash available to enable the state to pay its bills.

As noted earlier, the securitization debt service payment would amount to $62 million in 2002-03, leaving $476 million available in the budget year for various health programs. The administration's estimate of annual debt service costs for the bonds assumes a 23-year bond maturity, a level-payment structure of $190 million annually in 2003-04 and thereafter (where initial principal payments are relatively small, like with a typical home mortgage), and an interest rate of about 5 percent (similar to that for investment-grade general obligation debt).

We are advised that the administration's plan for issuing the bonds would give bondholders "first call" on the state's receipts from the legal settlement until the bonds are retired. Put another way, the administration's securitization plan assumes that, should future TSRs be less than expected, bondholders would be promised that their payments would "come first" and any TSR shortfall would be passed along to the health programs supported from the TSF.

State legislation would be necessary to implement the Governor's plan. That is because authorization is needed to incur long-term debt. Legislation is also being sought because the statute creating the TSF speci-

fies that, in 2002-03 and thereafter, the total amount of the state's share of monies received pursuant to the tobacco settlement agreement is to be deposited in the TSF. Under the Governor's proposal, the share of settlement funds needed for debt service would not be deposited in the TSF.

The question of whether securitization makes sense involves two separate issues: (1) does securitization make sense from a strictly *financial* perspective, and (2) is it desirable from a *policy* perspective, both in terms of its implications for the state's health-related programs and its overall effect on budgeting for the state's future needs?

Does Securitization Make Financial Sense?

From a strictly financial perspective, a determination of whether securitization is a good or a bad idea for the state depends upon the specific provisions included in the securitization arrangement involved and several other key factors. These additional factors are:

- The risk premium that investors demand as reflected in the interest rate on the bonds or other provisions, given the uncertainty about future TSRs.
- Whether the bonds will be tax-exempt versus taxable.
- What percent of future dollars the state feels is reasonable to give up in order to get dollars today.
- Whether bond-related reserve funds have to be maintained and, if so, how they can be invested and who gets the proceeds.
- The extent to which TSRs in excess of debt-service costs in any given year must be used to accelerate retirement of the bonds, versus being available to the state.

From a financial perspective, securitization should only proceed when all of the above factors have been taken into account and it can be shown that its net financial outcome is beneficial to the state. However, neither a detailed securitization proposal nor a comprehensive financial analysis has thus far been presented to the Legislature that explains how the administration's plan takes these key factors into account.

Is Securitization a Sound Health and Budget Policy?

Several Factors to Consider. Two important factors should be weighed in any determination as to whether securitization is an appropriate policy from a health and budgeting perspective. These include the potential impact of shifting a portion of the resources now dedicated by statute to health programs to debt repayment, including the further effect on these

programs if future TSRs fall short of projections or if the cost of borrowing the $2.4 billion is higher than anticipated. The Legislature should also consider the longer-term impact on overall state finances of borrowing against these future revenues.

Proposal Would Revise Recent Funding Commitments. Adoption of the Governor's securitization plan would represent a revision of the policy adopted last year to commit all TSRs received during 2002-03 and thereafter to certain health programs.

The impact of securitization in the budget year would be to divert from the TSF an estimated $62 million for securitization debt-service payments that would otherwise be used for the support of health programs. However, as it considers the impact of securitization, the Legislature should also take into account the additional reductions that would have to be made in health programs (as well as other types of state programs) if the plan to borrow against future TSRs does not go forward. The administration has indicated that it would make much deeper cuts in health programs in the budget year if the $2.4 billion gained from securitization were not available to help close the overall state budget gap between projected revenues and expenditures.

Impact on Fund Greater After 2002-03. Securitization would only divert about 12 percent of the TSF revenues that the Department of Finance estimates would otherwise be available for expenditure during 2002-03. The ongoing impact of securitization upon the state's health programs would become more significant in 2003-04 and the fiscal years that follow, however. This is because, in 2003-04, the share of the TSF that would be diverted to debt service would grow as the state's remaining share of TSRs declined. Specifically, the administration estimates that the debt service for the securitization bonds would increase in 2003-04 from $62 million to about $190 million and would remain at that level until the bonds were retired in 2024.

The administration has stated its intention to backfill the future loss of TSF for health programs with General Fund resources. However, the administration has also acknowledged that, in the event of future budget shortfalls, these programs would henceforth have to compete with other state programs for support from the General Fund. This is because the TSRs would no longer be dedicated to their support.

Settlement Revenues Subject to Uncertainties. The full budgetary impact of securitization on health programs could be greater than discussed above because of the continued uncertainty about how much the state will actually receive in TSFs. This funding stream is subject to a variety of risks.

For example, potential disputes between the tobacco companies and the states that are a party to the settlement agreement over the calculation of their regular settlement payments could result in reduced TSR payments. In addition, a decline in cigarette consumption that is sharper than the decline that was projected when the settlement was structured could result in a shortfall in future receipts. Finally, the inability of U.S. tobacco companies to make their full payments due to financial problems could reduce payments to the states.

All of these risks add uncertainty to the accuracy of the long-term projections of the TSRs the state is expected to receive. We would note that the state Department of Justice (DOJ) estimates of TSRs are lower than the administration's during the 2004 through 2007 calendar years by about $29 million annually.

Given the long-term nature of these estimates, we believe the administration's assumptions on TSRs are reasonable. But these differences in the administration's and DOJ's estimates over the long term do demonstrate that there is some risk that the monies available for health programs could be less than the administration has assumed in its securitization plan.

Of course, these risks to the flow of TSRs exist independent of whether any securitization proposal goes forward. Supporters of securitization have pointed out that one potential benefit of such a transaction is that it would permit the state to receive funding that it might never receive at all in the event that payments from tobacco companies were halted at some point in the future due to financial problems.

Debt Service Costs Could Be Even Higher. If the state proceeds with securitization, the ongoing funding available for health programs could also be affected by the terms that the state could get from the financial marketplace on its bonds. Given investor uncertainties about the amount of future TSRs, the cost of debt-service payments could turn out to be significantly higher than the administration has estimated, especially during the next several years. This situation could result if investors demanded a higher interest rate or other costly provisions in the transaction intended to make the bonds more secure, such as an accelerated repayment structure, when funds are available.

As an illustration of the potential impact of added costs, selling the bonds at an interest rate of 6 percent instead of 5 percent would increase debt-service costs by $8 million in 2002-03 and by $16 million annually thereafter. These added costs would leave less funding available for the TSF and put at greater risk the programs that are to be supported from that funding source.

Securitization and Budget Policy. In our December 2001 report to the Legislature, *Addressing the State's Fiscal Problem*, we urged the Legislature to consider a wide range of budget solutions, including options to augment revenues, reduce state programs, and "monetize" physical and financial assets that are not needed now. We also noted that the state could appropriately consider a mix of both one-time solutions as well as those that are repeatable or ongoing in nature. Securitization of TSRs was identified as an example of such an option. Our analysis suggests that securitization is, in and of itself, a feasible and reasonable strategy that could be considered as part of a comprehensive budget solution. The question is: should we actually do it?

Analyst's Recommendation. In making its decision regarding the Governor's securitization proposal, the Legislature will need to assess several trade-offs. The Legislature will have to weigh the long-term, potentially adverse implications of securitization for health program funding against its contribution in the short term to addressing the state's budget problem. The Legislature will also have to take into account the alternatives to securitization—the various other spending and revenue actions that would probably have to occur in the absence of receiving the $2.4 billion from such a transaction. Finally, the Legislature must ensure that any securitization arrangement that is considered makes financial sense.

Accordingly, we recommend that, prior to budget hearings and any securitization of future tobacco settlement revenues, the administration present its specific securitization plan to the Legislature and an analysis of its estimated net financial outcome to the state. Absent this specific information, the Legislature cannot determine from a strictly financial perspective whether this proposed transaction is a good or a bad "deal" for the state.

If the Legislature confirms on the basis of that information that securitization makes financial sense and is an appropriate budget solution, there are additional issues it may wish to consider.

For example, if the Legislature deems the health programs now supported from the TSF to be an important priority, it should consider what specific steps could be taken this year to ensure that support for these programs is not disrupted when the share of tobacco settlement money diverted to debt service escalates beginning in 2003-04.

This could involve identifying alternative revenue sources or savings in state programs that, taken as a whole, would eventually be sufficient to offset the future loss of funding to the state that would result from securitization. Some revenue or expenditure reduction options considered by the Legislature might take until 2003-04 or later to realize their full impact. While such options might not be helpful in addressing the

2002-03 budget shortfall, acting on some of them now may help offset the impact of securitization on health program funding in subsequent years.

The Legislature may also wish to consider whether maintaining a separate special fund of proceeds from the tobacco settlement for the support of health programs would continue to make sense once almost half of this revenue stream is diverted to debt service for securitization bonds. One alternative approach would be to rescind the legislation creating the TSF, once again allow all future TSRs to be deposited in the General Fund, and provide future funding for those particular health programs now funded from the TSF that the Legislature deems to be its highest priority.

SETTLEMENT FUND COULD HAVE SHORTFALL

The amount of tobacco settlement revenues available for support of state health programs could be significantly less than the $476 million assumed in the Governor's budget, due in part to a pending dispute over payment amounts with one tobacco company. We recommend that the state Department of Justice, which monitors implementation of the tobacco settlement, report at budget hearings on whether the state is likely to face a shortfall in the funding available for health programs.

Funding Could Come Up Short. As noted earlier, the Governor's budget proposes to spend about $476 million in 2002-03 from the TSF for health programs. This total includes about $64 million in TSF funds that the budget plan assumes would go unspent in the current fiscal year and be carried over to the budget year for the support of health programs.

However, an ongoing dispute with one tobacco company over the amount of payment it owes under the settlement could result in significantly less funds being available to the state for the support of health programs. As a result of this dispute, we are advised that a $124 million payment received by the state on December 31, 2001, was about $12 million less than anticipated. Unless this dispute is resolved, an estimated $337 million payment due in April 2002 could also be below projections and the additional TSRs anticipated in the budget year could also be overstated, according to DOJ.

Analyst's Recommendation. The situation discussed above is unlikely to have any immediate effect on state health programs because $64 million was expected to be left unspent in the current fiscal year. However, if such shortfalls were to persist, they could complicate decision-making on the budget by potentially reducing the funding available in the budget year for the support of health programs by as much as several tens of millions of dollars. Accordingly, we recommend that DOJ report at the

time of budget hearings on TSRs and the related dispute over such payments, so that the Legislature can better assess the amount of funds that will be available for support of health programs in the budget year.

LIST OF TSF-SUPPORTED PROGRAMS WOULD CHANGE

The budget makes significant changes in the line-up of health programs that would receive support from the Tobacco Settlement Fund (TSF). The Legislature should consider whether the programs selected to receive dedicated funding from the TSF are in-line with its own health program priorities and how the line-up of programs it chooses to support from TSF would fit with the funding available from this revenue source in future years.

Although the amount of money allocated from the TSF for health programs under the Governor's budget for 2002-03 is about the same as the level of funding initially authorized in the *2001-02 Budget Act*, the Governor's budget plan would significantly change the way TSF resources would be allocated in the budget year. These proposed changes in TSF allocations are summarized in Figure 1(see next page).

This revised TSF spending plan primarily reflects the Governor's initial proposal to delay expansion of the Healthy Families Program to parents. (As discussed further in our analysis of the "Healthy Families Program" later in this chapter, the Governor has since indicated his intention to revise his budget plan to enable the program expansion to proceed in the budget year with a yet-unspecified source of state funding.) This expansion in program eligibility had been funded entirely with TSF resources in the *2001-02 Budget Act*, but would not be funded from any sources in 2002-03 under the Governor's January proposal. The spending plan would shift the ongoing Healthy Families Program for children from the General Fund entirely to the TSF, except for state operations costs.

Other health programs are also affected by the Governor's proposal. For example, support for the expansion of Medi-Cal Program coverage for aged, blind, and disabled with incomes below 133 percent of the federal poverty level would shift from the TSF to the General Fund, although this change in funding source would have no direct programmatic effect on this expansion in coverage.

The Governor's budget also proposes to strike all TSF resources in the budget year from the Child Health and Disability Prevention program (CHDP), in keeping with the Governor's 2002-03 budget proposal to eliminate the program and shift its caseload to Medi-Cal, Healthy Families, and the Expanded Access to Primary Care (EAPC) community clinic

Figure 1

Allocation of Tobacco Settlement Revenues

(In Millions)

	2001-02		
	Budget Act Allocation	Governor's Revised Budget Allocation	2002-03 Budget Year
Department of Health Services			
Medi-Cal Expansion for working poor	$123.0	$123.0	$127.1
Medi-Cal Aged, Blind, and Disabled with incomes below 133 percent of FPL	47.0	47.0	—
Breast and Cervical Cancer Treatment	14.4	14.8	27.9
Prostate Cancer Treatment	20.0	20.0	20.0
Expanded Access to Primary Care	—	—	17.5
Child Health and Disability Prevention Program	63.3	58.0	—
Youth Antitobacco Programs	20.0	20.0	35.0
Subtotals	$287.7	$282.8	$227.5
Managed Risk Medical Insurance Board			
Healthy Families	$114.2	$55.3	$247.1
Access for Infants and Mothers Program	—	—	1.7
Subtotals	$114.2	$55.3	$248.8
Totals	**$401.9**	**$338.1**	**$476.3**

program. The Governor proposes to fund a $17.5 million augmentation to EAPC to handle this increased caseload from the TSF.

The administration's spending plan would augment base funding for youth antitobacco programs by $20 million in the budget year, increase the budget-year allocation of TSF to the Breast and Cervical Cancer program by about $13 million in accordance with the caseload growth projected for that program, and replace $1.7 million in General Fund support for the Access for Infants and Mothers Program with TSF.

Fitting Programs to Funds a Future Problem. As it considers which programs to finance with TSRs in 2002-03, it should also consider how this program line-up would fit with the funding that would be available from this revenue source in future years. Our analysis indicates that the TSF program line-up proposed by the Governor would significantly ex-

ceed the TSRs available in 2003-04 and subsequent years. That is due to three factors:

- The increase from $62 million in 2002-03 to $190 million in 2003-04 (and thereafter) in the annual debt-service payments resulting from securitization.
- The fact that the 2003-04 TSF spending plan would not include the carryover of any unspent funds from the prior year. The 2002-03 budget plan proposes to spend all of the $64 million projected to be carried over from 2001-02 and sets no funding aside in reserve for future needs.
- Significant caseload and cost increases expected in the Healthy Families Program for children, which the Governor proposed to shift to support from TSF in the budget year. We estimate that the cost of this caseload would grow by as much as $90 million in 2003-04, and continue to have cost increases in the range of tens of millions of dollars annually in subsequent years.

Taking into account the combination of these three factors, we estimate a gap of about $340 million in 2003-04 between the projected cost of these TSF-supported programs and the TSRs actually available to pay for them. We estimate that this gap would grow to about $450 million annually by 2006-07.

Analyst's Recommendation. We discuss the Governor's proposals relating to youth antitobacco programs, CHDP, and EAPC in the "Public Health" section of this chapter of the *Analysis*. Our review of issues related to the Healthy Families Program can be found in the section of our analysis of "Major Risk Medical Insurance Board" programs, which can also be found in this chapter.

The TSF spending plan proposed by the Governor reflects the administration's priorities for future health funding. Once the Legislature has determined which health programs it wishes to fund, and the level of support for these programs that it deems to be appropriate, it should carefully consider which health programs it wishes to fund from the TSF. The Legislature should also consider how the line-up of programs it chooses to support from the TSF would fit with the funding that would actually be available from this revenue source in future years.

HOSPITALS FACING FINANCIAL HEADACHES

Hospitals face a number of financial pressures in the next several years. Recent federal regulations limiting the amount the state can pay public hospitals participating in the Medi-Cal Program will further exacerbate financial problems for some of these hospitals. In the following pages, we summarize the role of these hospitals in California, examine their financial status, describe the challenges that hospitals face over the next few years, and identify issues that the Legislature might want to investigate further.

Background

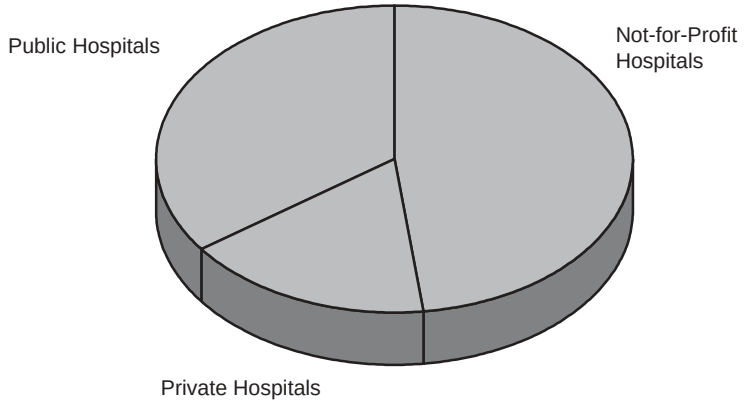
Not-For-Profit and Public Hospitals Care For Most Low-Income Patients. Figure 1 shows the three main types of hospitals in California and the share of low-income patients that they serve. In 1999, nearly half of all Medi-Cal and uninsured patient days were for care provided in not-for-profit hospitals and 35 percent were for care in public hospitals. In contrast, private hospitals provided considerably fewer days of care to low-income patients—only 17 percent of the total. Not-for-profit and public hospitals devote a larger share of their resources to providing care for low-income patients who have less of an ability to pay and, as a result, these hospitals are especially vulnerable to financial pressures.

Financial Condition of Hospitals Is Weakening. Our analysis of data from the Office of Statewide Health Planning and Development (OSHPD) and our review of several studies found that some key measures of financial health indicate that the general financial condition of hospitals in California has weakened in the last several years. The California Healthcare Foundation reported in 2001 that the years 1995 through 1999 were a period of weakening financial health for California's hospitals. It found that hospital operating revenues per discharge declined over this period. This study also reported that in 1999, more than one-half of all hospitals in California lost money from their operations.

Figure 1

Hospitals' Share of Low-Income Patient Days

1999



Our review of the OSHPD data found significant disparities in the operating margins or "profitability" of different types of hospitals. Investor-owned hospitals appear to be in relatively good financial health with average operating margins of nearly 5 percent in 1999, and 2 percent for the period of June 2000 to December 2000. (According to the California Healthcare Foundation, an operating margin of 3 percent to 5 percent is considered healthy.) In contrast, the operating margin of public hospitals was negative 14 percent in 1999 and dropped to negative 19 percent in the last six months of 2000. A negative operating margin indicates overall losses. The operating margin for not-for-profit hospitals was better—about negative 1 percent in 1999 and negative 2 percent for the period of June 2000 to December 2000. These findings indicate that public and not-for-profit hospitals may be most vulnerable to financial pressures.

California May Have Excess Hospital Beds. The weak financial condition of some hospitals could be in part a result of low hospital bed occupancy rates. Hospital occupancy rates have often been considered a measure of the efficiency of hospital operations because empty beds do not generate revenue while increasing hospital costs. The California Healthcare Foundation report cites numerous studies that have concluded that the state has more hospital beds than it needs. (The question remains

whether these beds are in the right places.) The hospital beds currently in place are more appropriate in terms of geography and facility type to the financial and health care needs of 30 years ago. The study finds that the medical practices and technologies used today require significantly fewer inpatient beds, as well as different types of facilities than are actually in operation. For example, advances in technology that reduce the time it takes to heal from a surgical procedure have shifted many procedures to outpatient settings or greatly reduced the amount of recovery time that must be spent in the hospital.

Our analysis of the OSHPD data found that the hospital bed occupancy rates for all California hospitals (excluding data from state hospitals) was 55 percent in 1999 and 54 percent in 2000. In comparison, the average hospital occupancy rate in the United States in 2000 was 65 percent, about 10 percent higher than California's average occupancy rate.

There was significant variance in the occupancy rate depending upon the type of hospital bed. For example, acute respiratory care beds were heavily occupied while half of regular medical or surgical beds were vacant at any given time. We found that the average occupancy rates were relatively consistent between the different types of hospitals, but that rates are more likely to vary according to the size of the hospital.

The combination of hospitals operating at one-half of their potential occupancy and an increase in fiscal pressures could create an opportunity for reform and consolidation in the hospital marketplace. Some of this change has already occurred and data from OSHPD indicates that the number of hospitals operating in the state since 1995 (not including state hospitals) has declined by 25 percent. These closures have resulted in an 11 percent increase in occupancy rates since 1995, most likely because a number of hospital closures occurred during this same time period while the demand for hospital beds remained stable.

Hospitals Face A Number of Financial Pressures

We discuss the set of financial pressures hospitals face in more detail below.

Seismic Compliance Costs. Chapter 740, Statutes of 1994 (SB 1953, Alquist), requires all hospitals to meet certain seismic safety standards by 2008 and an even stricter set of standards by 2030. Specifically, the legislation established standards of survivability for nonstructural and structural components of all general acute-care inpatient hospital buildings. The major provisions of Chapter 740 require the following of OSHPD:

- By January 1, 2001 all general acute care inpatient hospitals must be evaluated and placed into structural and nonstructural seismic performance categories.
- By January 1, 2001 hospitals statewide must meet certain nonstructural performance categories, including establishing compliant communication, emergency power, and fire alarms systems.
- By January 1, 2008 all acute-care inpatient hospitals must be seismically sound so as not to pose a risk of collapsing in a major earthquake.
- By January 1, 2030 hospitals must be in "substantial compliance" with Chapter 740 and be operational after a major earthquake.

The OSHPD estimates that almost 50 percent of California's acute care hospitals will have to be upgraded or replaced to meet the 2030 standards. Chapter 740 does not require the state to have a financing role in its implementation and hospitals may face major difficulties securing the financing to comply with the new standards. The California Healthcare Association (CHA) estimates that compliance would cost billions of dollars over 30 years, but this number has not been independently verified. Noncompliance may mean that hospitals in already underserved areas could face closure or diminished capacity to serve their communities.

Chapter 740 limits the role of the state to assessing seismic safety plans and overseeing hospital compliance with the requirements of the act. The Legislature has recognized challenges posed by the act. Several bills to address the issue were proposed in the 2001-02 session including SB 842 (Speier), which proposes to extend the 2008 deadline by five years for certain hospitals provided that after 2013, they meet the 2030 standard. Also introduced and signed into law were Chapter 228, Statutes of 2001 (AB 832, Corbett), which revises specified seismic evaluation requirements and clarifies OSHPD's ability to grant flexibility to hospitals in meeting seismic safety standards, and Chapter 247, Statutes of 2001 (AB 656, Chan), which extends the deadline for county-owned hospitals to meet certain nonstructural seismic safety requirements.

Compliance Costs for the Health Insurance Portability and Accountability Act. Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) in 1996. As we discussed in the *Analysis of the 2001-02 Budget Bill*, and this year's *Analysis*, HIPAA's primary purpose is to improve the portability and continuity of health insurance for workers and their families. Both private and public sector organizations, including hospitals, that provide health care services and use patient or other health care data must comply with HIPAA. Many of these new standards will result in system changes for hospitals and physicians.

A national study by Tillinghast-Towers Perrin estimates the cost for hospitals to comply with certain HIPAA requirements ranges from $725,000 to $3.5 million for each hospital. Similarly, the American Hospital Association estimates that it might cost each hospital approximately $4.6 million annually for the first five years of implementation to comply with all of the HIPAA-related rules or a total of approximately $9 billion for all hospitals in California. The federal government did not provide any funding to assist effected organizations in complying with the rules. However, CHA states that hospitals recognize that compliance with some of the rules will result in a return on the investment once the manual systems are eliminated. According to CHA most, if not all, hospitals have begun work on implementing HIPAA and plan to meet the compliance deadlines.

Reduction in Medicare Payments to Hospitals. The federal Balanced Budget Act of 1997 (BBA) established a new methodology for reimbursing hospitals for services provided to Medicare beneficiaries. The methodology cut total Medicare payments to California hospitals by approximately $5.5 billion for payments in 1998 through 2002. The federal Balanced Budget Refinement Act of 1999 reconsidered the issue and provided about $401 million in federal relief from these cuts to California hospitals. The federal Medicare, Medicaid, and State Child Health Insurance Plan Benefits and Improvement and Protection Act of 2000 provided an additional $621 million to increase payments to California hospitals for outpatient services. The overall reduction in Medicare payments to hospitals still represents a significant decrease in federal funding despite the approximately $1 billion in relief provided to the state's hospitals by the federal government.

Funding Available to Medi-Cal Disproportionate Share Hospitals Has Declined. The state began the Disproportionate Share Hospitals (DSH) Program in 1991 during a period of severe state budget problems to generate new federal funding to supplement Medicaid payments to hospitals that serve a disproportionate share of Medi-Cal and other low-income individuals. The state funds the DSH program by combining local funding from public entities such as counties, the University of California, and hospital districts with federal dollars. (Neither the state nor private hospitals contribute to the program.) Hospitals that serve a disproportionate share of Medi-Cal patients and the uninsured are eligible for DSH funding. In 1998-99, 131 public and private hospitals, about one-in-four statewide, were eligible for Medi-Cal DSH funds.

The BBA fixed in law each state's Medicaid DSH allotment through 2002 and reduced the amount of federal funding that would be available each year. The federal government restored some of the federal DSH funding that it previously cut in 2000, but the result was still a net reduction in the federal allotment. As outlined in the BBA, each state's federal DSH

allotment will increase annually starting in federal fiscal year 2003 (during the 2003-04 state fiscal year). For the next three years, the allotment would increase by the previous year's amount in addition to the percentage change in the Consumer Price Index.

The total amount of funding available for DSH hospitals will be will be about $2.1 billion in the current fiscal year and will decrease by $238 million to $1.8 billion in 2002-03.

The State's DSH "Takeout." In addition to the overall decrease in DSH funding described above, the Governor's budget proposes to increase the state's takeout from the DSH allocation. The practice of the state using a portion of DSH funding for the Medi-Cal program began in the early 1990s during state fiscal constraints. By 1995-96, the state was making almost $240 million of this funding available for general Medi-Cal program benefit costs. Over the last several years, as the state's fiscal condition improved, the state reduced its takeout from DSH funding. This resulted in savings to public hospitals because the total amount of funding they transferred to the state decreased while they still received the maximum allowable DSH payments. The state's takeout in 2001-02 is about $30 million.

The Governor proposes to increase the state's takeout from DSH to about $85 million in the budget year (the level in 1999-00) which will result in General Fund savings of $55 million. This action will cause hospitals that participate in DSH to have to increase the amount of funding they must transfer to the state to participate in the DSH program.

Nurse-to-Patient Staffing Ratios. In January 2002, the state proposed nurse-to-patient staffing ratios of one nurse for every six patients on general medical floors of hospitals. Hospitals must adhere to these standards by July 2003. There is some debate about the estimated cost of compliance. The CHA contends that hospitals may have to spend as much as $400 million a year to add 5,000 nurses to meet the new nurse-to-patient ratio requirements. In contrast, a University of California San Francisco professor and associate director of the university's Center for Health Workforce Studies estimates that the regulations would cost hospitals about $137 million a year.

California's Ailing Emergency Services System. Emergency departments (EDs) and trauma centers face growing financial losses. Under state and federal law, any person seeking care at an emergency department must be provided emergency care regardless of their ability to pay. According to OSHPD Hospital Annual Disclosure Reports (1996-99), 14 percent of ED patients were uninsured and 7 percent were paid for by county indigent programs, resulting in little or no compensation to the hospital for these patients. The problem is aggravated by the use of EDs and trauma centers as a point of access for nonemergency services (primary and ur-

gent care). The California Medical Association estimates that more than 80 percent of all Medi-Cal and uninsured patient visits to EDs were for conditions that could have been treated in a nonemergency setting.

Some of the cost of uncompensated care is offset by supplemental Medi-Cal reimbursements and subsidy programs for county facilities. For example, the County Healthcare for Indigents Program provides funding to counties for uncompensated hospital, physician, and other health care services. In addition, separate augmentations have been made to address this issue including $25 million in the current year and a similar amount proposed for the budget year. The *2001-02 Budget Act* provides a one-time augmentation of $25 million (General Fund) for local trauma center support to the Emergency Medical Services Authority.

In addition to the financial problems discussed above, the next pressure we will discuss will further exacerbate these problems and could have a significant fiscal impact on the state's General Fund.

New Federal Rule Could Increase State Costs

A major change in federal rules relating to the reimbursement rates for Medicaid programs appears certain to impose additional financial pressures on California's public (county and University of California) hospitals. This change, more than any other we have described, could increase state costs and require the state to closely examine the Medi-Cal rates it pays hospitals for inpatient and outpatient services.

Change in Federal Rule Will Reduce Medi-Cal Payments to Hospitals. A federal rule change effective March 2002 will phase out a provision in federal regulations that enabled states to increase the federal Medicaid funding they received without increasing their state contributions. Under this practice, some states paid city- or county-owned health care facilities more than the actual cost of health services, thereby generating additional federal funding, and then required the facilities to return the additional funds to the state. Some states, like California, used the additional funding for health-care related expenses. However, many states used little or none of the money for health-related costs.

The new federal rule gradually reduces the amount a state can pay public hospitals by establishing an "upper payment limit" equal to 100 percent of estimated Medicare payments for the same services.

California will have an eight-year period, until 2010, to comply with the rule. To do so, the state will have to eventually lower the payments it makes under the Medi-Cal Program to nonstate owned (county and the University of California) public hospitals by hundreds of millions of dollars annually. The Medi-Cal Program currently pays this class of hospitals

more than 150 percent of their costs of care when the amount of contract rate payments and supplemental payments from other funds are taken into account. Since the limit of 100 percent of Medicare payments already applies to private hospitals, they will not be affected by this new regulation.

State Expenditures Might Increase. As the upper payment limit phases in, the state is likely to face difficult questions as to whether it should—or must—step in to maintain the hospital network that serves Medi-Cal patients and the uninsured. In part, this could be accomplished by setting Medi-Cal rates for hospitals at the maximum allowable level of Medicaid funding under federal law, 100 percent of Medicare, instead of negotiating separately with hospitals. The California Medical Assistance Commission (CMAC) estimates that, under this scenario, total General Fund costs (including managed care payments to hospitals) would increase by approximately $500 million General Fund annually. Even after such an increase, CMAC estimates that public hospitals would still be reimbursed significantly less than they were prior to the implementation of the upper payment limit.

Supplemental Hospital Financing Programs Most Likely Will End. Phase-in of the upper payment limit will probably result in the eventual elimination of two of California's supplemental hospital financing programs: the state's Emergency Services and Supplemental Payments fund (also known as the SB 1255 program) and the Medi-Cal Graduate Medical Education program. The elimination of these funding sources will reduce funding to a variety of hospitals including private safety-net, childrens, teaching, and public.

Lawsuit Settlement Provides Some Relief

Hospital Outpatient Rates Would Increase. Hospitals have been in litigation with the state over reimbursement rates for hospital outpatient services since 1990 in a case known as *Orthopaedic Hospital v. Belshe*. The DHS had set rates based on what it deemed necessary to encourage enough hospitals to participate in the Medi-Cal Program. However, the courts interpreted federal law to require reimbursement based upon a determination of "reasonable costs".

The settlement of the case is now anticipated to be completed in 2001-02. California's hospitals would be paid $175 million for past Medi-Cal claims and be provided a retroactive increase in Medi-Cal reimbursement rates for outpatient hospital care of 30 percent. Under the proposed settlement, rates would be further increased by 3.3 percent for each of the next three years.

The original terms of the settlement called for a $350 million payment for prior claims, to be evenly split between the federal and state government. However, implementation of the settlement was delayed because of a dispute between the federal and state governments over this portion of the proposed settlement. According to the Governor's office the terms of a new tentative agreement will require that DHS pay its share of the $350 million—$175 million General Fund—and be held harmless for any additional costs for the prior claims. Attorneys representing the hospitals anticipate that final agreement will be reached on the terms of the settlement in spring 2002 and that hospitals will begin receiving settlement payments in May or June 2002. Funding for this purpose is included in the current-year budget.

Ensuring a Stable Hospital System

The state has an interest in the financial stability of the network of hospitals that provide health care services to Californians, especially those public hospitals providing services for patients enrolled in the state's Medi-Cal Program and the uninsured. We outline a number of steps the Legislature could take, even in the current difficult fiscal situation, to maintain the financial viability of California's network of hospitals.

In the following section, we offer a number of options that the Legislature could consider, even as the state faces a serious budget problem, to begin to assess the financial pressures hospitals face. These include directing the OSHPD to assess hospital bed vacancy rates, options for assisting emergency departments, and directing DHS and CMAC to conduct a fiscal assessment of the upper payment limit.

Study Hospital Occupancy. The OSHPD develops policies, plans, and programs to assist health care systems in meeting current and future needs of Californians and improving the overall delivery and accessibility of health care in the state. The Legislature may wish to consider directing OSHPD to review statewide hospital bed occupancy data to examine how the occupancy rates vary by region and to determine, on a regional basis, if there is an oversupply or undersupply of hospital beds. As discussed earlier in this review, there is evidence of excess bed capacity in some areas of the state. The OSHPD should also use occupancy rate data and financial information to identify opportunities for hospital consolidation.

The bed data collected by OSHPD would also enable the Legislature to identify specific areas in the state where there is a shortage or potential shortage of hospital beds. The availability of such data would help the Legislature to determine when and if state assistance is warranted to prevent the closure of hospitals needed to maintain access to services for Medi-Cal patients and the uninsured.

Options for EDs. The Legislature may wish to consider several options related to the cost pressures affecting EDs and trauma centers. As discussed in more detail in our analysis of the Medi-Cal budget, the Legislature could consider increasing the copayment for nonemergency care in EDs in the Medi-Cal and Healthy Families Programs. We believe this approach could relieve some financial pressure on EDs by discouraging nonemergency use.

The Legislature might consider making it easier for providers to access unspent county Emergency Medical Services Funds (EMSF) by removing the restriction that prevents EMSF providers from recovering only half of their cost of uncompensated care. This option is discussed in *Options Addressing the State's Fiscal Problem*. The most recent fund condition statement (1999-00) indicates that counties had more than $55 million in fund reserves that could be used for uncompensated care in EDs. The Legislature could use this option to augment the overall amount of resources available to support EDs. Alternatively, it may wish to consider using these resources in place of the Governor's budget year proposal to provide a $24.8 million augmentation of Proposition 99 funds to help offset the cost of uncompensated care in EDs.

Conduct Fiscal Assessment of the Upper Payment Limit. The Legislature should consider directing DHS and CMAC to conduct a fiscal assessment to determine the impact of the federal upper payment limit on hospitals. This assessment should estimate the total amount of funding hospitals will lose, and attempt to determine the potential impact of the new rule on the services provided by these hospitals. The assessment should also identify which hospitals are at the greatest financial risk as a result of this federal action. This information will enable the Legislature to fully assess the impact of the upper payment limit rules. A small portion of the DSH takeout that the Governor's budget proposes for DHS and CMAC could be used to provide for staffing and consulting resources needed to initiate work on these issues.

CONCLUSION

We have described many of the issues that will create serious financial headaches for hospitals during the next several years. We have also suggested some steps the Legislature could take to begin to assess and address these issues.

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, and drug abuse. Services include prevention, early intervention, detoxification, and recovery. The treatment system will provide services to approximately 360,000 clients in 2001-02. The DADP allocates funds to local governments (including funds provided under the Substance Abuse and Crime Prevention Act, the 2000 initiative also known as Proposition 36) and contract providers and negotiates service contracts. The department also coordinates the California Mentor Initiative, a multidepartmental effort targeting youth at risk of substance abuse, teen pregnancy, educational failure, and criminal activity.

Current-Year Expenditures. The Governor's budget proposes a nearly $50 million reduction in expenditures (all funds) in the current fiscal year below the level of spending authorized in the *2001-02 Budget Act.* This drop in spending largely reflects a technical adjustment in the department's federal spending authority to recognize the termination of certain one-time federal grants that have lapsed. The revised budget plan for the current fiscal year also incorporates a proposal presented by the Governor in November to revert $10.5 million in General Fund appropriation authority for the Drug / Medi-Cal Program that more recent esti-

mates show is no longer needed to pay past claims for treatment services. After accounting for these adjustments, total current-year expenditures for DADP are estimated at $591 million (of which $257 million is General Fund).

Budget-Year Expenditures. The budget proposes $544 million from all fund sources for support of DADP programs in 2002-03, a decrease of about $47 million, or 8 percent below the revised expenditure plan for the current fiscal year proposed by the Governor. The budget would provide $223 million from the General Fund, about a $37 million or 13 percent reduction compared to the proposed current-year spending level.

The proposed decline in spending on alcohol and drug treatment programs in the budget year is partly the result of revised estimates in the Drug / Medi-Cal Program caseload, as well as an administration plan to indefinitely postpone an expansion of Drug / Medi-Cal day-care rehabilitative services authorized by Chapter 108, Statutes of 2000 (AB 2876, Aroner) and the federal government. Other alcohol or drug treatment programs, such as drug courts and perinatal services, would also be reduced to help address the state's fiscal problems. The decline in spending in the budget year is also partly the result of a one-time carryover of funding from the prior year to the current fiscal year.

The funding that would be provided in the budget year for drug treatment programs established under Proposition 36 is set by the terms of the voter-approved initiative at $120 million annually and remains unchanged. The budget also proposes to continue the allocation to counties of more than $8 million in federal funds for drug testing of Proposition 36 offenders.

Assessing the Governor's Proposed Budget Reductions

The Governor's budget plan proposes further significant reductions in local assistance for drug/alcohol treatment services in addition to the reductions taken in the current fiscal year. The combined effect of these reductions could be a violation of federal maintenance-of-effort requirements and result in the eventual loss of some additional federal funds.

Current-Year Budget Act Included Significant Reductions. Because of the state's significant fiscal problems, the Legislature and the Governor acted last year to make some significant reductions (totaling almost $42 million General Fund) in DADP programs to provide local assistance for drug or alcohol treatment services.

The Legislature accepted an administration proposal to save more than $24 million from the General Fund (about $50 million all funds) by postponing a planned expansion of Drug / Medi-Cal services. Previous state legislation (Chapter 108) had authorized DADP to add both day-care rehabilitative (DCR) services and case management / relapse preven-

tion (CM/RP) services to the types of treatment provided for Medi-Cal eligibles subject to federal approval of changes to the state Medicaid Plan. Federal authorities have since disapproved the addition of CM/RP services but concurred with adding DCR services. (The administration has proposed to further delay the addition of DCR services to beyond the budget year because of the state's current fiscal problems.)

The Legislature also accepted a proposal by the Governor to save an additional $7.7 million by scaling back an expansion of drug and alcohol treatment programs for adults. The Legislature rejected a proposed $5.7 million reduction in funding for a youth treatment program, but the Governor subsequently vetoed the funding from the *2001-02 Budget Act*. A proposed $8.5 million reduction in state-supported drug court programs was also rejected. In this case, the Governor vetoed a lesser amount of $3 million from the 2001-02 spending plan. Finally, the Governor vetoed $1 million for perinatal services from the budget bill that he had not previously proposed for reduction.

Further Budget-Year Reductions Proposed. Citing the state's continued fiscal problems, the Governor's 2002-03 budget proposes additional reductions to DADP's local assistance programs. These proposals include:

- A reduction of $8 million in funding for state operations and local assistance provided under the Drug Court Partnership Act, one of two existing state-funded programs to support drug courts that had been set to expire at the end of the budget year. About $7 million would remain in the budget year for grants funded under the Comprehensive Drug Court Implementation program.
- A further $2.5 million reduction in perinatal drug or alcohol programs, which provide case management, transportation, child care, health education, and various other services to pregnant and parenting women with substance-abuse problems.
- An as-yet unallocated $7.5 million General Fund reduction in local assistance for alcohol or drug treatment services. The department has not yet determined what specific programs or services would be affected by this proposed cut.
- An $850,000 reduction in technical assistance grants provided to help communities provide appropriate treatment services to specific populations, such as Native Americans and African Americans.

Maintenance-of-Effort (MOE) Could Be a Concern. We are advised by DADP that the cumulative impact of the General Fund expenditure reductions proposed by the Governor creates some risk that the state will violate the MOE requirements for the federal Substance Abuse Prevention and Treatment (SAPT) block grant program. The SAPT block grants

are provided to states on the condition that they maintain a specified ongoing level of state support for their drug or alcohol programs. States that violate their MOE requirement are at risk of losing one federal dollar of SAPT block grant funding for every state dollar they spend below the required MOE level.

The DADP indicates that it could seek federal relief from the MOE requirement on the grounds that is "within material compliance" with the rule. If such relief were not granted, however, DADP has estimated that the state could lose $3 million in SAPT funding during the 2003-04 fiscal year.

Details Lacking on Reduction Proposal

We withhold recommendation on the proposed $7.5 million General Fund reduction in local assistance for alcohol and drug treatment services because the Legislature lacks sufficient information about this unallocated reduction and, thus, is unable to judge the merit of the proposal.

Unallocated Cut Proposed. As indicated earlier, one of the Governor's DADP budget reduction proposals would reduce the General Fund allocation for drug or alcohol services by $7.5 million. However, the budget plan does not identify the specific programs or services that would be affected by this cut or the effect of the reduction on state drug treatment policies or program caseloads. At the time this analysis was prepared, the administration indicated that the specific details of the proposed reduction were under review, and that this information would be provided to the Legislature when the review and approval process for the reductions had been completed.

Analyst's Recommendation. Without prejudice to its possible merit, we withhold recommendation on this proposal pending the receipt of more information from the administration about how this proposed reduction would be implemented. Until more information about this proposal is forthcoming, it will be difficult for the Legislature to assess the fiscal and policy impact of the reduction and reach judgment about its merit. We recommend that DADP report this information prior to budget hearings, along with its assessment of the impact of the specific reductions that it identifies on caseload and affected programs.

Drug Court Reduction Could Be Counterproductive

The Governor's proposal to reduce drug court programs by $8 million General Fund could result in offsetting increases in state criminal justice system costs, including state prison expenditures. We withhold recommendation on this proposed budget reduction until the completion

of an evaluation due March 1, 2002 that will shed light on the program's cost-effectiveness.

One of Two State Programs Would Be Eliminated. The Governor's budget plan would eliminate all $8 million in state funding for state operations and local assistance provided under the Drug Court Partnership Act (DCPA), one of two existing state-funded programs to support drug courts. The DCPA program, established by the Legislature as a four-year demonstration project, was to expire at the end of the budget year, but would be eliminated one year earlier under the Governor's proposal. About $7 million would remain in the budget for grants funded under the Comprehensive Drug Court Implementation program.

As it considers this proposal, one issue the Legislature may wish to consider is the possibility that the reduction could result in an offsetting increase in state criminal justice system costs, including state prison expenditures. A statutorily-mandated evaluation of the drug court program is not due to be released to the Legislature until March 1, 2002. However, preliminary data from this study that was released last year by DADP indicate that the program was diverting a significant number of offenders to treatment who would otherwise be incarcerated. There were also preliminary indications that the treatment being provided to drug- and alcohol-addicted offenders was reducing the rates at which they committed new offenses.

A full assessment of the costs and benefits of the DCPA program, or the Governor's proposal to eliminate it cannot be made until after the DADP study has been completed and submitted to the Legislature. Also at issue is whether the Legislature should continue the DCPA as a separate statutory program or consolidate it with the ongoing, but statutorily separate, Comprehensive Drug Court Implementation program.

Analyst's Recommendation. We withhold recommendation on the proposed elimination of state funding for the DCPA because the report evaluating this program has not yet been released to the Legislature. The information in this report will assist the Legislature in weighing the cost and benefits of this program before determining whether to accept the $8 million cut proposed by the Governor. We would note that, should the Legislature decide to continue the program with General Fund support or some other funding source, it may wish to consider statutory changes to consolidate the program with the Comprehensive Drug Court Implementation program for which the budget proposes to continue funding.

Reductions Could Be Offset With Federal Funds

As a result of congressional action, as much as $15.4 million in additional federal grant funds will be available to California that are not accounted for in the Governor's spending plan. The Legislature has the option of using these funds to restore drug or alcohol programs that were eliminated from the state budget last year or to preserve those proposed for reduction in the 2002-03 budget plan.

Additional Federal Grant Funds Likely. The Governor's budget plan assumes that the state will spend about $237 million during the 2002-03 fiscal year from the SAPT block grant program discussed earlier. This sum would represent about a $2.6 million decrease in spending compared to the prior year due primarily to the expiration of certain one-time grant funds. However, at the time DADP prepared its budget estimates in the fall, Congress had not yet acted on the federal appropriations bill which establishes funding levels for SAPT.

Final congressional action on the measure in December increased the national allocation of funding for SAPT block grants during the 2002 federal fiscal year by $60 million. Although it has yet to receive formal notice from the federal government, DADP has indicated that is likely to receive an additional $15. 4 million in SAPT funds from this source. We are advised that these resources could be expended during the 2002-03 state fiscal year, and that the administration intends to prepare a May Revision proposal for this purpose.

The Legislature could modify the Governor's budget plan to recognize the additional SAPT block grant funds that are likely to be available during the budget year. It could allocate these resources for DADP programs that were reduced in the current fiscal year or proposed for reduction in 2002-03 budget. Under this approach, the Legislature would determine which types of treatment programs and which specific target groups receive funding priority. Alternatively, the additional SAPT funds could be distributed to county governments in accordance with DADP's customary funding distribution formulas, thus permitting local officials to set their own funding priorities based upon local needs.

Analyst's Recommendation. We recommend that the Legislature consider using the additional SAPT funds that are likely to be received by the state as a means to finance alcohol or drug programs that are a priority for the Legislature, but have either already been reduced or are facing reduction under the Governor's budget proposal. As it considers this strategy, the Legislature should also carefully consider which programs should be allocated General Fund support and which should be supported from other funding sources, such as SAPT. Depending on such funding choices, it would be possible to restore the programs without increasing General Fund costs.

Asset Forfeiture Proceeds Could Bolster Treatment Efforts

The Legislature has the option of using a portion of the proceeds received from the seizure of assets from illegal narcotics traffickers to help prevent crime through an increase in support for substance abuse treatment programs. This approach could enable the state to maintain sufficient state funding for such programs to avoid federal sanctions that would result in the loss of additional treatment funds.

Use of Forfeiture Proceeds Could Be Shifted. As discussed earlier, the Legislature could use forthcoming SAPT funds to restore drug or alcohol programs that were eliminated from the state budget last year or to preserve those proposed for reduction in the 2002-03 budget plan. However, this approach would not resolve the potential MOE problem we identified earlier that could result in the loss of as much as $3 million in federal funds. Absent federal forgiveness of its MOE requirement, additional discretionary state resources would be needed to avoid the loss of federal funds. Because of the state's fiscal problems, the Legislature may wish to consider alternatives to using General Fund resources to address the potential MOE problem.

One such alternative would be to enact statutory changes (similar to those adopted in some other states) to shift between $4.5 million and $10 million of the approximately $50 million in asset forfeiture proceeds received each year to support DADP local assistance programs. These funds are the proceeds gained from the seizure of assets found to have been used in illegal drug-trafficking activities.

Such funding shifts would primarily come at the expense of local law enforcement agencies involved in criminal investigations that result in asset forfeiture, although under this option the funding would be returned to various local agencies in the form of more resources for drug or alcohol treatment services. The policy rationale for such changes would be to shift more resources from law enforcement to crime prevention by investing in treatment programs that studies indicate can be cost-effective in reducing involvement in criminal activities by persons who would otherwise remain addicted to drugs.

State law currently requires that 24 percent of the $21 million in asset forfeiture proceeds now being received each year (about $4.5 million) be deposited in the state General Fund. A statutory formula allocates the remaining proceeds among prosecutors, the California District Attorneys Association, and the law enforcement agencies that were involved in the seizure of criminal assets. However, all of the $30 million per year in federal asset forfeiture proceeds goes directly to the California agencies involved in these criminal cases.

Our analysis indicates that the Legislature could modify state law, as Oregon, Utah, and other states have done, to require that part of the federal asset forfeiture proceeds received by California agencies be redirected to specific state programs—in this case, support of substance abuse treatment. Although current U.S. Department of Justice (U.S. DOJ) guidelines require that federal asset forfeiture proceeds be used primarily to support specified law enforcement activities and equipment purchases, those guidelines do permit up to 15 percent of such proceeds to be used for drug treatment programs. In California, allocation of 15 percent of federal asset forfeiture proceeds could generate about $4.5 million annually to support DADP's local assistance programs. Any such reallocation of funds would be subject to review by U.S. DOJ.

The Legislature could also take the further step of changing the way state asset forfeiture proceeds are allocated to provide increased state funding for DADP local assistance efforts. If state law were changed to require that the state share of such proceeds be increased from 24 percent to 50 percent, an additional $5.5 million could be generated to support DADP's local assistance programs, or for other state purposes.

Analyst's Recommendation. We recommend that the Legislature consider the option of modifying state law to redirect a portion of asset forfeiture monies to support drug treatment programs. We believe this option, which other states have adopted, could be justified on policy grounds as an effort to shift only a portion of these resources from law enforcement to crime prevention, particularly if the funds were used to preserve or expand programs targeted at individuals, such as juveniles, who are or were at risk of becoming criminal offenders.

Implementation of the asset forfeiture funding option could also help the state avoid a potential violation of the conditions of its SAPT grant by providing an additional allocation of state funding for DADP's drug or alcohol treatment programs that could be counted against California's MOE requirement. As noted earlier, the option for shifting support for some DADP programs from the General Fund to federal funds would not resolve the MOE problem.

CALIFORNIA MEDICAL ASSISTANCE PROGRAM (4260)

In California, the federal Medicaid Program is administered by the state as the California Medical Assistance Program (Medi-Cal). This 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 additional federal funds for (1) disproportionate share hospital (DSH) payments, which provide additional funds to hospitals that serve a disproportionate number of Medi-Cal or other low-income patients, and (2) matching funds for state and local funds in other related programs.

At the state level, the Department of Health Services (DHS) administers the Medi-Cal Program. Other state agencies, including the California Medical Assistance Commission, the Department of Social Services, the Department of Mental Health, the Department of Developmental Services, the California Department of Aging, and the Department of Alcohol and Drug Programs receive Medi-Cal funding from DHS for eligible services that they provide to Medi-Cal beneficiaries. At the local level, county welfare departments determine the eligibility of applicants for Medi-Cal and are reimbursed by DHS for the cost of those activities. The federal Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration) oversees the program to ensure compliance with federal law.

Proposed Spending. The budget for DHS proposes Medi-Cal expenditures totaling $27.2 billion from all funds for state operations and local assistance in 2002-03. The General Fund portion of this spending ($10.2 billion) increases by $367.3 million, or 4 percent, compared with estimated General Fund spending in the current year. The remaining expenditures for the program are mostly federal funds ($15.2 billion) or 1 percent less than the federal funds estimated to be received in the current year.

The Governor's spending plan assumes that the state will receive $400 million in federal funds in the current fiscal year to offset a projected decrease in the federal cost-sharing ratio (Federal Medicaid Assistance Percentage [FMAP]) for the state's Medicaid payments. The FMAP is based on per-capita income and revised by the federal government each year. In the budget year this decrease in the federal sharing ratio would require an increase in state funding of $174 million from the General Fund for the Medi-Cal Program. The impact of the FMAP change on other state departments in the budget year is estimated to be $48.2 million. The budget plan does not indicate how this $400 million in anticipated relief would be allocated among the different health programs.

The spending total for the Medi-Cal budget includes an estimated $1.8 billion (federal funds and local matching funds) for payments to DSH hospitals, and about $3.5 billion budgeted elsewhere for programs operated by other departments, counties, and the University of California.

MEDI-CAL BENEFITS AND ELIGIBILITY

What Benefits Does Medi-Cal Provide?

Federal law requires the Medi-Cal Program to provide a core of basic services, including hospital inpatient and outpatient care, skilled nursing care, doctor visits, laboratory tests and x-rays, family planning, and regular examinations for children under the age of 21. California also has chosen to offer 34 optional services, such as outpatient drugs and adult dental care, for which the federal government provides matching funds. Certain Medi-Cal services—such as hospitalization in many circumstances—require prior authorization from DHS as medically necessary in order to qualify for payment.

How Medi-Cal Works

Based on recent caseload information, half (51 percent) of the Medi-Cal caseload consists of participants in the state's two major welfare programs, which include Medi-Cal coverage in their package of benefits. These programs are (1) the California Work Opportunity and Responsibility to Kids (CalWORKs) program, which provides assistance to families with children and replaces the former Aid to Families with Dependent Children program, and (2) the Supplemental Security Income / State Supplementary Program (SSI / SSP), which assists elderly, blind, or disabled persons. Counties administer the CalWORKs program through county welfare offices which determine eligibility for CalWORKs benefits and Medi-Cal coverage concurrently. Counties also determine Medi-

Cal eligibility for persons who are not eligible for (or do not wish) welfare benefits. The federal Social Security Administration determines eligibility for SSI/SSP, and the state automatically adds SSI/SSP beneficiaries to the Medi-Cal rolls.

Generally, persons who have been determined eligible for Medi-Cal benefits (Medi-Cal "eligibles") receive a Medi-Cal card, which they use to obtain services from providers who agree to accept Medi-Cal patients. Medi-Cal provides health care through two basic types of arrangements—fee-for-service and managed care.

Fee-for-Service. This is the traditional arrangement for health care in which providers are paid for each examination, procedure, or other service that they furnish. Beneficiaries generally may obtain services from any provider who has agreed to accept Medi-Cal payments. The Medi-Cal Program employs a variety of "utilization control" techniques (such as requiring prior authorization for some services) designed to avoid costs for medically unnecessary or duplicative services.

Managed Care. Prepaid health plans generally provide managed care. The plans receive monthly "capitation" payments from the Medi-Cal Program for each enrollee in return for providing all of the covered care needed by those enrollees. These plans are similar to health plans offered by many public and private employers. More than half (2.9 million of the total of 5.6 million Medi-Cal eligibles in August 2001) are enrolled in managed care organizations. Beneficiaries in managed care choose a plan and then must use providers in that plan for most services. Since payments to the plan do not vary with the amount of service provided, there is much less need for utilization control by the state. Instead, plans must be monitored to ensure that they provide adequate care to enrollees.

Who Is Eligible for Medi-Cal?

Almost all Medi-Cal eligibles fall into two broad groups of people. They either are aged, blind, or disabled or they are in families with children. More than half of Medi-Cal eligibles are welfare recipients. Figure 1 (see next page) shows for each of the major Medi-Cal eligibility categories, the maximum income limit for eligibility for health benefits and the estimated caseload and total benefit costs for 2001-02. The figure also indicates, for each category, whether an asset limit applies and whether eligible persons with incomes over the limit can participate on a "spend down" basis. If spend down is allowed, then Medi-Cal will pay the portion of any qualifying medical expenses that exceed the person's "share-of-cost," which is the amount by which that person's income exceeds the applicable Medi-Cal income limit.

Figure 1

Major Medi-Cal Eligibility Categories

2001-02

	Maximum Monthly Income Or Grant[a]	Asset Limit Imposed?	Spend Down[b] Allowed?	Enrollees (Thousands)	Annual Benefit Costs (Millions)[c]
Aged, Blind, or Disabled Persons					
Welfare (SSI/SSP)	$1,352	✓	—	1,199	$8,660
Medically needy	954	✓	✓	170	1,189
133 percent of poverty equivalent	1,298	✓	✓	—[d]	—[d]
Medically needy—long-term care	Special limits	✓	✓	67	2,760
Families					
Welfare (CalWORKs)	$1,112[e]	✓	—	1,647	$2,465
Section 1931(b)-only[f]	1,561	✓	—	2,394	3,010
Medically needy	1,190	✓	✓	—[g]	—[g]
Children and Pregnant Women					
200 percent of poverty—pregnancy service and infants	$3,032	—	—	184	$579
133 percent of poverty—ages 1 though 5	2,046	—	—	99	88
100 percent poverty—ages 6 though 18	1,561	—	—	108	83
Medically indigent—ages 6 though 18	1,190	✓	✓	125	259
Medically indigent adults—all services	1,190	✓	✓	6	72
Emergency Only					
Undocumented immigrants who qualify in any category are limited to emergency services (including labor and delivery and long-term care)				577[h]	$852

a Amounts are for an aged or disabled couple (including the standard $20 disregard) or a four-person family with children (including a $90 work expense disregard).

b Indicates whether persons with higher incomes may receive benefits on a share-of-cost basis.

c Combined state and federal costs.

d Enrollment and costs included in amounts of Medically Needy Aged, Blind, or Disabled persons.

e Income limit to apply for CalWORKs (including a $90 work expense disregard). After becoming eligible, the income limit increases to $1,765 (family of four) with the maximum earned-income disregard.

f Includes Transitional Medi-Cal, which extends coverage for families who leave CalWORKs or 1931(b)-only for up to 12 months.

g Enrollment and costs included in amounts for Section 1931(b) family coverage.

h About 244,400 additional undocumented immigrants are included in other categories at a cost of $1.1 billion.

Aged, Blind, or Disabled Persons. About 1.4 million low-income persons who are (1) at least 65 years old or (2) disabled or blind persons of any age receive Medi-Cal coverage—about 23 percent of the estimated total Medi-Cal caseload for the current year. Overall, the disabled make up more than half (61 percent) of this portion of the Medi-Cal caseload. Most of the aged, blind, or disabled persons on Medi-Cal (83 percent) are recipients of SSI/SSP benefits and receive Medi-Cal coverage automatically.

The other aged, blind, or disabled eligibles are in the "medically needy" category. They also have low incomes, but do not qualify for, or choose not to participate in SSI/SSP. For example, aged low-income noncitizens generally may not apply for SSI/SSP (although they may continue on SSI/SSP if they already were in the program as of August 22, 1996). As another example, some of the medically needy persons in this category have incomes above the Medi-Cal limit and participate on a share-of-cost basis.

Included in the number of eligibles in the "medically needy" category are aged and disabled persons with incomes up to 133 percent of the poverty level. Beginning January 1, 2001, these persons could receive Medi-Cal coverage without a share-of-cost.

The number of Medi-Cal eligibles in long-term care is small—only 66,900 people, or 1 percent of the total caseload. Because long-term care is very expensive, benefit costs for this group total $2.8 billion, or 14 percent of total Medi-Cal benefit costs.

Almost 60 percent of the aged or disabled Medi-Cal eligibles also have health coverage under the federal Medicare Program. Medi-Cal generally pays the Medicare premiums, deductibles, and any copayments for these "dual beneficiaries," and Medi-Cal pays for services not covered by Medicare, such as drugs and long-term care. Medi-Cal also provides some limited assistance to a small number of Medicare eligibles who have incomes somewhat higher than the medically needy standard.

Families with Children. Medi-Cal provides coverage to families with children in three eligibility categories. The first two categories were created by Section 1931(b) of the Social Security Act, which required states to grant Medicaid eligibility to anyone who would have been eligible for cash-assistance under the welfare requirements in place on July 16, 1996. One of these categories consists of CalWORKs welfare recipients who automatically receive Medi-Cal. The second category—referred to as the 1931(b)-only group—consists of families who are eligible for CalWORKs, but who choose only to receive Medi-Cal services. The income limit for families in this second category is 100 percent of the federal poverty level (FPL). However, once enrolled in Section 1931(b) coverage, families may

work and remain on Medi-Cal at higher income levels (up to about 155 percent of the FPL indefinitely, or a higher amount for up to two years).

A third eligibility category referred to as the medically needy, consists of families who do not qualify for CalWORKs, but nevertheless have relatively low incomes. These families have incomes up to 80 percent of the FPL, have less than $3,300 in assets, and meet additional requirements. Families whose incomes are above the medically needy limits, but who meet all of the other medically needy qualifications, may receive Medi-Cal benefits on a share-of-cost basis.

About 27 percent of all Medi-Cal eligibles are CalWORKs welfare recipients. Although CalWORKs recipients constitute the largest single group of Medi-Cal eligibles by far, they account for only 17 percent of total Medi-Cal benefit costs. This is because almost all CalWORKs recipients are children or able-bodied working-age adults, who generally are relatively healthy. Similarly, 1931(b)-only and medically needy families who are Medi-Cal eligible account for 39 percent of all Medi-Cal eligibles and only 15 percent of total benefit costs.

Women and Children. Medi-Cal includes a number of additional eligibility categories for pregnant women and for children. Medi-Cal covers all health care services for poor pregnant women in the medically indigent category, which has the same income and asset limits and spend-down provisions as apply to medically needy families. However, pregnancy-related care is covered with no share-of-cost and no limit on assets for women with family incomes up to 200 percent of the FPL (an annual income of $35,300 for a family of four).

The medically indigent category also covers children and young adults under age 21. Several special categories provide coverage without a share-of-cost or an asset limit to children in families with higher incomes—200 percent of the FPL for infants, 133 percent of the FPL for children ages 1 through 5, and 100 percent of the FPL for children ages 6 through 18. Pregnant women and the FPL-group children also may use a simplified mail-in application to apply for Medi-Cal or Healthy Families Program coverage (for children above the Medi-Cal income limits). Medi-Cal also provides family planning services for women or men with income up to 200 percent of FPL who do not qualify for regular Medi-Cal.

Emergency-Only Medi-Cal. Noncitizens who are undocumented immigrants, or are otherwise not qualified immigrants under federal law, may apply for Medi-Cal coverage in any of the regular categories. However, benefits are restricted to emergency care (including labor and delivery). Medi-Cal also provides prenatal care and long-term care to undocumented immigrants. These services, as well as nonemergency services

for recent *legal* immigrants, do not qualify for federal funds and are supported entirely by the General Fund.

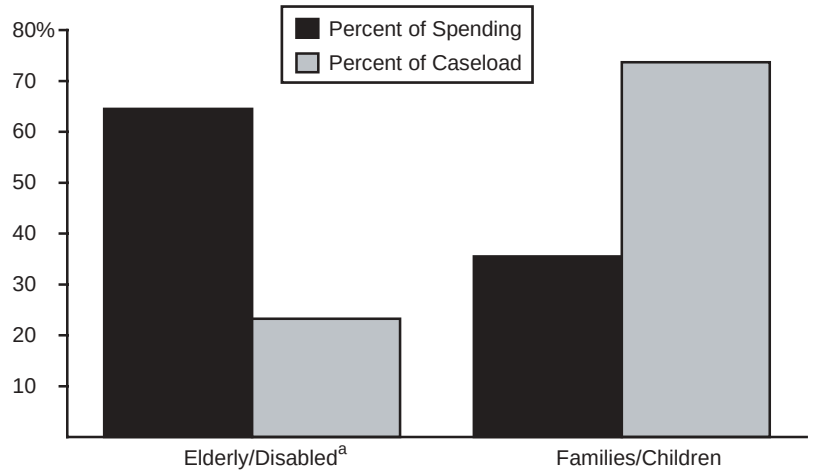
Most Medi-Cal Spending Is For the Elderly or Disabled

The average cost per eligible for the aged and disabled Medi-Cal caseload (including long-term care) is much higher than the average cost per eligible for families and children on Medi-Cal. As a result, almost two-thirds of Medi-Cal spending is for the elderly and disabled, although they account for only about one-fourth of the total Medi-Cal caseload, as shown in Figure 2.

Figure 2

Medi-Cal: Most of Caseload Is Families/Children Most Spending Is For Elderly/Disabled

2001-02



[a]Includes long-term care.

MEDI-CAL EXPENDITURES

Moderate Overall Spending Growth in the Current Year

Figure 3 (see next page) presents a summary of Medi-Cal General Fund expenditures in the DHS budget for the past, current, and budget years.

Figure 3

Medi-Cal General Fund Budget Summary[a]
Department of Health Services

(Dollars in Millions)

	Revised			Change from 2001-02	
	Actual 2000-01	Estimated 2001-02	Proposed 2002-03	Amount	Percent
Support (state operations)	$77.7	$91.3	$91.6	$0.2	0.3%
Local Assistance					
Benefits	$8,680.2	$9,120.3	$9,458.4	$338.1	3.7%
County administration (eligibility)	408.3	487.9	514.3	26.4	5.4
Fiscal intermediaries (claims processing)	79.0	96.5	99.1	2.6	2.7
Subtotals, local assistance	$9,167.6	$9,704.7	$10,071.8	$367.1	3.8%
Totals	**$9,245.3**	**$9,769.0**	**$10,163.3**	**$367.3**	**3.8%**
Caseload (thousands of beneficiaries)	5,286	6,195	6,499	304	4.9%

[a] Excludes General Fund Medi-Cal budgeted in other departments.

The budget estimates that for the current year the General Fund share of Medi-Cal local assistance costs will increase by about $537 million (5.9 percent), compared with 2000-01. The bulk of this increase is for benefit costs, which will total an estimated $9.1 billion in 2001-02. Other local assistance costs will also increase in the current year compared with 2000-01. For example, county administrative costs for eligibility determinations will go up about $80 million (about 20 percent) and costs related to claims processing by the fiscal intermediary will increase by about $18 million (about 22 percent).

Caseload Increase Reflects Eligibility Expansions and Simplification. Most of the $537 million increase in benefit costs will accommodate an estimated additional 900,000 Medi-Cal eligibles, about a 17 percent increase over the prior year. The major factors driving the caseload growth are policy decisions to simplify enrollment procedures. This includes decisions to provide continuous eligibility for medical benefits to children

19 years of age and younger and persons leaving the CalWORKs program, as well as the elimination of the quarterly status reports.

Caseloads are also growing because of the prior decision to expand eligibility for families with children in the so-called 1931(b) category with income at or below 100 percent of the FPL, as well as the decision to provide Medi-Cal benefits without a share-of-cost to aged, blind, and disabled persons with current income equivalent to 133 percent of FPL or less. The budget pays for these two program expansions from the Tobacco Settlement Fund in the current year.

Settlement of Hospital Litigation. The settlement of a ten-year-old lawsuit (*Orthopaedic Hospital v. Belshe')* and other related lawsuits over the amount Medi-Cal pays for hospital outpatient services was originally proposed to be paid in 2000-01. However, the settlement was not paid at that time because of a delay in federal approval of the retroactive portion of the settlement. Final agreement is now expected to be reached in the current fiscal year, which would increase expenditures in that period by $255 million General Fund. The settlement provides for a lump-sum payment of $350 million ($175 million General Fund) for retroactive payments and $80 million General Fund for 30 percent rate increases. Under the agreement, rates are to be increased 3.3 percent annually in the following three years.

Other Costs Increasing Current-Year Expenditures. The remainder of the cost increase reflects items funded in the *2001-02 Budget Act* to provide a state contribution of $24 million annually to the Los Angeles Medicaid Demonstration Project, rate increases for nursing facilities, and supplemental reimbursements of about $7 million from the General Fund for freestanding long-term care facilities.

General Fund Deficiency in 2001-02—$54 Million

The Governor's budget proposes a net increase in Medi-Cal spending of $54 million above the levels anticipated in the *2001-02 Budget Act*. This is primarily because DHS has determined that savings the Legislature included in the 2001-02 budget cannot accrue to the current fiscal year—specifically, anticipated savings of about $24 million for the collection of drug rates and $25 million for antifraud savings. In addition, the fiscal intermediary's costs are expected to increase by $5.5 million for the inclusion of half-year costs for the implementation of the Health Insurance Portability and Accountability Act (HIPAA) that were previously budgeted in the HIPAA Fund—Item 9909.

The net cost of the deficiency is projected to be $54 million because there are also some savings from new proposals that partly offset addi-

tional costs that would be increases in the Medi-Cal Program in the current year. For example, effective October 1, 2001, Medi-Cal has begun covering the cost of tests that allow for the early detection of preterm labor. The DHS anticipates that this will save $18 million General Fund in the current year (and also result in full-year savings of $24 million General Fund in 2002-03).

Budget-Year Expenditure Growth

The Governor's proposed budget estimates that total General Fund spending for Medi-Cal local assistance will be $10.1 billion in 2002-03, an increase of $367 million, or 3.8 percent, above the estimated spending in the current year. If $400 million in financial relief were provided by the federal government—as assumed under the Governor's budget plan—and the Medi-Cal Program received $174 million of that sum, the year-to-year growth in Medi-Cal expenditures would be $541 million or 5.7 percent rather than the smaller increase shown in Figure 3. The budget estimates that the Medi-Cal caseload will increase by 300,000 (about 5 percent) in 2002-03 to a total of almost 6.5 million average monthly eligibles—roughly 18 percent of the state's population. Most of the added spending in 2002-03 is for benefit costs. General Fund costs for Medi-Cal benefits would increase by $338 million (nearly 4 percent) in 2002-03. Figure 4 shows the major components of the change in benefit costs, which we discuss below.

Increased Utilization and Cost-of-Services. The increase in Medi-Cal benefit costs in the budget year is due in large part to higher costs for drugs. This includes price and utilization increases of about $230 million for existing drugs and for new drugs added to the Medi-Cal formulary. These costs are partly offset by rebates of about $61 million obtained through the ongoing drug-rebate program.

Medi-Cal "buy-in" payments for Medicare premiums also are increasing. Medi-Cal pays Medicare premiums for Medi-Cal enrollees who also are eligible for Medicare (dual eligibles) in order to obtain 100 percent federal funding for those services covered by Medicare. The budget estimates that the General Fund cost of these buy-in payments will increase by $52 million in 2002-03. The budget also projects a $5 million increase in the monthly premium that the Medi-Cal Program pays to health maintenance organizations that have enrolled beneficiaries eligible for both the Medi-Cal and Medicare programs.

Caseload Increases. The $42 million in caseload-related cost increases is primarily due to two components—previous eligibility expansions for the working poor and the aged, blind, and disabled.

Figure 4

Medi-Cal Benefits
Major General Fund Spending Changes
Governor's Budget

2002-03
(In Millions)

Price and Utilization of Services	
Increased pharmacy costs	$230
Increased cost for Medicare and Medicare HMO premiums	57
Increased savings from drug-rebate program	-61
Caseload	
Continued expansion of eligibility for working poor and aged, blind, and disabled	$42
Past and present eligibility simplifications	35
Caseload shift due to elimination of the Child Health and Disability Prevention program	30
Caseload impacts from "Express Lane Eligibility" for children in the school lunch program and providing enrollment information to families receiving food stamps	21
Expanded coverage for beneficiaries in clinical cancer trials	8
Pass-Through Funding for Other Departments	
Increased cost of Medi-Cal services provided by DMH	$85
Increased cost of Multipurpose Senior Services Program and Adult Day Health Care Program	34
Changes in Payments	
Increased cost from reduction in the federal sharing ratio	$174
New Cost-Saving Proposals	
Drug program reductions	-$100
Provider rate reductions	-78
Increase in the DSH state administrative fee	-55
Additional provider rate reductions to be offset by copayments	-31

First, the phase-in of the program to expand 1931(b) eligibility to cover both children and parents in families with incomes at or below 100 percent of the FPL was initially slower than anticipated, but the caseload growth is now expected to eventually exceed the original estimates. Continuing caseload growth in this eligibility group is expected to increase General Fund costs by $22 million.

Second, legislation enacted in 2000 expanded Medi-Cal benefits for aged, blind, and disabled persons. Effective January 2001, Medi-Cal benefits are being provided without a share-of-cost to all aged, blind, and disabled persons with current income equivalent to 133 percent of the FPL or less. The approximately $20 million increase in the budget year for this eligibility group is due to continued growth in the number of persons over age 65 applying for this program.

Past and present simplifications in the eligibility process are anticipated to further increase the caseload in the budget year and result in additional costs of about $35 million to the General Fund. This includes an increase of about $21 million to fund additional caseload increases from implementation of continuous eligibility to children 19 years of age and younger, and $9.6 million for caseload increases resulting from eliminating quarterly status reporting requirements for parents—both effective January 1, 2001. In addition, under the provisions of the Healthy Families parental expansion waiver, children applying for Medi-Cal through the so-called single point of entry will be eligible for accelerated eligibility at an increased General Fund cost of $4.1 million.

About $21 million in caseload growth is expected to result from the implementation of Chapter 894, Statutes of 2001 (AB 59, Cedillo) and Chapter 897, Statutes of 2001 (SB 493, Sher) in July 2002. Chapter 894 establishes "Express Lane Eligibility" for children by deeming that any child enrolled in the National School Lunch Program has met the eligibility requirements for the Medi-Cal Program. Both new laws require county welfare departments to provide notices regarding Medi-Cal to persons applying for nonassistance food stamps.

Pass-Through Funding for Other Departments and Programs. Costs are expected to increase for some of the health programs that are funded by Medi-Cal but are administered by other state departments. The cost of mental health services administered under the Department of Mental Health, including services provided to children under the Early and Periodic Screening, Diagnosis, and Treatment Program, are expected to increase about $85 million. In addition, costs for the Multipurpose Senior Services Program and the Adult Day Health Care Program are expected to go up by $34 million because of an increase in the number of providers and allowable patients per site.

Changes in Payments. Each year, the federal government calculates its cost-sharing ratio for each state's Medicaid program. This sharing-ratio referred to as the FMAP is based on per-capita income. The budget assumes that in October 2002, the federal sharing ratio will decrease due to recalculations of per-capita income based on the 2000 Census. This will result in a General Fund increase of $174 million to replace the lost fed-

eral funding. As noted earlier, the Governor's budget assumes that the federal government will provide, in the current year, a lump-sum payment of $400 million to offset the effect of the FMAP decline on Medi-Cal and other affected health programs.

New Proposals to Reduce Costs. The budget contains a number of steps anticipated to produce Medi-Cal savings. About $100 million in General Fund savings would be captured through strategies to reduce drug costs, including:

- Negotiation of contracts with generic drug manufacturers that include a rebate (estimated $27 million savings).
- Ensuring that the Medi-Cal list of approved antipsychotic and antiinflammatory drugs includes the most cost-effective drugs without compromising patient needs (estimated $23 million savings).
- Negotiation of contracts that include a rebate for nutritional products (estimated $9 million savings) and a reduction of pharmacy reimbursement for these products (estimated $11 million savings).
- Negotiation with medical supply manufacturers of blood glucose strips to obtain a lower price (estimated $9 million savings).
- Monitoring the number and types of prescriptions filled by beneficiaries to identify patterns of misuse (estimated $8 million savings).
- Negotiation with manufacturers of AIDS and cancer drug suppliers to obtain rebates (estimated $7 million savings).
- Addressing the existing backlog of drug rebate contract disputes (estimated $7 million savings).

Sixteen additional positions and four contract staff are proposed to be added to the Medi-Cal Drug program at a cost of $2 million ($634,000 General Fund) to achieve these savings.

The budget plan also reduces the rates paid to selected providers of medical services for adults by $78 million. The reductions target the services that had received rate increases in 2000-01 and are allocated in such a manner to leave intact the rate increases for providers of childrens' services and long-term care services. The budget also proposes to impose copayments on adult patients receiving specific Medi-Cal outpatient services and reduce the provider rates for these services by the copayment amounts for estimated savings of $31 million General Fund. Under this proposal, copayments will not be required for some services such as those for individuals under 18, women receiving pregnancy services, and emergency services. In addition, a $55 million savings would result from replacing General Fund resources with an increase in the state's "takeout"

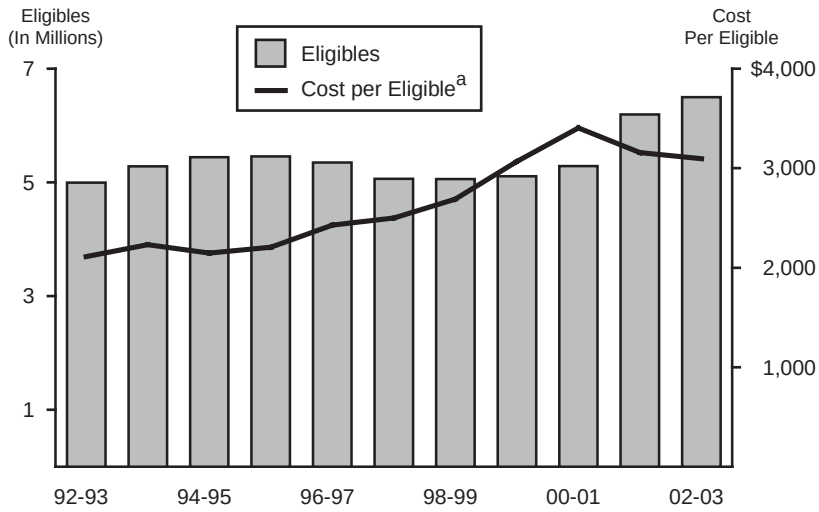
from the DSH state administrative fee. These reduction proposals will be discussed in more detail later in this *Analysis.*

MEDI-CAL COST AND CASELOAD TRENDS

Figure 5 illustrates how Medi-Cal caseload and per-eligible costs have changed since 1992-93, along with projections of these measures for 2001-02 and 2002-03 based on the budget estimates.

Figure 5

Medi-Cal Caseload Still Increasing As Cost Per Eligible Declines



[a]Excludes pass-through funding for programs outside of the Department of Health Services.

Budget Forecasts Continued Caseload Growth and Dropping Costs

The budget projects that in the current year the number of eligibles will grow and the cost of benefits per eligible will decline. This trend is projected to continue in the budget year.

Caseload. Between 1992-93 and 1995-96, the Medi-Cal average monthly caseload grew from 5 million eligibles to 5.5 million eligibles. The Medi-Cal caseload subsequently leveled off, and then dropped by

almost 300,000 eligibles (5.4 percent) in 1997-98. The change in the Medi-Cal caseload roughly paralleled changes in the CalWORKs welfare caseload. Caseload began a sharp drop at that time in response to the turnaround in the state's economy, and greater emphasis on moving families from welfare-to-work in the wake of the enactment of state and federal welfare reform legislation. Another factor contributing to declining welfare and Medi-Cal caseloads was probably the reluctance among immigrant Californians to make use of public benefits because of concerns about whether such use might adversely affect their ability to naturalize or to sponsor the immigration of family members in the future.

From 1997-98 through 1999-00, the Medi-Cal caseload remained relatively flat even though the CalWORKs caseload continued to decline. The Medi-Cal caseload did not decline during this period primarily because of the backlog of eligibility determinations for former CalWORKs recipients that resulted from the delay in implementation of Section 1931(b) Medi-Cal eligibility by DHS and the counties. In the current year and 2002-03, the budget estimates that the Medi-Cal caseload will grow once more, primarily due to a variety of eligibility expansions and simplified eligibility processes.

Cost Per Eligible. While the caseload has gone up and down, the cost trend per eligible had been almost steadily upward until 2000-01. The average annual growth rate of the estimated cost of benefits per eligible (excluding pass-through funding to other departments and local governments) is 4 percent during the period of 1992-93 through 2002-03, which is twice the rate of general inflation during this period, as measured by the Gross Domestic Product deflator.

The temporary dip in the cost per eligible that occurred in 1994-95 and 1995-96 was partly the result of a change in the caseload mix, rather than an underlying drop in health care costs. This is because the rapid increase in the number of families on welfare (whose health care costs are relatively low) temporarily reduced the *proportion* of aged and disabled persons (relatively high-cost groups) in the Medi-Cal caseload, and this change in the mix tended to reduce the average cost per eligible. As the CalWORKs welfare caseload subsequently fell, the elderly and disabled share of the Medi-Cal caseload returned to its earlier level of about 26 percent, and the cost per eligible resumed its growth in 1996-97. Between 1996-97 and 2000-01 the average annual estimated cost per eligible increased by 8 percent.

Based on the Governor's budget, these costs would decrease by 7 percent in the current year and further decrease by 2 percent in the budget year. The turnaround in the trend seen in 2001-02 and 2002-03 appears to be the result of an increase in the number of healthy beneficiaries rather

than a decrease in health care costs. The simplification that has occurred in the eligibility process means that the Medi-Cal Program probably is retaining a greater number of children and families on its caseload who do not regularly need health care services. In the past, these individuals might not have submitted quarterly status reports because they did not need health care services at that time and, as a result, they were dropped from Medi-Cal coverage. These individuals would probably reenroll later when they needed health care services. With continuous eligibility, these individuals are much less likely to leave the program. Therefore, the Medi-Cal caseload increase will include a larger segment of the population that is healthy, resulting in fewer additional program costs compared to other beneficiaries, such as the aged, blind, and disabled.

Overall Caseload Estimate Reasonable

We find that the budget's overall estimate for the Medi-Cal caseload is reasonable. We will monitor caseload trends and recommend appropriate adjustments at the time of the May Revision.

Figure 6 shows the budget's forecast for the Medi-Cal caseload in the current year and 2002-03. The majority of the projected Medi-Cal caseload growth consists of families and children. The budget estimates that the caseload for this group will increase by 22 percent in the current year and about 6 percent in the budget year. Nonwelfare families account for most of the projected increase in Medi-Cal eligible families and children. The budget estimates that the caseload of Medi-Cal eligible nonwelfare families will increase by about 59 percent in the current year, and an additional 11 percent in the budget year. While the projected growth is significant, our analysis found that recent caseload estimates by DHS have tracked caseload growth fairly closely.

The projected caseload increase for the families and children caseload is primarily the result of the implementation of new continuous eligibility rules for children, elimination of the quarterly status reporting requirements for adults, and growth in the 1931(b) program. Some additional growth in this caseload is the result of the elimination of the Childhood Health and Disability Prevention program which the Governor's budget projects will add 54,000 eligibles to the Medi-Cal Program.

Caseloads for the aged, blind, and disabled are expected to grow by about 55,000 in the current year and 30,000 in the budget year. This budget forecast also appears reasonable, given the recent expansions of eligibility for this group and recent caseload trends.

Major Uncertainty: The Economy. It is highly uncertain at this time whether the caseload trends will be sustained. There are a number of fac-

Figure 6

Medi-Cal Caseload
Governor's Budget Estimate

(Eligibles in Thousands)

			Change From 2000-01			Change From 2001-02	
	2000-01	2001-02	Amount	Percent	2002-03	Amount	Percent
Families/children	**3,741**	**4,563**	**821**	**22.0%**	**4,845**	**282**	**6.2%**
CalWORKs	1,764	1,647	-117	-6.6	1,601	-46	-2.8
Nonwelfare families	1,502	2,394	981	59.3	2,651	257	10.7
Pregnant women	170	191	21	12.1	202	12	6.1
Children	305	331	27	8.7	391	60	18.0
Aged/disabled	**1,386**	**1,441**	**55**	**4.0**	**1,471**	**30**	**2.1**
Aged	513	538	26	5.0	550	12	2.2
Disabled (includes blind)	873	903	30	3.4	921	18	2.0
Totals	**5,243**	**6,004**	**761**	**14.5%**	**6,316**	**312**	**5.2%**

tors that could result in higher caseloads as well as factors that could produce lower caseloads. The biggest single factor contributing to this uncertainty is the current economic downturn. This is the first significant recession since the expansion and simplification of eligibility in the Medi-Cal Program and federal welfare reform in 1996. It is possible that a number of the individuals who may have recently become unemployed as a result of the recession 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. Alternatively, children of newly unemployed persons who were not on Medi-Cal previously may now enroll instead in the Healthy Families program.

Potential Risks to Accuracy of Caseload Projections and Cost Estimates. The accuracy of the department's caseload projections and cost estimates are also dependent upon a number of other more general factors. Among the factors that could cause the Medi-Cal program's caseload and cost to vary from the projections are:

- ***Federal actions*** such as a federal minimum wage rate increase or the enactment of laws expanding Medi-Cal eligibility and benefits.
- ***Further changes in state laws and regulations*** adopted by the Legislature and the Governor or through the initiative process. For example, pursuant to legislation, regulations setting new

minimum nurse-to-patient staffing ratios are likely to be finalized this year that could affect hospital and managed care rates. Also, the state minimum wage was increased in January 2002.

- ***Effect of the Governor's Budget Proposals***. The Governor's proposal to impose copayments on beneficiaries for the use of certain medical services could reduce utilization of those services (for example, requiring copayments for services in nongovernment health care plans has reduced the use of some services) and further increase the estimated savings. The proposal to reduce funding for media campaigns and other outreach activities for the Medi-Cal and Healthy Families Programs could minimize caseload growth.

In summary, we do not recommend a specific budget adjustment at this time because we believe that there is both upside and downside risk to the caseload estimate. That is because it is not yet clear whether the economic downturn will significantly impact the Medi-Cal caseload. Accordingly, we will continue to monitor the Medi-Cal caseload trends and recommend appropriate adjustments at the time of the May Revision.

ASSESSING THE GOVERNOR'S BUDGET REDUCTION PROPOSALS

Assumption on Federal Relief is Risky

The Governor's budget assumes that federal legislation will be enacted to provide California with an additional $400 million in federal funds to offset the cost of medical services. However, there is a significant risk that the state will receive only some or none of the anticipated federal relief. We recommend that the Legislature closely monitor the prospects of a federal stimulus package that offers Medicaid relief and consider other ways to achieve savings if these funds are not forthcoming.

The Governor's Proposal. As we discussed earlier, the federal cost-sharing ratio for the Medi-Cal Program will decrease in the budget year and 2003-04. The Governor's budget assumes the enactment of federal legislation that would provide California with an additional $400 million in federal funds in the current year to offset the cost of medical services—in effect, a 2 percent increase in the federal cost-sharing ratio in the current year. The Department of Finance estimates the FMAP decrease would otherwise result in cost increases of $222 million in the budget year in the various departments that provide services to Medi-Cal eligibles, as shown in Figure 7. Notably, while the majority of the impact of the FMAP shift

actually occurs *in the budget year* and *2003-04*, the Governor's budget assumes that the federal relief will be provided *in the current year.*

Figure 7

General Fund Impact of Reduced Federal Cost-Sharing for Medi-Cal

2002-03
(In Millions)

Department	General Fund
Health Services	$173.6
Social Services	19.5
Mental Health	13.3
Developmental Services	11.4
Aging	2.9
Alcohol and Drug Programs	1.1
Total	**$221.8**

State Medicaid Matching Rates and Federal Relief. Other states, like California, are experiencing a reduction in their federal Medicaid matching rates and are seeking relief from Congress in order to avoid reductions in coverage and benefits for Medicaid recipients. One estimate of the potential impact of the FMAP reduction on California will be a loss of several hundreds of millions of dollars in the federal fiscal year 2003 (October 2002 to September 2003).

Several ways to provide federal relief have been under consideration. For example, a federal stimulus package proposed last fall included $1.4 billion in relief nationwide to boost the federal match to states' Medicaid programs. Others have proposed that the relief could take the form of an across-the-board short-term 1 percent increase in the FMAP rate. Raising the FMAP by 1 percent would increase California's federal Medicaid funding by $292 million. A number of other approaches to the provision of federal relief are possible. For example, the National Governor's Association has proposed that the federal government could hold states harmless for the decrease for half of the 2002 federal fiscal year. Relief could be targeted to states with high unemployment or higher percentages of nonelderly, nondisabled adults and children—the persons most likely to suffer from higher unemployment.

However, at the time this analysis was prepared, there were few public indications that Congress would approve any version of an economic stimulus package or federal relief related to changes in the FMAP. Given this situation, the prospects for substantial federal relief that will benefit California are highly uncertain.

Analyst's Recommendation. We recommend that the Legislature closely monitor federal activity and gauge the likelihood of federal relief for changes in the federal Medicaid matching rate. Because the receipt of federal relief is highly uncertain, we recommend that the Legislature consider other ways to help close the state's budget gap if these funds are not forthcoming. Our office has offered other budget reduction options in a separate report.

Provider Rate Reductions Could Reduce Access to Care

We recommend that the Legislature not adopt the Governor's proposal to cut provider rates by $78 million General Fund because Medi-Cal rates are generally so low that further reductions might reduce patient access to care. There are other, better options the Legislature could consider to reduce General Fund expenditures for the Medi-Cal Program. We further recommend the Legislature require the Department of Health Services to establish a rational rate-setting process for fee-for-service provider rates so that the state can ensure reasonable access in the future to health care services. (Increase Item 4260-101-0001 by $78 million and Item 4260-101-0890 by $78 million.)

Background. The Medi-Cal Program will spend an estimated $1.1 billion ($500 million General Fund) during 2001-02 for physician services in the traditional "fee-for-service" portion of the program in which providers are paid for each examination, procedure, or other service that they furnish. In addition, a significant portion of the estimated $4.6 billion ($2.2 billion General Fund) in premiums that Medi-Cal provides to health plans for beneficiaries in managed care indirectly pays for physician services. About half of the persons eligible for Medi-Cal are enrolled in managed care organizations while the remainder receive services under the fee-for-service portion of the program.

Proposed Rate Reductions Partially Roll Back Recent Increases. The *2000-01 Budget Act* included provider rate increases for a variety of medical services totaling approximately $800 million ($403 million General Fund). These substantial increases in rates generally targeted services for which Medi-Cal physician rates were relatively low in comparison to the Medicare Program (as well as private purchasers of health care). The 2000-01 budget increased payments for long-term care services by 10 percent, increased rates for medical procedures performed by physicians by

16.7 percent, and various other rates increased from 7 percent to 250 percent. The amount paid to managed care plans for the services they provide was adjusted to reflect these increases. These were the first across-the-board rate increases in the Medi-Cal Program since 1985-86.

The Governor's budget proposes provider rate reductions of $155 million ($78 million General Fund). The proposed rate reductions which are summarized in Figure 8 represent the overall savings that would occur in each service category and, thus, assume savings both from fee-for-service and managed care providers. The actual percentage rate reductions for specific services within each service category has not yet been determined by DHS. For example, DHS could reduce the rate physicians are paid for adult office visits, but not change the amount paid for childrens' examinations. The Administration has indicated that it intends to restore funding for provider rates when the state's fiscal condition improves.

Figure 8

Governor's Budget Proposes To Reduce Provider Rates

(In Thousands)

Service Category	Increases[a]	Reductions[b]
Physicians	$95,300	$58,450
Comprehensive perinatal	2,600	1,050
Dental	17,700	6,950
Psychologists	3,000	1,880
Physical/occupational/ speech/audiology therapy	2,700	1,150
Respiratory care	60	60
Chiropractic	500	750
Wheelchair/litter van	4,600	1,870
Shift nursing/waiver	8,400	4,600
Home health	1,400	800
Totals	**$136,260**	**$77,560**

a Represents increases provided in *2000-01 Budget Act*.

b Represents reductions proposed in *2002-03 Governor's Budget*.

According to DHS, the proposed rate reductions would generally minimize the impact to providers that serve children and long-term care

patients. The DHS has indicated that it plans to convene stakeholder meetings in 2002 to discuss the proposed decreases and to gather information that would help it determine where to make the cuts. A similar process was used by DHS to implement the 2000-01 rate increases.

Provider Rates Are Still Low. A PricewaterhouseCoopers study completed last year found that, even after accounting for the rate increase provided in 2000-01, Medi-Cal payment rates continue to significantly lag behind those of other purchasers of health care coverage in California. The gap in rates narrowed for physicians who provide services in primary care settings or who practice in emergency rooms or community clinics. However, the study found that Medi-Cal fee-for-service payment levels amounted to 35 percent to 60 percent of what private health care plans paid for the same services. Another study released last year found that while the 2000-01 Medi-Cal rate increases were substantial, they collectively only brought the Medi-Cal provider rates from 58 percent to 65 percent of California's average Medicare payment rates.

Even after implementation of the 2000-01 rate increases, Medi-Cal's fee-for-service physician payment rates ranked 42 out of 51 of the Medicaid programs in the country when adjusted for differences in the cost of living. The trend nationally has been to equalize Medicaid payments to more closely match the rates paid by other health care purchasers. A study by the Lewin Group indicated that 14 states now pay rates that average at least 90 percent of those paid by Medicare, 26 states pay rates that average at least 80 percent of Medicare, and only six states pay rates that average below 60 percent of Medicare.

Studies Link Rates and Health Care. There is some evidence that the rates paid to providers could affect access to health care and the quality of care to patients. A recent national analysis of Medicaid physician rates by The Urban Institute concluded that physician fee levels affect both access and outcomes for Medicaid patients. The Urban Institute cited a study which found that higher rates were associated with a small, but significant, decline in the infant mortality rate. Another study found that children enrolled in Medicaid programs with relatively higher physician fees were more likely to obtain care at a doctor's office.

The findings of this national study are consistent with a recent survey of Medi-Cal beneficiaries. The Medi-Cal Policy Institute reported that 80 percent of program participants believe that they are receiving high-quality medical services. However, 56 percent reported difficulty finding doctors who would provide them treatment.

No Rational Basis for Rate System. The DHS has no regular process in place for the periodic evaluation of the adequacy of physician rates or for periodically adjusting them. Rate adjustments approved in recent years

in the budget process have generally been adopted on an ad hoc basis, usually in response to complaints about limited access to specific services and to provider requests for rate increases. (We explain this process in more detail in our February 2001 report entitled, *A More Rational Approach to Setting Medi-Cal Physician Rates*.) In comparison, Medicare uses a comprehensive, annually updated, rate-setting system that is available for use by other government programs and the public generally.

The rate increases included in the 2000-01 budget, for example, were based upon general legislative concerns about the adequacy of rates and overall budget priorities. They were not based on any specific objective measures of the adequacy of those rates in ensuring patient access to care or quality of care. While DHS has used additional funding received through the budget to adjust Medi-Cal physician rates to reduce some of the disparities with Medicare, large differences still exist for some medical procedures.

Our analysis indicated that the lack of a rational system for physician rate setting has significant potential ramifications for the provision of health care for Medi-Cal beneficiaries and the administration of the program: (1) the state will not ensure reasonable access to quality health care services; (2) physician services will be used less efficiently, with overpayments for some medical procedures and underpayments for others, providing an incentive for the overuse of some services and the underuse of others; (3) some medical providers may not be fairly compensated for certain medical procedures; and (4) the Medi-Cal rate system will remain complex and difficult to administer for DHS and participating physicians.

Future Rate Setting. Because of these concerns, we continue to recommend that the Legislature establish a process for establishing Medi-Cal fee-for-service rates and for periodically reviewing and adjusting those rates. Under this approach, DHS would perform a comprehensive analysis of access to physician services and the quality of care provided to Medi-Cal beneficiaries, and offer proposals for periodic future adjustments to physician rates based upon that analysis.

Managed Care Rates Are Based on Fee-For-Service Payments. The DHS uses historical fee-for-service Medi-Cal data as the basis for establishing the managed care rates and the upper payment limit for these rates. The problems with this approach are discussed in more detail in our analysis of Medi-Cal managed care.

Alternatives to Reducing Provider Rates. In our view, there are better options for reducing General Fund expenditures for the Medi-Cal Program than provider rate reductions. For example, expanding the medical case management program to additional Medi-Cal patients would achieve estimated savings of $17 million General Fund (this is described in greater

detail in our analysis of Medi-Cal managed care programs later in this section). Making corrections to overpayments in the managed care program could result in an estimated savings of up to $7 million General Fund. We discuss these and other opportunities for reducing Medi-Cal costs in this *Analysis* and in a separate document entitled *Options for Addressing the State's Fiscal Problem*.

Analyst's Recommendation. The Governor's rate reduction proposal to help balance the budget does not consider how cuts in provider rates might affect access or quality of care. The evidence suggests that the rate reduction could negatively affect access to care and quality of care. Although rates are intended to be restored when the state's fiscal condition improves, because of the significant cost of increasing rates, cutting rates now would also make it less likely that rates will keep up in the future.

Accordingly, we recommend that the Legislature not adopt the Governor's proposal to reduce provider rates and consider alternative approaches to achieving savings in the Medi-Cal Program such as those we have discussed above. We further recommend that the Legislature enact legislation to require the department to establish a rational rate-setting process for fee-for-service provider rates. A more detailed discussion of this recommendation can be found in our February 2001 report *A More Rational Approach to Setting Medi-Cal Physician Rates*.

Proposed Copayments Decrease Provider Rates

We recommend that the Legislature not adopt the Governor's budget proposal to reduce some provider rates by an amount equivalent to copayments for a General Fund savings of $31 million. We instead recommend an alternative approach that could save the state tens of millions of dollars by imposing significant increases in copayments for nonessential services.

Background. Current state law requires many Medi-Cal patients to make a small copayment, $1 in most cases, each time they receive a prescription drug or medical service. The payment may be collected and retained, or waived by the provider. However, both state and federal law prohibit the denial of health care services if a patient cannot or does not make the copayment. State and federal law also specify that copayments cannot be required for Medi-Cal beneficiaries who are 18 years old and under, for those 21 years old or younger living in boarding homes or institutions, and for any children living in foster care. Also exempted from copayments are pregnant women, institutionalized individuals, managed-care enrollees, beneficiaries receiving family planning services, and individuals receiving emergency services (although copayments are allowed

for nonemergency services in emergency rooms). State law, but not federal law, prohibits copayments for inpatient care.

Proposal Requires State Law Change. Current state law prohibits the department from reducing reimbursement due to the provider by the amount of a beneficiary copayment. In effect, copayments currently are compensation provided *in addition* to existing rates. The Governor's budget proposes to change state law and achieve savings of $31 million General Fund by reducing the amount the Medi-Cal Program pays providers for 22 types of services by the amount of proposed copayments. Providers would have the option of billing a patient receiving one of these services the amount of the copayment in order to make up the difference.

Providers Might Not Be Able to Collect Copayments. If a provider cannot collect the proposed copayment because of a client's inability to pay, the provider's payment amount is, in effect, reduced. Our analysis indicates that providers might not be able to collect the copayment because, as we noted, state and federal law specifies that services cannot be denied to Medi-Cal patients who cannot afford the copayment. In addition, because the copayment amounts are so small, some providers are likely to determine that the collection of copayments entails additional administrative expense and therefore that attempting to collect the payments would not be cost-effective.

For these reasons, the main effect of the Governor's approach to copayments will probably be a further reduction in rates for providers. Seven of the 22 service categories that have been proposed to receive copayments are also services that the budget targets for provider rate reductions. Providers of these services, thus are particularly at risk of being discouraged from participating in the Medi-Cal Program. These services are identified in Figure 9 (see next page).

Effects of Copayments on Utilization Are Varied. Little information is available about the ability of Medicaid providers in California or other states to collect copayments. However, studies have been conducted which examine the impact of copayments generally on health care. Our review of these studies found that the effects of copayments may vary considerably. For example, copayments have been found to reduce the unnecessary use of medical services especially for low-income populations, with even nominal cost-sharing leading to decreased use. However, these studies also indicate imposing cost-sharing on low-income populations could do more than target inappropriate and medically unnecessary care—it could also affect appropriate and medically necessary care. The underutilization of services that might result could have some adverse health effects. Anecdotally, others have said that copayments have a minimal impact on state Medicaid programs.

Figure 9

Budget Proposals for Copayments and Rate Reductions Partially Overlap

	2002-03	
Service Category	**Copayment Amount**	**Rate Reduction**
Acupuncture	$1	—
Ambulance	1	—
Chiropractic services	1	Yes
Dental services	3	Yes
Hearing aids	3	—
Heroin detoxification	3	—
Home health	1	Yes
Hospital outpatient	5	—
Optician	2	—
Optometry	2	—
Outpatient clinic	3	—
Pharmacy prescriptions	1	—
Physical therapy/ occupational therapy/ speech and audiology	1	Yes
Physician	2	Yes
Podiatry	2	—
Psychologists	2	Yes
Rehabilitation clinic	3	—
Rural clinic	3	—
Surgical clinic	3	—
Wheelchair/ litter van	1	Yes

Notably, the Governor's budget does not assume any savings from the decreased use of services that may occur once copayments are implemented. Given the likelihood that few copayments will be collected under the administration's proposal and many of these services previously required copayments, we believe that its effect on medical utilization would probably be minor.

Copayments May Increase Emergency Room Use. Reducing the rates paid to providers of primary care services by copayment amounts could

discourage providers from seeing new Medi-Cal patients or cause providers to withdraw completely from the Medi-Cal Program. Such a reduction in providers could make it more difficult for Medi-Cal patients to access primary-care services. Studies have shown that when patients lack access to primary-care providers, they are more likely to visit emergency rooms for routine sick care.

Inappropriate use of emergency rooms is already a problem. A study focused on New York conducted by the Commonwealth Foundation in 2000 found that in 1998, excluding emergency room patients admitted to the hospital, nearly 75 percent of all emergency room visits were for conditions that could have been treated less expensively in a primary care setting. The study concluded that low-income New Yorkers might depend on emergency room care even more as Medicaid physician reimbursement rates are cut and the primary care delivery system deteriorates.

Thus, to the extent California's experience is similar to New York's, the Governor's copayment proposal could indirectly result in additional costs to the Medi-Cal Program from a rise in the use of emergency departments. The amount of these additional costs is unknown and would depend upon the extent that rate reductions limited access to primary care and the extent to which beneficiaries who did not receive such care (or do not seek it due to the copayment requirement) subsequently developed more serious illnesses that required emergency or inpatient services.

Structure Copayments to Encourage Certain Behaviors. We believe that it is possible to structure a copayment system for Medi-Cal that does not further reduce provider rates, creates a deterrent to overutilization of certain services without undue harm to Medi-Cal patients, and generates some program savings.

Under our proposal, preventive services, such as those provided by physicians, and essential medications, such as insulin, would be exempt from cost-sharing to increase the likelihood that patients would obtain these essential services.

Under our proposal, the maximum federal copayment (ranging from 50 cents to $3 depending on the state's payment for the services) would be imposed on services which are valuable but not as essential as others—chiropractic, podiatry, acupuncture, and transportation to and from medical care. Our approach would also attempt to discourage the misuse of services which some experts believe occurs, by implementing a copayment of $25 for the nonemergency use of emergency rooms as well as for elective surgeries. The State of Washington's Medicaid program, for example, has implemented a $25 copayment for the nonemergency use of emergency rooms. We estimate that the state could achieve General Fund savings of up to tens of millions annually by discouraging the

misuse of these services. Our proposal would not change the rules regarding which patients can be charged copayments.

Under the LAO approach, consistent with current state law, all copayments would constitute payments that would be received by providers in addition to provider reimbursements, as opposed to the Governor's proposal to reduce provider rates by copayment amounts.

Analyst's Recommendation. For the reasons discussed above, we recommend that the Legislature not adopt the Governor's copayment proposal to reduce provider rates. We recommend an alternative copayment system for Medi-Cal that would be less burdensome to medical providers and create a deterrent to overutilization of certain services without undue harm to Medi-Cal patients. Specifically, we recommend eliminating copayments for essential services and increasing copayments for nonessential services. We further recommend that the Legislature direct DHS to provide, at budget hearings, its assessment of the feasibility and fiscal impact of our alternative approach. The exact savings from this approach are unknown at this time, but we estimate that they would probably amount to tens of millions of dollars in savings annually to the General Fund.

Drug Budget Savings Rely on Filling Pharmacists Positions

We recommend adoption of the budget proposal to reduce the Medi-Cal drug budget by $201 million ($100 million General Fund). To ensure the Governor's plan achieves the proposed level of savings, we recommend the Legislature modify the budget proposal to provide for higher-level pharmacists positions. We further recommend that the Legislature direct the department to implement competitive contracting for durable medical equipment and laboratory supplies for an additional savings of $17 million to the General Fund. The Legislature could also consider limiting payment for certain over-the-counter drugs covered by the Medi-Cal Program to achieve additional General Fund savings of $7.4 million annually. (Reduce Item 4260-101-0001 by $17 million and reduce Item 4260-101-0890 by $17 million.)

Proposed Drug Budget Reduction Could Achieve Significant Savings. The Governor's budget includes several proposals anticipated to achieve savings of $201 million ($100 million General Fund) in the Medi-Cal drug program. These include:

- Negotiation of contracts with generic drug manufacturers to include a rebate (estimated $27 million savings).
- Ensuring that the Medi-Cal list of approved antipsychotic and antiinflammatory drugs includes the most cost-effective drugs without compromising patient needs (estimated $23 million savings).

- Negotiation of contracts that include a rebate for nutritional products (estimated $9 million savings) and a reduction of pharmacy reimbursement for these products (estimated $11 million savings).
- Negotiation with medical supply manufacturers for blood glucose strips to obtain a lower price (estimated $9 million savings).
- Monitoring the number and types of prescriptions filled by beneficiaries to identify patterns of misuse (estimated $8 million savings).
- Negotiation with manufacturers of AIDS and cancer drug suppliers to obtain rebates (estimated $7 million savings).
- Addressing the existing backlog of drug rebate contract disputes (estimated $7 million savings).

Based on our analysis, we believe that it is likely that taking these proposed steps will result in savings to the Medi-Cal drug budget.

Achieving Savings Requires Additional Staff. The department does not currently have the staff needed to implement this proposal. Therefore, to achieve the proposed savings, the budget proposes to increase the DHS staff by eight pharmacists (and to contract with the state's fiscal intermediary for the services of four more), one nurse consultant, and seven other staff (two staff services managers, four associate governmental program analysts, and one office technician) at a cost of $2 million ($643,000 General Fund). The salaries of the pharmacist positions and the nurse consultant are eligible for a federal funding match of 75 percent while the other positions are eligible for 50 percent federal funding.

While we believe the Governor's proposal has merit, DHS's inability to hire and retain pharmacists could reduce the savings it could otherwise achieve. Presently, the department has 11 pharmacist positions authorized, of which six are vacant. One position has been vacant since May 2001. Four vacancies are positions provided in the *2001-02 Budget Act* that DHS has not been able to fill. One position became vacant in December 2001. The department attributes the persistent staffing difficulties to a nationwide pharmacist shortage and the discrepancy between DHS salaries and those offered by its competitors. The maximum DHS pharmacist salary is $6,323 per month, while the University of California at Davis pays a maximum of $8,767 per month—nearly 40 percent more. The private sector offers relatively inexperienced pharmacists (entry level) nearly $8,000 per month in addition to signing bonuses, that DHS cannot provide.

Part of the department's difficulty in hiring pharmacists is a requirement that the department only fill the positions through internal promotion of existing staff. The department has obtained a waiver from this state policy, and plans to send a job description letter to all pharmacists

practicing in California to interest them in DHS positions. This approach was successful in the early 1990s. However, the department is concerned it may not work as well this time to solve the problem because of the increased demand for pharmacists in the job market.

If the department cannot fill the pharmacist positions, the savings that it can achieve will be significantly less because implementing most of the strategies requires pharmacists. We estimate that the savings could be reduced to only $16 million General Fund absent such staffing.

To attract the pharmacists that are needed, the department should consult with the Department of Personnel Administration to establish a higher-level pharmacist position that offers a salary commensurate with the public and private sector. This approach should increase the likelihood that DHS can fill the existing vacancies and new positions. The department should estimate and report to the Legislature at budget hearings on the additional state operations cost from upgrading the level of these positions. Because as much as 75 percent of the cost of these positions would be supported with federal funding, increasing the level of these positions should not significantly increase General Fund expenditures.

Additional Drug Budget Savings Proposals. In addition to the Governor's proposal, we believe there are other opportunities for the department to achieve savings in the drug budget.

Presently, the department does not competitively contract for durable medical equipment and laboratory supplies. Instead it uses a "cost-plus" approach, reimbursing providers for the cost of the item plus an additional amount as a service fee. We estimate that implementing a competitive contracting program to contract for durable medical equipment, such as wheelchairs and hearing aids, as well as for various clinical laboratory services would result in estimated General Fund savings of about $17 million.

Also, the department could achieve savings by excluding over-the-counter cough and cold drugs from Medi-Cal benefits coverage. The coverage of these drugs is not required by the federal government and the state has the option of limiting drug expenditures by reducing the drugs it covers. Elimination of cough and cold drugs (including aspirin and Acetaminophen) could save the state $7.4 million annually. This option would in effect conform Medi-Cal drug coverage more closely to many private health coverage plans.

Analyst's Recommendation. We recommend the Legislature adopt the Governor's proposal to reduce Medi-Cal drug budget expenditures by $100 million General Fund ($201 million all funds). To ensure the Governor's plan achieves the proposed level of savings, we recommend the Legislature modify the budget proposal to provide for higher-level

pharmacists positions. The DHS should be directed to report at budget hearings on the additional cost of reclassifying existing positions as well as the new positions that are proposed. We further recommend that the Legislature adopt budget bill language directing the department to implement a contracting program for certain laboratory services and durable medical equipment (for a savings of $17 million General Fund). We also recommend the Legislature consider limiting payments for certain over-the-counter drugs now covered by the Medi-Cal Program to achieve additional savings.

Cuts Proposed in Medi-Cal Hospital Funding

The state began the Disproportionate Share Hospitals Program (DSH) in 1991 during budgetary constraints to generate new federal funding to supplement Medicaid payments to hospitals that serve a disproportionate share of Medi-Cal and other low-income individuals. The Governor's budget proposes to increase the state's takeout from the DSH allocation in 2002-03 for a General Fund savings of $55 million. We recommend the Legislature adopt the Governor's proposal to reduce the budget shortfall.

Please see our discussion of hospital financial problems in the "Cross-cutting Issues" section of this chapter for our discussion of the Governor's proposal to reduce the total funding available to Medi-Cal hospitals that receive DSH funding.

MEDI-CAL MANAGED CARE: WHERE DO WE GO FROM HERE?

Nearly ten years have passed since the Department of Health Services released a strategic plan to move the Medi-Cal Program toward managed care throughout California in 1993. In this section we review options that the Legislature may wish to consider for reform in Medi-Cal managed care. These options include changing the managed care rate-setting methodology, increasing competition, and enrolling the elderly and disabled in managed care.

Background. The number of enrollees in Medi-Cal managed care has increased significantly since legislation accompanying the *1992-93 Budget Act* gave the department broad authority to expand managed care in California with the goals of improving beneficiary access to care and containing costs in the Medi-Cal Program. In August 2001, 2.9 million of the total 5.6 million Medi-Cal eligibles—more than half—were enrolled in managed care.

Under managed care, providers are reimbursed on a "capitated" basis or a predetermined amount per-person per-month regardless of the number of services an individual received. In contrast, under the fee-for-service system, the other payment mechanism the Medi-Cal Program uses to reimburse providers, a provider receives an individual payment for each medical service that is provided.

Managed Care Rates Lack Basis

When the Medi-Cal Program first expanded its use of managed care in the early 1980s, rates were based on information the department collected about the use of services by patients enrolled in fee-for-service and the rates paid to those providers. Today, managed care rates are still based on fee-for-service rates. Basing capitation rates on fee-for-service provider rates was clearly appropriate at a time when the fee-for-service population was comparable to the managed care population.

However, the majority of the current fee-for-service population (elderly and disabled) is no longer comparable to *most* of the managed care population (children and families). Now, mostly children and families with lesser medical needs are enrolled in Medi-Cal managed care plans, while the elderly and disabled who typically have greater health care needs are enrolled in the fee-for-service portion of Medi-Cal. Thus, the Medi-Cal population enrolled in fee-for-service is no longer representative of the medical needs and utilization patterns of beneficiaries enrolled in managed care. According to DHS, the historical fee-for-service data upon which managed care rates are based has not been representative of actual program costs since 1996-97.

This is an important issue for the Medi-Cal Program's operations and finances. Under the current rate-setting system, health care plans are being paid rates that might be inappropriate for the cost of the care they are actually providing to Medi-Cal patients. If the rates are inadequate, DHS runs the risk that health care plans might eventually withdraw from participation in Medi-Cal. In that event, beneficiaries might have to return to a fee-for-service environment. If the rates are excessive, the state may be spending more than is necessary for managed care.

Efforts to Improve Process Unsuccessful. Despite the department's awareness for several years that managed care rates lack a sound analytical basis, so far there has been little apparent progress toward new methodologies for setting managed care capitation rates. The DHS could not indicate when a new methodology would be developed or explain the reasons for the delay in its development.

However, it is apparent that part of the reason DHS has not made progress is because of its lack of complete and accurate data about the utilization of managed care services by Medi-Cal patients. A Medi-Cal Policy Institute report released in 2001 analyzed the Medi-Cal Programs Medical Management Information System's Decision Support System (MIS / DSS) that the Legislature instructed DHS to develop in 1996. This system, which has cost the state more than $44 million to develop since 1997, was intended to integrate data from managed care plans so that DHS would have the tools to monitor and evaluate the quality of care provided to beneficiaries, establish provider rates, and analyze ways to improve both the managed care and fee-for-service systems. The Medi-Cal Policy Institute's study found, however, that the data in the MIS / DSS system is not accurate or complete enough to use to determine provider rates or make sound policy decisions.

The Medi-Cal Policy Institute's study found that part of the problem is that DHS has not worked with providers, health care plans, and contractors to solve problems in data collection. The Institute recommended that DHS make it a priority throughout the department to improve the quality of the managed care data being collected.

Whether managed care rates would increase or decrease if the rate-setting process were improved is not clear. The DHS does not know if it pays providers too much or too little for the services they deliver under managed care because managed care rates are based on fee-for-service utilization data from patients with greater health needs. While DHS attempts to adjust managed care rates for this factor, there is no way now to determine whether these adjustments have resulted in managed care rates that are adequate, inadequate, or excessive.

Rate-Setting Methods to Consider. Other states have taken different approaches to setting rates for their Medicaid managed care programs. The Legislature may wish to consider whether any of these rate-setting methods should be implemented for Medi-Cal.

Five states have designed diagnosis-based risk-adjustment payment systems for their Medicaid programs. That means that these systems estimate the expected level of health care services for specific groups and individuals enrolled in managed care based on their medical history and set rates accordingly. The payment rates are designed to be adequate to ensure access for high-risk patients and to make health plans compete on efficiency and quality of care.

Some states use a different system that was initially developed for disabled populations. This rate-setting approach recognizes the differences in health care needs for individuals with disabilities. The system

analyzes information about a patient's use of services to come up with a relative "risk score" that is used to determine payment rates to health plans.

An increasing number of states (17 in 1999) use a process involving both competitive bidding and negotiation of individual rates with health care plans. For example, Arizona, which has enrolled most of its Medicaid population in managed care, competitively bids and negotiates rates under five-year contracts that include interim adjustments for inflation, and programmatic and legislative changes. Arizona's Medicaid program contracted with outside actuaries to develop a set of appropriate payment ranges that it used as a frame of reference during the negotiation process. The ranges were not disclosed to the health care plans.

Performance Incentives to Promote Quality of Care. Once DHS establishes a sound methodology for setting managed care rates and sets appropriate rates for Medi-Cal managed care plans, it could develop incentives to motivate plans to improve the high standard of quality of care. The department could use data about health outcomes and the preventative services provided by the plans to measure the quality of the services each health plan provides. These quality measures could also be used during rate negotiations or to reward plans with a small payment when they meet specific goals, such as providing preventative services to a certain specified percentage of the enrolled Medi-Cal population. The DHS could also impose financial sanctions on plans that fail to meet quality standards.

Nonfinancial incentives could also be effective. For example, DHS could be directed to create award programs and to publicize information about health plan performance against the standards for quality of care.

Increasing Competition Could Reduce Costs

There are three main models of Medi-Cal managed care in California: the Two-Plan Model, County Organized Health Systems (COHS), and Geographic Managed Care (GMC). Under the Two-Plan Model that exists in 12 counties, DHS contracts with one county-developed health care plan and one commercial health plan. In the seven COHS locations there is one plan operated by the county and enrollment is mandatory for almost the entire Medi-Cal population. The GMC model, in place in two counties, allows multiple health care plans to operate in a designated region. For the most part, the Medi-Cal program relies on one or two health care plans in each region to provide services to Medi-Cal patients. In our view, this approach does not ensure adequate competition in managed care—increased competition could help contain program costs.

The United States General Accounting Office (GAO) reviewed the Medi-Cal program in 1995 and found that more competition would im-

prove California's plan to expand managed care. The GAO reviewed the level of competition in the regions that operate a two-plan model and reported that, while the state sought to benefit from competition, allowing only two plans to serve an area did not create a competitive environment and limited beneficiaries' choice of health plans.

The study noted that limiting a region to two health plans actually requires plans that normally compete against one another to form joint entities that are large enough to handle the enrollment requirements of some counties. Thus, plans that are supposed to compete with one another are forced under state limits on competition to share confidential information. Also, GAO noted that limiting competition could make health plans unresponsive to market demands for increased quality of care.

According to GAO, the two-plan model also puts the state at a serious disadvantage as it contracts for Medi-Cal managed care services. Because the Medi-Cal Program has a strong interest in ensuring that patient care is not disrupted, DHS could be compelled to continue existing contracts even if one of the two plans is performing poorly.

The Legislature should consider whether the Two-Plan Model should be modified to allow "all comers" to compete to participate in the Medi-Cal managed care system. The ability of Medi-Cal to introduce competition and achieve additional savings should also be explored in regions where one plan now dominates—such as the COHS and GMCs.

Expanding Managed Care to the Elderly and Disabled

Most of the population enrolled in Medi-Cal managed care is children and nondisabled adults. This is largely because, in the majority of counties, enrollment in managed care is mandatory for children and families and voluntary for the elderly and disabled. Nevertheless, currently about 230,000 or 15 percent of the total number of elderly and disabled Medi-Cal patients are enrolled in managed care plans.

Like California, most Medicaid programs in other states have focused on enrolling children and nondisabled adults in managed care rather than the elderly and disabled. High-need populations such as the elderly and disabled were traditionally carved out of Medicaid managed care because of the challenges associated with controlling costs and delivering comprehensive services to these groups. However, several states have started to enroll nonelderly disabled patients into managed care using federal waivers. Approximately 1.6 million persons with disabilities were enrolled in Medicaid managed care programs in 36 different states in 1996.

Benefits of Managed Care. The state has been interested in managed care in the form of health maintenance organizations for several reasons.

Two of those reasons are that managed care can eliminate incentives for overutilization of services and provide an incentive for reducing costs.

This approach could also improve medical care for the elderly and disabled. Managed care has the potential to provide such groups which have relatively high medical needs with a "medical home" that would help to ensure the coordination of their care. In this regard, the Medi-Cal Program could establish contracts with managed care plans that require them to provide case management services for such high-risk populations.

In addition, enrolling a higher percentage of the Medi-Cal population in managed care would enable the state to better predict its Medi-Cal costs. In 2001-02, about two-thirds of the program's total expenditures are projected to be for the elderly and disabled. Establishing capitated rates for their coverage would mean the state would generally know in advance what it would pay for health care. The only significant variable in budgeting after rates are set would be Medi-Cal patient caseload in each health plan.

The COHS as a Model. Eight counties operate COHS and require enrollment in managed care for almost every Medi-Cal patient, including the elderly and disabled. The COHS approach could thus serve as a model—relying on case management services and coordination of care—for expanding managed care to the elderly and disabled.

Improved Rate-Setting Method Is Critical. If Medi-Cal were to expand enrollment in managed care for the elderly and disabled, it would be important to ensure that the rates paid to managed care plans generally are appropriately based on the relative health care needs of enrollees. This may require DHS to develop more complex rate-setting methods, such as the risk-based adjustment system that we described earlier. Providers may be discouraged from participating in an expanded managed care system if rates were inadequate. Inappropriate rates could also result in access problems for high-risk enrollees, or result in the state spending more than is necessary for the care of these individuals.

Potential Savings. If managed care were expanded to the elderly and disabled we would suggest that the state start doing so in counties that have existing managed care plans. This would involve about one million beneficiaries. Initially establishing managed care rates at a level somewhat below fee-for-service expenditures, and phasing in this population over a two-year time frame, could result in General Fund savings of up to $70 million in 2002-03 and up to $140 million in 2003-04. These estimated savings are less than 3 percent of what the state currently pays for Medi-Cal services for the elderly and disabled population on a fee-for-service basis.

Our estimate is based on the department's current practice of setting managed care rates at a fixed percentage lower than fee-for-service costs in order to achieve savings. Our estimate of savings assumes that certain services, such as long-term care and some drug costs, would continue to be provided on a fee-for-service basis rather than under managed care. As noted earlier, the quality of information about managed care is poor. Our estimate is based on the best information available at the time this analysis was prepared and, thus, is subject to revision. Implementation of such a change would be subject to approval by the federal government.

Options

In this analysis, we have discussed several approaches to reforming Medi-Cal's managed care system:

- The Legislature could consider directing the department to complete development of new managed care rate-setting methodologies by the end of the current fiscal year so that they can be implemented in the budget year. This would enable the department to ensure that appropriate rates are paid.
- Because additional state savings could be achieved by increasing competition in counties where Medi-Cal managed care has been introduced, the Legislature could direct DHS to report on the feasibility of the approaches we have discussed in this report for increasing competition in specified counties where the opportunities for success are the best.
- If the Legislature wishes to consider enrolling the elderly and disabled Medi-Cal population in managed care coverage, more detailed analysis would be needed to determine the likely level of savings. The Legislature could direct DHS to estimate these potential savings.

MORE OVERSIGHT NEEDED FOR ANTIFRAUD ACTIVITIES

We recommend the adoption of supplemental report language directing the Department of Health Services to submit an annual report evaluating the department's antifraud activities and the overall cost-effectiveness of resources allocated for this purpose.

Antifraud Efforts Now in Third Year. Since 1999-00, the DHS has received additional funding and positions to combat the problem of Medi-Cal fraud and abuse. That year, DHS received $2.7 million ($1.3 million General Fund) and 41 new positions for this purpose. In the following

year, 2000-01, DHS received an additional $21 million ($9 million General Fund) and 192 more positions for the Governor's Medi-Cal Fraud and Fiscal Integrity Initiative. Now in its third year, the antifraud efforts are continuing with these augmented resources.

According to DHS, the beneficial fiscal effects of the antifraud efforts are twofold: cost savings and cost avoidance. Savings are deemed to have occurred as a result of the antifraud effort when providers already enrolled in the program are found to be engaging in fraud or abuse and their activities are stopped. "Cost avoidance" is deemed to have resulted primarily when new providers who are potentially fraudulent are prevented from enrolling in the Medi-Cal Program. The savings estimates include General Fund and federal funds. According to DHS, antifraud activities resulted in $95 million in savings and $226 million in cost avoidance in 2000-01. These results are displayed in Figure 10 which indicates a savings of $3 for every $1 spent. The DHS originally had estimated that it would achieve $75 million in savings in 2000-01.

Figure 10

Savings and "Cost Avoidance" Resulting From Antifraud Activities

All Funds
(In Millions[a])

	Actual	Projected	
	2000-01	2001-02	2002-03
Savings	$95	$108	$163
Dollars saved per $1 spent	3	4	6
Cost avoidance	226	126	173
Dollars avoided per $1 spent	9	4	6
Totals	**$321**	**$234**	**$336**
Dollars saved and avoided per $1 spent	$12	$8	$12

[a] Except for dollars saved and dollars avoided per $1 spent.

The DHS estimates that antifraud activities conducted in 2001-02 will produce $108 million in annual savings and $126 million in annual cost avoidance. Budget-year actions are projected to result in $163 million in savings and $173 million in cost avoidance. Therefore, for every $1 spent on antifraud activities, they are predicted to achieve an additional $4 in

savings for actions taken in 2001-02 and an additional $6 in savings for actions taken in 2002-03.

The savings and cost avoidance outcomes from antifraud activities discussed above are different from the figures for savings and cost avoidance that are displayed in the Medi-Cal budget as offsets that reduce General Fund expenditures for the program. This is because of technical differences when the savings and cost avoidance resulting from antifraud activities are counted.

Analyst's Recommendation. Given the large number of additional staff that were provided to DHS for antifraud efforts in recent years, we believe that the Legislature should receive the information necessary on an ongoing basis to evaluate the cost-effectiveness of these resources. Accordingly, we recommend adoption of supplemental report language directing DHS to report to the Legislature by December 1 of each year on its antifraud activities and the results of those activities. The report should include a description of each type of activity, the nature and quantity of actions taken as a result of each antifraud activity, the savings and cost avoidance associated with the actions taken, and the overall cost-effectiveness of the resources allocated for antifraud activities. We recommend the adoption of the following language:

> The Department of Health Services shall report annually to the Chair of the Joint Legislative Budget Committee and the chairs of the fiscal committees of both houses of the Legislature on its antifraud activities that occurred in the prior fiscal year. The report shall include a description of each type of activity, the nature and quantity of actions taken as a result of each antifraud activity, the savings and cost avoidance associated with the actions taken, and the overall cost-effectiveness of the resources allocated for antifraud activities. The report shall be due on or before December 1 of each year.

NURSING HOME PROPOSAL WOULD ADD 55.5 POSITIONS

We recommend approval of the Governor's proposal to change staffing standards and rate-setting for Medi-Cal nursing homes with some modifications. Specifically, we recommend deleting 11.5 of the proposed 55.5 positions and the adoption of budget bill language requiring that unspent funding from salaries for positions that are approved revert to the General Fund. (Reduce Item 4260-001-0001 by $336,000 and Item 4260-001-0890 by $336,000.)

Background. Chapter 684, Statutes of 2001 (AB 1075, Shelley) directs DHS to complete two major tasks. First, by August 1, 2003, DHS must develop minimum staffing requirements at nursing homes based on the

ratio of nursing staff to patients. Currently, nursing home staffing rules are based on the number of hours of nursing care required for each patient.

Second, by August 1, 2004, DHS must implement rates based on the specific acuity level of patients at each Medi-Cal certified nursing facility, including both so-called freestanding facilities and those that are parts of hospitals. Currently, Medi-Cal rates paid to freestanding nursing facilities generally are a flat rate, based on the median of all of the facilities' costs reported to DHS annually. Rates paid to hospital-based facilities generally are based on a facility's cost or on a median cost of similar facilities, whichever is lower.

The changes in these staffing requirements and the rate system would result in significant additional workload for DHS. In order to develop this new rate methodology, DHS indicates that it would hire a rate-development contractor at an estimated cost of $1 million. The DHS indicates that it would also need to verify the accuracy of operating cost and patient acuity data reported by nursing facilities that participate in Medi-Cal through an audit of each of the freestanding facilities once every three years by its audit staff. The DHS estimates that this would generate an additional 417 audits per year, more than double the number it now conducts each year. The audits would expand not only in number but in scope to include a review of payroll records and other labor-related reports.

According to the department, licensing and certification staff would conduct separate reviews of each facility, also every three years, in order to verify the accuracy of the patient acuity data reported by the nursing facilities. The DHS has not reviewed such data in the past, since patient acuity has not been a factor in establishing new rates for nursing facilities.

In order to implement the new staffing-ratio standards required by Chapter 684, DHS will be required to develop regulations and to verify compliance with the new regulations. The department also will need to assess the impact of the new standards on rates once they have been developed.

Governor's Proposal. The Governor's budget proposes to add 55.5 positions and $5.3 million ($2.7 million General Fund) to implement the requirements of Chapter 684. This funding would be in addition to $1 million in funding previously provided in the DHS budget for review of alternative rate systems.

Specifically, the proposal would add 35 positions for audits and investigations, 13.5 positions for licensing and certification, five positions for medical care services, and two positions for legal services. Three of the positions would be two-year limited-term positions. All positions are budgeted for the full year. Figure 11 summarizes these proposed positions and provides a brief explanation of their purpose. We are advised

that this proposal represents the full number of positions that DHS anticipates it would need to implement the requirements of Chapter 684.

Figure 11

Governor Proposes 55.5 Positions To Implement Chapter 684

Division/Number of Positions Proposed	Purpose
Audits and Investigations—35 positions	
• 28 auditors	Audit facilities' operating costs.
• 2 office technicians	
• 5 managers	
Licensing & Certification—13.5 positions	
• 9 health facility evaluators	Verify patient acuity data.
• 1 manager	
• 1 systems analyst	
• 1.5 health facility evaluators	Verify compliance with staffing ratios.
• 1 analyst (limited term)	Develop staffing-ratio regulations.
Medical Care Services—5 positions	
• 3 research analysts	Develop nursing facility rates, determine impact of staffing ratios on rates.
• 1 research specialist	
• 1 research manager	
Office of Legal Services—2 positions	
• 1 analyst (limited-term)	Develop staffing-ratio regulations.
• 1 staff counsel (limited-term)	Provide legal support for new facility-specific rate development.
Total positions—55.5	

Analyst's Recommendations. We recommend approval of the Governor's proposal with some modifications.

First, we recommend deleting 1.5 health facility evaluators in Licensing and Certification and three analysts proposed for Medical Care Services, because establishment of these positions in 2002-03 would be premature. Specifically, the proposed Licensing and Certification positions

would verify compliance with staffing ratios that would not exist until 2003-04. Similarly, we believe three Medical Care Services positions would not be needed until the development of facility-specific rates is much further along.

In addition, we recommend deleting five auditor positions because the budget proposal overstates the number of freestanding nursing facilities. Assuming a three year audit cycle as proposed by the department, we estimate that Audits and Investigations would audit about 363 facilities each year instead of the 417 estimated by DHS. (This is based on a total number of 1,090 facilities that participate in Medi-Cal.)

Finally, we recommend denial of the two positions requested for the Office of Legal Services. The Governor's proposal does not explain why currently authorized positions in the office could not be directed to develop staffing-ratio regulations or to provide legal support for the development of the new rate methodology.

The DHS' plan to hire all of the proposed positions by July 1, 2002 is ambitious. Ordinarily, such a large expansion in staff would take many months into the new fiscal year to accomplish. If that were to happen, the Governor's proposal would provide DHS more funding and positions than it could actually use in the budget year. We are advised that in order to accomplish the proposed hiring schedule, the department will seek to redirect other existing positions that would be filled in advance of the start of the new fiscal year. The DHS is seeking an exemption from the statewide hiring freeze that would allow this to occur. However, at the time this analysis was prepared, the exemption from the hiring freeze had not been approved. Given the uncertainty that would remain, in any event, over DHS' ability to fill and maintain so many new program positions so quickly, we recommend the adoption of budget bill language specifying that any salary savings resulting from these new positions revert to the General Fund at the end of the budget year. Accordingly, we recommend the following language under Item 4260-001-0001:

> Notwithstanding any other law, any salary savings resulting from positions authorized for the implementation of Chapter 684, Statutes of 2001, shall revert to the General Fund at the end of 2002-03.

Deletion of the 11.5 positions would result in a total savings of $672,000 ($336,000 General Fund). We recommend approval of the remaining 44 positions.

DUAL ENROLLMENT IN HEALTHY FAMILIES AND MEDI-CAL

An unknown but probably substantial number of individuals enrolled in the Healthy Families Program are also enrolled in Medi-Cal. We recommend that the Department of Health Services and the Managed Risk Medical Insurance Board report at budget hearings on the steps they are taking to ensure that the state is not paying twice for health coverage for the same individuals.

A recent study conducted by the Department of Mental Health suggested that an unknown, but probably substantial, number of individuals enrolled in the Healthy Families Program are also enrolled in Medi-Cal. Please see our analysis of the Managed Risk Medical Insurance Board and the Healthy Families Program later in this chapter for our discussion of this issue.

PUBLIC HEALTH

The Department of Health Services (DHS) 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. Other programs are solely state-operated programs such as those that license health facilities.

The Governor's budget proposes $2.6 billion (all funds) for public health programs in the budget year, a 1.4 percent ($37 million) decrease from the previous year. The budget proposes $510 million from the General Fund in the budget year, a 6 percent ($30 million) decrease from the previous year. This decrease is largely due to reductions in DHS state operating costs, the Cancer Research Program, and the elimination of the Child Health and Disability Prevention (CHDP) program. Offsetting increases include augmentations to the Expanded Access to Primary Care (EAPC) community clinic program, California Children's Services (CCS), and Youth Antitobacco programs.

Significant changes in the Governor's proposed budget for public health programs include the following.

Childhood Lead Prevention Program (CLPP). The CLPP is the primary agency responsible for ensuring that children at an increased risk for lead poisoning are tested for the presence of lead in their blood. The CLPP also monitors the case management of children identified as having lead poisoning, tracks the extent of childhood lead poisoning throughout California, and works to reduce environmental exposure to lead.

Total state spending for the program is proposed at $26 million in 2002-03, an increase of $3.2 million from the revised spending level proposed by the Governor for the current year. However, General Fund support for the program would decline by about $3 million to a total of $1.4 million, due in part to a shift in program support to fees. Fees assessed on past and present manufacturers of lead products would be increased by $10 million to a total of $22 million, the maximum allowed

under state law. The budget also requests eight additional staff. The Governor's proposal would (1) increase local assistance for lead poisoning prevention activities, (2) provide for increased testing of blood for lead contamination, and (3) increase local and state enforcement of lead abatement laws.

AIDS Drug Assistance Program (ADAP). The ADAP is a subsidy program for persons with HIV with incomes up to $50,000 annually, who have no health insurance coverage for prescription drugs and are not eligible for Medi-Cal. Eligible individuals receive drugs through participating local pharmacies under subcontract with the statewide contractor. Clients with incomes up to 400 percent of the federal poverty level (FPL) (about $34,360 for a single childless adult) pay no copayment or premium, individuals with incomes between 400 percent of FPL and $50,000 annually pay a sliding scale copayment.

The budget proposes about $191.4 million for the ADAP program in the budget year. General Fund support for ADAP would increase $20 million or 32 percent from the previous year. The increase is primarily due to ADAP caseload and drug price increases.

Women, Infants, and Children (WIC) Nutritional Program. The WIC Nutritional program provides nutritional support and education for low-income women, infants, and children who are at risk for malnutrition. Women can redeem food vouchers at authorized grocery stores throughout the state for specific foods. The WIC program is funded entirely with federal funds.

The budget requests authority for 9.5 new positions in the budget year to create an antifraud unit to prevent, detect, and prosecute WIC program fraud. The positions will be funded through the annual federal grant provided to the state. The request is made in response to an increase in the number of reported allegations of WIC abuse as well as the number of documented findings of program fraud.

California Children's Services. The CCS program provides medical diagnosis, case management, treatment, and therapy to financially eligible children and young adults under 21 years of age with specific medical conditions, including birth defects, chronic illness, genetic diseases and injuries due to accidents or violence.

The budget proposes about $101 million in total spending for the CCS program in the budget year, a $9 million or 14 percent increase in General Fund spending from the previous year, due primarily to caseload increases.

County Medical Services Program (CMSP). The CMSP provides medical and dental care to low-income adults between 21 and 64 years of age who are not eligible for the state's Medi-Cal Program and reside in one of

34 participating small California counties. Funds from the 34 counties are pooled to provide services to CMSP clients. The CMSP governing board sets eligibility requirements, benefit levels, and provider reimbursement rates, but contracts with DHS to administer a program offering uniform benefits and to provide claims processing functions.

Funding for CMSP includes realignment revenues (from the 1991-92 realignment), Proposition 99 revenues, county funds, and hospital settlements (audit recoveries for overpayments to hospitals). Until 1999-00, the state General Fund was also a fund source. Legislation was enacted in 1992 to cap the General Fund responsibility for CMSP at $20.2 million, which was the estimated amount needed for the program in 1991-92. The General Fund appropriation for CMSP was suspended in 1999-00, keeping intact the statutory $20.2 million General Fund commitment for subsequent fiscal years. However, there have been subsequent one-year suspensions of the state's contribution to CMSP in recognition that there were large reserve balances available to the program.

The Governor's budget proposes budget implementation legislation to permanently suspend the state's General Fund appropriation of $20 million to CMSP.

Expanded Access to Primary Care Program. The EAPC program, established in 1988 by Chapter 1331, Statutes of 1989 (AB 75, Isenberg), provides grant funds to primary care clinics for care to uninsured persons with incomes at or below 200 percent of the FPL. The clinics provide outpatient care, including preventive health services, diagnosis and treatment services, and laboratory services. They also provide case management services, including management of all physician services, arrangements for hospitalization, and follow-up care. Participating clinics bill for services on a per-visit basis until their allocation is exhausted. As a condition of receiving EAPC funds, clinics are required to provide, or arrange and pay for, medically necessary follow-up care for any condition detected as part of a CHDP health screen.

The budget proposes about $49 million for the EAPC program in the budget year. This includes an $18 million augmentation due to anticipated caseload increases at EAPC-funded and other community clinics as the result of the elimination of the CHDP program. This is discussed in greater detail later in this analysis.

In this section of the analysis, we also discuss proposals in the Governor's budget relating to CHDP and youth antitobacco programs.

CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

Background

The CHDP program was established by Chapter 1069, Statutes of 1973 (AB 2068, Brown), to provide preventive health, vision, and dental screens to uninsured children and adolescents in low-income families. It is modeled after the federal Medicaid benefit called Early and Periodic Screening, Diagnosis, and Treatment services. The CHDP program currently reimburses public and private providers for completing health screens and immunizations for children and youth less than 19 years of age with family incomes at or below 200 percent of the FPL.

The program is jointly administered by DHS and county health departments. The DHS provides statewide oversight of the program, including making payments to providers. The county health departments develop local plans to recruit CHDP providers, ensure CHDP provider outreach and education, and handle client referrals and follow-up. As a condition of receiving Proposition 99 funding for indigent health care, counties are required to provide treatment services for medical conditions detected as part of a CHDP health examination. An estimated 1.7 million screens will be provided in 2001-02.

In our January report, *CHDP Fails as Gateway to Affordable Health Care*, we found that CHDP missed opportunities to provide comprehensive health coverage for low-income children and use available federal funds to help pay for this care. We recommended several steps to address these problems, which are somewhat different from the Governor's budget proposal.

The Budget Proposal. The Governor's budget proposes to eliminate the CHDP program in the budget year and shift eligible children into the Healthy Families and Medi-Cal Programs. Children ineligible for these programs would be served by the EAPC program. The administration estimates the elimination of CHDP in the budget year would save the state $111.9 million, ($46.6 million General Fund).

The administration estimates that the elimination of CHDP would result in the enrollment of an estimated 99,000 additional children in Medi-Cal and about 20,700 additional children in Healthy Families by the end of the budget year at an estimated total cost of $42.3 million. For the 25 percent of CHDP children whom the administration estimates would not qualify for Medi-Cal or Healthy Families, the budget proposes a $17.5 million (Tobacco Settlement Fund [TSF]) augmentation to the EAPC program. In summary, these program shifts are estimated to result in a net savings of $52.4 million ($12.5 million General Fund and $39.9 million TSF) in the budget year. Figure 1(see next page) summarizes the estimated costs and savings of the proposal.

The Governor's proposal would also result in the elimination of six positions at DHS for an estimated state savings of $207,000 General Fund, and the redirection of four other DHS positions to the CCS and the Genetically Handicapped Persons programs to reduce the backlog of eligibility determinations in these programs.

Figure 1

State Savings and Costs Associated With Proposal to Eliminate CHDP

2002-03
(In Millions)

Savings	Amount
CHDP (local assistance)	$111.7
CHDP (state operations)	0.2
Total	**$111.9**
Costs	
Medi-Cal	$36.4
Healthy Families	5.9
EAPC	17.5
Total	**$59.5**
Net Savings	**$52.4**
General Fund	$12.5
Tobacco Settlement Fund	39.9

Advantages of the Governor's Proposal

The Governor's proposal to eliminate the Child Health and Disability Prevention program and move eligible children into the Healthy Families and Medi-Cal Programs would eliminate duplicative eligibility and provide net budgetary savings, eliminate any double payment for children already enrolled in Medi-Cal or Healthy Families, maximize federal funds, and provide more comprehensive care for children moving into Medi-Cal and Healthy Families.

Most Children in CHDP Are Eligible for Medi-Cal or Healthy Families. The changing healthcare landscape has made CHDP eligibility duplicative for most children. When CHDP was established in 1973, the availability of subsidized health care for children was very limited. Changes

in Medi-Cal eligibility and the implementation of the Healthy Families Program have expanded low-cost health coverage to infants and children in families with incomes up to 250 percent of the FPL, as shown in Figure 2.

As a result, children using CHDP are either (1) eligible to enroll for full Medi-Cal benefits, (2) eligible to enroll in Healthy Families, or (3) undocumented immigrants, and therefore ineligible for either of the other two programs. (Undocumented immigrants qualify for no-cost Medi-Cal, but only for emergency care, including labor and delivery services.)

Figure 2

Income Eligibility Criteria for CHDP, Medi-Cal, and Healthy Families

Age	Family Income (As Percent of Federal Poverty Level)
CHDP	
0-18 years	At or below 200 percent.
Medi-Cal (poverty group)[a]	
0-11 months	At or below 200 percent.
1-5 years	At or below 133 percent.
6-18 years	At or below 100 percent.
Healthy Families	
0-11 months	Between 200 percent and 250 percent.
1-5 years	Between 133 percent and 250 percent.
6-18 years	Between 100 percent and 250 percent.

[a] Children who meet eligibility criteria for enrollment in no-cost Medi-Cal.

Risk of Double Billing. The change in the health care environment resulted in the state establishing a new role for CHDP—as a "gateway" facilitating children's enrollment in the Healthy Families Program. Because the gateway was never fully established, some children receiving services through CHDP may in fact already be enrolled in the Medi-Cal or Healthy Families Programs. In some cases, it appears, the state is paying twice for the same services for these children by reimbursing CHDP providers for services that are included in the monthly health insurance premium the state pays for children enrolled in Medi-Cal and Healthy Families.

Medi-Cal, Healthy Families and Community Clinics Offer Comprehensive Care. The inability of CHDP to provide an effective gateway to other programs also has important consequences for the care received by children in the program because Medi-Cal and Healthy Families offer more comprehensive services than the CHDP program. Like CHDP, the Medi-Cal and Healthy Families Programs offer free or low-cost preventive health screenings and immunizations. Unlike CHDP, both programs offer a full range of benefits that include comprehensive drug coverage, vision services, and dental care. Community clinics that receive EAPC funding similarly provide a broader range of primary and preventive care services than does CHDP.

Proposal Would Maximize Federal Funds. The Governor's proposal would maximize the state's use of available federal funds by shifting an estimated 120,000 children from the state-supported CHDP program to the joint federal-state supported Medi-Cal and Healthy Families Programs. The federal government generally pays approximately a 50 percent and 65 percent share of costs, respectively, for health care services for children provided through the Medi-Cal and Healthy Families Programs. This means that shifting children from the CHDP program, which is supported almost entirely with state funds, to Medi-Cal and Healthy Families would result in significant net savings to the state. There would also be savings for counties that would otherwise have to spend county funds for CHDP follow-up treatment.

Governor's Proposal Needs Work

The Governor's proposal to eliminate the Child Health And Disability Prevention (CHDP) Program does not include sufficient detail about how it would be implemented, does not provide funding that would be needed for outreach and enrollment of CHDP children in Medi-Cal and Healthy Families, and does not adequately address access issues for children who would remain ineligible for the Medi-Cal or Healthy Families Programs.

Many Details of Proposal Are Missing. The administration has not determined many of the details regarding how this proposal would be implemented, making it difficult for the Legislature to assess whether it could be implemented as proposed. The administration recognizes that some details are lacking and has proposed to convene a "stakeholder" work group to solicit input on a more detailed plan to implement this proposal. The administration advises that more detailed information about how the Governor's proposal would be implemented will be presented to the Legislature at the time of the May Revision.

Dearth of CHDP Caseload Information. It is unclear how many children receive services through CHDP because funding for CHDP provid-

ers is allocated according to the number of health screens provided, not according to the number of children served. This lack of caseload data makes it difficult for the Legislature to evaluate whether the additional funding proposed by the Governor for shifting children receiving services through CHDP into Medi-Cal, Healthy Families, and EAPC is at the appropriate level.

Access for Some Children May Be Limited. The Governor's proposal recognizes that for undocumented immigrants who are not eligible for Medi-Cal or Healthy Families under state law, CHDP is an important "safety net" program. To address possible access issues, the administration proposes a $17.5 million augmentation to the EAPC program and also rescinds a prior proposal to reduce EAPC by $10 million.

The EAPC proposals are intended to expand the capacity of the community clinic system to provide services for children who would be ineligible for Medi-Cal and Healthy Families and, thus, would no longer have access to CHDP providers.

However, some children who now rely on CHDP for services may be geographically isolated from the EAPC network of clinics, particularly in those counties with no EAPC contractors (Alpine, El Dorado, Kings, Lake, Plumas, and Tehama). In contrast, there are currently CHDP providers in all 58 counties in the state. The elimination of CHDP could reduce access to health screenings and immunizations for children in areas where there are no EAPC-funded clinics. The administration has acknowledged that this is a potential problem, and has indicated that it intends to explore various solutions in its stakeholder group meetings.

Program Shifts Would Affect Clinics. The CHDP program provides funding for EAPC clinics as well as other community health clinics. Under the Governor's proposal, some of these clinics will lose CHDP funds thereby potentially placing them in a precarious financial condition. On the other hand, some clinics may gain additional funding. At the time this analysis was prepared, DHS was not able to provide information regarding how much funding clinics currently receive through CHDP. The lack of information makes it difficult for the Legislature to evaluate this aspect of the administration's proposal. Thus, the Governor's proposal could result in a net financial gain for some clinics through the EAPC augmentation, but could negatively affect others.

Proposal Lacks Transition Planning and Funding. In its current form, the Governor's proposal does not provide any additional resources that would help children now receiving services through CHDP to enroll in the Medi-Cal and Healthy Families Programs. For example, there is no funding in the Governor's proposal for outreach and enrollment activities even though the administration estimates that 75 percent of the chil-

dren receiving services through CHDP are eligible for either of the programs. Resources for outreach and enrollment activities are even more important given the administration's proposed funding reduction in these areas in the Medi-Cal and Healthy Families Programs.

In addition, the Governor's proposal provides no additional resources to DHS for the increased administrative workload associated with an increase in the number of EAPC grants it will have to screen and approve. Instead, in order to help address the state's current budget problems, the budget proposes to eliminate one position in the EAPC program in the budget year. Absent additional resources, DHS may be unable to process applications for EAPC grants and oversee the allocation of such funds to clinics in a timely manner.

Finally, we are not certain whether it will be possible for DHS to implement all of these major program shifts in such a relatively short time—by July 1, 2002.

Analyst's Recommendation

While we agree in concept with the Governor's plan to shift children from the Child Health and Disability Prevention program to other health programs, we withhold recommendation on the budget proposal pending a more detailed report from the Department of Health Services at budget hearings on key issues relating to how the plan would actually be implemented. We also offer options the Legislature may wish to consider to improve the proposal.

Need For Implementation Plan. We recommend that DHS provide the Legislature with a detailed implementation plan for the elimination of the CHDP program that includes proposed funding and mechanisms for addressing the transition issues noted in this analysis. First, DHS should provide a more complete assessment of the time needed to complete the proposed transition, dismantle the CHDP program, enroll children in Medi-Cal and Healthy Families, and help a number of families find a new place for care.

An important element of these transition issues is enrollment of children in Medi-Cal and Healthy Families. We recommend that DHS specifically include information regarding the costs and mechanisms to encourage eligible children to enroll in Medi-Cal and Healthy Families. These may include increasing the number of application assistants in community clinics or creating an incentive program to encourage clinics and former CHDP providers to enroll eligible children.

Options for Improving Plan. If the Legislature, upon receiving this information, decides to accept the Governor's plan to eliminate CHDP,

there are steps it could take to minimize the problems that could otherwise result from this change. For example, the Legislature could adopt supplemental report language directing DHS to assess the impact of the elimination of CHDP on community clinics, including EAPC clinics. This information would enable the Legislature to adjust clinic funding levels as appropriate. We believe such a post-implementation assessment is warranted because the lack of CHDP caseload data means it is unclear how many additional children will seek services through community clinics. That assessment would examine the impact the elimination of CHDP would have on individual clinics, and consider whether the $17.5 million EAPC augmentation was the sufficient and appropriate amount of funding needed for these clinics to deliver the health care services previously provided through CHDP.

Further, the Legislature should assess the extent to which the Governor's proposal to expand EAPC will address a possible reduction in access for children who are not eligible for Medi-Cal or Healthy Families. The Legislature should consider the extent to which other clinic programs, such as the Seasonal Agricultural and Migratory Workers Program or the Grants in Aid for Clinics programs should be used to assist children now served under CHDP.

Finally, given the proposed increase in EAPC grants, the Legislature should consider maintaining EAPC administrative staffing at current levels if it decides to accept the Governor's plan to abolish CHDP. Accordingly, if the Legislature chooses to eliminate the CHDP program we would recommend adoption of the following supplemental report language:

> It is the intent of the Legislature that the Department of Health Services (DHS) report to the Chair of the Joint Legislative Budget Committee and the chairs of the fiscal committees of both houses of the Legislature, information regarding the effect of the elimination of the Child Health and Disability Prevention (CHDP) program. The DHS report shall include, but not be limited to, an assessment of the impact of the elimination of CHDP in regard to:
>
> (a) Changes in the caseloads and financial condition of community clinics, including clinics that receive grants through the Expanded Access to Primary Care (EAPC) program. The DHS shall specifically evaluate whether the additional resources provided to clinics as part of the plan to close the CHDP program were sufficient and appropriate;
>
> (b) The adequacy of health care being provided to children who were previously enrolled in CHDP, but who will no longer be served by that program. The DHS shall specifically evaluate the adequacy of health care provided to children formerly receiving CHDP services who are not eligible for either the Medi-Cal or Healthy Families Programs;

(c) The impact of the elimination of the program on the number of children receiving health screens and immunizations;

(d) Detailed information on how additional EAPC funding provided as a result of the elimination of the CHDP program was distributed, according to geographic area and any other factors deemed relevant by the department.

The DHS may conduct its assessment, in part, by examining what it deems to be a representative sample of community clinics and counties.

An initial report on the department's findings shall be provided to the Legislature by April 1, 2003, with a complete and final report of the department's findings provided by December 2003 .

TOBACCO PREVENTION PROGRAMS

Background

Historically, tobacco tax revenues from Proposition 99 have been the state's main source of support for smoking prevention activities. Proposition 99 is a 1988 initiative that allocated revenues from an increase in taxes on tobacco products to various health, environmental, and research programs. The budget proposes to allocate about $134 million in Proposition 99 funds for antitobacco activities in 2002-03.

A 1998 multistate settlement of litigation with the major tobacco companies is now providing additional funding for tobacco prevention efforts in California. The settlement of the tobacco litigation is estimated to provide California state and local governments with $21 billion over 25 years, with one-half going to the state and one-half to the counties. There has been significant public and legislative interest in using these revenues for smoking cessation programs and other health care proposals. Last year, the state budget for the first time provided funding for youth antitobacco efforts from a new special fund, the TSF, that was created to receive the state's share of proceeds from the lawsuit settlement.

The Budget Proposal. The Governor's budget proposes a total of $35 million from the TSF for youth antitobacco programs in 2002-03. This includes continuation of the $15 million allocated from the TSF in the *2001-02 Budget Act* for youth smoking prevention programs administered by DHS and allocation of an additional $20 million for these same purposes, in the budget year. Another $5 million provided in the *2001-02 Budget Act* was a one-time allocation.

Specifically, the budget plan would provide an increase in funding for antitobacco activities targeted at 18- to 24-year olds, enforcement of local tobacco control laws, continuation of youth advocacy coalitions,

enhancement of tobacco control interventions in special populations, technical assistance, evaluation and surveillance, and smoking cessation services.

The primary components of the proposal are summarized in Figure 3 and are discussed in greater detail below.

Figure 3

Proposed Spending On Youth Antitobacco Programs

(In Millions)

Activity Description	DHS Expenditure Plan 2001-02	DHS Expenditure Plan 2002-03	LAO Recommendation 2002-03
18-to-24 year-old interventions	$6.0	$8.0	$6.1
Enforcing tobacco control laws	0.8	4.2	1.1
Advanced youth advocacy coalitions	0.8	0.9	0.9
Regional project media augmentation	2.0	—	—
Special populations	3.0	7.0	—[a]
Technical assistance	3.6	8.5	4.0
Evaluation and surveillance	2.0	3.5	2.0
Direct cessation services	—	3.0	—
Unallocated	1.8	—	—
Totals	**$20.0**	**$35.1**	**$14.1**

[a] To date, no current-year funds have been encumbered and, thus, would be available in the budget year.

- ***Activities Targeting 18- to 24-Year Olds***. The budget proposal would provide $8 million in the budget year, an increase of $2 million over the previous year, in grants to local agencies to conduct programs that target this population. Specific activities may include reducing the amount of tobacco marketing and promotion on college campuses and publishing antitobacco advertisements in the alternative press.
- ***Local Enforcement of Tobacco Laws.*** Under the proposal, a total of $4.2 million would be provided in 2002-03 to local law enforcement and health departments to enhance local law enforcement activities, such as undercover operations to prevent the sale of

tobacco products to minors. This is an increase of $3.4 million from the current year.

- ***Youth Advocacy Coalitions***. The administration proposes $910,000 to continue Youth Advocacy Coalition activities in 2002-03. Under this proposal, college and high school students form coalitions that undertake various activities aimed at reducing smoking in their communities. The coalitions are modeled after a program in Contra Costa County that worked to pass an ordinance restricting the marketing and sale of tobacco products to youth.

- ***Special Population Tobacco Control Interventions.*** The budget proposes $7 million, a $4 million increase over the current year, to focus tobacco control efforts in special populations including various racial and ethnic groups, gays and lesbians, military families, blue-collar workers, and new immigrants. To date, no contracts to provide tobacco control interventions in special populations have been secured.

- ***Technical Assistance.*** The proposal includes a total of $8.5 million in the budget year for technical assistance, a $4.9 million increase from the current year. Specifically, the proposal calls for $2.5 million in contracts with the University of California to provide technical assistance to the Tobacco Control Section of DHS and $6 million for technical assistance to various grantee agencies to help carry out new and existing tobacco control programs. Technical assistance includes coordination of activities and providing expertise about specific populations.

- ***Evaluation and Surveillance.*** The proposal calls for $3.5 million for evaluation and surveillance, an increase of $1.5 million over the current year. Proposed projects include an evaluation of tobacco use changes among special populations, and a survey of attitudes toward tobacco control among law enforcement.

- ***Direct Cessation Services.*** The budget proposes $3 million for new direct smoking cessation programs and to augment the California Smoker's Helpline. There is no funding in the current year for this proposal. The Helpline provides smoking cessation counseling in multiple languages via a toll-free hotline.

In addition to the $35 million in TSF money, the budget proposes another $134 million from Proposition 99 funds and $1.3 million from federal sources and private organizations for antitobacco activities in 2002-03. In sum, a total of $170 million is proposed from all sources in overall spending for antitobacco-related activities conducted by several state agencies including DHS.

Budget Year Program Expansion Not Justified

We recommend that the 2002-03 budget proposal to expand funding for youth smoking prevention efforts be reduced by $20.9 million given the lack of persuasive evidence that doubling funding for these programs will be effective in preventing or reducing youth smoking in California. (Reduce Item 4260-111-3020 by $20.9 million.)

Limited Evidence Specific Proposals Will Be Effective. In our *Analysis of the 2001-02 Budget Bill*, we noted that while it is well documented that tobacco control spending is generally cost-effective, the effectiveness of the proposed new programs had not been demonstrated. As a result, we recommended eliminating all but $2 million of the $20 million proposed for youth antitobacco activities.

Since that time, the department has provided more detailed information about program activities as well as information explaining the theoretical foundation for specific programmatic efforts. However, it has provided little evidence that an expansion of current efforts would be effective in preventing youth smoking. For example, while it has shown that there has been an increase in the rate of smoking prevalence among young adults, the department has no scientific data to validate the effectiveness of specific approaches it is taking to target smoking prevention to 18 - to 24-year olds. It has also provided little detail on how funding for activities targeting special populations and law enforcement activities would actually be used by local agencies.

Some Current-Year Funds Have Not Been Allocated. According to the department, $1.8 million in current-year funding from TSF has not been budgeted for specific youth antitobacco activities. In addition, none of the $3 million from TSF budgeted in the current year for tobacco interventions in special populations has been allocated, and the department does not expect their request for applications to be released until May 2002. Therefore, activities in this area will probably not begin until the budget year.

Analyst Recommendation. Given the serious fiscal constraints now faced by the state, we recommend that the Legislature not augment ongoing funding for youth smoking prevention programs that offer little evidence of efficacy at this time. Accordingly, we recommend that the Legislature provide $14.1 million to fund youth antitobacco programs in the budget year, a reduction of about $5.9 million from the funding level approved in the *2001-02 Budget Act* and $20.9 million less than the Governor has proposed for the budget year. Our recommendations for specific allocations are summarized in Figure 3.

This level of funding would enable the department to continue, without any disruptions, antitobacco activities that have already been implemented in the current fiscal year. Increasing funding for such efforts could be reconsidered once these programs have been evaluated and the state's fiscal condition has improved.

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 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 provides health coverage for uninsured children in families with incomes up to 250 percent of the FPL who are not eligible for Medi-Cal.

The budget proposes $777 million from all funds for support of MRMIB programs in 2002-03, which is an increase of $104 million, or about 15 percent, over estimated current-year expenditures. This increase is due primarily to projected caseload increases in AIM and Healthy Families. In addition, the administration proposes shifting all but $1.8 million (General Fund) from MRMIB programs to the Tobacco Settlement Fund (TSF) in the budget year.

The January budget also proposes to delay implementation of the Healthy Families eligibility expansion to include parents until July 2003, for estimated savings of about $54 million in the current year and about $160 million in the budget year. (The Governor has since indicated his interest in proceeding with the parent expansion in the budget year provided that funding is available.) The budget further reflects caseload increases due to the proposed elimination of the Child Health and Disability Prevention (CHDP) program. Finally, the budget proposes suspending the Rural Health Demonstration Project (RHDP) in the budget year for an estimated savings of $2 million.

HEALTHY FAMILIES PROGRAM

Background

The federal *Balanced Budget Act of 1997* (BBA) made available approximately $40 billion in federal funds over ten years to states to expand health care coverage for children under the State Children's Health Insurance Program (SCHIP). The BBA also provided 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.

California decided in 1997 to use its approximately $4.5 billion share of SCHIP funding to implement the state's Healthy Families Program. Funding for the program generally is on a 2-to-1 federal/state matching basis. Families pay a relatively low monthly premium and can choose from a selection of managed care plans for their children. Coverage is similar to that offered to state employees and includes dental and vision benefits.

The program began enrolling children in July 1998. In 1999, it was expanded to include children with family income up to 250 percent of the FPL as well as legal immigrant children, who are not eligible to receive federal funds and therefore do not draw federal matching funds. In December 2000, the state submitted a waiver request to the federal government to expand the Healthy Families Program to uninsured parents of children eligible for the Healthy Families or Medi-Cal programs up to 200 percent of the FPL. In January 2002, MRMIB resubmitted the waiver—with no significant further policy changes—under the new Health Insurance Flexibility and Accountability (HIFA) initiative procedures established by the federal Centers for Medicare and Medicaid Services (CMS). Federal authorities announced shortly thereafter that the waiver to extend Healthy Families eligibility to parents up to 200 percent of the FPL had been approved. As state statute requires, the administration has indicated its intention to submit an amendment to the waiver further expanding eligibility for parents up to 250 percent of the FPL.

The Budget Proposal

As shown in Figure 1, the January budget proposes state expenditures of $657 million ($1.8 million General Fund) in MRMIB's budget for the Healthy Families Program in 2002-03. This is an increase of about 18 percent over estimated current-year expenditures. The budget proposes $5.5 million for Healthy Families state operations and $652 million for local assistance.

Figure 1

Managed Risk Medical Insurance Board Healthy Families Expenditures

(In Millions)

	2001-02		2002-03 January Budget
	Budget Act	Revised	
Local Assistance	$648.6	$549.6	$651.5
Children	498.5	535.6	649.3
Parents	150.1	14.1	2.2
State operations	6.3	6.6	5.5
Totals	**$654.9**	**$556.3**	**$657.0**
Tobacco Settlement Fund	$114.2	$55.3	$247.1
General Fund	128.3	148.7	1.8
Federal funds	399.2	340.1	398.6
Reimbursements	13.2	12.2	9.4

After accounting for program expenditures (outreach and related Medi-Cal benefits) in the Department of Health Services (DHS) and related expenditures in other departments, the total budget for the Healthy Families Program is proposed at $795 million ($42 million General Fund), a decrease of about 3 percent from the current year. The decrease is due primarily to proposed reductions in state operations support and outreach in the DHS, and decreases in expenditures in the Department of Mental Health.

In the current year, $62 million from TSF was appropriated for projected enrollment of 150,000 parents up to 250 percent of the FPL by June 2002. It was assumed that parent enrollment would begin on October 1, 2001. As a result of the January budget's proposal to delay the expansion of eligibility to parents until July 2003, the budget reflects a reduction in TSF funding to $8 million in the current year. Only $54 million in state savings was realized in the current year because some expenditures were made in the current year in preparation for the expansion to parents. The January budget proposal reflects a $160 million TSF reduction for the proposed delay of parent enrollment until July 2003.

Caseload Issues

Budget Reflects Growing Children's Caseload

The administration's estimates of Healthy Families caseload and associated expenditures are reasonable. We recommend approval of the request for $58 million (Tobacco Settlement Fund) in the budget year for caseload growth.

Caseload Estimate. The budget proposes total expenditures of about $649 million from all funds (including federal funds) for an estimated 644,000 children enrolled in Healthy Families in 2002-03. This includes about a $58 million increase in TSF in the budget year from the revised current-year spending level for caseload growth. This increase is due to the estimated addition of 85,000 children in the program during 2002-03. As we discuss later in this analysis, part of this increase (20,700) results from the proposed elimination of the Child Health and Disability Prevention (CHDP) program and the resulting transfer of some of these children to the Healthy Families Program. The MRMIB anticipates total enrollment in the budget year of about 610,000 children who qualify for federal matching funds (referred to as "base population") and about 33,600 legal immigrant children who do not qualify for federal funds and thus are funded entirely through state funds. Figure 2 shows MRMIB's Healthy Families caseload projections for the current and budget years.

Figure 2
Healthy Families Caseload Estimates

	Budget Estimate	
	Revised 2001-02	Proposed 2002-03
Children	**558,888**	**643,972**
Base population of children	538,195	610,334
Legal immigrant children	20,693	33,638
Parents[a]	—	—
Totals	**558,888**	**643,972**

[a] Reflects January 2002 budget proposal.

The MRMIB anticipates that growth rates in the enrollment of its base population will level off for children under 200 percent of the FPL and will slow to about 1 percent average monthly growth for children between

201 percent and 250 percent of the FPL by the end of the budget year. The projected growth in enrollment of immigrant children is expected to hold steady at about 4 percent each month in the budget year. Enrollment of this group is expected to continue to increase until full enrollment is achieved.

The January budget assumes that no parents are enrolled in the Healthy Families Program until 2003-04 due to the proposed delay in this program expansion.

Caseload Tracking Close to Estimate. In preparing this analysis, we compared actual caseload trends for each of the Healthy Families Program enrollment groups to the administration's caseload projections. The data indicate that the estimates for each group are consistent with actual program growth. We would note that the administration intends to update its caseload and cost projections for the Healthy Families Program at the time of the May Revision.

Risks to the Accuracy of the Projections. Any projection is at risk of being in error, and there are several factors that could influence the accuracy of the projections of the Healthy Families Program caseload. One of these factors is the economy. California is experiencing the first recession since the implementation of the Healthy Families Program and it is unclear what affect it may have on the rates at which children enroll and disenroll in the program.

Enrollment could be greater than estimated to the extent that additional individuals lose their jobs and their health insurance. If one parent in a two-parent family loses his/her job or a parent's work hours are reduced, then the family's income could decrease to the point that they become eligible for the Healthy Families Program. At the same time, disenrollment in the Healthy Families Program could increase as parents in low-income families already enrolled in the program lose their jobs or enough income such that the family qualifies for the Medi-Cal Program.

The accuracy of the department's caseload projections and cost estimates are also dependent upon a number of other factors. These include:

- ***Federal actions*** on such matters as state plan amendments to California's SCHIP plan or waiver requests, as well as congressional actions relating to the appropriation and carryover of SCHIP grants.
- ***Further changes in state and local laws and regulations*** adopted by the Legislature and the Governor or through the initiative process.
- ***Effects of the Governor's budget proposals***. The Governor's proposal to reduce funding for media campaigns and other outreach

activities for the Medi-Cal and Healthy Families Programs could slow caseload growth.

Analyst's Recommendation. While the economy and other factors pose a risk to the accuracy of the Healthy Families caseload and cost projections, it is not yet clear whether the economic downturn will significantly impact the Healthy Families caseload. Accordingly, we recommend approval of a $58 million (TSF) increase in the budget year for Healthy Families children's caseload growth. We will continue to monitor caseload trends and recommend appropriate adjustments at the time of the May Revision.

Elimination of CHDP Would Increase Caseload

We withhold recommendation on the $5.9 million allocated for children's caseload growth related to the elimination of the Child Health and Disability Prevention program, pending a more detailed report from the Department of Health Services at budget hearings on several key issues.

The budget proposes eliminating the CHDP program in the budget year for an estimated savings of about $52 million. The administration maintains that most children in the CHDP program are eligible for Medi-Cal or Healthy Families. As a result of the proposed elimination of the CHDP program, the budget estimates that about 20,700 additional children will enroll in the Healthy Families Program in the budget year. However, this estimate may not reflect the true magnitude of the impact on the Medi-Cal and Healthy Families caseloads primarily because it is not clear how many children receive services through CHDP. Accordingly, we withhold recommendation on the proposed increase of $5.9 million pending a more detailed report from DHS at budget hearings on key issues relating to how the plan would actually be implemented. (Please see the "Public Health" section of this analysis for a more detailed discussion of the proposed elimination of the CHDP program.)

Healthy Families Parent Expansion

The January budget proposes delaying the implementation of the Healthy Families parent expansion until July 2003. Should the Legislature wish, however, to proceed with the expansion in the budget year, we offer an alternative for doing so at a reduced state cost.

Background

California, along with a number of other states, has not spent all of the federal funds that are available to it through the state's federal SCHIP

(Title XXI of the Social Security Act) allotment. Recognizing that states needed additional flexibility to expand health insurance coverage and spend their allotted federal funds, CMS (formerly the Health Care Financing Administration [HCFA]) issued guidelines in July 2000 for demonstration project waivers. Specifically, CMS indicated that the Secretary for the U.S. Department of Health and Human Services (DHHS) would consider five-year waivers that would allow states to use a portion of their SCHIP allotments for (1) coverage of parents of SCHIP enrollees and (2) public health initiatives designed to address or supplement targeted health needs of children.

California's SCHIP Waiver. Chapter 946, Statutes of 2000 (AB 1015, Gallegos), directed MRMIB to seek a federal waiver to expand the Healthy Families Program to uninsured parents of children in families with incomes up to 250 percent of the FPL. In December 2000, the Secretary for the California Health and Human Services Agency submitted a request to federal authorities to expand eligibility to parents with incomes up to 200 percent of the FPL.

After ongoing communications with federal authorities, the state resubmitted its waiver request under the new HIFA waiver process in January 2002. The HIFA initiative, announced by DHHS in August 2001, promises to provide states with expedited review of their waiver proposals if they follow structured guidelines in designing and applying for proposed pilot or demonstration projects.

California's waiver request was approved shortly after resubmittal with no substantial changes from the original request. We are advised that a condition of approval was a federal request that the state conduct a feasibility study of the possibility of expanding eligibility to parents by helping them pay premiums for employer-sponsored health coverage.

Federal approval of the expansion of the Healthy Families Program to include parents was delayed in part due to state and federal negotiations over details of the proposal, including the way that income eligibility for parents would be calculated under the waiver. The state reviewed the issue and decided not to modify the waiver request, thereby establishing income eligibility rules for parents that would be consistent with the existing family income calculations for enrollment of children in the program.

Implementing the Expansion

January Budget Proposes Delay in Parent Expansion. State law requires implementation of the parent expansion to commence no later than four months after the date a waiver is approved. However, the January budget proposed to delay implementation of the parent expansion until

July 2003. The Legislature accepted an administration proposal to revert current-year funding for the parent expansion, but did not approve language proposed in SB 6xxx (Peace) to require a delay in the implementation of the Healthy Families Program until July 2003. In effect, legislative action to date would allow the parent expansion to commence on July 1, 2002, unless contrary action is taken during deliberations on the *2002-03 Budget Bill*.

Since the release of the January budget, the Governor has indicated that the administration is interested in going forward with the parental expansion provided funding is available. The Governor suggested he would work with the Legislature to identify possible funding sources.

Expansion Could Start at Lower Budget-Year Costs. Chapter 946 requires the state to seek a federal waiver to cover parents up to 250 percent of the FPL. At the time this analysis was prepared, however, MRMIB had not yet submitted a further request to CMS to amend its HIFA waiver to expand parent eligibility further to 250 percent of the FPL. Thus, currently federal approval only allows the state to extend parental expansion to 200 percent of the FPL.

If the parent expansion, as currently approved by the federal government, were implemented on July 1, 2002 it would cost the state an estimated $96 million (TSF) in the budget year and provide health coverage for about 187,000 parents. We recognize that the expansion of Healthy Families to parents has been an important legislative priority. Should the Legislature elect to proceed with the implementation of the expansion in the budget year, it could reduce state costs by $66 million by delaying expansion until January 1, 2003. This option would cost the state an estimated $30 million in the budget year and require a change in state law.

STATE FACES POTENTIAL LOSS OF SCHIP FUNDS

The state is at risk of losing $750 million in unspent federal State Children's Health Insurance Program funds over the next two years in the absence of congressional action. We suggest the Legislature work with the congressional delegation regarding the availability of these funds. We also present examples of options to minimize this potential loss of federal funds.

Background

Each federal fiscal year (FFY) since 1998, California has received a share of the nationwide SCHIP appropriation. The first appropriation was to be used within three years, while subsequent allotments were to be

used within two years. Like many other states, California was not able to establish new health programs and to expand enrollment in health programs quickly enough to use all of its FFY 98 and FFY 99 allotments within the designated time period. In 2000, however, Congress authorized states to retain part of these allotments until September 30, 2002. Of the amounts not spent, California was allowed to keep about 63 percent of its FFY 98 allocation and about 42 percent of its FFY 99 allotment. The MRMIB advises that all of its FFY 98 funds will be spent prior to September 30, 2002. As a result, any unspent FFY 99 funds are at risk of reverting to the federal government after September 30, 2002. In addition, under current federal law, the state would lose all of its unspent FFY 00 allotment at the end of FFY 02 and all of its unspent FFY 01 allotment at the end of FFY 03.

State Could Lose Hundreds of Millions in Federal Funds. In the absence of further federal action regarding the FFY 00 allocation and beyond, our analysis indicates that California is at risk of losing $750 million in federal funds through reversions to the federal government. The federal administration recently proposed allowing California and other states to retain part of their unspent SCHIP allotment. Any such relief would be subject to congressional action.

If the Healthy Families parent expansion is delayed past the budget year as the January budget proposes, a total of almost $1 billion of the state's unspent SCHIP funds could be lost at the end of FFY 02 and FFY 03. Figure 3 (see next page) provides estimates of the amount of federal SCHIP funds which the state is at risk of reverting under several possible scenarios.

Options for Preventing Loss of Some Federal Funds. As previously indicated, hundreds of millions of dollars of unspent SCHIP funds are at risk of reverting to the federal government. As a first step, we believe the Legislature should work with the California congressional delegation to extend the deadline on the availability of these funds. If Congress allows the states to retain some of these funds, there are several options, both one-time and ongoing, that may help to minimize the loss of the state's SCHIP allotment.

As an example of one-time options, the state could attempt to draw down federal matching funds for limited duration activities such as abatement of lead in schools and low-income residences, short-term youth violence prevention programs, or the provision of health and dental services for children in geographically isolated areas. This approach would not only allow the state to reduce the amount of unspent SCHIP funds subject to reversion, but preserve SCHIP funds in future years when spending for programs supported by SCHIP funds may outpace the amount of the funds available.

Figure 3

Potential Federal Funds Loss for FFY 99, FFY 00, and FFY 01 Under Alternative Proposals

(In Millions)

	Federal Fiscal Year		
	2002[a]	2003[b]	Total Two-Year Loss
• January Proposal: Delay eligibility expansion to parents until July 1, 2003.	$770	$214	$984
• Delay eligibility expansion to parents up to 200 percent of FPL[c] until January 1, 2003.	770	111	881
• Expand eligibility to parents up to 200 percent of FPL beginning July 1, 2002. Delay expansion to 250 percent of FPL until July 1, 2003.	754	—	754

a Ending September 30, 2002.

b Ending September 30, 2003.

c Federal poverty level.

As an example of an ongoing program option, the state could offer premium assistance to low-income or recently unemployed workers. The federal administration is encouraging states to integrate and coordinate any waiver proposals with the private health insurance market (especially the group health plan market) through premium assistance programs. This option, which has been implemented by Massachusetts, Wisconsin, Mississippi, and other states, would use SCHIP funds to pay for part of the premium for health coverage offered by employers. Under Rhode Island's Rite Share Premium Assistance Program, for example, working families who are eligible for Medicaid can enroll instead in employer-sponsored insurance coverage. The state pays the employee's monthly health insurance premium. This approach could expand coverage to lower-income working families at less cost to the state than providing full coverage through a state program.

All of these options would require federal approval, a step that could significantly delay their implementation. Some of these options might also involve a state funding match that may be difficult due to the state's fiscal problems. In addition, implementing ongoing programs could create General Fund pressure beyond the budget year to the extent that spend-

ing on programs supported by the state's SCHIP allotment outpaces available federal funds.

DUAL ENROLLMENT IN HEALTHY FAMILIES AND MEDI-CAL

An unknown, but probably substantial number of individuals enrolled in the Healthy Families Program are also enrolled in Medi-Cal. We recommend that the Department of Health Services and the Managed Risk Medical Insurance Board report at budget hearings on the steps they are taking to ensure that the state is not paying twice for health coverage for the same individuals.

A recent study conducted by the Department of Mental Health (DMH) suggested that an unknown, but probably substantial, number of individuals enrolled in the Healthy Families Program were also enrolled in Medi-Cal. State regulations do not allow dual enrollment for patients without a share-of-cost in Medi-Cal and Healthy Families, however there is no mechanism currently in place that prevents individuals from being simultaneously enrolled in both programs. Although individuals may be enrolled in both programs, it is uncertain if there are duplicative payments for them. The DMH attributes the dual enrollment problem in part to the lengthy delay in disenrollment that can occur in the Healthy Families Program.

Analyst's Recommendation. We recommend that DHS and MRMIB report at budget hearing on the steps they are taking to ensure that the state is not paying twice for health coverage for the same individuals.

DEPARTMENT OF DEVELOPMENTAL SERVICES (4300)

A developmental disability is defined as a disability, related to certain mental or neurological impairments, that originates before a person's eighteenth birthday, constitutes a substantial handicap, and is expected to continue indefinitely. The state Lanterman Developmental Disabilities Services Act of 1969 entitles individuals with developmental disabilities to a variety of services, which are overseen by the state Department of Developmental Services (DDS). Individuals with developmental disabilities have a number of residential options. While most live with their parents or other relatives, thousands live in their own apartments or in group homes that are designed to meet their medical and behavioral needs.

Community Services Program. This program provides community-based services to clients through the regional centers (RCs). The RCs are responsible for client assessment and diagnosis, the development of an individualized program plan, case management, and the coordination and purchase of various services, such as residential, supported living, and day program services. Day program services include early intervention services for infants and young children and daytime activity programs for adults. The department contracts with 21 RCs to provide services to more than 170,000 clients each year.

Developmental Centers Program. The department operates five developmental centers (DCs), and two smaller facilities, which provide 24-hour care and supervision to approximately 3,700 individuals.

Budget Proposal. The budget proposes $2.9 billion (all funds) for support of DDS programs in 2002-03, which is a 5 percent increase over estimated current-year expenditures.

General Fund expenditures for 2002-03 are proposed at $2 billion, an increase of $128 million. This increase is partly the result of caseload and

cost increases for community-based services. This includes an increase to treat individuals with autism, an increase to move or divert consumers from Developmental Centers to the community, and cost increases for DC janitorial contracts. The budget also includes proposed reductions, including $52 million in savings as a result of unspecified statewide standards for the purchase of services for RC consumers, a decrease in DC operations due to a decline in population, and a reduction for a proposed elimination of 33 headquarters positions.

The budget proposes $2.2 billion from all funds ($1.6 billion from the General Fund) for support of the Community Services Program in 2002-03. The budget proposes a $135 million General Fund increase over the previous year for caseload and utilization growth in RC purchase of services.

The budget proposes $625 million from all funds ($346 million from the General Fund) for support of the DCs in 2002-03.

THE REGIONAL CENTER SYSTEM: ITS MISSION AND FUNDING ARE MISALIGNED

The cost of operating regional centers (RCs) for the developmentally disabled have more than doubled since 1995-96, from $943 million to more than $2 billion, driven up by multiple factors, including annual caseload and cost adjustments for service entitlements, a decline in federal waiver support, and an absence of statewide service standards. Despite this rapid growth in expenditures, some RCs are having financial problems and some communities may be facing shortages of certain services. The Governor's budget includes a modest proposal to reduce RC spending but does not address fundamental fiscal problems with the RC system. In this review, we propose some initial steps the Legislature could take to achieve additional savings in RC programs that could be used either to slow General Fund spending on RCs or to reinvest in the RC system.

Background

The state's Lanterman Developmental Disabilities Services Act ("Lanterman Act"), first passed in 1969 and significantly amended in 1977, provides the basis for the state's commitments to fund community services for persons with developmental disabilities. 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.

In order to deliver services to persons with developmental disabilities, the Lanterman Act specifies that the state contract with RCs, which are nonprofit agencies that coordinate and develop services within their community. The state opted to contract with RCs, rather than use state or county agencies for service delivery, due to the complex service coordination needs of persons with developmental disabilities and their families. That coordination requires RCs to address social, medical, economic, legal, and other challenges that persons with developmental disabilities face.

The state now contracts through the Department of Developmental Services (DDS) with 21 RCs whose catchment areas cover the entire state. The RCs must serve all persons who meet the state's definition of a developmental disability and all children under age three who have or are at risk of developmental delays. In 2000-01, the RCs served more than 165,000 persons, including nearly 63,000 children and 86,000 adults with developmental disabilities and 16,000 children under age three who have or are at risk of developmental delays.

How and Why RC Costs Are Growing

Regional Center Expenditures Growing Rapidly

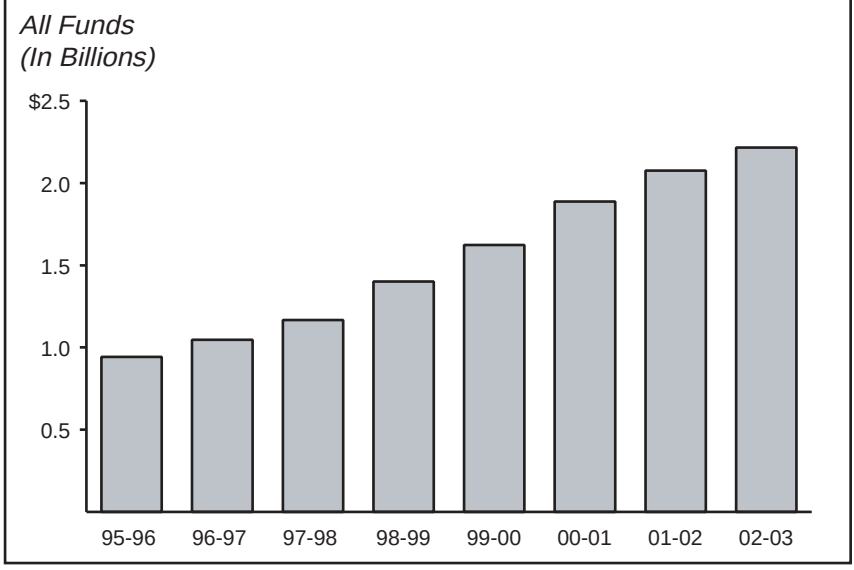
Since the mid-1990s, the RC budget (inclusive of General Fund, federal funds, and other fund sources) has more than doubled, from $943 million in 1995-96 to an estimated $2 billion in 2001-02. This trend is shown in Figure 1. General Fund expenditures also more than doubled, from nearly $600 million in 1995-96 to an estimated $1.5 billion in 2001-02.

In 2002-03, the total RC budget will reach $2.2 billion. These budget increases represent an average annual growth rate in total spending over seven years of almost 14 percent. About 5 percent of this growth represents increases in caseload, nearly 3 percent is due to inflation, and the remaining 6 percent represents other factors, such as growth in utilization of services and cost increases exceeding the rate of inflation.

General Fund Growth. Most RC support comes from the state General Fund. General Fund spending will be $1.6 billion or 74 percent of the expenditures proposed for 2002-03. General Fund dollars would grow by $145 million above current year spending, or by about 10 percent in 2002-03, under the Governor's budget proposal. This is less than in previous years. However, the rate of growth proposed for the budget year is still greater than for most other major health and social services caseload programs. If the state were to maintain this growth rate for RCs, General Fund expenditures by RCs over the next five years would grow by another $1 billion, to about $2.6 billion, by 2007-08.

Figure 1

Regional Center Budget Has More Than Doubled In Eight Years



Types of Expenditures. The RC budget is comprised of two major types of expenditures. The first type is RC operations, which includes client assessment and diagnosis, the development of individualized program plans for clients, and service coordination (also known as case management). The other major category of RC expenditures is purchases of services such as residential care, day programs, or transportation. The RCs are supposed to be the payer of last resort—they generally pay for services only if they cannot refer an individual to a so-called "generic" community service.

The purchase of services budget, which accounts for more than 80 percent of the total RC expenditures would reach $1.8 billion in 2002-03. The budget takes into account savings of $52 million that are to result from unidentified standardized statewide purchase of service practices that the department and stakeholder groups have yet to develop.

Figure 2 (see next page) provides a breakdown of the proposed purchase of service budget for the budget year according to each general category of service. As the figure indicates, most of these funds would be allocated to residential care and day programs. Residential care is estimated to cost about $594 million, and day programs are estimated to cost about $554 million. Total expenditures for transportation services are es-

timated to be $154 million. However, the budget estimate prepared by DDS for RC expenditures does not itemize the costs of certain other categories of services, such as health care, respite, and support services, which together total another $535 million in purchases of services.

Figure 2

Regional Center Purchases of Services

2002-03
(In Millions)

Service	Proposed Budget (All Funds)
Residential	$594
Day programs	554
Transportation	154
Other services (including health care, respite, and support services)	535
Subtotal	$1,836
Savings (to be identified)	-$52
Total	**$1,784**

Detail may not total due to rounding.

Entitlement Drives Service Costs

Eligibility. The RCs provide services to individuals who have been diagnosed with mental retardation, cerebral palsy, epilepsy, autism, or a disabling condition requiring treatment similar to that required for mental retardation. To qualify for services, individuals' disabilities must have originated before the age of 18, and they must constitute what is considered a substantial handicap.

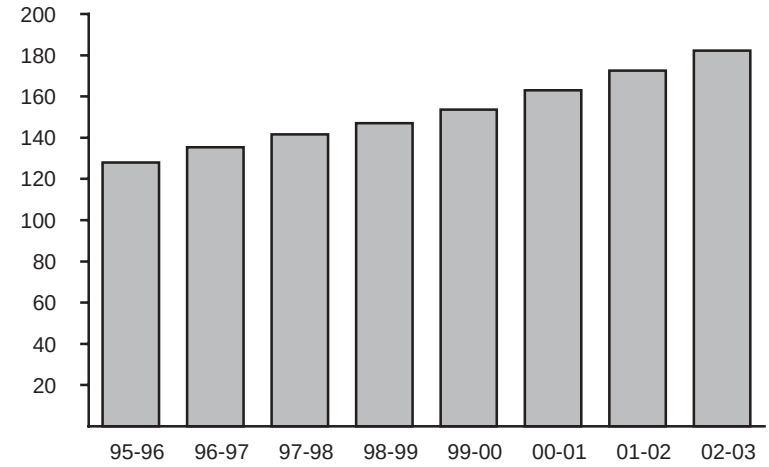
Unlike most health and social services provided by the state, eligibility to receive both case management and community services does not depend on a "means" test or determination of financial need that is based on income level or assets. Further, with a few minor exceptions, services are provided without any requirement that those benefiting from the services, and who have the ability to contribute, pay a share of cost. For that reason, RCs generally do not collect data on the income or means of the clients or the families whom they serve.

Caseloads. Unlike other states, which have waiting lists for services, California does not place limits on the number of people who can receive services. Caseloads, therefore, have grown steadily according to demand, as shown in Figure 3. Between 1995-96 and 2002-03, the RC caseload is expected to increase from 128,000 to 182,000 clients. That amounts to more than 5 percent growth per year.

Figure 3

Regional Center Caseload Growing Steadily

(In Thousands)



One significant component of this growth is the number of individuals diagnosed with autism. Autism caseloads have grown at an average rate of about 16 percent per year.

Individual Program Plans Determine Services. Under the Lanterman Act, RCs must assist each client in developing an individual program plan (IPP), which identifies a person's needs and goals, and the services necessary to meet those needs. The IPP becomes the general basis for determining the community services to which an individual is then entitled. The RCs have the responsibility of ensuring that services identified in the IPP are actually provided.

Although individuals are entitled to the services identified in their IPPs, those services nevertheless must be delivered within annual bud-

getary appropriations. However, the annual appropriations in support of the entitlement for caseload growth and the cost and utilization of services are generally adjusted each year based on historical spending patterns. Those adjustments increased the RC budget by $138 million in 2000-01 and by $177 million in 2001-02. The Governor's budget plan proposes a further increase in 2002-03 of $152 million.

Lack of Statewide Standards

Amount of Services Not Limited or Monitored. Also unlike most health and social services provided by the state, such as the Medi-Cal health program for low-income individuals, the amount of services provided by RCs is not limited through statewide standards. Without statewide standards on the availability of services, General Fund support has grown according to demand, not according to any predetermined policy or strategy to allocate dollars for services deemed to have the highest priority or the greatest effectiveness. Notably, DDS does not collect statewide data on the number of users and frequency of use for many services, and the department does not routinely analyze that data for utilization trends to identify opportunities to control costs.

Uncontrolled Growth in Services. Respite care is an example of a service that is growing dramatically in cost in the absence of any statewide standards to control its utilization. It allows family members of persons with developmental disabilities temporary relief from caregiving. Respite care can be provided in the home by a friend, family member, or agency, or outside of the home in a day facility or a 24-hour facility (in the case of overnight stays). One benefit of respite is that its availability can make it possible for persons with developmental disabilities to live at home instead of being placed in a 24-hour facility for care.

The RC expenditures for respite services have been growing significantly, from $70 million in 1997-98 to the nearly $176 million proposed for 2002-03—an overall increase of 150 percent over five years. Part of the increase in respite care costs—about $8 million in the budget year—is attributed to the autism caseload growth we discussed earlier. The DDS data suggest that the rapid growth overall in respite care expenditures is driven by a growing frequency of use of this service by users as well as caseload and rate increases.

Disparities in Service Levels. The absence of statewide standards has created wide variances across RCs in the delivery of services. The Bureau of State Audits found in 1998 that RC clients with similar needs were provided significantly different levels of financial, clinical, and social supports through the program. The DDS later studied these variances and likewise found some significant disparities among RCs in the extent and

frequency of the services provided. For example, the DDS study found that the *average* transportation costs for clients attending day or work programs ranged from about $630 to nearly $3,000 per user. Notably, transportation service costs also are growing significantly. Transportation costs were about $99 million in 1997-98, but would increase to $154 million in 2002-03. That is an overall growth of 56 percent, or an average annual growth rate of 11 percent.

State Could Be Receiving More Federal Funds

Waiver Programs. The state has received federal approval for a Medicaid waiver program that allows federal financial participation for a broad array of home and community-based services (HCBS) to which RC clients are entitled, including personal care, day programs, transportation, and respite for caregivers. These services are provided to eligible individuals who, without them, would require institutionalization in an intermediate care facility for the mentally retarded (ICF/MR) or a more restricted setting.

The state first established the HCBS waiver program in 1982, and received approval for an expanded number and type of participant and services eligible for reimbursement in late 1992. In recent years, federal approval further expanded the waiver to include certain work programs provided by the state Department of Rehabilitation. Enrollment in the HCBS program is capped. The cap initially established in the 1980s allowed 3,360 individuals to participate at any one time. Subsequently, the cap was raised over the years to about 45,000, and by 2006 would reach about 51,000 individuals.

Waiver Enrollment. When the waiver program was first established, 449 persons participated. That number grew to about 3,300 in 1991-92. Since then, the number of clients billed to the waiver grew from 16,000 persons in 1992-93 to a peak of about 35,000 in 1996-97, as Figure 4 (see next page) shows.

Due to a federal review of the state's waiver activities the following year, which found noncompliance with certain health and safety monitoring requirements, the federal government froze enrollment under the waiver. This meant that RCs could no longer add clients to the waiver even to replace clients who lost waiver eligibility and that the state was no longer eligible for the federal funds associated with those clients. Thus, the number of clients enrolled subsequently dropped by about 6,000.

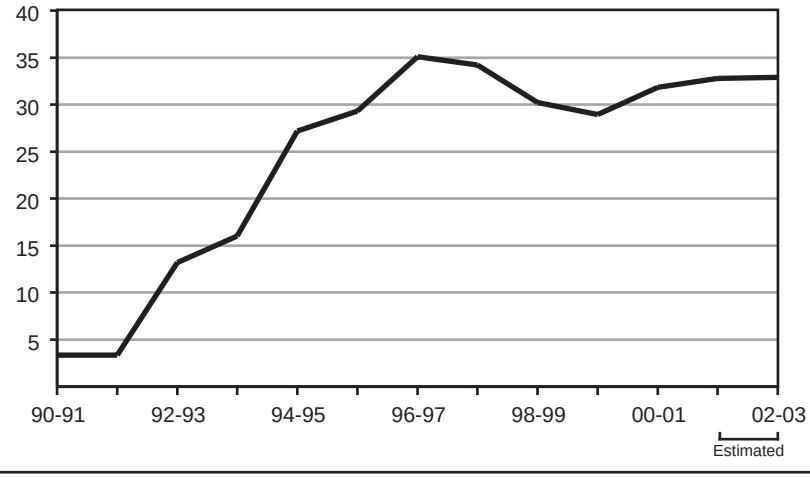
Since October 2000, 19 of 21 RCs have met compliance requirements and are no longer subject to the freeze on enrollment. The number of persons actually participating under the waiver program remains significantly below the number permitted to do so under the state's enrollment

cap. However, the numbers have been slow to rebound. According to DDS and the RCs, this is partially because RCs lack adequate resources to administer the waiver. We discuss this further later in this review.

Figure 4

Number of RC Clients Receiving Services Under the Medicaid Waiver

(In Thousands)



State Compliance Efforts. Over the past several years, the state has committed additional resources to ensure compliance with federal requirements under the waiver, as well as to enhance the health and safety of individuals receiving community-based services. For example, the *2001-02 Budget Act* appropriated about $7 million in ongoing funding for a new system to improve the reporting by RCs of abuse, neglect, and exploitation of persons with developmental disabilities. The *2002-03 Governor's Budget* proposes another $2 million for implementation of this system. Other recent budget appropriations provided funding to improve the training of staff who take care of individuals living in community care facilities. In committing these new resources, the state has committed to comply with federal standards that allow the state to receive federal dollars for many services provided in the community. However, the state still has not sufficiently enhanced its efforts to capture the federal dollars for which it is eligible.

Community Services and Operations Face Financial Problems

Even with the dramatic growth that has occurred in RC funding, there are indications that community services and operations face financial problems. Service providers and the Association of Regional Center Agencies (ARCA) have expressed concerns that inadequate rates paid to service providers have resulted in high staff turnover, difficulty in attracting qualified staff, and in some cases, a lack of services for clients. Rate increases for some community service providers have not kept pace with the rate of inflation over the last ten years. The DDS released a draft report in May 2001 based on the work of a private consultant and of stakeholder groups that identified additional funding needs in the range of hundreds of millions of dollars annually for RC residential services. A forthcoming report on nonresidential services this spring also is expected to identify substantial additional funding needs. For purposes of this analysis, we did not attempt to independently validate the findings of the DDS study. However, it is clear that financial problems exist for RC providers.

The RCs likewise have indicated that inadequate funding of their operations budget has made it difficult for them to operate and manage their ever-growing caseloads. The RCs in high cost areas have reported problems in finding affordable space to rent and in recruiting and retaining the service coordinators who are critical to RC service delivery.

Their claims generally are supported by a 1999 study conducted by Citygate Associates which examined the RC operations budget. This study found that the method used by DDS to determine the RC operations budget did not generate the funds needed for RCs to meet their state and federal mandates. At the time of the 1999 study, the shortfall in funding needed by RCs to fulfill their mission was estimated to be nearly $80 million annually, or about 24 percent more funding than was actually being provided. The budget method generally has not changed since that time.

Governor's Budget Proposes Modest RC Savings

The Governor's budget proposes an unspecified reduction of $52 million in RC purchases of services. According to DDS, these savings will be realized through the development and implementation of statewide standards for purchase of services in the community without changing the entitlement to services. The DDS indicates that the administration will propose trailer bill language to authorize the implementation of statewide standards. We believe the Governor's proposal to establish statewide standards for purchases of services is a step in the right direction to

address rapidly growing costs. As we further discuss below, the proposal has yet to be fully developed and does not include any detail on the estimated savings level associated with such standards. Our analysis suggests, however, that the establishment of meaningful statewide standards such as those now in place for other types of health service programs could be effective in helping to control costs.

In our view, the Governor's proposal does not go far enough to address the fundamental problem—an RC system that has few limits on caseloads and costs yet still faces financial problems.

For example, the proposed budget assumes no improvement in state efforts to obtain federal funding under the home and community-based services waiver. As indicated in Figure 5, the proposed budget for the RCs assumes enrollment under the waiver remains almost unchanged at about 33,000 clients in the budget year. As a result, there is also no increase in the percentage of clients billed to the waiver. In fact, federal reimbursements would decline 1 percent, continuing a trend by which expenditures increase while the percentage of federal dollars claimed continues to drop. Federal funding comprised 20 percent of total expenditures in 2000-01, but would be 17 percent of the total expenditures anticipated for 2002-03.

Figure 5

Home and Community-Based Waiver Enrollment and Expenditures

(Dollars in Millions)

	2000-01	2001-02	2002-03
Number of clients billed to waiver	31,837	32,771	32,906
Total number of regional center clients	162,970	172,505	182,230
Percentage billed to waiver	20%	19%	18%
Waiver expenditures[a]	$586	$589	$597
Total expenditures for regional center clients[b]	1,493	1,658	1,784
Waiver expenditures as a percentage of total	39%	36%	33%
Federal reimbursements under waiver	$302	$303	$301
Federal reimbursements as a percentage of total expenditures	20%	18%	17%

[a] Excludes Department of Rehabilitation expenditures.

[b] Represents Purchase of Service budget only.

We would note that DDS has hired a consultant in the current year to study the possibility of increasing Medicaid federal dollars, including what can be done under the approved waiver. At the time this analysis was prepared, however, the consultant's findings were not yet available and no specific proposals had been included in the budget plan for the purpose of increasing federal dollars.

Recommendations and Options

We withhold recommendation on the Governor's proposal to reduce funding for regional center (RC) purchases of services by $52 million until the Department of Developmental Services provides more specific information to the Legislature as to how these savings would be achieved. We also recommend a $50 million reduction in General Fund support in the RCs purchase of service budget, and a corresponding increase in federal spending authority, as part of a strategy to take full advantage of a federal waiver allowing some client services to be supported with available federal funds. We further recommend an increase of $5 million in General Fund spending authority in the RCs' operations budget to implement this strategy. (Reduce Item 4300-101-0001 by $45 million. Increase Item 4300-101-0890 by $50 million.)

In addition, we propose options for the Legislature to consider to reduce General Fund expenditures, including requiring clients to pay a share of cost for services based on their ability to pay. Savings resulting from the implementation of any of the options could be used to reduce General Fund spending for RCs, or to reinvest in RC services in the community.

First Steps to Control Growth in General Fund

The Legislature has already indicated its concern about weaknesses in the RC system. One proposal to enhance community services currently under consideration is Assembly Bill 896 (Aroner), which would require closure of some of the Developmental Centers (DCs) now operated by the DDS and transfer of the savings on DC operations to community services. In order to ensure that all of the funds remain available to serve those with developmental disabilities, the bill would create one unified budget to encompass both DCs and community services.

At the time this analysis was prepared, the measure had passed the Assembly and was pending in the Senate. However, even if the Legislature were to choose that approach to bolstering RC resources, the long planning period needed to close a DC means that it could be some time before any savings from closing DC facilities would materialize.

In this section, we suggest some first steps the Legislature could take as it considers the 2002-03 budget to generate significant savings in RC expenditures that could be used either to help address the state's current fiscal problems or to reinvest in the RC system.

Analyst's Recommendations

Unspecified Reduction of $52 Million. As we noted earlier, the Governor's budget proposes an unspecified reduction of $52 million in RC purchases of services. According to DDS, these savings would be realized through the development and implementation of statewide standards for purchase of services in the community without changing the entitlement to services and supports. The DDS indicates that the administration will propose a budget implementation bill authorizing statewide standards for RC services. The department has not yet documented how this estimated level of savings would be achieved. Consequently, the Legislature does not have the information it needs to determine whether the administration proposal would actually achieve the level of savings that are claimed.

Accordingly, we withhold recommendation on this budget reduction proposal until DDS provides more specific information to the Legislature as to how these savings would be achieved. We recommend that DDS provide the Legislature with specific standards for purchase of services, estimated dollar reductions for each service standard, a timeframe for implementation, and proposed implementing language.

Because multiple factors drive purchase of services costs, it may be difficult to trace whether the standards eventually adopted under the Governor's proposal actually result in any savings. Caseload and utilization adjustments likely will result in a net increase in purchases of services of more than $150 million annually in the following budget year even with the implementation of standards. Therefore, we recommend that DDS also provide the Legislature with baseline data on historical growth assumptions that could be used to measure savings from implementing any new standards.

Potential for Federal Waiver Funds. As we noted earlier, the state has federal approval for a Medicaid waiver program that allows federal financial participation for a broad array of home and community-based services (HCBS) to which individuals are entitled, including personal care, day programs, transportation, and respite for caregivers. The state could add up to 13,500 clients to access additional federal funds for community services and still remain within its enrollment limit of 46,500. We estimate that the state could receive nearly $120 million annually in additional federal funds if it were able to take full advantage of the current waiver.

An alternative approach would be to add fewer clients, but target for inclusion under the waiver those clients who have the most needs for care. If the state added to the waiver about 3,000 clients living in community care facilities or in supported living arrangements, we estimate the state could save as much as $50 million General Fund annually by being able to claim additional federal funds. We also estimate that the state would need to spend about $5 million to achieve these savings, for a net General Fund savings of $45 million.

Administration of the waiver program depends on the RCs, whose staff have the critical responsibilities for conducting eligibility determinations, evaluations and reevaluations of persons enrolled on the waiver, and for completing all necessary documentation associated with those functions. Waiver administration significantly increases RC workload. The RC's proposed budget assumes no growth in waiver enrollment or in federal dollars. Although RCs currently receive some funding to administer the waiver—about $600 annually for each RC client billed to the waiver—the amount has remained unchanged for about five years and, according to ACRA, is below the actual costs that RCs must incur for administration of the waiver program.

Our analysis indicates that these potential barriers to increased enrollment under the waiver could be overcome if the RCs were permitted to retain 10 percent of any increase in federal dollars achieved in the budget year as a result of their addition of new clients to the waiver. The dollars that RCs would retain would be in addition to the funds currently allocated for their waiver administration activities. This incentive would only apply to the 19 RCs that have passed DDS' compliance reviews to ensure that RCs meet health and safety and internal management requirements.

We believe that DDS could identify and that RCs could add at least 3,000 additional clients to the waiver in the budget year who are now living in community care facilities and in supported living arrangements. In keeping with this estimate, we therefore recommend a $50 million General Fund reduction in the RCs purchases of services budget, and a corresponding increase in federal spending authority to recognize the additional federal resources that would result from this recommendation. We also recommend that the Legislature increase the budget for RC operations by $5 million from the General Fund and adopt budget bill language specifying that these funds are available to RCs which place additional RC clients on the waiver program. The language would further require that any unused incentive funds revert to the General Fund at the end of 2002-03. The language would be placed in Item 4300-101-0001 and read as follows:

> Of the funds appropriated in this item, $5,000,000 shall be available for Program 10.10.010—Operations, for allocation to regional centers (RCs) which increase enrollment under the home and community-based services waiver. Waiver enrollment targets for December 31, 2002 and June 30, 2003 shall be incorporated into RC contracts with the Department of Developmental Services (DDS). The DDS shall allocate the funds, equivalent to 10 percent of the anticipated federal dollars that result from adding new clients to the waiver. Any funds not allocated to RCs for this purpose will revert to the General Fund at the end of the 2002-03 fiscal year.

We further recommend that the department report at budget hearings on the findings (if they are available) of the contractor hired to study ways to increase federal financial participation for Medicaid-funded services. The Legislature would then be in a position to consider additional steps to maximize federal financial participation, particularly those findings that could have an impact in the budget year.

Share-of-Cost Options

As we discussed earlier, RCs purchase services for children and adults with developmental disabilities, generally at no cost to the clients or their families. One notable exception is a monthly fee now paid by some parents who have children in 24-hour care facilities. The Legislature may wish to consider other options for requiring some clients to pay a share of cost, or increased fees based on the ability of the client or the client's family to pay. Adoption of these options would provide savings to the RC program that could be used to reduce General Fund costs for RC services or be reinvested in the RC system to strengthen community services. Requiring a share of cost for services could also deter overutilization of services that might otherwise occur, thereby further reducing General Fund costs. Finally, establishing such cost-sharing for those who have an ability to pay would make RC services more consistent with other state-supported health programs.

The exact savings that would result from these options are difficult to estimate because, with the exception of those parents with children in 24-hour facilities, the RCs do not collect data on the incomes of the clients or their families. Our estimates discussed below do not take into account any potential effect on utilization of RC services. We also note that implementation of any of these alternatives would require statutory changes.

Parental Fees. Currently, parents of children under the age of 18 who receive 24-hour care in a state or community facility pay a monthly fee, based on (1) their gross income, (2) the number of persons dependent on that income, and (3) the age of the child receiving the care. The maximum fees that DDS charges have remained largely unchanged since 1984. They

are $386 per month for a child from birth to age six, $418 per month for a child from seven to 12 years of age, and $473 per month for a child from 13 to 18 years of age. State law specifies that fees not exceed the cost of caring for a normal child at home.

Adjusting the maximum fee that can be charged to reflect the increase in the cost of living over the last 17 years would generate about $1 million annually that could be used to offset General Fund expenditures for these services. Additional revenue could be generated if the fee schedule were adjusted so that more families paid the maximum monthly fee.

Alternatively, the fees could be further increased to more fully reflect the actual costs of caring for a child in a 24-hour facility. Under this option, the fees that would be charged would no longer be limited as they are now to the costs of raising a child without developmental disabilities at home. However, in no case would the fees exceed the parents' ability to pay. This alternative, which would require legislative action, could generate about $5 million annually in revenues that could offset General Fund costs for these services.

Respite Services. Respite services for the families of RC clients (both children and adults) are generally provided at no cost, regardless of the income of the client or the parents or relatives with whom a client lives. As noted earlier, these costs have been growing rapidly. The proposed budget estimates RC expenditures for respite services to be nearly $176 million in 2002-03. Medicaid payments, under the home and community-based services waiver, will cover only about $21 million of these costs in the budget year. We estimate that requiring those who can afford to do so to pay for all or a part of services not covered by the Medicaid waiver would reduce General Fund expenditures by as much as $155 million in the budget year. As we previously indicated, the exact savings are difficult to estimate because the RCs do not collect data on the incomes of the families they serve.

Other Services for Children Under 18. The RCs spend about $300 million annually for various services for children under 18. Respite services and 24-hour residential care account for about one-third of these costs. Copayments already exist for two services—day care and diapers. However, other children's services, such as speech therapy and behavior management, could also be subject to contributions from families with an ability to pay. We estimate that contributions could result in up to $5 million in savings to the General Fund.

Parental fees would not be imposed for early intervention services provided by RCs to children under three years of age. We are advised that the federal grant award that partially funds early intervention services requires that they be provided at no cost to families. We offer an

alternative approach for addressing the $65 million cost for these services in a later option.

Ability to Pay. State law requires persons with developmental disabilities who reside in a DC to pay DDS for their cost of care and treatment, subject to the clients' (not the parents') ability to pay. In 2001-02, the department expects to collect about $16 million from DC clients in private payments and insurance.

This option would extend the same financial responsibility to adult RC clients that is now required for DC clients. The fees collected under this approach would result in an offset to General Fund expenditures. Assuming that the department could collect an amount from RC clients proportional to that generated from DC clients, the General Fund offset would be at least $50 million annually.

This option would affect only a small percentage of RC clients. The majority of adults with developmental disabilities have a low income, as evidenced by the high percentage who are eligible for Supplemental Security Income/State Supplementary Program (SSI/SSP), a cash grant award for low income individuals, and Medi-Cal, the state's health program for low income individuals.

Other Options

Respite Services. Previously in this report, we noted that the Legislature has the option of imposing a share of cost for respite services. An alternative approach to controlling the cost of respite care would be to establish a limit on the maximum allowable annual expenditure for these services for each client. Setting a limit at two-thirds of the current average spending level, for example, would result in General Fund savings of about $55 million. Imposing any utilization controls on respite services would require a statutory change.

Early Intervention Services. The Early Start program, jointly administered by the State Department of Education and DDS, provides early intervention services to children under age three who have disabilities, or who are at risk of having disabilities, in order to enhance their development and to minimize the potential for developmental delays. The RCs receive nearly $20 million in federal funds under Part C of the Individuals with Disabilities Education Act to purchase these services in their communities.

In recent years, state costs for early intervention services have exceeded federal mandates by several million dollars. In addition, state-only funded early intervention services amount to another $45 million in expenditures. This option would shift part or all of the state's General Fund cost of the program to Proposition 98, thus permitting a net reduc-

tion in non-Proposition 98 General Fund expenditures. Shifting only those costs of the program for which the state receives federal funding would result in a net savings of $2 million. Shifting all costs incurred would result in a net savings of $45 million. Our analysis indicates these expenditures could appropriately be considered an education program eligible for support under Proposition 98.

Adoption of this option would require a statutory change. The savings we have estimated also presume that the state does not overappropriate the Proposition 98 minimum guarantee. Adopting this option would result in a reduction in funding for other K-14 educational programs proposed in the *2002-03 Governor's Budget*, unless the estimated minimum funding guarantee increases in the May Revision as a result of new personal income data to be released by the federal government in the spring. As discussed in this *Analysis*, the minimum funding guarantee could increase by as much as $900 million.

The RC Performance Contracts. The state contracts with RCs for the provision of services for persons with developmental disabilities. State law requires that those contracts include incentive payments to RCs that meet or exceed established performance standards. The DDS' practice has been to provide these incentives to qualifying RCs by reappropriating up to one-half of an RC's budget savings. In recent years, these reappropriations have ranged collectively from $4 million to $11 million annually. Suspending the incentive payments until such time as the state's financial condition improves would result in a savings to the state General Fund.

Conclusion

The 2002-03 budget for the regional centers program has been growing rapidly. If current trends continue, expenditures would increase by another $1 billion over the next five years. Yet, as we have noted, despite the dramatic growth in RC funding, there are indications that community services and operations face financial problems and that RCs have found it difficult to operate and manage their ever-growing caseloads. This review outlines some first steps the Legislature could take in the budget year to begin to slow the growth in RC expenditures. Some of these options and recommendations could result in significant state savings which could be used to help address the state's current fiscal problems. The Legislature could also choose to reinvest the savings in the RC system to address its financial problems.

BUDGET ADJUSTMENTS

Community Placement Plan Funding Should Be Offset With Federal Funds

We recommend that the Governor's proposed augmentation for the Community Placement Plan expenditures be reduced by about $7 million to reflect federal funds available to offset the cost to the General Fund. We also recommend the adoption of budget bill language reverting any unspent General Fund monies for this program at the end of the fiscal year. (Reduce Item 4300-101-0001 by $6.9 million.)

Background. Since 1994, when DDS settled the lawsuit *Coffelt v. Developmental Services,* the department has implemented a Community Placement Plan (CPP) each year to assist RCs with moving DC residents into the community. The plan is also intended to help reduce admissions to DCs by ensuring the adequacy of community resources. The Governor's budget provides funding for the CPP, covering costs incurred for placing individuals in the community in the budget year and the continued costs of individuals placed in the prior year.

Since the initial placement of 2,000 individuals in the community required under the *Coffelt* settlement, DDS has continued to move clients from DCs to the community each year. However, according to the department, the rate of placement has slowed down in the last few years.

Regional Center Budget. Each year, the proposed budget for the RCs includes additional funding for new community placements. Since the *Coffelt* settlement, funding has been based on formulas which estimate the average cost of such client placements. In the past three years, not all of the funding was used for this purpose and instead has been redirected to other community services. The *2002-03 Governor's Budget* proposes to change the way client placement costs are computed. In general, average costs would no longer be used to determine the amount of funding available to DDS for CPP. Funding would instead be based on the estimated costs of placing in the community specific clients whom RCs already have identified. As a result, CPP resources would more closely approximate the actual costs of such placements.

The CPP costs in the current year, which were estimated under the old methodology, are projected to be about $30 million. The budget proposes to increase CPP funding by $20 million in 2002-03 to $50 million—a 67 percent increase. The vast majority of these resources are from the General Fund.

Of the additional $20 million proposed in the budget year, $1.5 million would be provided to RCs to assess individuals in DCs who could be placed in the community, and to develop community resources for future placements. An additional $3 million would pay start-up costs for new community facilities, and $14.5 million would be spent for services such as residential facilities and day programs for clients placed in the community. The Governor's plan indicates that the CPP estimate will be updated at the time of the May Revision.

Proposal Should Have Factored in Federal Funding. We are concerned that the Governor's proposal does not factor in the availability of federal funds that could reduce the cost of these improvements to the CPP. The Governor's budget request for the CPP assumes in effect that the state will not receive any of the federal funds that are available under the home and community-based services waiver we discussed earlier in this analysis. Because the individuals placed by the CPP would have complex medical and behavioral needs, we believe it is likely that most individuals assisted under the CPP would qualify for services under the waiver.

Analyst's Recommendations. Given the state's serious fiscal problems, and the $124,000 to $157,000 annual cost to the General Fund of many CPP placements, we believe it is important that DDS and the RCs make an effort to enroll eligible CPP clients under the waiver. Accordingly, we recommend that the Governor's funding request for the CPP be reduced by $6.9 million to reflect the additional federal funds that could be received to offset the cost of the proposal under the home and community-based services waiver. That means the state could offset some of the General Fund cost of this proposal with the federal funds that would be generated under the waiver program.

We also recommend that funds under the CPP only be used for that purpose. Accordingly, we recommend the following budget bill language under Item 4300-101-0001:

> Any funds appropriated in this item for the department's Community Placement Plan, but not expended for that purpose, shall revert to the General Fund.

Technical Budget Adjustment for Leased Facilities

We recommend that the Department of Developmental Services report at budget hearings on the status of an interagency agreement with the Department of Health Services that could result in state General Fund savings of as much as $8 million for the operation of its Sierra Vista and Canyon Springs facilities. The department should also report at that time on the status of federal certification of the Canyon Springs facility.

Background. The DDS operates two leased facilities to care for individuals with behavioral needs—the Sierra Vista facility, a 58-bed facility located in Yuba City, and the Canyon Springs facility, a 63-bed facility located in Cathedral City. Sierra Vista was certified to receive payments for services by Medi-Cal (the state and federal health program for low-income individuals) in June 2001. Canyon Springs was expected to be certified for Medi-Cal payments on January 31, 2002.

Results of Interagency Agreement. The budget assumes that Sierra Vista and Canyon Springs will be reimbursed by the federal government for services provided for its residents at the same daily rate paid to intermediate care facilities in the community, rather than at the higher rate paid for care provided in institutions. The latter rate provides full reimbursement for all costs of services. The department reports that its budget request for the two facilities was based upon the lower rate because an interagency agreement with DHS that might result in reimbursement at the higher rate had not been completed.

However, the department recently indicated that an interagency agreement with DHS that would permit DDS to be reimbursed for these services at the higher rate was close to resolution. Such an agreement could mean that the Legislature could reduce General Fund expenditures by as much as $8 million and increase expenditure of federal funds by an equivalent amount.

We therefore recommend that the department report at budget hearings on the status of that agreement and, if the agreement is completed at that time, adjust the DDS budget accordingly to reduce General Fund expenditures for these facilities.

Federal Certification of Canyon Springs. At the time this analysis was prepared, Canyon Springs had not yet been certified. We therefore recommend that the department also report at budget hearings on the status of that facility's certification and any budget adjustments that the department would need to make in the case of a delay. Any delay in certification would result in an increase in the General Fund budget for the operation of Canyon Springs.

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) administer the Bronzan-McCorquodale and Lanterman-Petris-Short Acts, which provide for the delivery of mental health services through a state-county partnership and for involuntary treatment of the mentally disabled; (2) operate four state hospitals; (3) manage state prison treatment services at the California Medical Facility at Vacaville and, beginning in the budget year, 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, and mentally disordered offenders and mentally disabled clients transferred from the California Department of Corrections.

Budget Proposal. The budget proposes $2.2 billion from all funds for support of DMH programs in 2002-03, which is an increase of more than $100 million and 4.9 percent above estimated current-year expenditures. The budget proposes $943 million from the General Fund, which is a reduction of about $46 million, or 4.6 percent, below the Governor's revised budget plan for the current year. Reimbursements that would be received by DMH—largely Medi-Cal funding passed through to community mental health programs—would increase $150 million, or about 15 percent.

The overall proposed increase in DMH expenditures is primarily due to the expansion of the Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT) for children with emotional problems. The budget reflects a $134 million increase in 2002-03 in the reimbursements received from Department of Health Services for support of EPSDT ($70 million comes from an increase in Medi-Cal General Fund spending and the balance from federal funds). An additional $16 million in reimbursements

is provided in the budget for therapeutic behavioral services for EPSDT children ($7.9 million comes from an increase in Medi-Cal General Fund and the balance from federal funds). Also, an additional $14 million from the General Fund would be provided for caseload and other adjustments for managed care plans providing community mental health treatment.

Also contributing to the overall increase in DMH spending is a request in the state hospital budget for an augmentation of about $22 million from the General Fund (as well as a decrease of $12 million in reimbursements) for projected growth in the forensic patient population. The budget plan assumes that the overall number of hospital patients at the end of the budget year will be 4,687, about 390 more patients than were in the hospitals as of December 2001.

The net reduction in General Fund expenditures proposed by the Governor's spending plan results from an anticipated $35 million decrease in payments for state-mandated local programs as well as a series of other adjustments. This includes proposals to:

- Reduce supportive housing programs by $17.5 million, leaving $3.5 million available for additional projects.
- Defer about $12 million in support for services for special education pupils. Instead of receiving part of their state funding in advance though a categorical state program, counties would henceforth recover funding after the fact by filing claims for reimbursement against the state.
- Reduce Children's System of Care programs by $4.2 million.
- Discontinue about $2.7 million a year in payments that once were used to support a Santa Clara County mental health hospital but that had continued following its closure.
- Reduce by $1.5 million "dual diagnosis" projects intended to assist patients who have both substance abuse addiction and mental illness.

We discuss some of these specific proposals for spending increases and reductions later in this section of the analysis.

STATE HOSPITAL ISSUES

Hospital Growth Projections Lowered

The state hospital system is no longer projected to grow nearly as quickly as the Department of Mental Health had previously predicted. Even with the significant downward revisions in projections that have

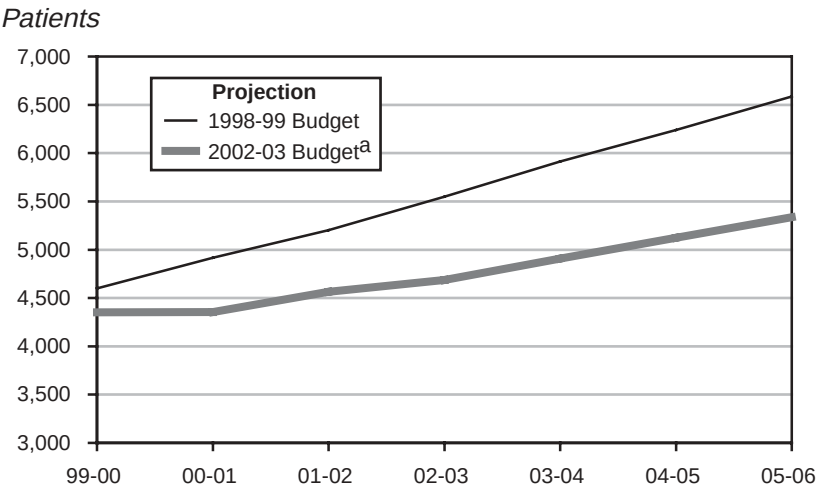
occurred over the last four years, however, the department still appears to overstate the growth that is likely to occur over the next decade. A key factor appears to be a slowdown in the rate at which mentally disordered offenders and other criminal offenders are being committed to state hospitals.

Ten-Year Projections Revised Downward. On a periodic basis, DMH prepares projections of how the state hospital population is expected to grow over the ensuing ten years. These ten-year projections forecast the overall numbers of patients expected to require state hospital beds. They also examine the specific, high-security bed needs of forensic patients—that is, those transferred to the hospitals because of their involvement in the criminal justice system. They also forecast the caseloads for other patients committed to the hospital system under the authority of the Lanterman-Petris-Short (LPS) Act and financially supported by counties. These projections are important because the department's budget requests and its capital outlay plans are largely based upon them.

Our analysis indicates that, over the past several years, the department's long-term population estimates have been dramatically revised downward. The change in the projections can be seen in Figure 1.

Figure 1

State Hospital Population Projections Have Dropped Significantly



[a]For the 2002-03 budget projection, the population shown for 1999-00 and 2000-01 fiscal years is actual data.

The earlier projections have already proven to be overstated. For example, the projections that were used as the basis for the 1998-99 budget plan assumed that the total population in the state hospital system would reach 4,900 as of June 2001. The actual patient population at that time was lower by about 550.

As a consequence, more recent projections—including the one released recently in support of the Governor's 2002-03 budget—have been repeatedly scaled back. For example, while the 1998-99 projections indicated that the hospital system would have 6,586 patients by June 2006, the most recent projections used as a basis for the 2002-03 budget plan suggests there will only be 5,337 by that same date—about 1,250 fewer patients than previously predicted.

The larger numbers assumed in the 1998-99 budget projections were based primarily on an assumption that there would be a strong and sustained growth of about 156 additional sexually violent predators (SVPs), per year, for a total of 1,545 SVP patients by June 2006. (The SVPs are prison inmates nearing release to parole who have been convicted of a violent sexual offense.) The most recent DMH projection is that the total number of SVPs as of June 2006 will be 658, based on a growth rate of about 55 additional SVPs per year.

Latest Projections Probably Still High. Barring major policy changes by the Legislature or court rulings that could change the rate of commitment of new patients to the state hospital system, our analysis indicates that even the lower, more recent DMH projections still overstate the growth that is likely to occur in the hospital system. Specifically, we estimate that the hospital system will have about 250 fewer patients at the end of 2002-03 than DMH is now projecting.

The primary explanation for the difference between our estimate and the department's is attributable to its methodology. The DMH projection is based upon a statistical three-year trending of data that does not sufficiently take into account more recent, and more moderate, trends in some population groups, or the programmatic changes that appear to explain why growth in certain groups has slowed.

For example, DMH projects ongoing growth in the mentally disordered offenders (MDOs) caseload (62 per year), even though the number of MDOs actually grew by four during 2001. For several years, the number of MDOs had been growing quickly, but the build-up in this population occurred during a period in which the number of offenders eligible for the MDO program dramatically increased and the efforts by the state to screen and refer state inmates to DMH for MDO commitments were escalating significantly.

The situation appears to have changed, however, in regard to both of these factors. The pool of offenders potentially eligible for MDO commitments is now fairly stable, and the number of MDO referrals, which had increased by a factor of six in four years, is growing much more modestly now (about 12 percent per year). The number of MDOs being discharged from the hospital system slightly exceeded the number of MDOs admitted during 2000-01, in keeping with DMH data showing a slight decline in the population during that same fiscal year. More recent data similarly suggest that growth in some other forensic groups, such as offenders deemed incompetent to stand trial, has also slowed and in some cases may actually be declining slowly now.

Legislature Needs Better Information. The department's population projections have significant ramifications both for state finances and the operation of the state hospital system. For example, the construction of a more than $300 million, 1,500-bed hospital in Coalinga for SVPs was justified largely on the basis of a projection that 1,500 hospital beds would be needed for SVPs by 2006. Had more accurate projections been available at the time, the Legislature might have considered authorizing a smaller facility or a different approach to meeting its future bed needs, such as further additions to existing hospitals.

Because of continuing disparities between the projections and actual population figures, both DMH and the Department of Finance (DOF) are reviewing how these projections could be modified to provide a more realistic forecast of future bed needs. We will continue to monitor these efforts and will advise the Legislature at the time of the May Revision what steps, if any, it should take to ensure it has better projections upon which to base major decisions on the future finances and capital outlay needs of the hospital system.

Patient Caseload Overbudgeted

We recommend a General Fund reduction of $12.6 million because state hospital caseload funding is overbudgeted. Additional General Fund savings in the Department of Mental Health budget of about $1.4 million are likely to occur in the current fiscal year due to lower caseloads. (Reduce Item 4440-011-0001 by $12.6 million.)

Governor's Proposal. The Governor's spending plan proposes to provide additional funding for DMH in both the current fiscal year and the budget year to accommodate the increases that the department projects will occur in the state hospital population.

For the current fiscal year, the administration has proposed a net increase of about $4 million in hospital funding relative to the funding pre-

viously authorized in the *2001-02 Budget Act*. This increase includes: (1) a $3 million General Fund increase for the treatment of certain forensic patients, (2) a $1.3 million increase in reimbursements paid to DMH from the California Department of Corrections (CDC) for the treatment of prison inmates, and (3) a reduction of $350,000 in reimbursements paid to DMH by counties. (In December, the DOF submitted a Section 27.00 letter notifying the Legislature of its intention to increase General Fund expenditures by $2.9 million to implement part of this budget proposal. However, the Legislature did not concur with this increase.)

For the budget year, the spending plan requests a net increase of $9.4 million for state hospital population caseload adjustments above the revised current-year spending level proposed by the Governor. The budget proposal would: (1) increase General Fund expenditures in the DMH budget for treatment of certain forensic patients by $21.6 million, (2) increase reimbursements paid to DMH for treatment of CDC inmates by about $2.6 million, and (3) reduce reimbursements paid to DMH from counties for LPS patients by about $14.8 million.

The budget request is based on the department's ten-year population projections that were discussed earlier in this analysis. The DMH assumes that the overall state hospital population (which was 4,297 in December 2001) will reach 4,565 by the end of 2001-02 and 4,687 by the end of 2002-03. The DMH budget request further assumes that (1) the number of county LPS patients will decline, (2) the number of CDC state prison inmates receiving treatment in the state hospitals will remain level, and (3) the number of other forensic patients supported through General Fund appropriations in the DMH budget will increase.

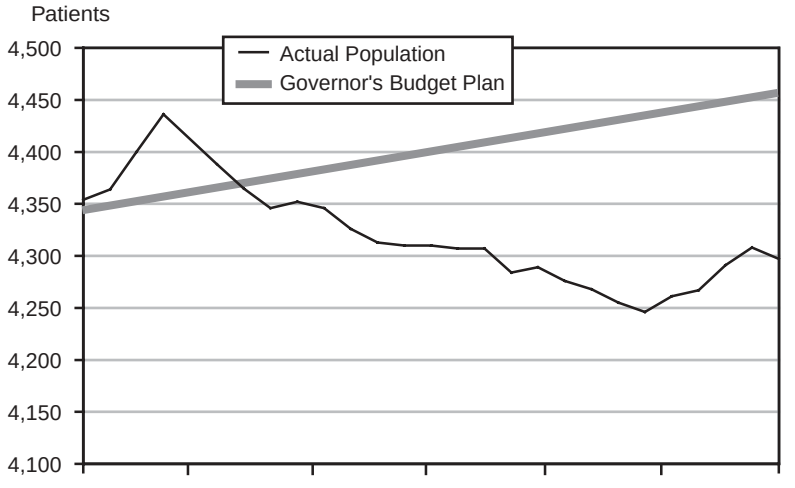
Projections Off Track. Our review of recent hospital population data indicates that the overall number of patients has actually been declining, and is not growing significantly as assumed in the Governor's budget. The gap between the budget projection and actual population trends is evident in Figure 2, which compares the population growth assumed in the Governor's budget plan for the first half of the 2001-02 fiscal year to the weekly population counts for that period.

If this disparity between the projections and actual population counts were to continue, the Governor's budget plan would provide the state hospitals significantly more money than is needed in both the current and budget year.

LAO Projection: Lower Caseload Growth. Because of our concerns about DMH population projections, we have prepared estimates of the patient population for the current fiscal year and the budget year. Our estimating approach more fully takes into account recent statistical trends and significant changes in programs. It also differs from DMH estimatesbecause an additional six months of actual data were available.

Figure 2

State Hospital Growth Falling Short Of DMH Projections



Our estimates assume a somewhat higher caseload of LPS patients over the course of 2002-03 than does DMH, but assumes a lower number of CDC patients in the state hospital system.

Our estimates, which are summarized in Figure 3 (see next page), indicate that the hospital population will grow from 4,297 (the number of patients reported as of the end of December 2001) to 4,435 patients by the end of the budget year. That is about 250 fewer patients than DMH has predicted will be present by that date.

Caseload Funding Needs Overstated. Based upon our population projections, we believe that the hospital caseload funding proposed by the Governor for the current fiscal year and the budget year is overstated. For the current fiscal year, we expect that the state will realize a net General Fund savings (partly in the DMH budget, and partly in the CDC budget) of about $8.7 million, as shown in Figure 4 (see next page). We would note that, because the hospital caseload has been running so far below projections, the Legislature has already captured savings of $2.9 million. Thus, about $1.4 million in additional General Fund savings are available in the DMH budget in the current year. In regard to the budget year, we estimate that the state could realize savings of about $20 million from the General Fund (again, partly in the DMH budget and partly in the CDC budget).

Figure 3

How Budget and LAO Population Projections Compare

2002-03 Year-End Population

	Budget	LAO	Difference
County LPS patients	776	776	—
CDC inmates	255	180	-75
Non-CDC forensic patients	3,656	3,479	-177
Totals	**4,687**	**4,435**	**-252**

Figure 4

LAO Projection of How the Funding Needed for Caseload Has Changed[a]

(In Millions)

	2001-02	2002-03
DMH General Fund	-$4.3[b]	-$12.6
DMH reimbursements (county LPS patients)	2.9	2.4
CDC General Fund (DMH reimbursements)	-4.4	-7.1
Net change in funding	**-$5.9**	**-$17.3**

a Changes are relative to the Governor's budget plan, not the *2001-02 Budget Act*.

b Total includes $2.9 million captured by the Legislature in the Third Extraordinary Session.

Detail may not total due to rounding.

Analyst's Recommendation. For these reasons, we recommend that the Legislature reduce General Fund expenditures for DMH and CDC in the budget year by a combined total of $19.7 million. We further recommend a partly offsetting increase in the DMH budget of $2.4 million for increased reimbursements from counties for the additional LPS patients that we have projected.

The state hospital beds used by CDC are provided through a memorandum of understanding with DMH in order to ensure CDC's compliance with a federal court order for the appropriate care of seriously mentally ill inmates. In order to ensure continued compliance with the court order, we recommend the adoption of budget bill language that would ensure that CDC could obtain General Fund deficiency authorization if its use of DMH hospital beds increased in compliance with the requirements of the court. The language would also require the automatic reversion of any funding provided to CDC for the purchase of beds in state hospitals that is in excess of its needs. In such situations, this should result in an equivalent matching decrease in the DMH budget of reimbursements from CDC.

Additional Beds Not Needed Yet

We recommend that the Legislature deny requests to spend an additional $3.4 million from the General Fund in the budget year to activate additional beds for patients at two state hospitals. Due to slower state hospital population growth, these additional beds will not be needed until 2003-04 at the earliest. (Reduce Item 4440-011-0001 by $3.1 million.)

Modular Space Added. The *2001-02 Budget Act* provided $6.9 million in one-time funding to DMH to purchase 25 modular trailers that would be placed at Patton State Hospital and Atascadero State Hospital and used as program space for patients. The addition of the modular units would permit space previously used for treatment and recreation to be converted into temporary beds for as many as 500 additional patients. The funding was justified on the basis that the state hospital system would run out of bed space for patients requiring a secure setting in 2002-03.

The Governor's 2002-03 spending plan would provide $3 million to DMH from the General Fund for additional staffing for groundskeepers, clinical staff, instructors, and other staff that would be needed to activate the Patton and Atascadero beds. The budget would also provide an additional $427,000 from the General Fund to CDC, which provides perimeter security at Patton, due to the planned increase in the population at the hospital. The funding requests are again justified on the basis that the hospital system will run out of space in 2002-03 for these types of patients.

Analyst's Recommendation. We recommend that the DMH and CDC requests for this funding be denied because the slowdown in state hospital population means the additional beds would not be needed until 2003-04 at the earliest. The activation last year of a secure new 258-bed facility at Atascadero means that DMH would continue to have a surplus of about 125 such beds *at the end of the budget year*. The surplus in these

secure beds might even be sufficient to meet the state hospital system's needs until 2004-05, when a new state hospital in Coalinga is scheduled to open.

New Prison Facility May Face Delay

The scheduled opening of a new mental health facility at Salinas Valley State Prison is reportedly being delayed for at least five months. The Department of Mental Health (DMH) and the Department of Corrections (CDC) should report at budget hearings on the status of its activation and the savings that could result if its opening is postponed. If the opening is postponed, the Legislature should adjust the DMH and CDC budgets to reflect the savings that will occur, which could be as much as $3.7 million.

The *2001-02 Budget Act* provided $2.3 million to DMH for the partial-year cost of activating a newly constructed 64-bed psychiatric facility at Salinas Valley State Prison that will be staffed with DMH clinicians. (These funds were provided as reimbursements from CDC to DMH.) About $174,000 of the funding was for one-time costs for activation of the facility, with the remainder of the $2.3 million to be used for activation of the new facility as of April 2002. The Governor's 2002-03 budget plan would provide an additional $3.1 million in reimbursements from CDC for the facility. After accounting for the expiration of one-time funding from the current year, a total of about $5.4 million would be provided during 2002-03 for the anticipated full-year operation of the new mental health beds.

DMH Advised of Delays. Although CDC had not confirmed any change in the construction timetable at the time this analysis was prepared, DMH has indicated that it has been informed by CDC that the completion date of construction of the new Salinas Valley facility has been delayed until September 2002. According to DMH, it was advised by CDC to delay recruitment of staff for the new facility because neither the medical unit nor administrative space would be available until that date to house any staff.

If activation of the facility is postponed until September 2002, much of the $2.3 million appropriated in the current fiscal year, and as much as $1.4 million of the appropriation for the budget year, would not be needed. The savings could presumably be even greater than $3.7 million should the activation of the Salinas Valley beds be delayed beyond September.

Analyst's Recommendation. Given the uncertainly now about when the new Salinas Valley facility will be activated, the DMH should provide a status report on this issue at budget hearings. If activation of the facility is postponed, DMH should estimate the savings that will result both in

the current and budget year from the delay and the Legislature should adjust the CDC and DMH budgets accordingly.

Budget Should Be Realigned

About 20 percent of the positions authorized for the state hospital system were vacant as of January 1, 2002, and a number of factors make it unlikely that most of these positions will be filled during the budget year. We recommend that the Legislature review a pending study on Department of Mental Health vacancies that should help determine which of the growing number of unfilled positions should be abolished. We further recommend that the Legislature direct the Department of Finance to prepare a revised 2002-03 hospital spending plan that more closely reflects (1) the number of staff positions that the hospitals system will actually be able to fill and (2) how excess funding from vacancies is actually being used for overtime, temporary help, operating expenses and equipment, and any other purposes.

High Vacancy Rate Persists. The Governor's revised budget plan for 2001-02 authorizes about 8,650 positions for state hospital staff. However, many of the positions have not yet been filled and will probably remain vacant through the end of the fiscal year. Midway through the 2001-02 fiscal year, DMH has indicated that about 1,750 of the authorized positions remain vacant. This represents a vacancy rate of about 20 percent—a rate far in excess of the 5 percent vacancy rate that is the standard for operation of most state agencies, and a rate higher than the 15 percent vacancy rate reported by the department at the same time the previous year.

Part of the reason for the high vacancy rate in the hospitals is that some positions included in the 2001-02 spending plan, such as those for a new unit at Salinas Valley State Prison, were never scheduled to be filled until later in the year. But the major reason so many positions go unfilled is the severe difficulties the department has experienced in recruiting and retaining nurses, mental health professionals, and certain other staff positions subject to labor shortages.

The funding that goes unspent as a result of these large numbers of vacancies is used to pay for hiring temporary staff or overtime for the hospital workforce. Additional funding originally intended for positions that were left vacant has been redirected to pay other operating expenses and equipment needs of the hospital system.

In response to legislative concerns about the high vacancy rates at DMH and other departments, the administration announced that it intended this spring to review the vacancy situation at 11 state agencies, including DMH, to reduce the number of excess vacant positions in state service.

Legislative Accountability Undermined. The disparity between the way funding and personnel are budgeted by the Legislature for the hospital system and the way these resources are actually used has become very significant. The DOF estimated that about $39 million in savings from vacant positions within DMH was shifted to other purposes in 1999-00.

At least 1,000 of the nearly 8,800 hospital positions proposed in the Governor's budget for 2002-03 would probably go unfilled all year, meaning that more large funding shifts are almost inevitable. We acknowledge that, in most cases, unused funding from vacancies are being used for other appropriate purposes, such as overtime for workers needed to take the place of authorized but unfilled positions. But this situation makes it difficult for the Legislature to hold DMH accountable for spending its funding for state hospital operations (now a $611 million a year operation) for the purposes for which it was approved.

Analyst's Recommendations. Some steps have already been taken to assist DMH and other state agencies in attracting qualified staff to its ranks. However, a widespread shortage of certain types of workers such as nurses probably means that large numbers of state hospital positions will continue to go unfilled. Rather than continue to authorize large numbers of positions that will probably not be filled during the budget year, we recommend that the Legislature act this year to ensure that department funding and staffing are more closely aligned with the way that the state hospitals are actually being operated.

One step would be to carefully consider the results of the forthcoming administration review of vacancies at DMH (as well as other state agencies). This study should provide guidance to the Legislature regarding which positions now in existence, and the funding associated with those positions, should be abolished.

Given the sizable number of vacancies in the state hospital system, and the increase in its vacancy rate compared to last year, we would further recommend that the Legislature direct the DOF to include in its May Revision of the 2002-03 budget, a revised funding plan that more closely reflects the number of staff positions that the hospitals will actually be able to fill in the budget year and that more accurately reflects actual departmental expenditures for overtime, temporary help, operating expenses and equipment, and any other appropriate purposes.

This technical realignment of the DMH budget is intended to directly budget appropriate levels of funding for these needs. It is also intended to permit the department to continue to meet its salary savings requirements, as well as have a reasonable opportunity to shift more of its personnel budget from overtime and temporary help to permanent full-time workers.

COMMUNITY SERVICES PROGRAM ISSUES

Mental Health Services For Special Education Pupils

Background

In 1976, Congress passed the Education for All Handicapped Act, guaranteeing handicapped children the right to receive a free appropriate public education, including special education and related services—such as mental health—necessary for the child to benefit from his or her education.

While local educational agencies initially were responsible for providing all the necessary services to special education children, Chapter 1747, Statutes of 1984 (AB 3632, W. Brown), and Chapter 1274, Statutes of 1985 (AB 882, W. Brown), shifted the responsibility for providing mental health services to counties. This local mental health program, in turn, became known as the "AB 3632" program.

Like other special education programs, the AB 3632 program is structured as an entitlement program, available free of charge to all children needing services. While little program utilization data are available, the DMH estimated that the program served about 17,000 pupils in 1997, including about 1,000 pupils in residential care.

Over the last decade, counties have paid for the cost of this program from a variety of sources:

- Categorical funding provided by DMH under the Assessment, Treatment, and Case Management of Special Education Pupils program.
- Mandate reimbursements for Services to Handicapped Students, pursuant to Article XIII B, Section 6 of the California Constitution.
- Public and private health insurance programs.
- Realignment resources.

While full program cost data are not available, state resources provided counties under the DMH, categorical program and as mandate reimbursements total nearly $100 million in the current year ($12.4 million categorical funding and $82.7 million in mandate funding). This level of direct state support has increased steadily from $41.2 million a decade ago.

Budget Proposal

The Governor's budget proposes to eliminate the categorical funding for the AB 3632 program. Because this categorical funding is consid-

ered an "offset" in calculating the amount counties may claim as mandate reimbursements, eliminating the categorical funding will result in a commensurate increase in the funding counties may claim as mandate reimbursements. The budget, however, proposes only $47.9 million for AB 3632 mandate reimbursements in 2002-03, less than one-half the amount of state support provided in the current year. As a result, the proposed budget may result in a significant budget-year deficiency.

In addition to the budgeting concern discussed above, our review of the administration's AB 3632 proposal raises two issues relating to legislative oversight of this program.

Legislature Has Little Authority to Direct Resources for "Mandated" Programs

Whenever a program is funded through the mandate process rather than a statutory formula, the distribution of resources varies markedly in a manner that reflects local record-keeping and claim-filing practices more than policy objectives, need, or legislative intent. Figure 5 shows the average annual mandate reimbursement received in regard to AB 3632 by ten counties between the years 1995-96 and 1999-00. As a point of reference, this figure also shows the number of K-12 pupils in the county in 1999. As the figure indicates, counties vary markedly in terms of funds reimbursed. For example, while the San Diego County has seven times more students than San Francisco, San Francisco's reimbursement was nearly 25 times the amount received by San Diego.

This vast difference in reimbursement levels reflects local choices regarding treatment services, collection of insurance and other health program payments, and—as we discuss further below—county reimbursement claiming practices.

Significant Controversy Regarding Mandate Claims

Over the last two years, the State Controller's Office (SCO) has audited county AB 3632 mandate reimbursement claims dating back to 1997 (three years of claims for each audited county). Based on information provided by counties and professional mandate claims preparers, we understand that SCO auditors have found that many counties are claiming reimbursements for 100 percent of the cost of providing mental health treatment services to special education pupils, rather than the 10 percent specified under the terms of this mandate. In addition, some counties are not reporting revenues that auditors indicate should be included as mandate cost "offsets." The magnitude of these auditing concerns is unknown, but could total as much as $100 million statewide for the three-year period.

Figure 5

AB 3632 Mandate County Claims

1995-96 Through 1999-00

County	Average Annual Claim	1999-00 Enrollment	Annual Cost Per Pupil
San Francisco	$4,750,380	62,041	$76.57
San Mateo	2,439,592	92,285	26.44
Orange	8,836,597	483,360	18.28
Sonoma	815,624	72,034	11.32
Riverside	3,301,597	307,055	10.75
Stanislaus	1,016,505	95,090	10.69
Alameda	2,123,015	217,080	9.78
Santa Clara	2,151,389	254,782	8.44
Los Angeles	8,644,835	1,650,948	5.24
San Diego	193,490	480,017	0.40

Ordinarily, after the SCO completes an audit of a local agency's claims, the office issues a draft audit. Once the local agency has responded to the draft audit findings, the SCO releases a final audit. If the SCO's final audit indicates that a local agency received state funds inappropriately, the SCO requests the local agency to repay the funds or withholds the amount from future mandate claims.

In this case, however, due to the magnitude of the issue and the focus of the program, the SCO has delayed issuing draft audits while counties investigate their options with the Commission on State Mandates for revising the mandate reimbursement methodology (referred to as the mandate's "parameters and guidelines"). The gray box on the following pages provides a time line of the events and the technical matters involved in this mandate claim dispute. In general, the controversy results from poor communication between the parties drafting the 1991 realignment legislation and the parties drafting the mandate's reimbursement methodology.

While a full review of this controversy is beyond the scope of this analysis, it is important to note that state costs and county revenues for this program in the budget and future years depend on resolution of this matter. Specifically, if many county prior-year mandate claims are found to be inappropriate, those counties may receive little or no net state support for this program in the budget year. Conversely, if the suspect county claims are determined to be acceptable, other counties likely will modify

their claiming practices to collect higher state reimbursements. These changes, in turn, would increase overall state program costs, potentially by tens of millions of dollars annually.

LAO Recommendation

We recommend the Legislature set aside funding for the AB 3632 program mandate—"Services to Handicapped Students"—pending development of a new program of county mental health services for special

Major Milestones in the AB 3632 Program Mandate Controversy

1976—Congress enacted the Education for All Handicapped Act, guaranteeing handicapped children the right to a free appropriate education, including special education and related services.

1979—The Legislature enacted the Short-Doyle Act. Pursuant to this act, each county adopted an annual mental health plan describing the services to be provided. The state paid 90 percent of the cost of implementing county mental health plans; counties paid 10 percent.

1984 to 1986—The Legislature shifted the responsibility for providing mental health services for special education pupils from schools to counties. The Legislature directed counties to include these services (and the cost of providing them) in their Short-Doyle Act plans. To help counties pay for case management and other costs associated with this program shift, the Legislature created a categorical program, "Assessment, Treatment, and Case Management of Special Education Pupils" in the Department of Mental Health.

1987—The County of Santa Clara filed a test claim with the Commission on State Mandates (CSM), alleging that county costs for this program constituted a state-reimbursable mandate.

1990—The CSM issued its decision, finding that the program shift imposed a mandate and that any net county program costs would be eligible for reimbursement as follows:

- Case management and assessment costs would be fully state reimbursable.
- Mental health treatment services would be reimbursable at the rate that counties paid for Short-Doyle Act programs, or 10 percent.

June 1991—The Legislature enacted realignment, transferring to counties the responsibility and funding for Short-Doyle Act mental health programs. The Legislature did not, however, transfer to counties funding for AB 3632's categorical program. Thus, AB 3632's Short-Doyle Act resources were included under realignment, but its categorical program funding was not.

education pupils. (Reduce Item 4440-295-0001 by $47.9 million. Shift funds to new Item 4440-104-0001.)

We recommend that the Legislature reject the administration's proposal to provide all state support for this program through the mandate reimbursement process. As discussed above, the mandate process does not distribute funds equitably among counties or encourage counties to seek reimbursement from other health programs and private insurance. Moreover, given the significant controversy regarding the mandate claims, the

Major Milestones in the AB 3632 Program Mandate Controversy (continued)

August 1991—The CSM, with county participation, adopted the mandate's reimbursement methodology (called its parameters and guidelines, or "Ps&Gs"), limiting county claims to "10 percent of any costs related to mental health treatment services rendered under the Short-Doyle Act." The CSM minutes do not indicate any discussion of realignment law, which had repealed the Short-Doyle Act.

October 1991—The Legislature enacted a realignment "clean up" bill, without reference to the AB 3632 program or the CSM Ps&Gs.

1992-1993—Superior Court and Court of Appeal decisions confirm that the Legislature intended AB 3632 treatment services to be part of the Short-Doyle Act program—and affirm CSM's decision to limit county reimbursements to 10 percent of treatment costs.

1996—At the request of the County of San Bernardino, CSM amended the Ps&Gs to reflect a technical matter. Counties did not propose to modify the Ps&Gs to reflect realignment.

1999—The State Controller's Office (SCO) began auditing county claims and found that some counties claimed 100 percent of treatment costs, instead of the 10 percent specified in the Ps&Gs.

2001—Counties proposed that CSM amend the Ps&Gs, retroactive to 1991, to allow counties to claim 100 percent of treatment costs. The Department of Finance objected, contending that counties receive Short-Doyle Act funding for this program under realignment. The CSM staff indicated that Ps&Gs must be consistent with the underlying mandate decision.

Status as of early February 2002—The SCO has not released its draft audits. The commission's authority to modify this mandate's Ps&Gs without modifying its underlying decision remains under discussion. Parties are examining CSM's authority to revise its earlier mandate decision, without requiring a county to file a claim alleging that realignment constitutes a mandate. Such a test claim, if successful, would invoke the "poison pill" provisions in realignment law, making the provisions of realignment inoperative.

Legislature has no assurance as to the level of resources counties will receive for this program in the budget year if offsets are made to county claims.

Instead of funding this program as a mandate, we recommend that the Legislature set aside the $47.9 million to support the development of a new program for county special education mental health services. In developing this new program, the Legislature could create a funding formula that provides greater equity across counties and could eliminate the legal uncertainties surrounding the current mandate reimbursement process. Given the mandate provisions of the California Constitution, however, the Legislature would need to structure the new program so that it was attractive enough for counties to "opt into" it. (Any county choosing not to opt into the new program would remain eligible for funding under the existing system. The Legislature could specify that counties remaining under the existing mandate program would be limited to claiming costs permissible under the existing mandate reimbursement methodology.)

What Approach Should the Legislature Take in Developing the New Program? To maximize county flexibility concerning this program, encourage cost containment, and promote efforts for early detection and intervention, we recommend the Legislature consider providing funding as a supplement to existing county mental health realignment funding. In allocating these funds among counties, we recommend that the Legislature consider the number of children attending school in the county—as mental health problems tend to be distributed across all populations.

We recommend that the Legislature also consider initiating a greater state effort to provide so-called early intervention services for children with emotional difficulties. Evaluations have indicated that the Early Mental Health Initiative (EMHI), a ten-year-old school-based program administered by DMH, has been effective in assisting kindergarten through third-grade children and minimizing the need for more costly services as the students grow older. The Proposition 98-funded program (currently budgeted at $15 million) could be broadened to more students and focused on intervening before children begin suffering more severe emotional problems—and become entitled to far more costly special education services.

In determining the total level of resources to support this new program, we recommend the Legislature consider:

- Supplementing the $47.9 million proposed for this mandate by the level of funding provided in the current year for the categorical program ($12.4 million).
- Increasing the resources available under the EMHI program. Additional funds could be provided under Proposition 98 without reducing other education programs if the minimum guarantee is revised upward at the time of the May Revision. (As dis-

cussed in the "Education Section" of this *Analysis*, we estimate the guarantee could increase significantly.

- Implementing a policy of partial audit forgiveness for counties opting into the new program.

TBS Costs of New Services Almost Double

The cost of expanding therapeutic behavioral services (TBS) to troubled children and older youth is almost double, on a cost-per-client basis, than the figures presented to the Legislature when a major expansion of this program was inaugurated last year. We withhold recommendation on the request for a net increase of $16 million for expansion of TBS pending an explanation from the Department of Mental Health at budget hearings on why the cost of the program is so much higher than was indicated last year and what steps if any could be taken to control the cost of these services.

Last year, the Legislature agreed to an administration proposal for the state to comply with a federal court order (in a case known as *Emily Q. v. Bonta*) mandating the provision of more intensive outpatient services for certain at-risk youth. These services, known as TBS, are an intensive, one-on-one, short-term intervention for children and older youth under age 21 who have serious emotional problems or mental illness. The TBS services are generally provided by counties at a time of emotional crisis or high stress with the aim of preventing the child's placement in a group home or, in some cases, a secure facility.

Last year, a federal court issued a permanent injunction requiring the state to implement TBS as a mental health service for a certain class of children and older youth as a component of the state's EPSDT program of mental health services. An estimated $18.8 million ($9.5 million General Fund) will be spent during the current fiscal year for the expansion of TBS services as ordered by the court.

The Governor's budget proposes to increase this funding total to $35.2 million in 2002-03. The money would be budgeted as reimbursements in the DMH budget from the DHS, which finances EPSDT mental health services through the Medi-Cal Program. Although counties play a key role in the delivery of TBS services, the state would pay the entire $17.4 million nonfederal share of TBS in the budget year.

EPSDT Costs Already a Concern. Our office has previously voiced concern about the 29 percent per year annual growth that has been occurring in the cost of EPSDT mental health services. We noted that the financial structure of the program, in which nearly all increases in nonfederal costs of these services are borne by the state, provides counties little in-

centive to ensure that programs are operated with appropriate cost controls. In response to legislative concern over the escalation in these costs, and the wide variation in EPSDT program costs from county to county, the Legislature adopted supplemental report language for the *2001-02 Budget Act* directing DMH to conduct a field audit to help explain the disparities in spending from county to county.

Costs Much Higher Than Expected. Based upon our review of the Governor's budget, we are concerned that the cost of this new component of EPSDT—TBS—is costing the state significantly more than had been anticipated. The increase in the projected TBS caseload that is assumed in the budget, from 1,928 to an estimated 2,167 clients, is relatively modest. However, the cost per-client has escalated sharply to an average of $15,351 for each client receiving services. That is almost double the $8,470 average cost that DMH had estimated last year for expansion of TBS.

The 2002-03 budget request is based on data indicating the reimbursements paid to counties for the provision of TBS during the 2000-01 fiscal year. In all, about $15 million was paid for TBS for a reported 982 clients. The cost in individual counties varied significantly. In Los Angeles County, for example, the average cost per client was $24,446—well above the statewide average cost of $15,351. In Riverside County, however, the average cost per client was only $3,142.

When DMH initially sought funding for expansion of TBS, it had estimated that each client would receive an average of 22 hours per week of services, for an average of 11 weeks, at an average cost of $35 per hour. The hourly rate was based on a survey of costs for a program providing services similar to TBS. At this time, DMH cannot explain why the cost of TBS has turned out to be much higher than estimated—whether the higher costs are due to a higher hourly cost, or to more weekly hours of service, or more weeks of services than expected. The department is exploring these issues and intends to modify its budget request for TBS at the time of the May Revision if it determines that a lower cost per client can be justified.

Analyst's Recommendation. Given the unexpectedly higher cost of this program, we recommend that DMH report at budget hearings on why the cost of the program is so much higher than was indicated last year and what steps, if any, can be taken to control the cost of these services. For example, the department should advise the Legislature as to whether any change in the financial structure of the program, such as a requirement that counties share in its cost, would result in better control of overall program costs. The ongoing field audit on EPSDT services, which is scheduled to be completed by April 1, 2002, could shed some light on how the TBS cost issue could also be addressed.

EMPLOYMENT DEVELOPMENT DEPARTMENT (5100)

The Employment Development Department (EDD) is responsible for administering the Employment and Employment Related Services (EERS), the Unemployment Insurance (UI) and the Disability Insurance (DI) programs. The EERS program (1) refers qualified applicants to potential employers; (2) places job-ready applicants in jobs; and (3) helps youths, welfare recipients, and economically disadvantaged persons find jobs or prepare themselves for employment by participating in employment and training programs.

In addition, the department collects taxes and pays benefits under the UI and DI programs. The department collects from employers (1) their UI contributions (2) the Employment Training Tax, and (3) employee contributions for DI. It also collects personal income tax withholding. In addition, it pays UI and DI benefits to eligible claimants.

The budget proposes expenditures totaling $8.7 billion from all funds for support of EDD in 2002-03. This is an increase $313 million or 3.7 percent over current-year estimated expenditures. This increase primarily results from higher unemployment insurance benefits payments. The budget proposes $28.2 million from the General Fund in 2002-03 which is a reduction of $6.8 million (19 percent) compared to the current year. This reduction is primarily attributable to the Governor's budget proposal to eliminate the Job Agent Program in the budget year.

BUDGET ISSUES

Workforce Investment Act Discretionary Funds

The Governor's budget proposes to use most of the available Workforce Investment Act (WIA) discretionary funds to support existing employment programs. We review the history of budgeting WIA funds and comment on the Governor's proposal.

Background. The federal WIA of 1998 replaced the Job Training Partnership Act, which provided employment and training services. The goal of WIA is to strengthen coordination among various employment, education, and training programs. The 63 member Workforce Investment Board (WIB) advises the Governor on the operations of the state workforce investment system; however, the Board's actions are not binding on the Governor.

Pursuant to federal law, 85 percent of WIA funds ($611 million in 2002-03) are allocated to local WIBs, formerly known as Private Industry Councils). The remaining 15 percent of WIA funds ($91.7 million) is available for discretionary purposes such as administration, statewide initiatives, current employment service programs, or competitive grants.

Budget Process for the Current Year. For 2001-02, the Governor's budget made no specific proposal for expenditure of discretionary WIA funds. Instead, the Governor asked the Legislature to appropriate funds without specifying their particular purpose, thereby leaving that decision to the administration. The conference agreement for the *2001-02 Budget Act* adopted the Governor's approach.

Although federal law and the Governor's budget do refer to these 15 percent monies as "Governor's discretionary" funds, this nomenclature is misleading. Section 191 of the WIA states that all WIA funds "shall be subject to appropriation by the State Legislature." Accordingly, these should be considered *state* discretionary rather than Governor's discretionary funds. We note that the federal *Balanced Budget Act of 1997* provided federal Welfare-to-Work 15 percent "Governor's discretionary" funds that were similarly subject to appropriation by the State legislature. At that time, the Governor's budget made specific proposals to expend the discretionary funds on a competitive grant program, and the Legislature approved those proposals as part of the budget process.

Governor's Proposal. In 2002-03, the Governor's budget has a supporting schedule that proposes a specific expenditure plan for the WIA discretionary funds. Figure 1 shows the Governor's expenditure plan based on information provided by the Department of Finance. As the figure shows, $23.4 million is proposed for administration, $27.5 million is budgeted for required WIA activities, and $40.7 million is dedicated to various proposed programs.

Nearly all of the $40.7 million for proposed programs is being used to offset General Fund costs in existing programs, backfill for reductions in other federal funding sources, or continue programs originally funded under the Job Training Partnership Act. Whether to continue any of these programs is a policy decision for the Legislature. As described in the next issue, if the Legislature rejects any of these new programs, some of the WIA funds could be redirected to the EERS program operated by EDD, resulting in General Fund savings.

Figure 1

Workforce Investment Act Discretionary Funds 2002-03 Proposed Expenditures

(In Millions)

Category	Amount
Administration	
Employment Development Department	$18.6
California Workforce Investment Board	4.8
Subtotal	($23.4)
Federally Required WIA Activities[a]	$27.5
Proposed Programs	
• Veterans / Disabled Veterans Employment Services	$1.5
• Governor's Award for Veteran's Grants	6.0
• Department of Education WIA Coordination/Program Integration	2.3
• Community Colleges WIA Coordination/Program Integration	2.3
• One-Stop Access to Services Initiative (with the Department of Rehabilitation)	1.4
• Los Angeles County Work Plan for Worker Retraining	6.0
• Youth Development and Crime Prevention	3.0
• Jobs for California Graduates	1.0
• Female Offenders Treatment and Employment Program	2.0
• Preventing Parolee Crime Program	10.6
• Programs Under Development	4.6
Subtotal	($40.7)
Total proposed expenditures	**$91.7**

[a] Includes incentive grants, technical assistance grants, assistance to locals for eligible youth, fiscal and management information system needs, eligible training provider list, program improvement activities, and One-Stop system operating needs.

Use WIA Funds To Offset Employment Services Costs

We recommend using $4.6 million in unbudgeted federal Workforce Investment Act state discretionary funds to replace Employment Development Department (EDD) Contingent Fund support for the Employment and Employment Related Services Program. Because excess EDD Contingent Funds are transferred to the General Fund, this action results in General Fund savings of $4.6 million. (Reduce Item 5100-001-0185 by $4,600,000.)

The EERS Program provides a variety of services to facilitate a match between employers' needs and job seekers' skills. Job seekers typically

receive these services through the "One-Stop" Career Center System. For 2002-03, the Governor's budget proposes $212.3 million (including $23.9 million from the EDD Contingent Fund for the EERS program. Because excess (anything above $1 million) EDD Contingent Funds are "swept" to the General Fund at the end of the fiscal year, any reduction in the EDD Contingent Fund expenditures results in General Fund savings.

As shown in Figure 1, there are $4.6 million in federal WIA state discretionary funds that are not budgeted for any specific purpose. (In the figure, these are noted as "Programs Under Development.") The WIA funds may be used to pay for the EERS program. Because there is no specific expenditure proposal for these funds, we recommend using $4.6 million in WIA discretionary funds to support the EERS program, and a corresponding reduction in EDD contingent fund expenditures. These actions will result in General Fund savings of $4.6 million. We note that if the Legislature elects to reject any of the other WIA expenditure proposals shown in Figure 1, up to about $4 million more in freed-up WIA funds could be used to offset General Fund costs in the EERS program.

ASSESSING THE FAITH-BASED INITIATIVE

For 2002-03, the Governor proposes $4 million to continue a competitive grant program that engages faith-based and community-based organizations in the delivery of social services. In this analysis we review this program's implementation in 2000-01 and 2001-02, and make recommendations should the Legislature elect to continue this program in 2002-03.

Background

The State of California, as well as the federal government, have increasingly considered using faith-based organizations (FBOs) as an alternative delivery system for providing certain social services. While only limited research measuring the effectiveness of faith-based social service delivery exists, state and local governments across the country have made investments in programs that engage the faith-based community in delivering services to the hardest-to-serve clients. The services provided by FBOs typically include education, job training, and life management skills designed to assist individuals in becoming self-sufficient.

Historical Perspective. Faith-based delivery of social services is not new. During the nineteenth and early twentieth centuries, religious organizations, and in particular the Catholic Church, played a large role in providing relief to impoverished individuals in the United States. The more recent government initiatives involving FBOs discussed in this re-

port are different from the past in that religious organizations themselves, rather than affiliates, may in certain circumstances receive government funds and provide services within houses of worship.

The "Charitable Choice" Provision. In 1996, the U.S. Congress passed and President Clinton signed federal welfare reform legislation. While the major thrust of this legislation was to overhaul welfare, it also contained provisions that permitted churches and groups to receive *federal* funds without having to remove the religious content from their programs. (This change is referred to as the charitable choice provision of federal law.) This means, for example, that organizations can display religious symbols and use religious principles and language when serving clients. However, they cannot use federal funds to proselytize, conduct worship services or Bible study, or for other doctrinal instruction. In addition, providers cannot require clients to participate in religious activities as a condition for receiving services. A secular alternative must be available for people who do not wish to be served by FBOs.

Recent Federal Developments. In July 2001, the U.S. House of Representatives approved HR 7, the Community Solutions Act of 2001, which would expand the role of religious charities in federal social programs. Under current federal law, religious charities are allowed to receive grants from a limited number of federal programs, such as Temporary Assistance for Needy Families (TANF), to provide various services to eligible individuals. The HR 7 legislation would expand grants for religious charities into nine specified areas including housing, domestic violence, juvenile delinquency prevention, programs authorized by federal WIA, programs authorized by the federal Older Americans Act, and hunger relief. The legislation also includes a series of tax deductions worth over $13 billion for corporate and individual charitable giving over a ten-year period. Finally, the legislation makes the charitable choice provision of federal law mandatory, rather than optional, for the states. This measure is currently pending in the U.S. Senate Committee on Finance.

California Program Initiated in 2000-01 Budget. The Legislature appropriated $5 million from the General Fund for a Faith-Based Initiative during 2000-01. The program was authorized through budget bill language adopted in EDD budget item (5100-001-0001) of the *2000-01 Budget Act*, rather than through stand-alone authorizing legislation. Under this initiative, EDD administers a grant program that funds FBOs that offer employment services to hard-to-serve individuals. An additional $4 million is included in the *2001-2002 Budget Act*. The EDD defines a faith-based organization as "an organization, corporation, institution, association, entity, partnership, intermediary or collaborative established by or related to a FBO that is not pervasively sectarian and that is tax

exempt under Section 501(c) (3) of the federal Internal Revenue Code and operates under its own auspices."

Theories Behind Faith-Based Social Service Delivery

Key Theories

There are several theories of why government and society might benefit from using FBOs to deliver social services. Some of these theories are discussed below. (We note that there is no systematic research that either proves or disproves the validity of these theories.)

Community Integration. Researchers, policymakers and practitioners often cite FBOs' integration into their community as a reason to use FBOs to provide government services. This integration may manifest itself in several ways, including both time-of-day and physical accessibility. Specifically, a FBO's close proximity and its potential for providing services beyond traditional business hours are characteristics that set it apart from its government counterparts.

Focus on Personal Change. In delivering social services, governmental organizations tend to focus on outcomes, such as did the individual complete the training, or did the individual obtain a job. Although FBOs are seeking similar positive outcomes, they may attempt to achieve these goals by changing the person on the "inside."

Avoiding Bureaucracy. Beneficiaries of services administered by FBOs often cite the lack of "red-tape" involved in receiving services. For some of the hard-to-employ, a government office may appear to be physically daunting and procedurally frustrating as a result of multiple steps in the assessment process. In contrast, a faith-based setting may be more "client-friendly" in that intake may require only one interview with one individual.

Reaching Out to Underserved Populations that May Fear or Dislike the Government. Some individuals who need employment services may fear or dislike the government due to prior contentious or unproductive relationships. For example, former and current foster care youth, may feel they have been "warehoused" by the foster care system and believe that government cannot help them enter the labor force. These and other such individuals may be more comfortable approaching an FBO for services because it may "speak their language " and the FBO is not part of the government. Faith-based social service organizations could be the first and / or last line of support for various underserved or unserved populations including immigrants, former foster youth, and parolees.

Research Assessing the Key Theories

Above we have reviewed some of the theories behind FBOs' potential as alternative social service delivery organizations. Only a limited amount of systematic research discussing these assertions exists. The research that is available is of an overwhelmingly qualitative nature; anecdotal, geographically specific, and difficult from which to generalize.

For example, a study conducted by John Orr of the University of Southern California's Center for Religion and Civic Culture, provided qualitative findings and conclusions about the California religious community's capacity and role in participating in the Welfare-to-Work program. This study concluded that FBOs can be more effectively encouraged by government to offer more and expanded services, but should not be looked to as a replacement for welfare agencies.

To develop this report, we interviewed policymakers, practitioners, and academics, to uncover relevant research on faith-based programs. At this time, completed quantitative studies, with experimental designs that measure the effectiveness of faith-based approaches compared to a control subject group, could not be identified.

California's Faith-Based Initiative

First Year: 2000-01

Funding Provided. In June 2000, the Legislature adopted the Governor's May Revision proposal for 2000-01 to provide $5 million from the General Fund to the California Faith-Based Employment Assistance Project. The purpose of this program was to provide competitive grants to FBOs that (1) had limited opportunity to compete for government fund sources and (2) had developed worthy proposals for assisting "the most difficult-to-serve and hardest-to-employ individuals." The Legislature also intended for EDD to assist organizations (1) in obtaining other funds, and (2) in coordinating with existing county programs.

Competitive Process. The EDD developed a competitive bid process in order to award funds to FBOs. Departmental staff sent out approximately 30,000 initial letters to organizations with 501 (c)(3) designations notifying them that applications were due in 80 days. (Organizations with active 501 (c)(3) status are tax exempt under Section 501(c)(3) of the federal Internal Revenue Code.)

Measuring the Level of Interest. Of the 30,000 initial letters sent, approximately 5,700 organizations responded either with letters of intent to apply, or otherwise established contact with EDD, asking for additional

information on the solicitation for proposals. Ultimately, approximately 230 proposals were submitted for formal review.

Classifying the Organizations. The EDD developed two funding tiers in order to organize applicants according to the level of the respective program's experience in serving clients, the degree of success in accessing grant programs, and the amount of funding requested. Applicants were required to choose a funding tier based on the eligibility requirements for that tier. Applicants competed solely against those in the same tier and were not allowed to change their tier selection once the application was submitted.

Tier One applicants were the most *experienced* of the applicants, having demonstrated some previous success in the administration of an employment services program and in obtaining funds from other competitive grant processes. Tier One applicants vied for individual grants of up to $600,000 from a $3 million portion of the legislative appropriation. Tier Two applicants were those less-experienced organizations that were targeted by the initiative for the purpose of building their organization's capacity for successfully starting and maintaining an employment services program. Tier Two organizations could submit proposals for up to $200,000 of the remaining $2 million.

Scoring the Proposals. Applications submitted to EDD for review could not exceed 30 pages. The EDD reviewed proposals for responsiveness to the bid requirements and could award up to 100 points. The proposal's description of the service delivery approach was given the largest point share (about 45 points). The proposals that received the highest scores clearly identified the population they aimed to serve, substantiated claims of need with labor market and demographic data, and indicated how the proposed services would achieve stated goals for the client group. Additionally, successful applicants identified partnerships and collaborative relationships with other organizations (particularly local WIBs and local employment centers).

Governor Makes Final Decision. After scoring all of the proposals, EDD then forwarded the top 13 proposals from each funding tier to the Governor's office in rank order. The Governor then selected the top 10 proposals from each tier. Figure 2 lists the grantee organizations and their grant awards.

Target Populations and Range of Services Provided. Recipient organizations varied widely in the populations they target, the services they offer, and their geographic location. Target populations include long-time public assistance recipients, parolees, current and former foster care youth, recent immigrants and limited-English speakers. Services include intensive case management, counseling, life skills development (such as phone

Figure 2

Faith-Based Initiative Grantees

2000-01

Grantees	Location	Total Award
Faithful Service Outreach	Los Angeles	$420,000
Northern California Indian Development Council	Eureka	420,000
CSU Long Beach Foundation-Center for Career Studies	Long Beach	410,000
Fresno Interdenominational Refugee Ministries	Fresno	409,000
Episcopal Community Services	San Diego	400,000
Ninth District CME, Community Development Corporation	Los Angeles	350,000
Open Gate Ministries, New Beginnings Partnership	Dinuba	300,000
Catholic Charities of Santa Rosa	Santa Rosa	212,000
African American Community Empowerment Organization	Inglewood	200,000
CHAMPIONs Recovery Alternative Programs	Hanford	200,000
Christian Partnership	Citrus Heights	200,000
Community Resource Talent Development	Inglewood	200,000
Reach Out-29	Twentynine Palms	200,000
Zaferia Shalom Zone Agency	Long Beach	200,000
The Millennium Ministries Group	Oakland	198,000
Welcome Home Ministries	Oceanside	192,500
Tabitha's House, Inc.	Bakersfield	175,000
Operation W.O.R.K.	Oxnard	139,000
Lutheran Social Services	Van Nuys	135,500
Gilead House	Novato	39,000
Total		**$5,000,000**

etiquette and proper dress), as well as job skills development. One program offers courses for becoming a Microsoft Office User Specialist, as well as a certificate course to become a certified nurse's assistant. Courses in vocational English as a second language are also offered in at least two programs. For illustration purposes, please see Figure 3 (see next page) for a detailed description of the programs offered by two of the FBO grantees, as of June 2001.

Monitoring for Legal Compliance. Program managers at EDD conduct regularly scheduled site visits on a roughly monthly basis. Program managers make trips to ensure that the program is operating according

Figure 3

How Funds Are Being Utilized: Early Examples From Two Faith-Based Programs

June 2001

California State University Long Beach, Center for Career Studies—Project F.A.I.T.H. (Forging Ahead in Technology and Health)

- ✓ ***Program Budget***. Proposal funded at $410,000.
- ✓ ***Number Served***. A total of 71 individuals have been served between two programs—health care and office support/computer literacy.
- ✓ ***Targeted Population***. The program targets economically disadvantaged and/or limited English speaking individuals that reside in the Long Beach area. The project will focus on older workers (over 50 years of age) who are in most need of retraining and job placement.
- ✓ ***Service Offered/Program Detail/Goals***. Project F.A.I.T.H. seeks to provide vocational training to a total of 70 eligible individuals over a two-year period. Project F.A.I.T.H. has two job tracks where courses are manageable and designed to produce in-demand, employable individuals. The health care track includes courses in Certified Nursing Assistant and Home Health Aide. The office support/computer literacy track offers a course in training for designation as a Microsoft Office User Specialist (MOUS). Basic literacy and Vocational English as a Second Language instruction are incorporated into the training.
- ✓ ***Referrals/Connections/Partnerships***. The primary partner of the Center for Career Studies is the Church of Elohim located in West Long Beach. The Church of Elohim will conduct the outreach recruiting for the program. The other partners include the local WIB and the Long Beach Career Transition Center (the area One-Stop Center operated by EDD) as well as area employers in both the public and private sectors.
- ✓ ***Early Results***. The first Certified Nurse Assistant training cohort graduated all 16 of its participants. The first MOUS cohort graduated 19 of its 20 participants. Twenty graduates have been placed in jobs; 16 Certified Nurse Assistant course graduates, and 4 MOUS course graduates.

Continued

to schedule, and provide assistance to organizations in meeting their prescribed performance benchmarks. Monthly reporting requirements serve as a written record of the organization's adherence to prescribed performance measures. Program managers also make trips in response to organizations that request in-person technical assistance.

Episcopal Community Services (ECS)/Youth Empowerment Services (YES)

- ***Program Budget***. In addition to the state's $400,000, the program's funding includes $20,000 from the Casey Family Programs for a chaplain who will serve as a case aide.
- ***Targeted Population***. The ECS/YES program targets current and former foster care youth between the ages of 16 and 25 who reside in eastern San Diego County. Research indicates that 45 percent of former foster youth are unemployed, and that half do not complete high school. In addition, 30 percent of former foster youth receive public assistance (welfare) from ages 18 to 24.
- ***Number Served***. The ECS/YES Program aims to recruit 50 participants annually. Fourteen youth had participated as of June 2001.
- ***Service Offered/Program Detail/Goals***. The ECS/YES program designed a course of study to develop necessary job skills. The daily modules include lessons in resume writing, interview skills, and lessons in writing effective cover letters. Intensive case management will also be offered to each participant to assist in meeting the short-term goal of summer employment and the long-term goal of developing basic life skills. So-called "life skills" include lessons in budgeting and responsible financial management, appropriate dress for varying environments, and proper phone and office etiquette.
- ***Referrals/Connections/Partnerships***. The ECS/YES collaborators includes the East County Career Center, the EDD area One-Stop, the Grossmont Union High School District, San Diego State University, the San Diego Workforce Partnership, the local Job Corps program, and the county's Independent Living Skills program (ILS), among others. Referrals to the ECS/YES program have been made by social workers, county ILS workers, group home staff, and by youth participant word-of-mouth.
- ***Early Results***. It is early in the program, and while only two of the 14 participant youth have been placed in job sites, the program is hopeful that at least four more participants who have completed the course of study will be placed in the immediate future.

Cost-Per-Client Served. A review of the 20 selected proposals indicates that 3,000 hard-to-employ clients were expected to be served in 2000-01. The EDD believes that these clients would otherwise have received no government services. This is because the proposals presented evidence that they would successfully identify and serve populations not being served by other government programs. Based on 3,000 clients, av-

erage annual cost-per-client was about $1,700 in 2000-01. We note that this estimate does not account for variations in intensity of service at the individual grantee level.

Comparing Program Costs. In order to provide a frame of reference for assessing costs for the Faith-Based Initiative, below we review the Job Agent program, operated by EDD.

The Job Agent program provides employment-related services to economically disadvantaged individuals with significant barriers to employment. Job Agent clients, like many targeted through the various Faith-Based grantees, include clients with a lack of job skills, lack of language skills, limited education, a disability, poor work habits, and / or legal problems. Based on preliminary data, the Job Agent program, funded at $2.7 million, served approximately 1,850 clients at an average cost per client of approximately $960. This average cost is substantially less than the cost-per-client in the Faith-Based Initiative. We note, however, that the Faith-Based Initiative may be reaching clients that are unwilling to apply for direct government services in programs such as Job Agent. Further, services in the faith-based program are typically more intensive and often include one-on-one counseling, life skills training, and job placement services.

Preliminary Outcomes. The data that has been compiled so far only covers the very beginning of the program through March of 2001. According to EDD, at the end of the first quarter of 2001, the Faith-Based Initiative had served close to 900 individuals, about 31 percent of the program goal of 3,000 individuals. Of this total, 152 individuals, or, roughly 16 percent had obtained unsubsidized employment. Another 8 individuals were placed in subsidized employment, such as work experience positions in public or private agencies.

Second Year: 2001-02

Funding. For 2001-02, the Legislature approved the Governor's proposal for an additional $5 million to fund a new round of grants. The Governor vetoed $1 million in order to bolster the budgetary reserve, leaving $4 million for the second year of the program.

Program. The Legislature modified the budget bill language governing the administration of this program to (1) broaden the initiative to include community-based organizations that have no religious affiliation, and (2) explicitly prohibited grantee organizations from discriminating in their hiring practices. In addition, the revised language omits the reference to allocating funds using a "competitive process." This later change appears to be inadvertent because all of the budget subcommittee discus-

sion of the initiative presumed a competitive process and EDD has elected to use virtually the same competitive process for allocating funds in 2001-02 as it used in the prior year. The two tier system will remain intact, as will the process for evaluating and scoring proposals. Finally for 2001-02, EDD decided that first year grantees may not compete for the new round of funding. Pursuant to the revised language, EDD may expend up to $250,000 of the $4 million appropriation for its program administration costs.

Legal Issues

Although California has provided funds to religious organizations prior to the Faith-Based Initiative, the new initiative has resulted in a lawsuit.

Lawsuit Concerning Preference Given to Religious Groups. The issue of giving a preference for FBOs in a competitive bidding process has resulted in a lawsuit against EDD. The lawsuit, filed by the American Jewish Congress on January 5, 2001, tests the constitutionality of the department's and initiative's statutory preference for FBOs over secular community-based organizations in the solicitation process. In a ruling on July 27, 2001, both the plaintiff's and defendant's motions for summary judgment, were denied.

This issue of preference was partially addressed by the control language adopted by the Legislature in the *2001-2002 Budget Act*. Specifically, the revised budget act provision invites all community-based organizations, inclusive of faith-based and secular organizations, to apply for funds.

Considering Religious Affiliation in FBO Hiring Practices. The charitable choice provision of the 1996 federal welfare reform legislation raises questions surrounding the protection of civil rights. Some FBOs wanted to preserve their religious mission. To this end, FBOs would be allowed, under the current version of HR 7, to consider a prospective employees' adherence to the organization's religious mission and tenets in their hiring decision. In California, the issue of an FBO considering an employee's religious affiliation in their hiring practices was not specifically addressed in the first year of the state's initiative.

In response to both national and state reactions to the potential for discrimination, the Legislature added control language in the *2001-02 Budget Act* that explicitly states that participating FBOs may not discriminate against "protected groups" in their hiring practices. The Legislature also reiterated the policy that FBOs may not discriminate against protected groups in their delivery of service to clients. The EDD

operationalized the prohibition against discrimination of protected groups in accordance with Government Code Section 12920. For example, FBOs may not discriminate against those seeking employment on account of race, religious creed, or age.

LAO Findings and Recommendations

In implementing the faith-based initiative, Employment Development Department (EDD) (1) did not develop specific standards and procedures for ensuring that grantee organizations do not deliver services in a "pervasively sectarian" manner, and (2) allocated 60 percent of the funding to organizations that had previously received other funding. If the Legislature elects to continue this program in 2002-03, we recommend that EDD (1) require potential grantees to explain how they will avoid pervasively sectarian service delivery as part of the application process and (2) incorporate unannounced site visits into their monitoring program. We further recommend that the Legislature clarify in statute that EDD should focus the majority of the funding on organizations which have had limited opportunity to obtain government funds to provide welfare-to-work services.

Above we have described the implementation of the faith-based initiative during 2000-01 and 2001-02 Below we present our key findings. If the Legislature elects to continue funding the faith-based initiative, we present recommendations for improving implementation of this program.

Allocation of Funds Appears Inconsistent With Legislative Intent

In authorizing the faith-based initiative, the Legislature specifically stated that funds were to go to organizations "that have been limited in their ability to take advantage of this funding due to limited resources and a lack of experience in dealing with competitive contracting processes." As described earlier in this report, EDD developed two tiers for organizations applying for funds: Tier One for larger more sophisticated organizations (that may have had some previous success in obtaining government funds) and Tier Two for smaller less experienced organizations. In fact, EDD allocated 60 percent of the budgeted amount to Tier One organizations ($3 million) and the remaining 40 percent to Tier Two organizations ($2 million). Further, at least three of the Tier One grantees had substantial past experience in soliciting and handling government and private funds. Based on the budget act language adopted by the Legislature, we believe it intended for the majority of funds to go to organizations that have more limited experience in obtaining government funds.

Recommendation. With respect to future funding allocations, we recommend that the Legislature clarify that a significant majority of funds be allocated to the less experienced Tier Two organizations. Larger organizations could be encouraged to apply for other state and federal funds. Specifically, counties use TANF funds to help welfare families obtain training and become self-sufficient. Such TANF funds are covered by the charitable choice provisions of current federal law and may be provided to FBOs.

Avoiding Pervasively Sectarian Service Delivery

Under the California initiative as adopted in budget act provisions in 2000 and 2001, participating FBOs are prohibited from, (1) using government funds to proselytize or conduct worship services, (2) requiring clients to participate in religious activities as a condition of receiving services, or (3) delivering services in a "pervasively sectarian" manner. Nevertheless, witnesses at budget hearings during 2001 expressed concerns that certain participating FBOs were providing services in a pervasively sectarian manner. The EDD disagreed with these assertions and stated that their program monitoring ensured compliance with the law. However, we have identified several weaknesses in EDD's approach to ensuring that FBOs do not deliver services in a pervasively sectarian manner.

Lack of Precision in Defining "Pervasively Sectarian." In our view, EDD has provided a technical definition of the term "pervasively sectarian" that provides virtually no guidance to FBOs on what does and what does not constitute, "pervasively sectarian." The EDD believes that its program staff that monitors the grantees would "know it when they see it," and so far, they have not identified any grantee that has delivered services in a pervasively sectarian manner. We note that a clearer definition and specific guidelines could improve the monitoring conducted by EDD staff.

Program Monitoring Could Be More Effective. Although EDD visits grantees, observes service delivery, and communicates program requirements, the visits are scheduled in advance. This approach has potential limitations in that organizations are never in a position to be observed spontaneously. By conducting unannounced visits, the EDD monitoring program would be more effective in identifying (and perhaps preventing) services from being delivered in a pervasively sectarian manner.

Message on Avoiding Pervasively Sectarian Service Delivery Could Be Strengthened. The grant application process generally awards points to bidders based on (1) who they are targeting for services, (2) identification of barriers faced by potential clients, (3) how the proposed program will help clients become self-sufficient by addressing the barriers, and (4) how the program will coordinate with other local resources. The scoring system does not consider how an organization will avoid pervasively

sectarian delivery of service. We believe this omission weakens the message concerning the importance of the prohibition on delivering services in a pervasively sectarian manner.

Recommendations. In order to ensure that FBOs adhere to the prohibition against delivering services in a pervasively sectarian manner, we make the following recommendations.

- ***Define Pervasively Sectarian More Precisely***. The EDD should define the term pervasively sectarian with more precision and establish specific guidelines for grantees. This will provide FBOs with better information on what approaches are acceptable and unacceptable and will assist EDD monitoring staff in detecting potential problems.
- ***Incorporate Unannounced Visits Into EDD's Monitoring Program***. In order to aid both EDD and organizations in maintaining compliance with the control language's provisions, the next round of grantees should be informed that unannounced visits could occur throughout the life of the program. Additionally, EDD should incorporate unannounced visits, as well as the regular, announced visits, into the monitoring program.
- ***Modify the Application Process to Avoid Pervasively Sectarian Service Delivery.*** The department's scoring system used in evaluating organizations' applications should include a criterion with a point value that scores the individual organization's plan for avoiding pervasively sectarian delivery of service. An organization that does not explain its method satisfactorily would risk a lower overall score and consequently jeopardize its competitiveness. Taking the above action would strengthen EDD's message concerning the importance of legal compliance. In addition, it would ensure that specific mechanisms are in place to avoid this problem.

DEPARTMENT OF REHABILITATION (5160)

The Department of Rehabilitation (DR) provides basic vocational rehabilitation and habilitation services to persons with disabilities. The purpose of vocational rehabilitation services is to place disabled individuals in suitable employment, while habilitation services help individuals who are unable to participate in vocational rehabilitation programs achieve a higher level of functioning. Services are provided in sheltered workshops under the Work Activity Program (WAP) and to groups or individuals at job sites through the Supported Employment Program.

In addition, the department helps legally blind clients support themselves as operators of vending stands, snack bars, and cafeterias throughout the state; provides prevocational rehabilitation services to newly blind adults; develops cooperative agreements with school districts, state and community colleges, and county mental health programs to provide services to mutually served clients; and assists community-based rehabilitation facilities such as independent living program, halfway houses, and alcoholic recovery homes.

The budget proposes an appropriation of $484 million from all funds for support of DR programs in 2002-03. This is an increase of $10 million, or 2.1 percent, over estimated current-year expenditures. The budget proposes $168 million from the General Fund, which is $1 million, or 1 percent, above estimated current-year General Fund expenditures.

Budget Suspends Statutory Rate Adjustment

The department is statutorily required to adjust rates for Work Activity Program providers every two years. The Governor proposes to suspend the July 1, 2002, rate adjustment, for an estimated General Fund cost avoidance of $3.8 million in 2002-03.

Current law requires the department to adjust rates for WAP providers every two years, based on actual service provider cost statements.

The next adjustment is scheduled to take effect July 1, 2002. Based on preliminary estimates, the department projects that WAP rates would increase by approximately 7 percent if the rate adjustment were provided. This would result in increased payments to WAP service providers of approximately $4.9 million ($3.8 million General Fund and $1.1 million federal funds). The Governor proposes budget trailer bill language to suspend the statutory adjustment, resulting in a General Fund cost avoidance of $3.8 million in 2002-03.

Legislature Needs More Information on Proposed Savings in the Habilitation Services Program

The Governor's budget proposes General Fund savings of $6 million in the Habilitation Services Program, associated with an overall reduction of approximately 5 percent. However, the budget does not specify how these savings will be achieved. We withhold recommendation on the proposed savings pending review of a more detailed proposal which should be submitted by the department prior to budget hearings.

After adjusting for caseload growth, the Governor's budget proposes to reduce expenditures in the Habilitation Services Program by 5 percent in 2002-03, resulting in a General Fund savings of $5.9 million. The budget assumes that the department will implement various unspecified cost containment measures in order to achieve this reduction. The department indicates that it has identified several areas where savings could be achieved, and that it will convene a group of stakeholders to develop specific restructuring proposals.

In order for the Legislature to assess both whether the proposed savings can be achieved and the programmatic impact of the proposed reduction, more information is needed. We therefore withhold recommendation on the Governor's proposal pending review of a more specific proposal which should be submitted prior to budget hearings.

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 58 county child support offices. 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 *2002-03 Governor's Budget* proposes expenditures totaling $995 million from all funds for support of DCSS in the budget year. This is a decrease of $205 million, or 17 percent, from estimated current-year expenditures. The budget proposes $288 million from the General Fund for 2002-03, which is a decrease of $163 million, or 36 percent, compared to 2001-02. Most of this decrease is attributable to the assumption that federal law will be amended to eliminate future automation penalties.

Assumed Federal Law Change Creates a General Fund Risk

Since 1998, California has been subject to penalties for failing to implement a statewide child support automation system. The budget assumes that federal law will be amended to eliminate approximately $181 million in General Fund automation penalties in 2002-03. Because no such legislation has been introduced, this assumption creates substantial risk in the Governor's budget plan.

The federal government usually pays two-thirds of a state's total child support administrative expenditures. However, pursuant to the Child Support Performance and Incentive Act of 1998 (Public Law 105-200), California has been subject to federal automation penalties which are levied in the form of a reduced federal share in these administrative costs. The General Fund has been used to backfill for these reductions in federal financial participation. From 1997-98 through 2001-02, California's

child support program will have incurred total General Fund penalties of about $372 million, including $157 million in 2001-02.

Budget Savings Depend on Federal Law Change. The Governor's budget assumes that Congress will enact legislation to provide California relief from the automation penalty, which is estimated to be $181 million from the General Fund in 2002-03. While California, Michigan, and several national organizations have been lobbying at the federal level to change the penalty structure, no such penalty relief legislation had been introduced at the time this analysis was prepared.

The assumption that California's automation penalty will be eliminated creates a substantial General Fund budget risk—up to $181 million in the budget year. We note that penalty reform proposals currently under discussion in Washington include (1) reducing the size of the penalty and (2) allowing states to reinvest a portion of the penalties into the child support program, rather than paying these funds to the federal government. Under these proposals, the penalty would not be entirely eliminated. Thus, even if some penalty relief is provided in 2002-03, the budget may overstate the associated savings.

Increased Revenues Not Reflected in Budget

We recommend an increase of $4.1 million in General Fund revenues because the budget does not reflect these collections attributable to increased child support staff in the Franchise Tax Board's budget. (Increase General Fund revenue by $4.1 million.)

Background. The DCSS collects and distributes most child support payments. However, under Chapter 906, Statutes of 1994 (AB 923, Speier), the Franchise Tax Board (FTB) began collecting delinquent child support on behalf of most California counties. Some of these collections are recouped as General Fund revenues to offset the costs associated with welfare expenditures.

Increased Revenues Not Reflected in the Budget. The Governor's budget proposes expanding the FTB's delinquent child support collection program by 31 positions in 2002-03. According to the administration's estimate, this increase in personnel is expected to result in a net increase of $17 million in child support collected on behalf of families and government. Of this amount, $4.1 million is expected to be recouped by the General Fund to offset welfare expenditures. However, this increase is not reflected in the DCSS estimate of revenues. Accordingly, we recommend an increase of $4.1 million in General Fund revenues, so that the budget will be consistent with its own assumptions.

Withhold Recommendation on Automation Oversight

We withhold recommendation on the redirection of $4.2 million from the Pre-Statewide Interim Systems Management Project to the California Child Support Automation System (CCSAS) Project pending receipt of additional information demonstrating the difference between the Department of Child Support Services' and Franchise Tax Board's oversight activities on the CCSAS Project.

The budget proposes to redirect $4.2 million within the department from the Pre-Statewide Interim Systems Management Project to additional DCSS oversight activities on the CCSAS Project. Chapter 479, Statutes of 1999 (AB 150, Aroner), required FTB to act as DCSS' agent for the procurement, development, implementation, and maintenance of the CCSAS Project.

Of the $4.2 million being redirected, $3.3 million are for activities similar to those already being funded in the FTB for the CCSAS Project. Since it is unclear how the proposed DCSS activities differ from FTB's current activities, we withhold recommendation on the DCSS request pending receipt of additional information (1) demonstrating the difference between the two departments' activities, and (2) the likelihood that the redirection will increase project success.

DEPARTMENT OF SOCIAL SERVICES
CALWORKS PROGRAM
(5180)

In response to federal welfare reform, 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 $5.9 billion ($2.2 billion General Fund, $155 million county funds, $30 million from the Employment Training Fund, and $3.6 billion federal funds) to the Department of Social Services (DSS) for the CalWORKs program. In total funds, this is an increase of $392 million, or 7.1 percent. Although the 2002-03 budget for CalWORKs is at the maintenance-of-effort (MOE) floor, General Fund spending is proposed to increase by $136 million (6.8 percent). This increase is primarily due to lower MOE spending in non-CalWORKs programs, which must be replaced by an increase in CalWORKs General Fund spending of the same amount in order to maintain MOE compliance. The increase in CalWORKs MOE spending is partially offset by deferring $25 million in spending for the Department of Labor's Welfare-to-Work program match requirement.

We note that the Governor's budget assumes that the Temporary Assistance for Needy Families (TANF) block grant will be reauthorized by October 1, 2002, and that California will continue to receive $3.7 billion annually in TANF funding. To the extent the TANF block grant is reauthorized at a lower level, this assumption represents a potential risk to CalWORKs program funding.

CASELOAD AND GRANTS

Caseload Decline Ends

The California Work Opportunity and Responsibility to Kids caseload has declined significantly since 1994-95. However, recent caseload data suggest that this trend may be ending. The Governor's budget projects that the caseload decline will end in the current year, and that caseloads will increase by 2 percent in the budget year.

The CalWORKs caseload has declined every year since 1994-95, when caseloads reached their peak. During 2000-01, the average monthly number of CalWORKs cases decreased by approximately 9 percent compared to the prior year. However, the Governor's budget projects that the caseload decline will end in 2001-02, when caseloads will begin to steadily increase for the first time since 1994-95. Caseloads are projected to continue to increase through the budget year, resulting in a year-over increase of 2 percent. Figure 1 illustrates the projected end of the caseload decline.

As shown in Figure 1(see next page), actual caseloads for the first part of 2001-02 (July through September, the most recent months for which actuals are available) were lower than the Governor's projections for these months. However, given the recent economic downturn and its projected impact on caseload growth, we believe the Governor's year-over caseload estimates are realistic. Because the CalWORKs caseload drives program costs, we will continue to monitor caseload trends and advise the Legislature accordingly.

Budget Suspends Statutory Cost-of-Living Adjustment

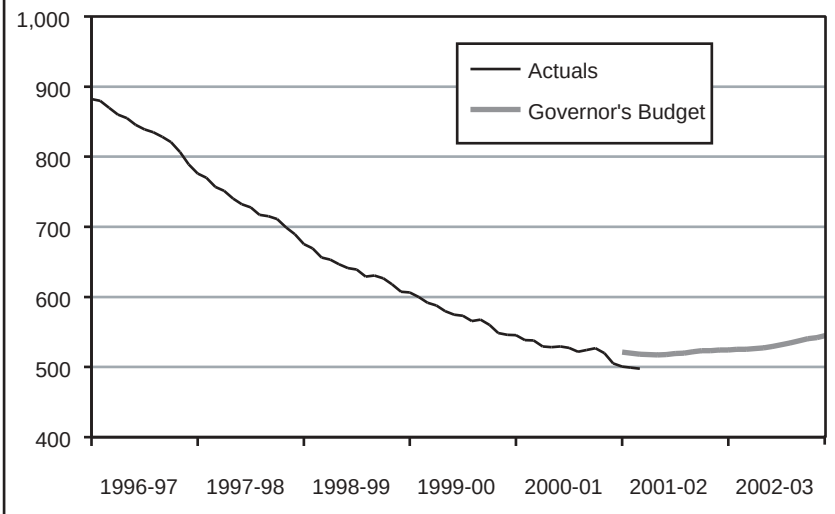
The Governor's budget proposes suspending the statutory cost-of-living adjustment. Compared to current law, this results in a savings of $112 million.

The Governor's budget proposes to suspend the statutory cost-of-living adjustment (COLA) effective October 2002. Compared to current law, suspending the COLA results in General Fund/TANF savings of $112 million. The statutory COLA is based on the change in the California Necessities Index (CNI) from December 2000 to December 2001 (3.74 percent).

Figure 2 (see page 191) shows the maximum CalWORKs grant and food stamps benefits for a family of three in the current year, and what the maximum grant and benefits would be in the budget year if the COLA were provided. As the figure shows, grants for a family of three in high-cost counties would have increased by $25 to a total of $704, and grants in low-cost counties would have increased by $24 to a total of $671.

Figure 1

CalWORKs Caseload Decline Ends



As a point of reference, the federal poverty guideline for 2001 (the latest reported figure) for a family of three is $1,219 per month. (We note that the federal poverty guidelines are adjusted annually for inflation.) Under current law, combined maximum grant and food stamps benefits in high-cost counties would be $978 per month (80 percent of the poverty guideline). Under the Governor's proposal to suspend the COLA, combined benefits in high-cost counties would instead be $964 per month (79 percent of poverty). Combined benefits in low-cost counties would be $960 per month (79 percent of poverty) under current law, versus $946 (78 percent of poverty) as proposed in the Governor's budget.

THE CALWORKS TIME LIMIT: IMPLEMENTATION ISSUES

The statute establishing the California Work Opportunity and Responsibility to Kids (CalWORKs) program does not resolve two issues related to time limits: (1) how counties should apply exemptions from the CalWORKs five-year time limit and (2) the circumstances under which employment services may continue to be provided after an individual reaches the time limit. We present options on how counties should apply exemptions from the CalWORKs five-year time limit. As regards

Figure 2

CalWORKs Maximum Monthly Grant and Food Stamps
Governor's Budget and Current Law
Family of Three

		2000-03		Change from Current Law	
	2001-02	Current Law[a]	Governor's Budget	Amount	Percent
High-cost counties					
CalWORKs grant	$679	$704	$679	-$25	-3.7%
Food Stamps[b]	285	274	285	11	3.9
Totals	**$964**	**$978**	**$964**	**-$14**	**-1.5%**
Low-cost counties					
CalWORKs grant	$647	$671	$647	-$24	-3.7%
Food Stamps[b]	299	289	299	10	3.3
Totals	**$946**	**$960**	**$946**	**-$14**	**-1.5%**

[a] Based on California Necessities Index at 3.74 percent.

[b] Based on maximum food stamps allotments effective October 2001. Maximum allotments are adjusted annually each October by the U.S. Department of Agriculture.

employment services, we recommend enactment of legislation to provide transportation assistance without a community service requirement for time-limited individuals working at least 20 hours per week.

Background

The federal welfare reform law of 1996, which created the TANF block grant, established a lifetime limit on federal assistance. Specifically, states may not use TANF funds to provide assistance to families in which an adult has received a cumulative total of 60 months of assistance. However, a state may exempt up to 20 percent of its caseload from the federal time limit for reasons of "hardship," as defined by the state.

States also have the flexibility to create a separate state program, using state-only funds, to provide assistance to families that have reached the federal time limit. Such families would remain eligible for assistance under the state program. California has availed itself of this option. Such state expenditures for post time-limit families are countable toward the state's maintenance-of-effort (MOE) requirement. Thus, the federal time

limit may be viewed more as a limit on the use of federal funds than a strict requirement that aid be limited to five years.

Adult CalWORKs recipients began hitting the *federal* five-year lifetime limit in December 2001. However, because the CalWORKs program did not start until January 1998, adult recipients will not begin to reach the *state* five-year lifetime limit until January 2003. The Governor's budget projects that about 100,000 families will reach their CalWORKs time limit during 2002-03.

The CalWORKs Time Limit. Under CalWORKs, adults are generally limited to 60 months of cash assistance. However, the CalWORKs statute provides for both categorical and county discretionary exemptions from the time limit. Conditions under which categorical exemptions shall be granted include age (60 or older), certain caretaking responsibilities, and disabilities.

In addition to these categorical exemptions, counties have discretion to extend the time limit for individuals who are unable to find and maintain employment (including individuals who are victims of domestic violence). This determination will be based in part on the individual's history of participation and cooperation. The department is currently in the process of developing regulatory guidance to the counties for making such a determination. These regulations will also provide guidelines to the counties on (1) when to notify recipients who are close to reaching their time limit, (2) establishing a process by which recipients may claim a time extension, (3) tracking cases that have been granted time extensions, and (4) reviewing such cases for redetermination.

Grant Reductions. Once a nonexempt adult reaches the time limit, the grant payment is reduced by the adult portion of the grant. Thus, in the case of a family of three (a parent with two children), the grant payment would be reduced to the maximum aid payment for a family of two. For cases in which the timed-out adult is working, the actual grant payment would depend on net income as determined by the CalWORKs income disregard policy. (Under this policy, some of an individual's earnings are disregarded for the purpose of determining the grant amount.) Reduced grants may be issued in the form of a voucher, at county option. Figure 3 illustrates the effect of grant reductions for a family of three.

Post Time-Limit Services. Working recipients who have reached their 60-month time limit are eligible to receive child care for up to 24 months after leaving cash assistance. For all other employment services, counties have the option to provide services to individuals who have reached their time limit, but whose families remain eligible for assistance. Similar to the employment services available to recipients before they reach the time limit, these county-optional services may include case management; men-

Figure 3

Total Family Income Before and After 60-Month Time Limit

	Before Time Limit	After Time Limit
Scenario 1: Single mother of two, not working		
Earned income	—	—
Minus income disregard	—	—
Net nonexempt income	—	—
Maximum aid payment	$679	$548
Grant amount	679	548
Total family income	**$679**	**$548**
Difference		**-$131**
Scenario 2: Single mother of two, working half-time at minimum wage		
Earned income	$585	$585
Minus income disregard	-405	-405
Net nonexempt income	$180	$180
Maximum aid payment	$679	$548
Less nonexempt income (from above)	-180	-180
Grant amount	$499	$368
Plus earned income (from above)	585	585
Total family income	**$1,084**	**$953**
Difference		**-$131**

tal health, substance abuse or domestic violence treatment and counseling; transportation; education and training; and other services needed to maintain employment.

Unresolved Policy Issues

While the CalWORKs statute clearly establishes a lifetime limit on cash assistance, it provides less clear direction on two important policy issues. These are (1) how counties should apply exemptions from the time limit and (2) the circumstances under which services may be provided after an individual reaches the time limit. Below we discuss these unresolved policy issues.

Issue 1: How Should Counties Apply Exemptions From the Time Limit?

State law states its intent that California not exceed the 20 percent federal exemption limit. Accordingly, if California exceeds that limit, counties that have granted time extensions to more than 20 percent of their caseload would be responsible for the costs associated with the additional cases. However, the statute also states that counties shall not be penalized "for circumstances beyond their control" (for example, high local unemployment rates). Thus, the state may reduce or waive the county share of costs if a county is determined to have good cause for exceeding its 20 percent limit. The department is currently in the process of establishing guidelines for this good cause review.

Administration's Funding Policy Eliminates County Fiscal Risk. In both the current and the budget years, the Governor's budget uses state-only funds for cases that have reached their federal time limit. In other words, the state will not claim *any* federal funds under the 20 percent federal exemption provision. As noted above, counties face a fiscal risk for exceeding a 20 percent exemption limit *only if the state exceeds the federal 20 percent limit*. Since there *is* no state risk of exceeding the federal limit when time-limited cases are shifted to the state-only program, the administration's funding policy essentially eliminates the fiscal risk to counties of exceeding the 20 percent exemption limit. Elimination of this fiscal risk means that counties essentially have no guidance (and therefore no limit) on the *number* of exemptions they can grant. As described earlier, this funding policy is possible (with no additional General Fund costs above the MOE floor) because such state-only spending is countable towards California's MOE spending requirement.

Policy Options. We have identified three approaches to address the issue of how time limit exemptions should be applied. These approaches are (1) the current practice of effectively permitting unlimited exemptions, (2) reestablishing a numerical guideline for the number of exemptions that counties may grant, and (3) statutorily limiting county discretion in granting exemptions.

- ***Current Practice.*** If the Legislature simply wants to avoid a federal penalty for exceeding the 20 percent exemption limit, then current law, in combination with the administration's funding policy, will achieve that goal. The administration's policy of using state-only funds for time-limited cases is consistent with that goal since it ensures that California does not exceed the federal limit.
- ***Reestablish a Guideline.*** If, conversely, the Legislature wants to provide counties and the department a guideline on the absolute

percentage of the caseload that should be exempted at any one time, then clarifying legislation is necessary. Clarifying legislation could be enacted to explicitly hold counties responsible for the costs associated with granting exemptions to more than a specified percent of their caseloads, *regardless of whether the state exceeds the 20 percent federal limit*. The good cause review provisions could remain intact.

- ***Limit County Discretion.*** We note that the amount of the federal 20 percent exemption limit is arbitrary. Accordingly, it may not reflect either the categorical exemptions that the Legislature has already established, or additional exemption policies the Legislature may wish to establish given a variety of factors, including local economic conditions. At the same time, giving counties the discretion to grant exemptions to an unlimited number of cases may significantly weaken the effect of the CalWORKs time limit policy. Therefore, rather than either setting a numerical exemption rate guideline or having none at all, a third approach would involve prescribing more specific conditions under which exemptions could be granted. Specifically, the Legislature could limit county discretion in determining whether an individual is unable to maintain employment. For example, counties might be allowed to grant exemptions only if the local unemployment rate is above a specified level, and only to individuals who have either shown a specified number of attempts to find employment and / or who have been sanctioned no more than twice.

Conclusion. Although all three approaches have merit, we are concerned that current practice of allowing unlimited exemptions may weaken the time limit policy. Accordingly, we would recommend that the Legislature either reestablish a guideline or statutorily limit county discretion.

Issue 2: Post Time-Limit Services

State law is unclear about the conditions under which a working adult who has reached the time limit can continue to receive employment services. Specifically, certain code sections conflict as to (1) whether time-limited recipients who are working must participate in community service activities in order to receive employment services, and (2) how long such recipients may receive these services. Further, current law does not specify an *hourly* requirement for community service activities.

Analyst's Recommendation. We recommend that clarifying legislation be enacted to remove this ambiguity regarding employment services for working, time-limited adults whose families continue to receive as-

sistance. Given that the goal of employment services is to help individuals find and retain employment, we believe that a community service requirement for individuals who are not working and wish to receive services has a sound policy basis. However, for individuals who are working, a community service requirement may disrupt their employment effort.

We therefore recommend that former recipients working at least 20 hours per week be provided transportation assistance without any community service requirement. Such assistance could be capped at a certain amount per month, and, similar to the availability of child care services, could be available for up to 24 months after leaving assistance. Because transportation is a critical work support service, providing such assistance to working, time-limited adults would likely result in lower grant costs in the short term, since working families receive a lower grant amount than nonworking families. It could also achieve long-term savings to the extent that enabling parents to remain employed and increase their earning potential results in more families eventually leaving cash assistance altogether.

For all other employment services, we further recommend giving counties the option to explicitly waive the community service requirement for individuals working at least 20 hours a week. We believe that counties are in the best position to judge whether families making a good faith effort to work and who demonstrate a need for additional employment services would benefit from a community service assignment. We also believe that counties are best able to judge whether such a benefit outweighs the costs associated with providing a community service assignment.

MOE SPENDING REQUIREMENT

Achieving General Fund Savings While Meeting MOE Requirement

The Governor's budget proposes the minimum amount of General Fund monies required by federal law for the California Work Opportunity and Responsibility to Kids (CalWORKs) program in 2002-03. Any net reduction in CalWORKs expenditures would generally result in federal block grant savings, but not General Fund savings. However, we identify two methods by which a CalWORKs reduction could result in General Fund savings, while meeting the maintenance-of-effort requirement.

Maintenance-of-Effort (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 re-

quirement increases to 80 percent if the state fails to comply with federal work participation requirements.) Although the MOE requirement is primarily met with state and county spending in CalWORKs and other programs administered by DSS, state spending in other departments totaling $364 million is also used to satisfy the requirement.

Proposed Budget Is at MOE Floor. For 2002-03, the Governor's budget for CalWORKs is at the MOE floor. The budget also proposes to spend all but $40 million of available federal TANF funds in 2002-03, including both the projected carryover of unexpended funds ($253 million) from 2001-02 and $189 million in reclaimed county performance incentives (discussed later in this *Analysis*). The $40 million will be held in a reserve for unanticipated future program needs. We note that any net augmentation to the CalWORKs program above the $40 million reserve amount would result in additional General Fund costs above the MOE requirement.

Conversely, because the budget proposes to spend the minimum amount of General Fund monies required by federal law, any net program *reductions* would generally result in TANF savings, but not General Fund savings. However, below we identify two methods by which CalWORKs savings could result in General Fund savings. These include (1) recognizing additional non-CalWORKs MOE-countable expenditures and (2) transferring freed-up TANF funds into the Social Services Block Grant (SSBG).

Method 1: Recognize Other MOE-Countable Expenditures. As noted above, the Governor's budget assumes that $364 million in spending in other departments will be used to satisfy the MOE spending requirement in 2002-03. If additional non-CalWORKs MOE-countable expenditures were identified, the required level of CalWORKs MOE spending would decrease by a like amount. Thus, General Fund spending in CalWORKs could be reduced while still maintaining MOE compliance. Achieving General Fund savings in this way would require either (1) a program reduction in CalWORKs or (2) drawing on the TANF reserve in order to keep the program whole.

Later in our analysis of this program, we recommend that certain current state spending for (1) supplemental cash payments to disabled adults and children, (2) nonemergency health services to legal immigrants, and (3) subsidized child care for certain families be counted toward the MOE requirement. Recognizing these payments (which we estimate to be in the range of $30 million to $100 million) as MOE-countable expenditures would permit a General Fund reduction in CalWORKs of a like amount. To the extent that TANF funds are available to replace any General Fund reduction, these General Fund savings could be achieved without a program reduction.

Method 2: Transfer Freed-Up TANF Funds Into the Social Services Block Grant (SSBG). The federal TANF block grant provisions allow California to transfer up to $373 million in TANF funds to the SSBG, also known as Title XX funds, under the condition that the transferred funds are spent on children or their families with incomes under 200 percent of poverty. Once transferred, the funds may be used to support any programs that meet the SSBG goals. These include achieving economic self-sufficiency, preventing abuse or neglect, enabling families to stay together, and preventing inappropriate institutional care.

For 2002-03, the Governor's budget proposes to expend the full amount of available SSBG funding to offset General Fund costs in programs that meet the SSBG goals. We estimate that an additional $125 million in current General Fund spending, mostly on developmental services, could be replaced with TANF funds transferred to the SSBG. Later in the Child Welfare Services section of this *Analysis*, we recommend transferring freed-up TANF funds into the SSBG for the purpose of reducing General Fund expenditures for developmental services.

Count Additional Spending Toward MOE Requirement

We recommend that the department count toward the California Work Opportunity and Responsibility to Kids maintenance-of-effort requirement General Fund expenditures for (1) supplemental cash payments to disabled adults and children, (2) nonemergency health services for certain immigrants, and (3) subsidized child care for certain families. We estimate such countable expenditures to be in the range of $30 million to $100 million. Counting such expenditures would increase legislative flexibility in allocating General Fund monies for CalWORKs.

Countable MOE Funds. Pursuant to federal welfare reform, California may count toward meeting its MOE requirement all state spending on families eligible for CalWORKs, even if they are not in the CalWORKs program. To be countable, such spending must be consistent with the broad purposes of federal welfare reform. These include providing assistance to needy families so that children may be cared for in their own homes and families can become self-sufficient. Countable expenditures must also satisfy a "new spending" test, whereby only the amount by which they have grown since federal fiscal year (FFY) 1995 is counted.

State Supplementary Program (SSP). The SSP supplements federal Supplemental Security Income payments for low-income aged, blind, and disabled individuals. For 2002-03, the Governor's budget proposes $3 billion from the General Fund for SSP payments. Some of these payments enable children to be cared for at home, and therefore are consistent with the intent of the federal welfare reform law.

After applying the new spending test described above, we believe that between $30 million and $50 million in SSP spending could be counted toward the MOE requirement in 2002-03. This includes payments to disabled children and payments to disabled adults with children.

Nonemergency Health Services for Federally Ineligible Immigrants. California currently uses state-only funds to provide nonemergency health services to certain legal immigrants who, pursuant to federal welfare reform, were made ineligible for federally reimbursable nonemergency services. Providing preventive health services for families with children keeps parents and children healthy, thereby assisting the parents in keeping regular work hours. Expenditures for such services are therefore consistent with the intent of federal welfare reform. Because they began after 1995, these expenditures also meet the MOE new spending test. We believe that at least $3 million in state spending on these health services could be counted toward the MOE requirement in 2002-03.

Subsidized Child Care. Currently, the budget recognizes $322 million in expenditures within the State Department of Education (SDE) for subsidized child care toward the MOE spending requirement. This amount only reflects expenditures for families who are current or former CalWORKs recipients. However, as noted earlier in our analysis of this program, spending for families that are *eligible* but not necessarily receiving assistance is also countable toward the MOE requirement. We believe a significant portion of SDE's child care expenditures (potentially in the tens of millions of dollars) in the general subsidized child care system are for such eligible families, and therefore would be countable toward the MOE requirement. Counting such expenditures may require amending the state TANF plan's definition of needy families for purposes of providing child care.

Statutory Change and State Plan Amendment Are Necessary. In order to count the identified SSP, health, and child care expenditures toward the MOE requirement, statutory changes recognizing such expenditures as counting toward the MOE requirement are likely to be necessary. Similarly, the state TANF plan may also need to be amended to recognize such expenditures. We note that neither a statutory change nor a state plan amendment would impact eligibility rules for CalWORKs assistance.

Analyst's Recommendation. We are working with the Department of Social Services to refine the estimate of countable MOE spending. Once this amount is determined, we would recommend that the CalWORKs budget reflect all countable SSP, nonemergency health, and subsidized child care expenditures toward the MOE requirement in 2002-03, and that the department amend the state TANF plan accordingly. We recommend

that the Legislature adopt the necessary statutory changes to recognize these expenditures as MOE-eligible. Recognizing additional MOE-countable spending creates options and policy trade-offs for the Legislature, which we discuss below.

One option is to count General Fund expenditures in CalWORKs above the MOE requirement toward California's remaining match requirement for the federal Welfare-to-Work block grant. We note that the remaining obligation—$69 million—must be spent by the end of 2003-04. Alternatively, if the Legislature wants to maintain CalWORKs spending at (or as close as possible to) the MOE floor, the Legislature could simply reduce General Fund spending in CalWORKs. This would be possible either by replacing General Fund monies with available TANF funds from the reserve, or, to the extent TANF funds are unavailable, through a program reduction. We note that the maximum General Fund savings that could be achieved without a program reduction would be $40 million (the proposed TANF reserve).

OTHER BUDGET AND POLICY ISSUES

Budget Proposes Redirecting County Performance Incentives

The Governor's budget proposes to redirect $189 million in unspent county performance incentives in 2001-02 and 2002-03. We comment on the advantages and disadvantages of this proposal.

Background. Prior to 2000-01, the CalWORKs statute provided that savings resulting from (1) exits due to employment, (2) increased earnings, and (3) diverting potential recipients from aid with one-time payments, would be paid to the counties as performance incentives. The 2000-01 budget trailer bill for social services—Chapter 108, Statutes of 2000 (AB 2876, Aroner)—changed the treatment of performance incentives in several important ways. Among these changes, it:

- Prohibited counties from earning new incentives beginning in 2000-01 until the estimated prior obligation owed to the counties had been paid by the state.
- Made future performance incentive payments subject to annual budget act appropriations, rather than being treated as an "entitlement."

Performance Incentives Expenditures. By the end of 1999-00, the last year for which an appropriation for new performance incentives was made, counties had earned approximately $1.2 billion in performance incentives, and had been paid $1.1 billion. The *2001-02 Budget Act* appropriated an additional $20 million to the counties, as payment towards the prior-year obligation for previously earned incentives ($97 million). However, as of October 2001, counties had spent only $161 million of their paid incentive funds, leaving $931 million in unspent funds. The department estimates that by the end of 2001-02, approximately $600 million in performance incentive funds will remain unspent.

Budget Proposal. In order to reduce CalWORKs funding pressures in 2002-03, the Governor proposes to redirect $189 million in unspent performance incentives to fund CalWORKs grants, basic services, and administration. Specifically, the Governor proposes budget trailer bill language to redirect the $20 million appropriation in 2001-02. In addition, the Governor proposes to (1) reclaim the estimated $600 million in unspent performance incentives in 2002-03, (2) reappropriate $431 million of the reclaimed amount to the counties as performance incentive funds, and (3) redirect the "recaptured" $169 million for grants, basic services, and administration. If the Legislature approves the redirections, the state's unpaid obligation to the counties for prior-year performance incentive earnings will be $266 million ($169 million plus the full prior-year obligation of $97 million).

Policy Considerations. The amount of unspent performance incentives to be reappropriated to the counties in the budget year, versus the size of the state's out-year obligation to repay the counties for previously earned performance incentives, is a policy decision for the Legislature. Specifically, the Legislature could retain more than the proposed $169 million redirection of unspent funds. These funds could be used, for example, to provide the statutory COLA (described earlier in our analysis of this program), augment the TANF reserve for future program needs, or to reduce General Fund expenditures through one of the methods described earlier in our analysis of the MOE requirement. The disadvantages of retaining additional incentive funds are that it (1) increases the obligation to the counties in the out-years and (2) reduces the level of services that counties are able to provide with these funds. We note that some counties believe their employment services allocations are insufficient to provide necessary services, and rely on performance incentive funds to provide such services.

Budget Expands County Block Grant But Proposed "Holdback" Is Disruptive

The Governor proposes three significant changes to the California Work Opportunity and Responsibility to Kids budgeting system. These changes include (1) funding county administrative and employment services costs at their current-year levels, (2) substantially expanding the county block grant, and (3) retaining up to 5 percent of the county allocations to pay for potential cost increases for assistance payments. We recommend that the Legislature (1) build on the Governor's county block grant proposal by including additional Temporary Assistance for Needy Families (TANF) allocations in this block grant but (2) reject the proposed 5 percent "hold-back" and instead establish a larger TANF reserve to pay for the potential program cost increases.

The CalWORKs Budget System. Funding for CalWORKs employment services, child care, and program administration are provided to the counties in a block grant known as the "single allocation." Counties have the discretion to move these block grant funds among programs in order to address actual need at the local level. Beginning in 2000-01, the budgeting system for the employment services component of the single allocation was changed from a statewide model to a county-driven system based on projected county costs, similar to the system used to budget the administrative cost component of the single allocation. Under this system, known as the proposed county administrative budget (PCAB) process, the department reviews the counties' PCAB requests for consistency with state law and workload needs and adjusts the county funding requests accordingly.

Budget Proposal. The budget proposes three significant changes to the CalWORKs budgeting system. These changes include (1) suspending the PCAB process, (2) replacing the single allocation with an expanded block grant known as a "county program grant," and (3) retaining up to 5 percent of the county allocations to cover potential cost increases for assistance payments.

- ***PCAB Suspension.*** Due to funding pressures in the CalWORKs program, the budget proposes to suspend the PCAB process for 2002-03. (This suspension also applies to funding for county administrative costs for Medi-Cal, Foster Care, and Food Stamps.) Specifically, the budget proposes to fund county administrative and employment services costs at their current-year funding levels, adjusted for caseload changes. Current funding levels will not be adjusted for inflation.

Analyst's Comments. Given the state's fiscal situation, suspending PCAB for CalWORKs and the administration of other health and social services programs appears prudent. It is difficult to estimate the savings to the CalWORKs program of suspending PCAB in the budget year. We note that in 2001-02, the budget for administration and employment services was frozen at the 2000-01 level, due to funding pressures. As a result, in the current year the counties' single allocations were approximately $250 million lower than what the counties had requested. Assuming the counties' funding requests for 2002-03 would have been at least equal to their 2001-02 requests, suspending PCAB in the budget year would result in savings to the CalWORKs program of about $250 million (the exact amount depends on what the department would have approved in the absence of funding pressures). We note that from the perspective of the counties, such program savings mean that the budget for core services and administration is underfunded.

- ***County Block Grant.*** The Governor proposes budget and budget trailer bill language to replace the county single allocation with a new county block grant, known as the "county program grant." In addition to the single allocation funding for services, administration, and child care, the county block grant will include $109 million in funding currently earmarked for mental health and substance abuse treatment and $201 million in funding currently earmarked for probation camps and juvenile treatment facilities. Rolling these separate allocations into a county block grant will increase county flexibility to move funds across program purposes as needed. It is our understanding that the department will introduce trailer bill language to prevent counties from using this increased funding flexibility to supplant existing county expenditures for probation and juvenile treatment services.

  Analyst's Recommendation. We believe that counties are in the best position to weigh the service needs of their CalWORKs caseloads against various competing county priorities, both within and outside of the CalWORKs program. We therefore believe that increasing county flexibility to determine the best use of available TANF funds has a sound policy basis. For this reason, we recommend building on the Governor's county block grant proposal by including additional proposed TANF funds currently categorically allocated to other agencies.

  Specifically, the Governor proposes to pass through $44 million in TANF funds to various state agencies and community-based organizations that provide (1) employment and educational ser-

vices to CalWORKs recipients and (2) teen pregnancy prevention services. These agencies and organizations include the California Community Colleges, the State Department of Education, the Department of Health Services, and local Boys and Girls Clubs.

We believe that counties are best able to evaluate the educational and employment needs of their caseloads, and to consider those needs in the context of available funding for other basic services, child care, and program administrative costs. Similarly, we believe that counties are in the best position to evaluate the effectiveness of local pregnancy prevention efforts and to weigh the merits of such efforts with competing TANF funding priorities within the CalWORKs program. Therefore, without prejudice to the merits of the particular services that would be funded with the proposed $44 million pass-through, we recommend that the Legislature include those TANF categorical allocations in the county block grant allocation. Counties would have the flexibility to contract with local colleges, universities, and community-based organizations on an as-needed basis.

- ***Holdback of County Allocations.*** The budget proposes budget bill language to retain up to 5 percent (approximately $95 million) of the county block grant allocations to cover potential cost increases for assistance payments in CalWORKs or the Kinship Guardianship Assistance Payment Program (Kin-GAP)—a program that enables dependent children to exit the foster care system and live with a relative guardian. Both CalWORKs and Kin-GAP assistance payments are entitlements, meaning that if grant costs exceed budget authority, funding is automatically provided to pay for the increased costs. Under current law, unanticipated increases in program costs due to caseload growth or changes in federal law would be funded automatically with either TANF or General Fund resources. Under the Governor's proposal, such program cost increases would instead be funded first from the 5 percent holdback funds, which would otherwise support employment services and program administration. In other words, the Governor proposes to use up to approximately $95 million of county program grant funds to mitigate the potential General Fund impact of unanticipated caseload growth.

  Analyst's Recommendation. The primary disadvantage of the Governor's 5 percent holdback proposal is that the potential $95 million reduction in county block grant funding would result in a lower level of employment services and a lower level of funding for county administrative costs. Additionally, because the actual amount of county funds that will ultimately be redi-

rected for grant payments is unspecified, the Governor's proposal is disruptive to the counties' planning process and their ability to budget for employment services and administrative costs.

While we recognize the need to limit the risk to the General Fund in the budget year given the General Fund condition, we believe that a less disruptive approach to protecting the General Fund in the event of unanticipated caseload growth would be to establish a larger TANF reserve. This could be accomplished either through an outright program reduction (for example, reducing the level of employment services), or by retaining a portion of the proposed $431 million reappropriation for performance incentives (discussed earlier in our analysis of this program). In our view, these incentive funds are not as necessary for core program services as the basic allocation for employment services. We therefore recommend that the Legislature reject the Governor's 5 percent "holdback" of the county block grant. To the extent the Legislature wishes to augment the TANF reserve for the purpose of protecting the General Fund, we would recommend that the Legislature retain a portion of the proposed reappropriation for performance incentives.

CalWORKs Needs Long-Term Budget Plan

Absent legislative action, funding pressures in the California Work Opportunity and Responsibility to Kids (CalWORKs) program will continue to erode the program's welfare-to-work component (employment services and administration). Accordingly, the Legislature faces difficult policy choices in determining the appropriate level of CalWORKs funding. We present policy considerations for the Legislature in developing a long-term budget plan for CalWORKs.

Background. Since its enactment in 1997, CalWORKs funding has remained essentially stable. The program's relatively flat funding level is due to a fixed amount of TANF block grant funds and the state's decision to limit its share of funding to the minimum MOE spending requirement. This funding level was sufficient to support the CalWORKs program in its early years for several reasons. Prior to the current year, the continuous caseload decline, coupled with the relatively slow implementation of the employment services component of the CalWORKs program, resulted in TANF reserves that were sufficient to fully fund the program's core elements—grants, basic employment services, and child care—as well as to provide the counties with approximately $1 billion in performance incentive funds, which could be spent on "noncore" program enhancements.

Beginning in 2000-01, however, no new funding has been provided for performance incentives. Further, in 2001-02, the budget for the welfare-to-work component (employment services and administration) was frozen at the 2000-01 level due to funding pressures. These pressures resulted from a combination of a slowing caseload decline, a matured welfare-to-work component, and fewer carryover TANF funds available from prior years.

Our February 2001 report on *Changing the Employment Services Budget Process* provided further evidence of upcoming funding pressures. Specifically, we showed that some counties' employment services and administrative cost allocations were underfunded. Building on this prior analysis, we find that in 2001-02, 11 counties (representing approximately 50 percent of the statewide caseload) had welfare-to-work allocations that were below a minimum funding standard that we calculated based on 1999-00 allocations to Riverside and San Bernardino Counties. (These are two relatively large counties with programs that have no particularly high-cost components, but are nevertheless successful in engaging the majority of participants who are subject to the CalWORKs work participation requirements.) The cost of bringing all counties up to this standard (without redistributing funding from the higher-funded counties) would be approximately $125 million.

Legislature Requests New Budgeting Methodology. Recognizing the likelihood that funding pressures would continue to intensify in future years, in 2001 the Legislature adopted budget trailer bill language directing the department to develop a new budgeting methodology for all components of the CalWORKs program as well as all non-CalWORKs programs funded with TANF funds. This methodology was due to the Legislature by November 15, 2001, and was to be the basis for the 2002-03 budget.

Governor's Budget Does Not Incorporate New Methodology. Although the department met with stakeholders as directed, the department has not submitted a new budgeting methodology to the Legislature, nor is the Governor's budget based on a new methodology. Instead, the Governor again proposes to use the budget for the welfare-to-work component as the "balancing entry" in order to maintain CalWORKs expenditures within available resources. Specifically, the budget proposes to (1) continue to freeze the county allocations for employment services and administration and (2) retain up to 5 percent of these allocations to cover potential cost increases for assistance payments. In addition, the budget "reclaims" $169 million in performance incentives from the counties in order to fund core program elements without exceeding the MOE floor. (These issues are discussed earlier in our analysis of this program.) The Governor's budget summary further indicates that funding pressure in future years will be addressed by reducing the county allocations as necessary.

Policy Considerations for the Legislature. As noted above, in certain counties the CalWORKs welfare-to-work component is underfunded in the current year. Because the Governor proposes to freeze budget-year allocations, this underfunding would persist in 2002-03. Funding pressures within CalWORKs are likely to intensify in future years, for several reasons. These include the potential for continued caseload increases as a result of the recession, counties exhausting their performance incentive funds, reductions in the level of TANF carryforward balances, the cost of providing the statutory COLA, and the potential for reduced federal funding pursuant to TANF reauthorization. These pressures will be only partially offset by savings due to some recipients reaching their five-year time limit on cash assistance. We believe the CalWORKs program requires a long-term budget plan to address these fiscal pressures. We have identified several issues for legislative consideration in developing such a plan. These include (1) whether to maintain General Fund spending at the MOE floor, (2) the relative importance of fully funding employment services versus maintaining grant levels, and (3) whether to standardize funding allocations for employment services and administration.

- ***Should the Legislature Fund CalWORKs Above the MOE Floor?*** Since CalWORKs was enacted, the Legislature has taken steps to maintain General Fund spending at the MOE floor. Prior to the current year, this budgeting approach was possible without funding reductions in core program elements. However, as caseloads increase and available resources decrease, maintaining General Fund spending at the MOE floor will require reductions either in the employment services level or in the level of assistance payments. The decision about whether to exceed the minimum state spending requirement therefore involves balancing the benefits of budgetary savings against the impact on CalWORKs families of a program reduction.

- ***How Should the Legislature Weigh Funding of Grants Versus Services?*** The decision about the appropriate funding level for CalWORKs also involves weighing the relative importance of two primary goals of a welfare-to-work program: (1) providing an adequate level of cash assistance to enable needy families to maintain a minimum standard of living and (2) providing an adequate level of employment services to enable recipients to gain the skills needed to work and eventually become self-sufficient. Investing in employment services is especially important given the lifetime limit on cash assistance for adult recipients. However, the costs of this investment must be balanced against the costs of ensuring that needy families are provided with sufficient income maintenance. We note that if the Legislature elected to reduce grants,

about 45 percent of any such reduction would be offset by an increase in federal food stamp benefits.

Current law—like the Governor's budget—favors preserving grant payments at the expense of funding employment services. Specifically, grant payments are an entitlement under state law, meaning that if grant costs are greater than budgeted, increased funding is automatically provided. State law also provides for statutory COLAs. Conversely, funding for employment services and county administration is capped by the annual budget appropriation. Thus, absent legislative action to increase funding for employment services and administration (or to redirect funding from grant payments), funding pressures will continue to erode the welfare-to-work component of the CalWORKs program.

- ***How Should Funds Be Allocated to Counties?*** Finally, developing a long-term budget plan requires consideration of how funding for employment services and administration is allocated among counties. As noted above, current funding allocations per aided adult vary widely across the counties. Such variation in allocations raises concerns about equitable access to employment services. In determining whether to implement a more equitable allocation process, the Legislature could consider allocating all funding for employment services and administration on a per-aided adult basis (because adults receive the employment services). Final allocations could be adjusted for high- and low-cost regions and for small counties with high fixed costs. In order to avoid unnecessary disruption, this change could be phased in over two to three years.

  Alternatively, in recognition that some variation in county allocations is to be expected—given differences in local economic conditions, costs of providing services, and program designs—the Legislature could consider standardizing funding only for the program administration component of the county allocation, and leaving intact the current allocation formula for employment services. For example, after determining an appropriate caseworker-to-recipient ratio, county funding for administration could be based on the number of cases with an adult. Again, adjustments could be made for high- and low-cost regions.

Summary. The Legislature faces difficult policy choices in determining the appropriate level of CalWORKs funding. Given the state's fiscal situation, the Governor's approach of freezing the budget for employment services and administration may be appropriate in the budget year. However, for future years, we believe that the Legislature should establish its priorities with respect to (1) the level of General Fund support for

CalWORKs (whether or not to go above the MOE floor), (2) the relative importance of income maintenance (grant payment levels) versus employment services, and (3) addressing the current inequities in funding allocations for employment services and administration. Given caseload and cost trends, we believe that continuing the practice of spending at the MOE floor is likely to result in further underfunding of the program.

Eliminate CalWORKs Grant Payments Under $150

We recommend eliminating grant payments for families with incomes (including earnings and benefits) of at least 122 percent of the federal poverty level. Such families currently receive relatively modest grant payments (up to about $150 monthly). Removing these families from cash assistance would preserve their time on aid for future periods during which they may become unemployed, and would result in program savings of approximately $37 million. (Reduce Item 5180-101-0890 by $37 million.)

CalWORKs Grant Payments. Under the CalWORKs income disregard policy, a portion of a recipient's earnings is disregarded for the purpose of calculating the family's grant payment. This policy—designed to "make work pay"—means that a working family of three would remain eligible for cash assistance as long as the family's monthly earnings are below $1,583 (130 percent of the federal poverty level). For example, a family of three with earnings of $1,400 would receive a grant of $91. While families with significant earnings receive relatively modest grant payments, the months in which they receive such payments are still counted toward their 60-month lifetime limit on cash assistance.

Interaction of Income Disregard Policy With Time Limits. We believe the earned income disregard policy is an important component of any welfare program that is designed to encourage recipients to make the transition from welfare to work. However, there is an inherent tension between California's relatively generous disregard policy and the CalWORKs lifetime limit on cash assistance. Specifically, the 60-month time limit may motivate recipients to leave assistance as soon as possible in order to preserve any remaining months on assistance for the future. However, the disregard policy enables working families to continue to receive increasingly modest grant payments until their earnings are well above the federal poverty level.

Analyst's Recommendation. We recommend eliminating grant payments for families with total incomes (including earnings and benefits) of at least 122 percent of the federal poverty level. Under this policy, a family of three could lose up to $150 in cash assistance. This would be partially offset by an increase of about $68 in food stamp benefits, leaving the family's total income at approximately 116 percent of the federal pov-

erty level. While this policy would reduce a family's total income somewhat, it would preserve the family's remaining time on aid for periods in which the recipient might become unemployed or unable to work. We note that currently families who leave cash assistance due to earnings may receive up to 12 months of post-employment services after leaving aid (at county option).

We estimate that this policy change would result in grant savings of approximately $19 million. In addition, we estimate that the administrative savings associated with this policy change would be approximately $18 million. Such savings (mostly TANF funds) could be used to augment the TANF reserve for future program needs, increase county block grant allocations (described earlier in our analysis of this program), partially adjust grant payments for inflation (in place of providing the full statutory COLA, also described earlier), or to reduce General Fund expenditures through one of the methods described earlier in our analysis of the MOE requirement.

Reinstate Senior Parent Deeming

We recommend that a senior parent's income be counted for the purpose of determining financial eligibility of a minor parent's child for California Work Opportunity and Responsibility to Kids assistance. This would result in program savings of approximately $11 million. (Reduce Item 5180-101-0890 by $11 million.)

Current Law. Under the Teen Pregnancy Disincentive policy—enacted by Chapter 307, Statutes of 1995 (AB 908, Brulte)—a minor parent is generally required to live with her parent(s) (referred to as "senior parents") in order to receive cash assistance. (Certain exceptions exist, for example, in cases in which the senior parent's home is unsafe for the minor parent and/or her child.) Although the minor parent cannot open her own CalWORKs case, the senior parent may apply for and receive aid on behalf of the grandchild, even if the senior parent's income would otherwise make the family ineligible for assistance. We note that prior to the implementation of the Teen Pregnancy Disincentive policy, the senior parent's income was "deemed" to the grandchild—meaning that the grandparent's income was considered to be available for the support of the grandchild, and therefore counted for the purpose of determining eligibility of the grandchild for cash assistance.

Policy Considerations. The advantage of current law is that it may encourage teen parents to live with their own parents, in what may be a more appropriate child-rearing environment than if the teen parent lived on her own. (We note that if the teen moved out, she would generally not be entitled to a grant for herself or her child pursuant to Chapter 307.)

The disadvantage of guaranteeing an aid payment for the minor parent's child (current law) is that it permits nonneedy families to receive cash assistance by establishing a "child-only" case. Because such cases do not include an adult, the family is not subject to either the CalWORKs work participation requirement or the 60-month lifetime limit on cash assistance.

Analyst's Recommendation. The primary mission of the CalWORKs program is to help needy families with children become self-sufficient through work. Providing income support to nonneedy child-only cases with no participation requirements is not consistent with that mission. We therefore recommend that the Legislature reinstate senior deeming in the case of a minor parent living at home. Reinstating senior deeming would result in about 3,000 nonneedy child-only cases (approximately 2 percent of the child-only caseload) losing monthly cash benefits of about $320.

We estimate that this policy change would result in savings of approximately $11 million (mostly TANF funds). Such savings could be used to augment the TANF reserve for future program needs, increase county block grant allocations (described earlier in our analysis of this program), partially adjust grant payments for inflation (in place of providing the full statutory COLA, also described earlier), or to reduce General Fund expenditures through one of the methods described earlier in our analysis of the MOE requirement.

The CalWORKs Child Care Program

As part of systemwide child care reforms, the Governor proposes to eliminate the Stage 3 "set-aside" designed to provide former CalWORKs families with child care beyond the two-year guarantee for such services. We review the Governor's child care reform proposals and their impact on the CalWORKs program.

The CalWORKs Child Care System. Under current law, CalWORKs child care is delivered in three stages. Stage 1 is administered by county welfare departments and begins when a participant enters CalWORKs. Participants transition to Stage 2, which is administered by the State Department of Education (SDE), once their situations become stable as determined by the counties. Participants can stay in Stage 2 while they remain on CalWORKs and for up to two years after they leave CalWORKs. Stage 3 refers to the broader subsidized child care system administered by SDE that serves both former CalWORKs recipients and working poor families who have never been on CalWORKs. Because there typically are waiting lists for Stage 3, in 1997 the Legislature created the Stage 3 "set-aside" as part of the CalWORKs child care system in order to provide continuing child care for former CalWORKs recipients who are unable to find "regular" Stage 3 child care once they "time-out" of Stage 2.

Budget Proposal. The Governor's budget proposes $1.3 billion for CalWORKs child care. This is a decrease of $271 million (17 percent) over the current-year appropriation. As discussed below, this decrease is due to savings associated with the Governor's child care reform proposals. Figure 4 summarizes the proposed spending plan. As the figure shows, the budget includes a reserve of $164.7 million for Stage 1 and Stage 2 child care. This total includes a "hold back" of 5 percent of the estimated need for Stages 1 and 2 ($64.7 million). The remaining $100 million is above the estimated need and represents a "true" reserve for Stages 1 and 2.

Figure 4

CalWORKs Child Care
Estimated Children Served and Proposed Budget

2002-03
(Dollars in Millions)

	Estimated Number of Children Served	Funding			
		Total	TANF	CCDF	General Fund [a]
Stage 1	78,500	$472.4	$353.2	—	$119.2
Stage 2	117,000	607.0	351.7	$43.5	211.8[b]
Child care reserve[c]	29,500	164.7	164.7	—	—
Stage 3 set-aside[d]	14,500	80.6	—	47.2	33.4[e]
Totals	**239,500**	**$1,324.7**	**$869.6**	**$90.7**	**$225.5**

a General Fund used toward CalWORKs maintenance-of-effort requirement.

b Proposition 98 funds including $15 million in the California Community Colleges.

c The reserve will be allocated to Stage 1 or Stage 2 depending on actual need.

d One-time funds to provide child care to families expected to "time out" of Stage 2 between July 1, 2002 and the end of March 2003.

e Proposition 98 funds.

Governor's Child Care Reform Proposal. The Governor proposes to reform California's subsidized child care system (which includes both CalWORKs and non-CalWORKs child care) by modifying current eligibility rules, reimbursement rate limits, and family fees. Specifically, the Governor proposes to reduce income eligibility limits, reduce reimbursement rates, implement fees for lower-income families, and increase current fees for higher-income families.

Impact on CalWORKs Child Care. The department estimates that the proposed reforms will result in savings of approximately $183 mil-

lion ($50 million in Stage 1 and $133 million in Stage 2). These savings result from a combination of higher family fees, lower reimbursement rates, and some families losing eligibility for CalWORKs child care. Specifically, about 6,000 children would lose eligibility. Additionally, many CalWORKs families will be responsible for a child care copayment for the first time. Families would be required to pay such fees directly to their child care providers. We note that the Governor proposes to reinvest the savings resulting from this proposal, thereby increasing the number of child care slots.

Eliminating the Long-Term Guarantee. In addition to these systemwide changes to California's subsidized child care system, the Governor also proposes to eliminate the Stage 3 set-aside for former CalWORKs recipients who have timed-out of Stage 2. Specifically, the Governor's budget includes funding for Stage 3 child care through the end of 2002-03 for families who time-out of Stage 2 between July 2002 and March 2003. Most families who will transition from Stage 2 during 2002-03 will thus be guaranteed Stage 3 child care through the end of the budget year. The proposed Stage 3 phase-out therefore results in minimal budget risk associated with former recipients returning to aid due to a lack of child care in 2002-03. However, the Governor's proposal may represent a budget risk in the out-years to the extent that the broader subsidized child care system is unable to absorb families who will time out of Stage 2 beginning in April 2003 as well as those families who will lose their Stage 3 guarantee at the end of 2002-03.

Policy Considerations. The primary advantage of eliminating the Stage 3 set-aside is that it would create more equitable access to subsidized child care. Specifically, ending the child care guarantee for former CalWORKs recipients who have been off aid for at least two years would help ensure that working poor families with similar income levels have an equal chance of receiving subsidized child care regardless of whether they have ever received CalWORKs assistance. The disadvantage of this approach is that former CalWORKs recipients—having received aid in the past—may be more likely to go back on CalWORKs if they lose their child care than would a non-CalWORKs working poor family, even though the incomes of the two families may be very similar.

No Penalty for Cash Management Violation

As directed by the U.S. Department of Health and Human Services, California will return unspent Temporary Assistance to Needy Families funds drawn down in violation of the Cash Management Improvement Act, along with interest earned on the advance draw-down funds, but will incur no penalties.

In our *Analysis of the 2001-02 Budget Bill*, we indicated that California's practice of paying counties performance incentives when they are earned, rather than when they are used for program purposes, may not be consistent with the Cash Management Improvement Act (CMIA) and U.S. Department of Health and Human Services (DHHS) regulations. In August 2001, the Administration for Children and Families (ACF), DHHS—which administers the TANF program—notified the department that California's advance draw down of TANF funds for county performance incentives was in violation of both CMIA and DHHS regulations. The ACF directed the department to return the unexpended incentives, including any interest earned on the funds.

To avoid any penalties, the department has negotiated the use of an offset process to recoup the unspent incentives, whereby no new TANF funds will be drawn down for assistance payments until the unspent incentives have been "repaid." The ACF has further agreed to accept the *actual* interest that counties have earned on the awarded incentives, rather than an amount based on an augmented (penalty) interest rate. Counties have been instructed to remit the interest they have earned through the end of 2001-02 by July 31, 2002.

Withhold Recommendation on Impact of Federal Eligibility Changes

We withhold recommendation on the estimated cost of recent federal eligibility changes, pending review of the Governor's May Revision of the budget.

Eligibility for CalWORKs is based on a number of factors, including the value of a household's assets. State law conforms the CalWORKs asset rules to the federal food stamp rules. As a result of recent federal food stamp changes affecting how vehicles are valued for the purpose of determining eligibility, more households are now eligible for CalWORKs assistance.

These eligibility changes only went into effect in June 2001. We believe that by the time of the Governor's May Revision, when more actual caseload data are available, the impact of these changes should largely be reflected in the basic caseload trend. We therefore withhold recommendation on the estimated cost of the federal changes pending review of the Governor's May estimates.

COMMUNITY CARE LICENSING

The Community Care Licensing Division (CCLD) develops and enforces regulations designed to protect the health and safety of individuals in 24-hour residential care facilities and day care. Licensed facilities include child care; foster family and group homes; adult residential facilities; and residential facilities for the elderly. The Governor's budget proposes expenditures of $117 million ($45 million General Fund) for the CCLD in 2002-03. This represents a 7 percent increase in General Fund expenditures from the current year.

Positions Exceed Estimated Complaint Investigation Workload

We recommend the Governor's request for 44 Community Care Licensing Division (CCLD) positions be reduced by 11 positions because the budget proposal (1) overestimates investigative complaint workload in foster family agency homes and (2) exceeds CCLD standard staffing ratios. (Reduce Item 5180-001-0001 by $425,000.)

State Law Transferred Investigation Responsibilities. Foster family agencies (FFAs) are nonprofit organizations that recruit foster parents, certify them for participation in the program, and provide training and support services. Originally, FFAs investigated complaints associated with their own certified foster family homes. However, Chapter 311, Statutes of 1998 (SB 933, Thompson), transferred the investigation of these complaints from the FFAs to CCLD. This transfer was effective July 1999. To meet this workload, the Legislature approved 42 positions—13.5 permanent and 28.5 limited term. (In 2000, 3.5 support staff positions were eliminated, leaving 25 limited-term positions.)

Governor's Proposal. The budget proposes 19 new CCLD positions and the conversion of the 25 two-year limited term CCLD positions, noted above, to permanent status. To calculate the budget-year FFA complaint workload, the budget uses the number of FFA homes as a proxy for the number of complaints. While the number of FFA homes was a reasonable approach to estimate an unknown workload several years ago, actual

caseload data is now available and we believe this is a better predictor of workload in this area.

Licensing Workload Overestimated. For our analysis, we used 2000-01 complaint data and CCLD's complaint investigation workload standard—16 hours per complaint—to determine recommended staffing. Using these data, we estimate five fewer licensing program analysts (LPAs) will be needed in 2002-03. Because support staff are budgeted according to the number of LPAs, the support staff should be reduced correspondingly by two and the supervisory staff reduced by one. Finally, we recommend a technical correction—denying three other support staff positions—as these exceed CCL statutory staffing and workload standards. Accordingly, we recommend the denial of 11 total positions (five LPAs; three office assistants; two office technicians; and one licensing program supervisor) for a $425,000 General Fund savings.

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 (FFH), (2) a foster family agency (FFA) home, or (3) a group home.

The *2002-03 Governor's Budget* proposes expenditures totaling $1.5 billion from all funds for foster care payments. The budget proposes $426 million from the General Fund for 2002-03, which is an increase of $9.8 million, or 2.3 percent, compared to 2001-02. The caseload in 2002-03 is estimated to be approximately 70,800, a decrease of 6 percent compared to the current year. Most of this decrease is due to child exits from foster care to the Kinship Guardianship Assistance Program, which is part of the California Work Opportunity and Responsibility to Kids program.

SUPPORTIVE TRANSITIONAL EMANCIPATION PROGRAM IS OVERBUDGETED

We recommend reducing General Fund support for the Supportive Transitional Emancipation Program by $4.6 million in 2002-03 to account for (1) implementation delays and (2) a reduced caseload. The program is overbudgeted in the current year by $1.1 million for the same reasons. (Reduce Item 5180-101-0001 by $4.6 million.)

Background. Chapter 125, Statutes of 2001 (AB 427, Hertzberg) created the Supportive Transitional Emancipation Program (STEP), which provides cash assistance—approximately $600 monthly—to eligible former foster youth. The purpose of this program is to provide former foster youth with cash assistance for a limited period of time while they

transition from foster care to independent living. To be eligible, former foster youth must (1) have been in either the Foster Care or Kin-GAP Program on their 18th birthday, (2) have been placed in foster care by a county that is participating in STEP, (3) be under 21 years of age, and (4) be following a county-approved independent living plan.

Chapter 125 became operative in January 2002. The budget proposes $3.7 million ($1.5 million General Fund) to support STEP in 2001-02 and $33.5 million ($13.4 million General Fund) in the budget year. Costs are shared by the state and counties 40 percent and 60 percent, respectively. County participation is voluntary. The proposed funding would provide cash assistance to an average of 1,000 youth per month in the current year and 4,700 youth per month in 2002-03.

Flawed Budgeting Assumptions. The budget proposal overestimates the amount needed to fully fund STEP because of three flawed assumptions that all tend to overestimate costs. Specifically, the assumptions are: (1) timely implementation by DSS and the counties, (2) participation by all 58 counties, and (3) participation by all emancipated foster youth.

State and County Implementation Delayed. In order for STEP payments to reach eligible youth, both DSS and the counties need to be fiscally and programmatically prepared to implement the program. Thus far, DSS has failed to meet key deadlines for a January 2002 start date. For example, neither written statewide guidance nor county fiscal claiming directions have been provided. We note that even after such key steps are completed by DSS, counties may need up to several months to implement changes to local policies and practices. Finally, due to the current economic environment and the significant county share of cost in STEP, counties have expressed concerns over the potential cost of STEP. At the time this analysis was prepared, only eight of the 58 counties had expressed a firm commitment to current-year participation in STEP.

Budget Assumes Universal Youth Participation. The budget assumes that all 58 counties will agree to implement STEP and that all eligible emancipated foster youth will choose to participate in the program, even though participation is voluntary. In our view, this assumption is unrealistic. We believe that some former foster youth will choose not to participate, perhaps on the basis that they are receiving adequate financial support from employment or other sources of public assistance. Other emancipated youth may choose not to participate because they dislike government programs or may object to the requirements of the independent living plan.

LAO Estimate of STEP Budget. We have developed an estimate of STEP costs taking into account (1) the delayed state and county implementation, (2) the degree to which fiscal concerns will prevent certain counties from participating, and (3) the degree of voluntary participation

by youth. Our estimate assumes (1) a three-month delay in implementation and (2) that ultimately, only 70 percent of eligible youth would participate in 2002-03. Under our assumptions, the savings would be $1.1 million from the General Fund in 2001-02 and $4.6 million General Fund in 2002-03, relative to the Governor's budget. This assumes that cash assistance would be paid to an average of approximately 300 youth per month in the current year and 3,100 youth per month in 2002-03. Even our estimate may overstate program costs because the Governor's budget may overestimate the universe of eligible foster youth. Specifically, data from Los Angeles County suggest that the newly eligible 18 year-old population may be significantly smaller than assumed in the Governor's budget. Nevertheless, at this time we would recommend that General Fund support for this program be reduced by $1.1 million in the current year and $4.6 million in the budget year.

EXAMINING THE ROLE OF FOSTER FAMILY AGENCIES

Based on our review of the Foster Family Agency (FFA) program, we conclude that (1) children stay longer in FFAs than in foster family homes (FFHs); (2) neither child nor family background differences explain the longer FFA stay; and (3) youth in FFHs are reunified with biological families and adopted at a much higher rate than FFA youth. Accordingly, we provide three options for limiting the number of FFA placements: (1) hold funding to current-year levels; (2) decrease FFA treatment placements by 20 percent; and (3) reduce FFA rates over time.

Background

Following the investigation of child abuse or neglect, county welfare departments make decisions regarding the health and safety of children and have the discretion to 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. The FFHs must be located in the residence of the foster parent(s), provide services to no more than six children, and be licensed by DSS. The FFAs are nonprofit organizations that recruit foster parents, certify them for participation in the program, and provide them with training and support services. Group homes may vary from small, family-like homes to larger institutional facilities and generally serve children with greater emotional or behavioral problems who require a more restrictive environment.

In theory, the respective foster care rates were designed to reflect the needs of children. These rates are: (1) FFH—$425 to $597 monthly plus "specialized care increments" for children needing special support services; (2) FFA—$1,589 to $1,844 monthly; and (3) group home—$1,454 to

$6,371 monthly. Figure 1 compares FFH and FFA rates, including the approximately $1,000 additional per child paid monthly to FFAs for services and administration.

Figure 1

Comparison of Foster Family Home and Foster Family Agency Rates

Age of Child	FFH Rate[a]	Foster Family Agency Rate			Difference From FFH Home Rate
		Paid to Family	Treatment and Administration	Total	
0 to 4	$425	$624	$965	$1,589	$1,164
5 to 8	462	660	988	1,648	1,186
9 to 11	494	689	1,008	1,697	1,203
12 to 14	546	743	1,044	1,787	1,241
15 to 18	597	790	1,075	1,865	1,268

[a] Does not reflect specialized care increments paid to families where the child needs special support services. The amount paid varies within and between counties.

History of Foster Family Agencies

Why Were Foster Family Agencies Created? In the mid-1980s, the Legislature became concerned about (1) the increased use of group homes; (2) the associated cost increases in the foster care program; and (3) county difficulties recruiting and retaining foster parents. The FFAs were created to address some of these concerns. The FFAs were intended to: (1) provide an alternative placement in a family setting to the more expensive group homes; (2) increase the availability of foster care placement resources; and (3) provide an enhanced level of service to foster children and families.

Rapid Growth of Foster Family Agencies. Since the creation of FFAs as an alternative placement: (1) the number of children placed in FFAs increased almost twentyfold between 1988 and 2000—from 2 percent to 36 percent of first time foster care placements; (2) the proportion of first time FFH placements declined significantly during the same time period, from 87percent to 55 percent of first time placements; and (3) the proportion of children placed in group homes remained relatively stable. We note that these trends are statewide and, therefore, vary among counties.

While the total statewide foster care caseload has declined in the past two years, FFA placements have continued to increase. According to counties, the growth in FFA placements is due to a shortage of nonrelative FFHs, not increased needs of the youth being served. In addition, the longer FFA length of stay, discussed below, has also contributed to the continued growth of FFA placements.

Foster Care Length of Stay

Youth Stay Longer in FFA Homes. For several years, FFAs have been the focus of concern regarding children's length of stay in foster care. This is because the longer a child is in foster care, the less likely it is that he or she will be reunited with his or her family of origin, placed permanently with relative caregivers, or adopted. In a report submitted to the Legislature by DSS in 1997, the department concluded that FFAs were "holding onto the children much longer than an average foster family home placement and there is a resulting loss of time for a child to be permanently placed, if at all." In our *Analysis of the 2001-02 Budget Bill*, we examined foster care length of stay and concluded that children stay in FFAs twice as long as children in nonrelative FFHs. The median length of stay for children in FFAs was two years, while the median length of stay for children in FFHs was one year.

In response to our earlier analyses, advocates and providers have suggested that county social work practices may contribute to the longer FFA length of stay. They argue that because FFA children have their "own" social workers (associated with the FFA), these children may receive less attention from county social workers. Less contact with a county social worker could result in a longer stay in foster care, as the county social worker's assessment is a key factor in returning a child to his or her home or placing the child for adoption. When we asked county child welfare administrators about this, they indicated that while this phenomenon may sometimes occur, it was not widespread. Therefore, while we believe county social work practice could influence FFA length of stay, we do not believe that it explains a significant portion of the variation between the time in foster care for FFH and FFA children.

Extended Length of FFA Stay Persists in New Analysis. This year, we analyzed data that include only children who were in foster care 30 days or longer, thereby excluding children who were in an emergency placement. Although the length of stay for FFA children is still greater than for children in FFHs, the difference is not as great as in our earlier analysis. Those children for whom a FFA was their primary placement stayed in foster care almost two years, or 25 percent longer than youth in nonrelative FFHs, who were in care for just under a year and a half. As discussed

above, increased time in foster care is generally considered undesirable, as children are less likely to be reunified with their family of origin or adopted.

Do Child or Family Characteristics Explain Length of Stay Differences?

New Research Conducted. Recent research from the University of California (UC) at Davis examined similarities and differences between FFH and FFA children, families, and services. The study included (1) several hundred phone interviews with foster parents, adolescent foster youth, and local program staff; (2) focus groups with each of these cohorts; and (3) a case file review of several hundred foster youth. Generally, the research findings indicate that the children in each placement type are similar to one another. Below, we discuss several findings of the new research.

Foster Youth Similar With Respect to Mental Health Needs. Longer stays in FFA homes might be justified if research indicated that the children in FFAs need more services before returning home or being adopted than do children in FFHs. The UC Davis study examined whether the children in the two placement types differed with respect to "special needs"—including psychological, physical, medical, and other problems. Notably, the two groups of foster children were actually quite similar with respect to foster parent reporting of psychological and abuse-related problems. This finding supports earlier findings that the special needs of children do not explain the increase in the number of FFA placements or the extended FFA length of stay.

FFH Youth Face Greater Physical and Medical Challenges. While the groups of children were similar in terms of mental health needs, they did differ in two other special needs areas. The UC Davis research suggests that FFH children face greater medical and physical challenges than their FFA counterparts. According to the reports of several hundred foster parents surveyed, the FFH children had more medical and physical problems than FFA children did. Medical problems included asthma, drug exposure, and HIV. Physical problems included motor, vision, and hearing disabilities. These findings, paired with the lack of differentiation in mental health needs, run contrary to the notion that children in FFAs face greater challenges. This research indicates, instead, that FFH children may actually have more special needs, at least in terms of physical and medical issues, than FFA children.

Parental Backgrounds Suggest That FFA Children Should Return Home at a Higher Rate. Child reunification with the biological family is one of the preferred permanency outcomes for children in foster care.

Longer stays in foster care might be justified if research indicated that the biological families of children in FFAs face more challenges that result in delayed reunification. However, research indicates that the opposite is true.

The UC Davis research shows that children in the FFA homes have more stable family backgrounds—suggesting a *greater* likelihood of reunification—than children in FFHs. For example, the biological parent(s) of FFA children were almost *twice* as likely to (1) have housing and employment and (2) be "law-abiding." Sibling bonding was also stronger for youth in FFA placements. Finally, biological parents of children in FFA placements visited their children in foster care more often than the parents of FFH children.

Children in FFHs Achieve More Stability in Living Situations. The UC Davis researchers surveyed foster parents about outcomes such as reunification, adoption, guardianship, or subsequent foster placement for the two groups of children. The study indicated that FFH children achieve more stability in their living arrangements, regardless of whether they return home or remain in foster care to be adopted later by foster parents.

First, FFH children were more likely to reunify with their families, while FFA children were more likely to move to another foster placement. Second, for those FFH children who were not reunified with their families, their foster parents were approximately twice as likely to pursue adoption than FFA foster parents. Finally, of those foster parents who pursued adoption or guardianship, FFH parents were twice as successful in finalizing adoption or guardianship than the FFA parents.

Conclusion

Based on our review of research and data on FFA placements, we conclude (1) children stay longer in FFAs than FFHs; (2) neither child nor biological family differences explain the longer stays; and (3) youth in FFHs have more positive permanency outcomes than their FFA counterparts. Finally, we would note that while the outcomes for children in FAAs are less positive than for children in FFHs, the costs for FFA placements are more than twice that of FFH placements. Accordingly, we believe that limiting the use of FFA placements could both improve foster youth permanence and result in savings. Below, we outline three options for the Legislature to consider for the budget year.

Earlier, we acknowledged the possible role that FFA and county social work practices may play in prolonging children's length of time in FFAs. According to the UC Davis research, there is little standardization across the state in FFA and county cooperation regarding case planning. Therefore, unclear responsibilities or poor communication between county

and FFA social workers may result in children remaining in foster care longer than is necessary. In addition to considering the options listed below, we suggest the Legislature clarify the roles and responsibilities of the respective county and FFA partners in expediting children's movement toward more permanent living situations.

Options for Reducing FFA Placements and Costs

While we conclude that there are significant problems associated with the use of FFA placements, such as extended length of stay, decreased permanency for children, and increased costs, we believe that FFAs do meet a need in California's continuum of foster care placements. In other words, FFAs provide an enhanced level of service relative to FFH placements and FFAs provide a less expensive placement option than more expensive group homes. However, we conclude that FFAs are relied on too heavily for children who do not require this enhanced level of service. Below, we present three options for reducing FFA placements and costs.

Hold Funding to Current-Year Levels. The first option for the Legislature to consider would be to limit the growth of FFA placements by holding funding to current-year levels. Halting projected year-over growth in FFA placements in this manner would result in an estimated $1.1 million in General Fund savings in the budget year.

Decrease the Number of FFA "Treatment" Placements. Alternatively, the Legislature could reduce the statewide number of funded FFA "treatment" placements from the Governor's budget. The FFA treatment placements are those for which approximately $1,000 per month per child is paid to the *agency* for treatment and administration. As several studies (including the most recent by UC Davis) indicate, many children placed in FFAs may not need these enhanced services. Therefore, we suggest the use of "nontreatment" rates, which currently allow foster families to receive the same monthly grant to care for the child, but would eliminate the monthly per child rate paid to the FFA.

For example, if legislation were enacted to require each FFA to reduce its treatment placements by 20 percent statewide by January of 2003, approximately 3,000 fewer of these placements would be funded. This reduction, midway through the budget year, would result in savings of approximately $4 million General Fund. In 2003-04, these savings would grow to approximately $8 million General Fund, relative to the 2002-03 Governor's budget.

Adjust FFA Treatment Rates. A final option, which we discussed in our *Analysis of the 2001-02 Budget Act*, is to adjust the FFA rates over time to encourage the movement of children toward reunification or adop-

tion. While the rate paid to the FFA foster *family* would remain the same over time, the portion of the rate paid to the FFA *organization* for services and administration would decrease the longer a child remained in care. For example, the monthly services and administration component per child could be reduced by one-quarter (between approximately $240 and $270), incrementally, after each six-month period.

Figure 2 shows an example of this incremental reduction in the treatment rate. Under this example, treatment and administrative costs would be funded at the full rate for the first six months a child is in placement. The funding would continue, at a reduced rate, for up to two years while a child remains in care. A similar step down of the treatment and administration component would be applied to all of the age-adjusted rates. (We note that many of the youth in FFAs are either reunified with their family of origin or adopted before two years has passed.)

Figure 2

Example of Incremental Foster Family Agency Rate Reduction

Child 5 to 8 Years of Age

Time in Placement	Foster Family Agency Rate		
	Paid to Family	Treatment and Administration	Total
0-6 months	$660	$988	$1,648
7-12 months	660	741	1,401
13-18 months	660	494	1,154
19-24 months	660	247	907
Over 24 months	660	—	660

This tapering of the treatment and administration component of the rates could create an incentive system by encouraging FFAs to move children toward reunification or adoption more quickly. However, a decrease in rates could reduce the number of participating FFAs. This option would result in approximately $5 million General Fund savings in 2002-03. We note that savings would increase to at least $15 million General Fund in 2003-04.

Analyst's Recommendation

Above, we outlined three options to address concerns related to FFA length of stay, child outcomes, and costs. These options are: (1) holding

finding to current-year levels; (2) decreasing the statewide number of FFA treatment placements; and (3) adjusting the treatment rates over time. While each of these options has merit, we believe that adjusting the FFA treatment rates over time may be the best option. This option should correct fiscal incentives, encourage the movement of children toward permanency, and control costs, while providing enhanced services to children and families for up to two years.

ASSESSING CALIFORNIA'S FOSTER CARE PROGRAM PERFORMANCE

New federal performance reviews of state child welfare services and foster care programs will be conducted in California for the first time in the fall of 2002. These reviews will rely, in part, on quantitative measures of state performance. Preliminary analysis indicates that California may fail to meet national standards on a number of these measures. Such failure could result in the loss of federal funding. We (1) describe the new federal review process; (2) examine California's performance on selected measures; and (3) make recommendations to improve California's performance.

Federal Government Shifts to New Review System

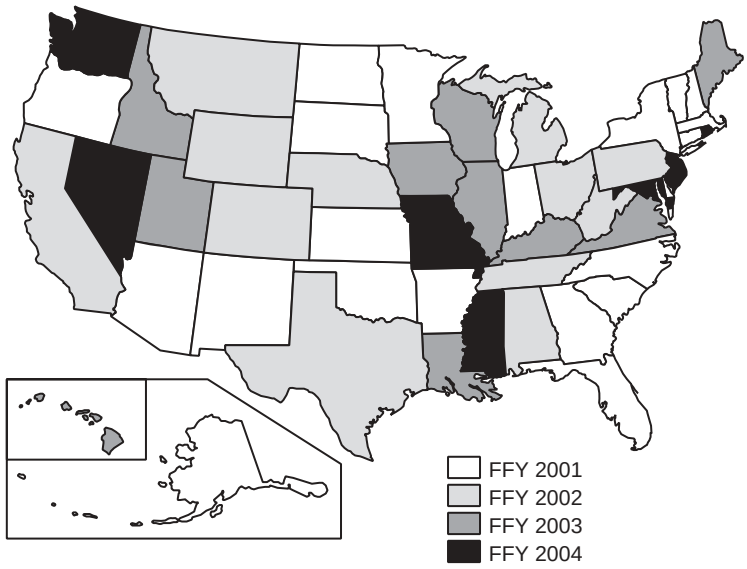
The federal Adoption and Safe Families Act (AFSA) of 1997 made the most sweeping changes to state child welfare services (CWS) and foster care programs since 1980. The principles of AFSA were to achieve child safety, permanency, and well-being. One significant requirement was that the federal Department of Health and Human Services develop a set of outcome measures and overhaul state performance review processes in the CWS and foster care programs.

The new Child and Family Service Reviews, resulting from AFSA directives, are a departure from prior federal evaluations of states in several ways. These changes include: (1) a focus on outcomes for children and families; (2) the use of multiple quantitative and qualitative measures to evaluate outcomes and performance; and (3) joint federal and state review teams. The federal Child and Family Service Reviews began in 2001. Figure 3 shows the schedule of state Child and Family Service Reviews over the next several years.

Of the 15 states reviewed in 2001, all have had to submit a performance improvement plan, indicating that none have "passed" all components evaluated during the reviews. California's review is scheduled for the fall of 2002.

Figure 3

Schedule of Federal Child and Family Service Reviews



Components of the Reviews

The federal review process has three major components: (1) the statewide data assessment, (2) county case file reviews, and (3) county interviews on seven "systemic" factors.

Statewide Assessment. For the statewide assessment, the federal government provides analysis of state data to indicate whether federal standards have been met. Each state then responds to the data review in narrative form to interpret federal findings on these quantitative measures.

County Case File Reviews. For the on-site component of the review, a team composed of federal and state representatives will review about 50 case files in each of three California counties to determine whether child safety, permanency, and well-being goals are being met. Los Angeles County will be reviewed in addition to two other counties. The two additional counties will be notified several months in advance of the on-site review.

County Interviews on Seven Factors. In addition to the initial case reviews, the review team will also interview children, staff, providers, and other stakeholders to examine seven systemic factors that impact the quality of services provided to children and families. These factors are the (1) statewide automation system; (2) array of services available; (3) case

review system; (4) staff training; (5) quality assurance system; (6) agency responsiveness to the community; and (7) foster and adoptive parent recruitment, licensure, and retention.

How Performance Is Measured On the Statewide Assessment

In General, What Are Outcomes and Their Indicators? Outcomes and their indicators aid in measuring program performance by providing a comparison of program results consistently and over time. In the context of child welfare, *outcomes* are a condition of children expressed as a *goal*. For example, "children are safe;" "children are living in stable living situations;" and "children are succeeding in school" are outcomes. An *outcome measure*, or *indicator* helps quantify the degree to which a desired outcome has been reached. An indicator is expressed using data that measure a specific condition.

Consider, for example, the outcome "children are safe." One indicator is the number of substantiated child abuse or neglect referrals per 1,000 children in a particular community, county, or state. Local variation in this measure could indicate underlying variation in local policies or demographics, or changes in family factors associated with child abuse / neglect, such as substance abuse or poverty.

What Are the New Federal Outcomes and Their Indicators? The goals (articulated in the Adoption and Safe Families Act) of child safety, permanency, and well-being provided the framework for the development of the federal outcome measures to be used in the Child and Family Service Reviews. The goal of *safety* is defined as the protection of children from abuse or neglect in their own homes or foster care. The goal of *permanency* is defined as children having stable and consistent living situations (such as living with their families of origin, adoptive families, or legal guardians). The goal of *well-being* is defined as children receiving education and physical and mental health services adequate to meet their needs.

The federal government identified six outcome measures ("indicators") in order to determine the extent to which states are meeting the goals of AFSA. Figure 4 shows the six outcome measures to be used in the Child and Family Service Reviews. The figure also identifies the related national standards which a state must meet in order to pass. These standards, shown in Figure 4, were set by the federal government based on the performance of the top 25 percent of the 50 states during federal fiscal year 1998.

These federal measures reflect several key aspects of child safety and permanency by providing information on the recurrence of child abuse and / or neglect; the rate of reunification and adoption; and placement

Figure 4

Federal Child and Family Service Reviews

Outcomes and Their Indicators	Federal Standard[a]
✓ **Reduce the Recurrence of Child Abuse and/or Neglect at Home**	
• The percentage of children who were reabused/neglected within six months of a prior incident.	6.1% or less
✓ **Reduce the Incidence of Child Abuse and/or Neglect in Foster Care**	
• The percentage of foster children who were abused while in foster care.	1% or less
✓ **Reduce the Time to Reunification Without Increasing Reentry To Foster Care**	
• The percentage of foster children who were reunited with their families within one year of entering foster care.	76.2% or more
• The percentage of foster children who entered foster care more than once in a 12-month period.	8.6% or less
✓ **Increase Placement Stability**	
• The percentage of children who had two or fewer foster care placements in one year.	86.7% or more
✓ **Reduce the Time in Foster Care Prior to Adoption**	
• Of foster children adopted, the percentage who were adopted in less than two years.	32% or more

[a] Based on national federal fiscal year 1998 data.

stability. For California's first review in 2002, federal fiscal year 2000 data will be used to judge performance on the six indicators. We note that these six indicators do not address the outcome of child well-being, which will be measured using qualitative measures elsewhere in the federal reviews.

Because the 2000 data are not yet available, we cannot predict performance. However, historic trends indicate that California's performance are not likely to vary widely from the 1998 data we present later.

What if California Doesn't Meet Federal Review Standards?

If California fails to meet the national standards on the six indicators (discussed above) or the seven systemic factors, it could face fiscal penalties in future years. These penalties would be levied as a percentage of

federal CWS (IV-B) funds and a portion of foster care (IV-E) administrative funds. For each of the six indicators and each of the seven additional systemic factors that California fails to meet, the state could initially lose 1 percent per year of this federal funding.

According to DSS, the penalties in the first year could range from approximately $400,000 to over $5 million, depending on the number of indicators and systemic factors the state fails to meet. The penalty would increase to 2 percent per measure per year following failure during a second review and 3 percent per measure per year following failure of a third review.

In order to avoid penalties, states have the opportunity to design a "performance improvement plan" (PIP) which outlines how the state intends to reach national standards on the measures it failed. If the state and federal governments agree on the PIP, penalties are suspended until the next scheduled review, which would follow two years later.

How Would the State Fare Under Selected Measures?

Below, we examine California's performance, relative to other large states, on five of the six federal indicators that will be used in the upcoming federal review. Data for the final measure, the frequency of abuse or neglect that occurs in foster care, are not currently available for many states, including California. Therefore, we do not discuss this measure. The data used for the five measures discussed are generally drawn from the federal fiscal year 1998, because that is what has been published by the federal Department of Health and Human Services. As noted earlier, for California's first review in 2002, federal fiscal year 2000 data will be used to judge performance on the six indicators. Thus, given the two-year difference, California's performance could be different than the 1998 data we present below.

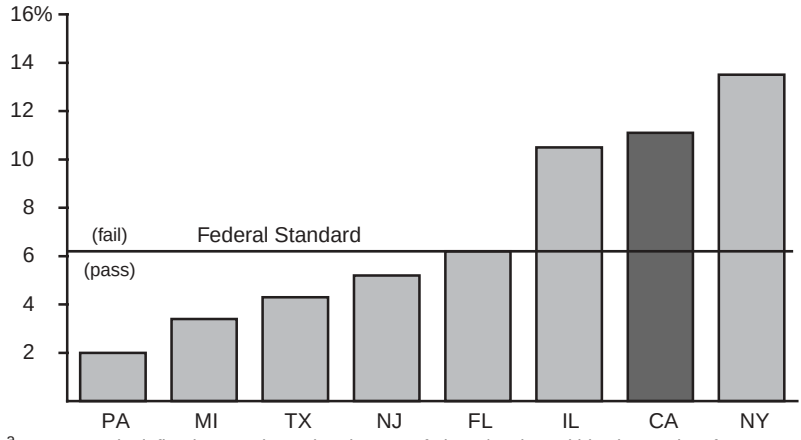
Child Abuse/Neglect Recidivism High in California. One measure of performance of the CWS and Foster Care Programs is the extent to which children served by the programs later return to these programs. Two of the federal measures are intended to capture this aspect of child safety. The first, the maltreatment recurrence indicator, measures the percent of children who have been reabused / neglected within six months of an earlier abuse / neglect incident. Included in this measure are children who were reabused after returning home from foster care and children who remained in their home following substantiation of earlier abuse / neglect. The second, the foster care reentry indicator, measures the percent of children who enter foster care more than once within a 12 month period.

For each measure, a lower percentage is more desirable. The national standard for the maltreatment recurrence indicator is 6 percent. The na-

tional standard on the foster care reentry indicator is almost 9 percent. Figures 5 and 6 (see next page) show large states' performance on these two measures.

Figure 5

California Fails Federal Maltreatment Recurrence[a] Indicator



[a]Recurrence is defined as a substantiated report of abuse/neglect within six months of a prior substantiation.

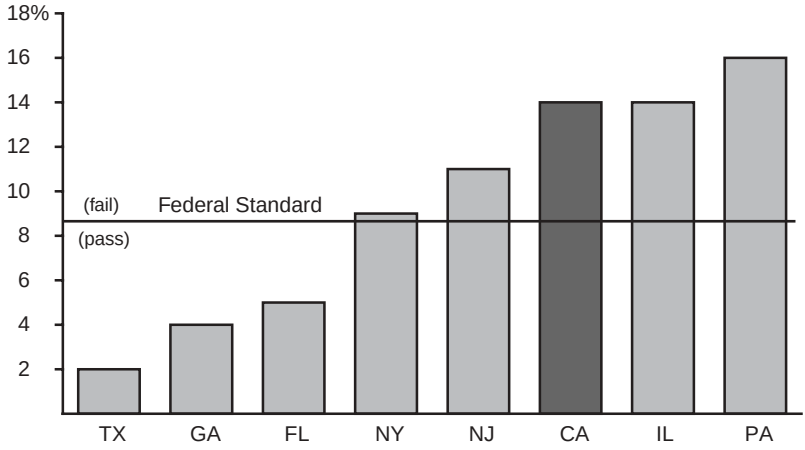
As regards the reoccurrence of abuse, California fails the national standard with 11 percent of children having a second substantiated abuse/neglect report within six months. New York and Illinois also exceed the federal standard among large states. As regards reentry into foster care, California also exceeds the federal standard, with 14 percent of children reentering foster care within 12 months of a prior entry.

California Fails Federal Standard on Timely Child Reunification. Federal and state policies generally view foster care as a temporary, rather than a long-term, solution when children are removed from an abusive or neglectful home. Generally, the goal is to reunify the child and family as soon as is reasonably possible. This indicator measures, of those foster care children who were reuniting with their family of origin, the proportion who did so within 12 months of entering the foster care system. A higher percentage indicates more satisfactory performance than a lower percentage on this measure. The national standard for this measure is 76 percent. Figure 7 (see next page) shows large states' performance on the child reunification indicator.

Figure 6

California Fails Federal Foster Care Child Reentry[a] Indicator

Percent of Children Reentering Foster Care
1998

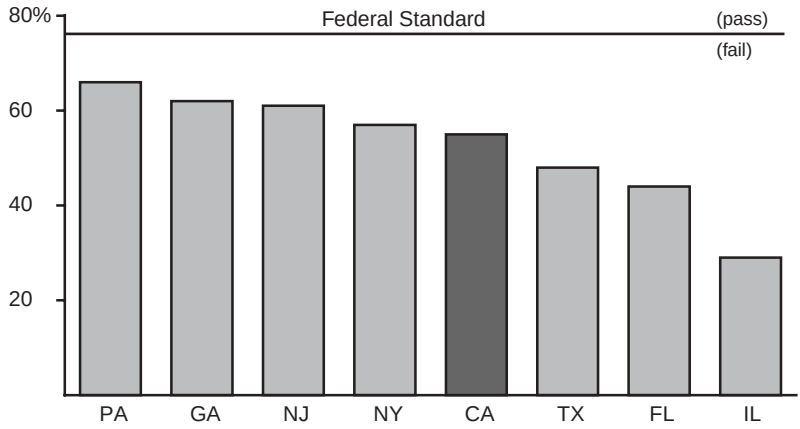


[a]Percent of children reentering foster care within 12 months of a prior entry.

Figure 7

Large States Lag Nation on Federal Timely Child Reunification[a] Indicator

Percent Reunified Within One Year
1998



[a]Less than 12 months from child in foster care to reunification with family of origin.

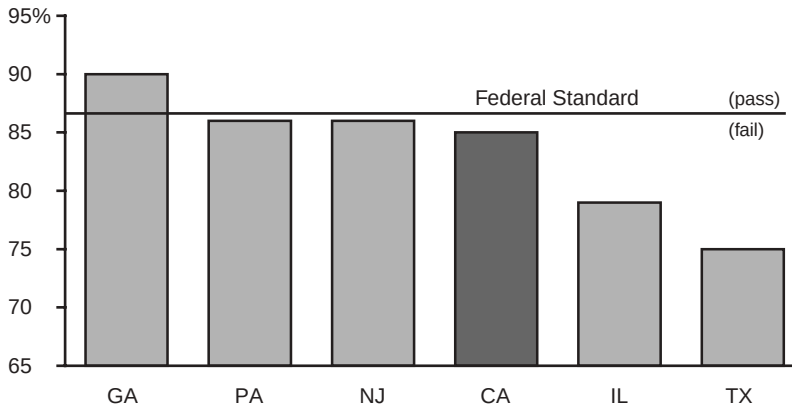
All the states shown in Figure 7 failed to meet the national standard. In California, only 55 percent of children who exited foster care to reunite with their families did so within 12 months of entering foster care. This performance places the state about 20 percentage points below the national standard for this measure. California ranks fifth among the eight states for which data were available.

California Provides Placement Stability for Most Foster Children. The next measure is the child placement stability indicator, which measures whether children have stable living arrangements. This indicator measures what proportion of children remained in either one or two foster care placements during the 12 months under review. A higher percentage indicates more satisfactory performance than a lower percentage on this measure. The national standard for this measure is about 87 percent. Figure 8 shows large states' performance on this measure.

Figure 8

California Approaches Satisfactory Child Placement Stability[a]

Percent of Children With Two or Fewer Placements
1998



[a]Placement stability is defined as two or fewer foster care placements within 12 months.

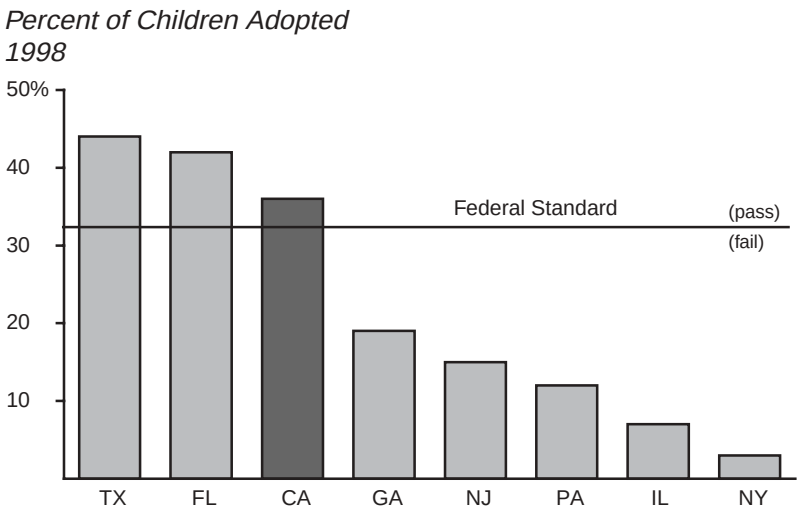
Georgia, with 90 percent of foster youth having two or fewer placements in 12 months, is the only state in the figure that surpasses the national standard, although Pennsylvania and New Jersey are each only one percentage point from the standard. California, too, is close to the

standard, with 85 percent of foster youth having two or fewer placements during the time period.

California Moves Children to Adoption in a Timely Manner. Another federal measure related to the permanency outcome is that children are adopted in a timely manner. A higher adoption percentage indicates more satisfactory performance than a lower percentage on this measure. The national standard for the adoption indicator is that 32 percent of children who are available for adoption are adopted within 24 months of placement in foster care. Figure 9 shows California's performance on the federal adoption indicator relative to other large states and the national standard. The graph shows that California, along with Texas and Florida, meets the national standard. This is the only federal measure, of the five we examine in this review, for which California meets or exceeds the national standard.

Figure 9

California Exceeds Federal Standard For Timely Adoptions[a]



[a]Percent of children adopted within 24 months of placement in foster care.

California Struggles With Federal Performance Measures

Of the five quantitative measures we examined above, California met or exceeded federal standards on only one measure. Although the 2002 reviews will rely on more recent state data, we have no basis upon which

to expect that California's performance will vary widely from the measures reported here.

On the timely adoption measure (Figure 9), California exceeded the federal standard. In addition, the state has received national recognition for the number of adoptions finalized in recent years. These results are impressive, but not surprising, since the state has funded both one-time and ongoing initiatives to increase the number and timeliness of adoptions. In addition, a number of laws have been enacted that encourage adoption as an alternative to foster care.

On other measures, however, state performance is lackluster at best. For example, the state fails to return an adequate number of children home within 12 months of their entering foster care (Figure 7), which means children may remain in foster care longer than is necessary. When children return home from foster care, child reabuse / neglect (Figure 5) occurs far more than is acceptable under federal standards, resulting in high rates of foster care reentry (Figure 6).

How Can the Legislature Aid in Improving Program Performance?

California faces significant challenges in attempting to improve the CWS and Foster Care Programs. There are potentially a number of strategies that can be employed to improve the state's performance. No single approach by itself is likely to result in significant improvement. At this time, we have identified several areas that may benefit from legislative focus: (1) state oversight of county programs; (2) decision making on child safety; (3) the role of early childhood interventions; and (4) replication of effective programs.

Capitalize on Improved State Oversight of County Programs. In the past, state reform efforts may have been limited in part by a lack of useful information about the progress of children and families through the CWS and Foster Care Programs. The federal Child and Family Service Reviews should provide new and useful *statewide* information to the Legislature and administration. However, because the on-site portion of the reviews will occur in only three counties, the reviews may fail to identify programmatic variation across the rest of the state.

Recently, Chapter 678, Statutes of 2001 (AB 636, Steinberg) was signed into law. This law, also known as the Child Welfare System Improvement and Accountability Act of 2001, requires DSS to (1) overhaul the county review process; (2) use the federal measures, discussed above, to measure individual county performance; and (3) choose additional measures to evaluate county performance. Ideally, the information that results from the Chapter 678 review process will provide new opportunities for legis-

lative oversight. As these reviews are being designed, the Legislature should consider what kinds of information would be most useful to future initiatives and ensure that this information is included. As the reviews are implemented, the Legislature should monitor the review process to ensure that information needs are being met in a timely manner.

Improve Decision Making. Another way for California to improve its CWS and foster care program performance is to improve decision making regarding child safety. Many decisions, from whether to investigate child abuse / neglect to whether a child is a likely candidate for adoption, all influence California's performance on the federal measures examined above.

In our *Analysis of the 2001-02 Budget Bill* (please see page C-223), we examined Structured Decision Making (SDM), one approach to risk assessment that improves the consistency and accuracy of child welfare decisions. The SDM approach is a series of tools that help workers determine: (1) when to investigate abuse / maltreatment decisions; (2) the degree of child safety at the time of an investigation; (3) the risk of future child maltreatment; (4) the targeted services to be provided to families at the highest risk of reabuse; and (5) whether to remove a child to foster care.

Evaluations from other states such as Michigan and Wisconsin have concluded that SDM has significant value in predicting the likelihood of future abuse or neglect and that it improves child welfare outcomes. Currently, about one-quarter of California counties—including some large counties—use some or all of the SDM tools. Expanding SDM to all counties, including a significant number that remain on a waiting list, could improve the statewide accuracy and consistency of decision making. Such improvements could increase child safety; permanency; and well-being, as well as provide resources to those children and families most in need of services.

Strengthen the Role of Targeted Early Intervention Programs. Increasing the role of effective early childhood program interventions is another area that may improve CWS performance, by decreasing or preventing child abuse / neglect. There is evidence that targeted early childhood intervention programs may be effective in preventing or decreasing child abuse. For example, targeted home visiting programs like the Elmira, New York Prenatal / Early Infancy Project have shown positive results. Under this program, nurses trained in parent education made 32 home visits over a three-year period to new mothers. The nurses provided the mothers with information on available support and services. Studies of the program indicated that it resulted in a variety of short-term and long-term health and social benefits, including fewer reports of child abuse and neglect. The program was particularly effective for high-risk families (single mothers with low socioeconomic status). When targeted to high-risk families, research concluded that the home visiting program

resulted in $18,500 in net savings to government per family. (For further discussion of such cost-effective programs, please see our report, *Proposition 10: How Does it Work? What Role Should the Legislature Play in Its Implementation?*, January 1999.)

We note that current funding streams, particularly those from the federal government, may encourage the placement of children in foster care, rather than encourage the use of effective early childhood programs. One fiscal resource that California has for funding early childhood intervention programs is the California Children and Families Program. Through this program, revenue generated by a per package surtax on cigarettes, pursuant to Proposition 10, will provide counties with over $650 million in 2002-03 to support local programs serving children through the age of five. This represents a source of potential funding for early childhood intervention programs.

Given the availability of these funds, the Legislature could consider establishing a state-funded voluntary matching program, which would fund (1) early childhood programs that have been shown to be cost-effective and/or (2) demonstration programs that are potentially cost-effective, based on existing research. (For further detail on a legislative matching program, please see our *2000-01 Analysis of the Budget Bill*, page C-54.)

Facilitate Identification and Furtherance of Effective Programs. California's CWS and Foster Care Programs are administered by 58 counties. This results in a wide variety of programmatic approaches and makes it difficult to judge which programs are most effective. We believe that DSS could improve CWS and foster care program performance by facilitating expansion of effective programs once they are identified. The DSS could accomplish this by increasing information sharing, and validating county "best practices."

For example, several California counties are currently using the Family Group Decision Making (FGDM) model as an approach to reducing child abuse and neglect. In the child welfare context, FGDM offers children, families, and child welfare workers an opportunity to make decisions and develop plans together that are intended to protect children from future abuse and neglect. This model, in contrast to other more adversarial approaches, recognizes that families have the most information about resources at their disposal and how child safety can be made a priority—thereby preventing further child abuse or neglect.

The Santa Clara County FGDM program has been studied by an independent evaluator for over three years and early findings indicate favorable outcomes: (1) a decrease in the number of children living in foster care; (2) an increase in the number of children living with kin; and (3) a decrease in the number of court proceedings. If these positive out-

comes are also found in the final report, which is due in the next few months, we believe DSS could provide all counties information on how to effectively implement FGDM.

The FGDM model is just one example of an innovative program that is currently used by some California counties and shows promising research results. We believe there are other strategies and practices that, if expanded, could improve statewide program performance. Such expansions could occur within the resources currently available to counties, especially if such programs result in offsetting savings elsewhere in the continuum of services available to children and families.

Conclusion

Our review indicates the need for improvement in California's CWS and Foster Care Programs. However, improving performance will not be an easy task. Given the competing demands for resources, it is important that available funding—whether new or existing—be used effectively. We believe that program performance can be improved by using better decision making tools (such as SDM); strengthening the targeted early intervention programs; and identifying and sharing "best practices" such as FGDM.

FOOD STAMPS PROGRAM

This program provides food stamps to low-income persons. With the exception of the state-only food assistance program (discussed below), the cost of the food stamp coupons is borne by the federal government ($1.6 billion). Administrative costs are shared between the federal government (50 percent), the state (35 percent), and the counties (15 percent).

California Food Assistance Program

Federal Restrictions on Benefits for Noncitizens. With respect to noncitizens, current federal law generally limits food stamp benefits to legal noncitizens who immigrated to the U.S. prior to August 1996, and are under the age of 18 or were at least 65 years old as of August 1996.

State Program for Noncitizens. In response to these federal restrictions, the California Food Assistance Program (CFAP) was created in 1997 to provide state-only funded food stamp benefits to (1) pre-August 1996 legal immigrants who are ineligible for federal benefits, and (2) a very limited number of post-August 1996 legal immigrants whose sponsors are dead, disabled, or abusive. In 1999 and again in 2000, CFAP eligibility was temporarily expanded to include all post-August 1996 legal immigrants who were otherwise eligible but for the fact they arrived after August 1996. Chapter 111, Statutes of 2001 (AB 429, Aroner), made this expansion permanent.

The CFAP purchases food stamp coupons from the federal government and distributes them to eligible recipients. Adult recipients are subject to a specified work requirement.

Assumed Federal Eligibility Restoration Creates Some Budget Risk

The Governor's budget assumes that federal food stamp eligibility will be restored for all otherwise eligible legal immigrants. This assumption represents a budget risk of up to $35 million General Fund. However, recent federal developments suggest that federal food stamp benefits will be restored for most legal immigrants, thus substantially mitigating the risk to the General Fund.

Budget Proposal. The budget assumes that federal food stamp eligibility will be restored for all otherwise eligible legal immigrants, effective July 1, 2002. Essentially, this means that legal immigrants who entered the country after August 1996 would be eligible for federally funded food stamp benefits. The budget therefore proposes no funding for CFAP in 2002-03.

We note that the Governor does not propose a statutory change to eliminate CFAP in the absence of such federal action. If federal eligibility were not restored for those immigrants currently eligible for CFAP, approximately 101,000 legal immigrants would receive CFAP benefits in 2002-03. This would represent a 2 percent increase over the estimated 2001-02 caseload. The projected state costs of the CFAP program in 2002-03 would be approximately $106 million absent federal action. This includes $80 million for the benefit coupons and $26 million for administrative costs.

General Fund Savings. Although CFAP costs absent federal action are estimated to be $106 million, the restoration of federal food stamp eligibility for the CFAP caseload would result in net General Fund savings of only $35 million. Net savings are less because of (1) the offsetting state costs of administering federal food stamp benefits for the newly-eligible caseload (approximately $10 million), and (2) the need to replace countable CFAP maintenance-of-effort (MOE) spending with California Work Opportunity and Responsibility to Kids (CalWORKs) MOE spending (discussed below).

As described in the "CalWORKs" section of this *Analysis*, California must meet a minimum spending requirement in order to receive the federal Temporary Aid for Needy Families block grant. Since the creation of CFAP in 1997, California has counted the portion of CFAP spending for families with children toward this MOE requirement. In 2002-03, absent restoration of federal eligibility, approximately $58 million of the projected CFAP costs would be counted in this way. In order to maintain MOE compliance, the Governor's budget increases General Fund spending in the CalWORKs program by the same $58 million. For technical reasons, additional county MOE spending of $3 million would be shifted to the General Fund as well. Together with the offsetting food stamp administrative costs, these shifts reduce total General Fund savings to only $35 million.

Pending Federal Action. There are two pending federal proposals to restore food stamp eligibility to legal immigrants. We note that both proposals are somewhat more narrow than the Governor's restoration assumption. Under the Bush administration proposal, benefits would be restored to all otherwise eligible legal immigrants *who have lived in the United States for at least five years*. At the time this analysis was prepared, this proposal was expected to be incorporated into the President's February budget proposal for federal fiscal year (FFY) 2003. The farm bill un-

der consideration by the U.S. Senate (S.1731) would also restore federal food stamp benefits, but for an even more narrow group of immigrants. Specifically, eligibility would be restored to immigrants who have worked in the country for at least four years and to recent immigrants who are under 18, blind, or disabled.

The Department of Social Services has estimated the net General Fund savings compared to current law associated with both proposals. Assuming the Bush administration's proposal becomes law effective October 1, 2002 (the start of the new FFY), the resulting net General Fund savings would be approximately $25 million in 2002-03 ($10 million below the savings assumed in the Governor's budget). Under the U.S. Senate's version of the farm bill, net savings would be approximately $14 million ($21 million below the savings assumed in the Governor's budget). This estimate also assumes that restoration would be effective October 1, 2002.

Budget Risk. As noted above, the Governor does not propose eliminating CFAP in the absence of federal action to restore eligibility. As a result, because federal proposals to restore benefits are still pending, the Governor's proposal represents a risk to the General Fund of up to $35 million (the net General Fund savings assumed in the Governor's budget). We will continue to monitor federal legislative actions and advise the Legislature accordingly.

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 $3 billion from the General Fund for the state's share of SSI/SSP in 2002-03. This is an increase of $228 million, or 8.1 percent, over estimated current-year expenditures. This increase is due primarily to the full-year cost of grant increases provided in the current year, caseload growth, and an increase in the federal administrative fee.

In November 2001, there were 336,478 aged, 21,780 blind, and 739,852 disabled SSI/SSP recipients. In addition to these federally eligible recipients, the state-only Cash Assistance Program for Immigrants is estimated to provide benefits to about 11,800 legal immigrants in November 2001.

Budget Proposes to Suspend State Cost-of-Living Adjustment

By proposing to suspend the statutory cost-of-living adjustment, the budget achieves General Fund savings of $127 million compared to current law.

Background. Under current law, both the federal and state grant payments for SSI/SSP recipients are adjusted for inflation each January. The cost-of-living adjustments (COLAs) are funded by both the federal and state governments. The state COLA is based on the California Necessities Index (CNI) and is applied to the combined SSI/SSP grant. The federal COLA (based on the Consumer Price Index for Urban Wage Earners and Clerical Workers, or the CPI-W) is applied annually to the SSI portion of the grant. The remaining amount needed to cover the state COLA is funded with state monies.

Budget Impact of Governor's Proposal. The Governor's budget estimates that the CPI-W will be 1.8 percent and that the CNI will be 3.9 percent. Based on these assumptions, providing the state COLA on January 1, 2003 would result in a six-month General Fund cost of $133 mil-

lion. Based on more recent actual data, however, the CNI will be 3.7 percent. Using the lower actual CNI, we estimate that suspending the state COLA in the budget year would result in a six-month savings of $127 million, a difference of approximately $6 million.

Impact on Recipients. Figure 1 shows SSI / SSP grants for January 2003 for individuals and couples under both current law and the Governor's proposal. Although the budget proposes suspension of the *state* COLA, the budget includes the "pass through" of the *federal* SSI portion of the COLA, resulting in maximum monthly grant increases above the current year of $9 per individual and $15 per couple.

Figure 1

SSI/SSP Maximum Monthly Grants
Current Law and Governor's Proposal
January 2002 and 2003

Recipient Category	January 2002	January 2003		Change from Current Law	
		Current Law	Governor's Budget	Amount	Percent
Individuals					
SSI	$545	$554	$554	—	—
SSP	205	224	205	-$19	-8.5%
Totals	**$750**	**$778**	**$759**	**-$19**	**-2.5%**
Couples					
SSI	$817	$832	$832	—	—
SSP	515	550	515	-$35	-6.4%
Totals	**$1,332**	**$1,382**	**$1,347**	**-$35**	**-2.5%**

Although SSI grants increase under the Governor's budget, the increase in the total grant is less than required by current law. Specifically, under the Governor's proposal grants would be 8.5 percent less (for individuals) and 6.4 percent less (for couples) than current law. As a point of reference, the federal poverty guideline for 2001 is $759 per month for an individual and $968 per month for a couple. Thus, under the Governor's proposal, the grant for an individual would be 6 percent above the *2001* poverty guideline and the grant for a couple would be 39 percent above the poverty guideline. (We note that the poverty guidelines are adjusted for inflation annually.)

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 own homes without such assistance. An individual is eligible for IHSS if he or she lives in his or her own 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 (SSI / SSP).

The IHSS program consists of two components: the Personal Care Services Program (PCSP) and the Residual IHSS program. Services provided in the PCSP are federally reimbursable under the Medicaid program. The PCSP limits eligibility to categorically eligible Medi-Cal recipients (California Work Opportunity and Responsibility to Kids [CalWORKs] and SSI / SSP recipients) who satisfy a "disabling condition" requirement. Personal care services include activities such as: (1) assisting with the administration of medications; and (2) providing needed assistance with basic personal hygiene, eating, grooming, and toileting. The following cases are excluded from the PCSP and, therefore, receive services through the Residual (state-only funded) IHSS program: cases with domestic services only, protective supervision tasks, spousal providers, parent providers of minor children, "income eligibles" (generally recipients with income above a specified threshold), "advance pay" recipients (eligible for payments prior to the provision of services), and recipients covered by third party insurance.

The budget proposes $1 billion from the General Fund for the IHSS program, which is an increase of 12 percent over estimated current-year expenditures. This spending growth is primarily attributable to increases in the caseload and the wages paid to providers.

Maximize Federal Funds Through Eligibility Changes

Recipients who (1) hire relative caregivers or (2) pay their providers in advance of receiving service are not eligible for federal funding and must be served in the state-only "residual" program. In order to maximize federal funds in the In-Home Supportive Services program without reducing services to recipients, we recommend (1) recipients be required to elect nonrelative caregivers and (2) the advance payment option be eliminated. These changes result in General Fund savings of approximately $35 million. (Reduce Item 5180-111-0001 by $35,000,000.)

General Fund Spending Has Nearly Quadrupled. From 1993-94 through 2001-02, IHSS has been the fastest growing social services program in terms of General Fund spending. During this time period, General Fund expenditures increased almost four-fold, rising from $232 million in 1993-94 to an estimated $903 million in 2001-02. This represents an average annual growth rate of about 19 percent. By comparison, General Fund spending in CalWORKs declined during this period and SSI/SSP spending increased at an average annual rate of 4 percent. For 2002-03, the budget proposes about $1 billion for IHSS, just less than the combined General Fund spending for Foster Care and Child Welfare Services. In-Home Supportive Services is now the third largest social services program, behind only SSI/SSP ($3 billion) and CalWORKs ($2.2 billion). Figure 1 (see next page) shows General Fund spending from 1993-94 through 2002-03.

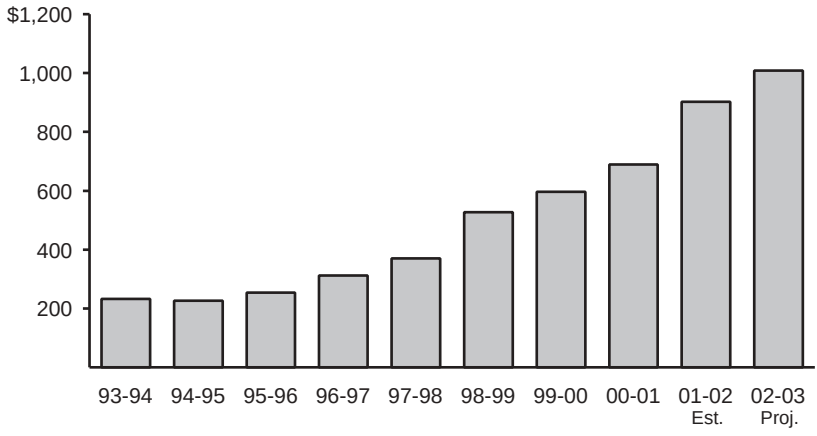
Why Has Spending Grown So Rapidly? Total spending growth from 1993-94 through 2001-02 was about $670 million, mostly attributable to caseload growth, increases in the hours of service per client, and higher wages for providers. Specifically, caseload and service hour growth, in combination with inflation, account for about $220 million of the increase. Higher wages for providers account for an additional $335 million of program cost growth. (This $335 million results from both minimum wage increases—about $205 million—and from discretionary wage increases for providers—about $130 million.) We cannot specifically identify the cause of the remaining increase, but some of it is due to the impact of court cases.

Controlling Costs By Increasing Federal Eligibility. As described above, the IHSS program is really two programs—the PCSP, which is 50 percent federally funded through the Medicaid program, and the residual program, which is funded exclusively with state and county funds. For 2002-03, about 210,000 recipients (75 percent) are in PCSP and about 75,000 recipients (25 percent) are in the residual program. Drawing down federal Medicaid funds in the PCSP saves about $2,000 per case, per year, compared to the residual program where no such federal funding is available.

Figure 1

In-Home Supportive Services
General Fund Expenditures

1993-94 Through 2002-03
(In Millions)



Relative Caregivers and Advance Payment Cases Not Federally Eligible. Under current law, IHSS cases in which recipients elect to have a relative act as their caregiver are not eligible for federal funding and must be served in the state-only residual program. There are about 14,500 such cases in which the recipient's caregiver is a relative, usually a spouse or parent. Current law allows certain severely disabled impaired recipients to receive payment before IHSS services are rendered. There are about 575 such "advance payment" cases, and, like cases with relative caregivers, they are not federally eligible.

Analyst's Recommendation. Requiring all IHSS recipients to elect nonrelative caregivers and eliminating the advance payment option would make about 15,000 IHSS cases eligible for federal funding, resulting in General Fund savings of about $30 million and county savings of about $18 million. Accordingly, we recommend enactment of legislation to require (1) all IHSS recipients to elect nonrelative caregivers and (2) to eliminate the advance payment option. This recommendation results in substantial savings without reducing services to IHSS recipients. It would require, however, that about 14,500 relative caregivers seek other part-time employment in order to maintain their household's income.

Governor Proposes to Suspend State Participation in Wage Increase

By suspending the In-Home Supportive Services revenue "trigger" for state participation in higher wages for certain providers, the Governor's budget achieves a General Fund cost avoidance of $26.7 million.

State Participation in Wage Increases. Chapter 108, Statutes of 2000 (AB 2876, Aroner), authorizes the state to pay 65 percent of the nonfederal cost of a series of wage increases for IHSS providers working in counties that have established "public authorities." The wage increases began with $1.75 per hour in 2000-01, potentially to be followed by additional increases of $1 per year, up to a maximum wage of $11.50 per hour. We note that state participation in wage increases after 2000-01 is contingent upon General Fund revenue growth exceeding a 5 percent threshold. Chapter 108 also authorizes state participation in health benefits worth up to 60 cents per hour worked.

2001-02: Wages Increased Absent Trigger. For 2001-02, revenue growth was below 5 percent. Thus, under the revenue trigger mechanism created by Chapter 108, state participation in a $1 per hour wage increase for public authority workers was not required. Nevertheless, state participation in a $1 wage increase to $8.50 per hour was provided, at a General Fund cost of approximately $23 million.

2002-03: Governor Proposes Suspending Trigger Mechanism. The Governor's budget estimates that an economic recovery beginning in the spring of 2002 will result in revenue growth (excluding transfers) of about 12 percent between 2001-02 and 2002-03. Because revenue growth exceeds the 5 percent threshold, under current law, state participation in a $1 per hour wage increase would be triggered. Given the state's difficult fiscal situation, the Governor proposes to suspend the application of this trigger. This results in a General Fund cost avoidance of $26.7 million in 2002-03.

We note that the decision to override the trigger in 2001-02 means state participation in IHSS wages is already $1 higher than the level contemplated in Chapter 108. Thus, suspending the wage increase in 2002-03 would put wages at a level equal to what they would have been absent last year's budget change.

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. The *2002-03 Governor's Budget* proposes $1.9 billion from all funds and $590 million from the General Fund for CWS. This represents an increase of less than 1 percent from the General Fund over current-year expenditures.

Maximize Federal Funds by Drawing Down Title IV-E Funds for Case Management

Currently the state uses a combination of federal Temporary Assistance for Needy Families (TANF) funds and county funds to provide case management services for children in the child welfare system. We recommend (1) replacing the TANF funds with General Fund monies in order to draw down additional Title IV-E federal funds and (2) using the freed-up TANF funds to offset General Fund costs in the Department of Developmental Services. Together, these actions result in net General Fund savings of $31.6 million. Finally, we recommend that the Department of Social Services report at budget hearings on the potential to draw down more federal Title IV-E funds, thereby resulting in additional General Fund savings in both the current and budget years. (Increase Item 5180-151-0001 by $38,300,000 and reduce Item 4300-101-0001 by $69,900,000).

Background. The Emergency Assistance (EA) Program, a component of the CWS Program, provides a variety of services to children who are placed in foster care or are at risk of foster care placement. Case management, one portion of the EA Program, provides funds for case planning and reviews; foster and adoptive parent orientation; and a variety of other services to support children and families in the CWS program.

Current Budget Practice. Federal Title IV-E funds are the largest federal funding stream for child welfare and foster care services. The 2002-03 budget, however, does not propose to use Title IV-E funds to support EA case management services in the CWS program. Instead, the budget proposes to continue the existing practice of using a combination of federal Temporary Assistance for Needy Families (TANF) and county funds. Together, the TANF funds ($69.9 million) and the county funds ($12.3 million) total $82.2 million. While TANF funds are received in the form of a fixed block grant, Title IV-E funds are available to match state funds on a dollar-for-dollar basis.

Substituting IV-E Funds for TANF Funds. If alternatively the state opted to draw down federal Title IV-E funds, the Department of Social Services (DSS) estimates that approximately 77 percent of California children in the CWS and foster care programs would be eligible for such funding in 2002-03. Thus, 77 percent of EA case management spending, or $63.3 million, would be eligible for 50 percent federal financial participation. The nonfederal costs of this option would be shared 70 percent state and 30 percent county. Accordingly, shifting the EA case management costs from TANF to Title IV-E would result in (1) a draw down of $31.6 million in federal Title IV-E funds, (2) a General Fund cost of $35.4 million, (3) an increase in county costs of $2.9 million (to a total of $15.2 million), and (4) $69.9 million in freed-up TANF funds.

Converting the TANF Funds Into General Fund Savings. As described more fully in our analysis of the CalWORKs budget, TANF funds may be transferred into the Title XX Social Services block grant. Once transferred, they then may be used to offset General Fund costs in the community-based programs in the Department of Developmental Services (DDS). Taking the actions described above would free up $69.9 million in TANF funds. These funds could then be used to offset $69.9 million in General Fund costs in DDS. Combining this General Fund savings of $69.9 million in DDS with the $35.4 million General Fund cost in the EA case management program would result in *net* General Fund savings of $34.5 million, and county costs of $2.9 million.

Analyst's Recommendation. We recommend replacing $69.9 million in TANF spending for case management in the EA Program with $34.5 million from the General Fund. This action would draw down an additional $31.6 million in federal Title IV-E funds and would free up $69.9 million in TANF funds. We further recommend transferring this $69.9 million to the Title XX Social Services block grant and using the transferred funds to offset existing General Fund costs in the community-based programs in DDS. Taken together, these recommendations would result in a net General Fund savings of $34.5 million with no reduction in service or change in program operation. In order to hold counties harmless, we also recom-

mend redirecting $2.9 million of the General Fund savings, back to the counties. Finally, given the potential for additional General Fund savings we recommend that DSS report at budget hearings on the potential to (1) draw down Title IV-E funds in the current year by changing our current claiming practice and (2) use Title IV-E funds to pay for other EA services.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT COMPLIANCE (9909)

It is uncertain whether the state will meet the deadlines for implementing the federal Health Insurance Portability and Accountability Act (HIPAA) because it is a significant undertaking affecting many programs and departments. The proposed funding reductions that are necessary in the current year could slow the state's efforts. Given the potential impact of these reductions on affected departments' efforts, we recommend that the Office of HIPAA Implementation report at budget hearings on the steps that are being taken in the current fiscal year to ensure departments' continued progress toward HIPAA compliance.

Background. The federal HIPAA was enacted in 1996 and set many goals for the health care industry. As we discussed in the *Analysis of the 2001-02 Budget Bill*, HIPAA's primary purpose was to improve the portability and continuity of health insurance for workers and their families. The bill also required the health care industry to take a series of actions to combat waste, fraud, and abuse; to improve access to health insurance; and to increase the efficiency and effectiveness of the health care system. Both private and public sector organizations that provide health care services and use patient or other health care data must comply with HIPAA.

To comply with these new protections, affected organizations will have to make some significant changes in how they conduct business that will result in substantial costs. For example, HIPAA requires national standardization of billing codes for medical procedures. The law also establishes requirements for the handling of certain health care information to ensure privacy of patient health care data. Figure 1 (see next page) shows the compliance deadlines for the standards.

Figure 1

Federal Deadlines for HIPAA Compliance

Proposed Rule	Examples of Rule	Compliance Deadline
Transactions	Enrollment, claims payment, eligibility	October 16, 2003
Code sets	Disease, injuries, impairment, procedures	October 16, 2003
Unique identifiers	Provider, employer, health plan, individual	Not yet issued
System and patient data security	Administrative procedures, physical safeguards	Not yet issued
Privacy	Information, entities, disclosures	April 14, 2003

Failure to comply with these deadlines could result in significant federal monetary penalties against the state and potentially even the loss of billions of dollars in federal reimbursements in its health programs (primarily the Medi-Cal Program). Moreover, HIPAA authorizes both civil and criminal penalties for failure to comply with its provisions. At the time this analysis was prepared, federal authorities had not yet adopted rules that would determine the specific penalties for noncompliance with HIPAA.

Office of HIPAA Implementation Is Responsible for State Oversight. To ensure the state's compliance with HIPAA's requirements, Chapter 635, Statutes of 2001 (SB 456, Speier), created the Office of HIPAA Implementation (OHI) within the California Health and Human Services Agency. By law, OHI must provide oversight and monitor departmental progress on HIPAA and report to the Legislature on implementation efforts. In addition, OHI is responsible for statewide leadership and coordination of the effort, national representation, policy formulation, and training.

The Budget Proposal. The *2001-02 Budget Act* and Chapter 635 included $92 million ($24 million General Fund) for various departments to fund HIPAA compliance activities. As shown in Figure 2, the Governor proposed in November 2001 to significantly cut current-year funding—by as much as 95 percent for one department.

For 2002-03, the Governor's budget proposes to restore state HIPAA funding to the levels originally established in the budget act and Chapter 635. This should enable departments to fully resume work on HIPAA compliance activities in July 2002.

The OHI's Statewide Assessment. Each state entity, including state departments, boards, commissions, and other organizational units of government, was directed to provide to OHI a completed HIPAA assessment

Figure 2

Proposed Reductions in Current-Year HIPAA Funding

(Dollars in Thousands)

Department	2001-02 Budget Act and Chapter 635	2001-02 Revised Budget	Reduction	Percent Change
Health Services	$78,623	$15,060	$63,563	-81%
Mental Health	2,423	172	2,251	-93
Developmental Services	2,514	118	2,396	-95
Alcohol and Drug Programs	6,042	714	5,328	-88
Office of HIPAA	2,623	2,023	600	-23
Totals	**$92,225**	**$18,091**	**$74,138**	**-80%**

form by December 31, 2001. The assessment is intended to enable OHI to determine which state entities are subject to HIPAA and to obtain information about the status of HIPAA efforts for those entities affected by HIPAA. Once OHI compiles this data, it will have a better sense of the full amount of funding required to implement HIPAA and will be better able to determine if the state will satisfy compliance deadlines. Chapter 635 requires that OHI report the statewide results of this assessment to the Legislature by May 15, 2002.

Continuing HIPAA Implementation With Limited Resources. The OHI anticipates that departments' progress towards compliance with HIPAA will be somewhat delayed by the funding cuts in the current fiscal year. Some departments' progress will be delayed more than others by the reductions and at this time it is uncertain which departments will meet the federal deadlines.

Despite the funding reductions, we found that some departments are adjusting the scope of their efforts and proceeding with HIPAA-related tasks with their remaining funds. For example, DHS plans to continue to work on conforming its codes for tracking claims associated with various types of Medi-Cal health care services to the comparable national set of codes. The DHS also plans to conduct a baseline assessment of what needs to be done to comply with the privacy regulations. Another department facing such reductions plans to use its remaining resources to establish program and task priorities based upon its OHI assessment and intends to work within its resources on the most critical tasks based on management direction.

Last fall, prior to any HIPAA-funding allocations, some departments began HIPAA-related work by redirecting existing resources to HIPAA tasks. Some departments are considering a similar approach for the current fiscal year. For example, the Public Employees' Retirement System (PERS), which did not receive a HIPAA appropriation, plans to utilize existing resources to continue with HIPAA implementation.

The state's HIPAA workgroup, which is comprised of representatives from various state and county departments subject to HIPAA requirements, is currently considering solutions for proceeding with compliance efforts with fewer resources. It has suggested that departments proceed with planning efforts, draw on experience gained during the state's Y2K efforts when resources available for compliance often came from redirections of staff and funding, keep HIPAA rules in mind when making purchases, and consider opportunities to partner with private sector businesses to achieve progress. According to the workgroup, with these actions departments may be able to minimize project restart times and prepare to do some tasks.

Others have recommended that organizations take advantage of processes established during Y2K remediation efforts to lessen HIPAA compliance burdens. For example, departments had conducted Y2K information technology inventories that could serve as a starting point for developing the resource management and inventory process required under proposed HIPAA security regulations for medical information and transactions. Other efforts completed during Y2K remediation that could be useful now for HIPAA compliance are security risk analyses as well as data backup and disaster recovery plans to be used in case of information system failures.

Despite these potential solutions, a few departments have stopped all HIPAA work in response to the budget cuts. The Department of Alcohol and Drug Programs has no staff assigned to HIPAA and the Office of Statewide Health Planning and Development's one HIPAA-related position is vacant and will not be filled as a result of a state hiring freeze that is currently in place.

Federal Delay in Deadline Is Misleading. Federal legislation signed by President Bush on December 27, 2001 delays by one year, until October 16, 2003, the date by when organizations must adopt certain national standards established by the federal government. These standards relate to the electronic transmission of health-related data and codes identifying certain types of health care information, such as diseases and medical procedures. This was the first set of HIPAA regulations issued by the federal government. However, the delay is not automatic and, in order to obtain a time extension, entities must submit a compliance plan to HHS

by October 16, 2002. The plan must include a budget, a schedule, a work plan, and an implementation strategy for achieving compliance. Given these requirements to obtain a time extension, departments would have to continue some level of effort during the current fiscal year to prepare to comply with HIPAA.

Analyst's Recommendations. Given the state's fiscal problems, we concur with the Governor's proposal to reduce funding in the current year by $74 million ($19 million General Fund) and restore this funding in the budget year. However, we believe that there are still steps that could be taken in the current year to make progress implementing HIPAA. Our findings are based on the actions being taken by some departments that are facing the resource reductions, as well as suggestions made by the state's HIPAA workgroup.

To ensure that the state meets the federal compliance deadlines (and avoids the loss of federal funds), OHI should take an active role in encouraging departments to continue to view HIPAA compliance as a priority. The OHI could encourage this response by conducting regular meetings with departments to discuss working with limited resources, preparing and distributing information that helps departments proceed with compliance efforts, and developing solutions to assist departments hindered by a lack of resources for HIPAA compliance work in the current fiscal year. For example, because OHI is monitoring the efforts of all affected departments in California and efforts in other states, it should be able to identify the most effective compliance strategies available and to promote those approaches to other departments. This could involve such activities as preparing guidelines to assist departments in designing work plans to comply with each of the rules and developing boilerplate agreements such as the employee confidentiality agreement required by HIPAA.

In addition, OHI should encourage departments to analyze their existing resources to determine how they could continue HIPAA implementation. Departments could also use the remainder of the current fiscal year to develop compliance plans and to otherwise prepare for the resumption of full activities in the budget year when funding would be restored.

Lastly, OHI should report at budget hearings on the steps it is taking in the current year to ensure departments' continued progress toward HIPAA compliance.

FINDINGS AND RECOMMENDATIONS

Health and Social Services

Analysis Page

Crosscutting Issues

Federal Funds

Workforce Development Proposal

Tobacco Settlement Fund

Analysis Page

budget problems. In deciding whether to securitize, the Legislature should weigh the potentially adverse implications for health programs against its contribution to solving the state's short-term problems. The Legislature should consider the transaction only if the administration presents a more detailed proposal and an analysis demonstrating that the net financial outcome would be beneficial to the state.

C-34 ■ **Fund Could Face Shortfall.** The amount of tobacco settlement revenues available to support health programs could be significantly less than the amount assumed in the budget. We recommend the state Department of Justice, which monitors the tobacco settlement, report on this situation at budget hearings.

C-35 ■ **Line-Up of Fund-Supported Programs Would Change.** The budget makes significant changes in the line-up of health programs that would receive support from the Tobacco Settlement Fund. The Legislature should consider whether the programs selected to receive dedicated funding from this source are in-line with its own priorities.

C-38 ■ **Hospitals Facing Financial Headaches.** We find that hospitals face a number of financial pressures in the next several years, including federal regulations limiting the amount the state can pay public hospitals participating in the Medi-Cal Program. We outline a number of steps the Legislature could take even in the current fiscal situation to maintain the financial viability of California's network of hospitals.

Department of Alcohol and Drug Programs

C-50 ■ **Assessing the Governor's Proposed Budget Reductions.** The combined effect of the Governor's proposed reductions in drug or alcohol services could be a violation of maintenance-of-effort requirements for federal grants received by the state.

C-52 ■ **Details Lacking on Reduction Proposal.** Withhold recommend on the proposed $7.5 million General Fund reduction in local assistance for alcohol and drug treatment services because the Legislature lacks sufficient information about this proposed reduction.

Analysis Page

C-52 ■ **Drug Court Reduction Could be Counterproductive.** Withhold recommend on proposed $8 million General Fund reduction to eliminate the Drug Court Partnership Act because it could result in offsetting cost increases in the state's criminal justice system. An evaluation report due March 1, 2002 may shed light on the program's cost-effectiveness.

C-54 ■ **Reductions Could be Offset with Federal Funds.** Congressional action could mean as much as $15.4 million in additional federal grant funds will be available that are not accounted for in the Governor's spending plan. The Legislature has the option of using these funds to restore programs eliminated last year or proposed for reduction in the 2002-03 budget plan.

C-55 ■ **Forfeiture Proceeds Could Bolster Treatment Efforts.** The Legislature has the option of using a portion of the proceeds from asset forfeitures to help prevent crime through an increase in support for substance abuse treatment programs.

California Medical Assistance Program

C-72 ■ **Caseload Estimate Reasonable**. We find that the budget's estimate for the California Medical Assistance Program (Medi-Cal) caseload is reasonable, but there are significant risks to this estimate that could result in the projection being overestimated or underestimated. Accordingly, we will monitor caseload trends and recommend appropriate adjustments at the time of the May Revision.

C-74 ■ **Assumption on Federal Relief is Risky.** Recommend that the Legislature closely monitor the availability of $400 million in anticipated federal relief from the reduction of the federal cost-sharing ratio for the Medi-Cal Program. The Legislature could consider the additional options for budget savings that we have proposed to address any shortfall in federal relief.

C-76 ■ **Provider Rate Reductions. (Increase Item 4260-101-0001 by $78 Million and Increase Item 4260-101-0890 by $78 Million.)** Recommend the Legislature not adopt the Governor's proposal to reduce provider rates by $78 million General Fund

Analysis Page

because Medi-Cal rates are generally so low. Further recommend that the Legislature require Department of Health Services (DHS) to establish a rational rate-setting process for fee-for-service so that the state can ensure reasonable access to care.

C-80 ■ **Copayment Proposal.** Recommend the Legislature reject proposal to reduce provider rates. The Legislature should direct DHS to report, at budget hearings, an assessment of the feasibility and fiscal impact of our alternative copayment structure.

C-84 ■ **Drug Budget Reductions. (Reduce Item 4260-101-0001 by $17 Million and Reduce Item 4260-101-0890 by $17 Million.)** Recommend adoption of the budget proposal to reduce the Medi-Cal drug budget by $100 million General Fund ($201 million all funds). The Legislature should modify the budget proposal to provide for higher level pharmacists positions to ensure that these savings can actually be achieved and consider additional strategies we have identified to achieve additional savings.

C-87 ■ **Medi-Cal Managed Care.** Recommend the Legislature consider options for reforming Medi-Cal managed care. These options include ensuring rates are appropriate, increasing competition among health plans, and enrolling more elderly and disabled in managed care plans.

C-93 ■ **More Oversight Needed for Antifraud Activities.** Recommend adoption of supplemental report language directing DHS to submit an annual report evaluating the department's antifraud activities and the overall cost-effectiveness of resources allocated for this purpose.

C-95 ■ **Nursing Home Proposal Would Add 55.5 Positions. (Reduce Item 4260-001-0001 by $336,000 and Reduce Item 4260-001-0890 by $336,000.)** Recommend approval of the Governor's proposal to implement Chapter 684, Statutes of 2001, with some modifications. Recommend deleting 6.5 positions and the adoption of budget bill language requiring that unspent funding from salaries for these positions revert to the General Fund.

Analysis Page

Public Health

C-103 ■ **Child Health and Disability Prevention.** While we agree in concept with the Governor's plan to shift children from CHDP to other health programs, we withhold recommendation on the budget proposal pending a more detailed report from DHS at budget hearings on key issues relating to how the plan would actually be implemented.

C-110 ■ **Tobacco Prevention Programs. Reduce Item 4260-111-3020 by $20.9 million.** Recommend reduction of $20.9 million proposed to expand youth smoking prevention efforts because the proposal lacks the justification needed to support an increase of this magnitude. The budget proposal does not present persuasive evidence that doubling funding for these programs will be effective in preventing or reducing youth smoking in California.

Managed Risk Medical Insurance Board

C-118 ■ **Healthy Families Caseload.** Recommend approval of $20.3 million in the current year and $58.1 million in the budget year to reflect children's caseload growth. Withhold recommendation on $5.9 million for anticipated children's caseload growth due to the elimination of the Child Health and Disability Prevention program.

C-120 ■ **Healthy Families Parent Expansion.** Should the Legislature decide to go forward with the parent expansion in the budget year, we recommend it consider an alternative plan to delay implementation of the program until January 1, 2003 in order to reduce state costs.

C-122 ■ **State Children's Health Insurance Program Federal Funds.** Recommend that the Legislature work with the California congressional delegation to extend the availability of state SCHIP funds, and further recommend that the Legislature consider options to utilize federal funds and prevent reversion of expired unspent funds. Options include one-time public health expenditures and premium assistance.

Analysis Page

C-125 ■ **Dual Enrollment in Healthy Families and Medi-Cal.** Recommend that the Department of Health Services and Managed Risk Medical Insurance Board report at budget hearings on the steps they are taking to ensure that the state is not paying twice for health coverage for the same individuals enrolled in both the Healthy Families and Medi-Cal Programs.

Department of Developmental Services

C-127 ■ **Regional Center (RC) Costs Growing Rapidly.** Regional center total costs have more than doubled since 1995-96, driven up by multiple factors, including annual caseload and cost adjustments for service entitlements, a decline in federal waiver support, and an absence of statewide utilization controls. Yet the RC system continues to have financial problems for some RCs and may face shortages of certain community services.

C-137 ■ **Unspecified Reduction of $52 Million.** Withhold recommendation on the Governor's proposal to reduce funding for RC purchases of services by $52 million until the Department of Developmental Services (DDS) provides more specific information to the Legislature as to how these savings would be achieved.

C-137 ■ **Home and Community-Based Services Waiver. Reduce Item 4300-101-0001 by $45 Million and Increase Item 4300-101-0890 by $50 Million**. Recommend a net General Fund reduction in the RCs' budget of $45 million, and an increase in federal spending authority of $50 million, as part of a strategy to take full advantage of a federal waiver allowing some client services to be supported with available federal funds. Also recommend budget bill language that gives General Fund spending authority to RCs, up to $5 million, to implement this strategy.

C-144 ■ **Community Placement Plan. Reduce Item 4300-101-0001 by $6.9 Million.** Recommend reduction to reflect federal funds that could be received to offset the cost of the proposal under the home and community-based services waiver. Recommend budget bill language to revert to the General Fund any funds not expended under the plan.

Analysis Page

C-145 ■ **Leased Facilities.** Recommend that DDS report at budget hearings on the status of an interagency agreement with the Department of Health Services that could result in state General Fund savings of as much as $8 million for the operation of its Sierra Vista and Canyon Springs facilities. The department should also report at that time on the status of federal certification of the Canyon Springs facility.

Department of Mental Health

C-148 ■ **Hospital Growth Projections Lowered.** The state hospital system is no longer projected to grow as quickly as the Department of Mental Health (DMH) had previously predicted. But the latest ten-year projections still appear likely to overstate the growth that is likely to occur over the next decade.

C-151 ■ **Hospital Caseload Probably Overbudgeted. Reduce Item 4440-011-0001 by $12.6 Million**. Recommend a net General Fund reduction of about $18 million in state hospital caseload funding provided in the budgets of DMH and the Department of Corrections (CDC). An updated caseload funding request is expected at the May Revision.

C-155 ■ **Additional Beds Not Needed Yet. Reduce Item 4440-011-0001 by $3.1 Million**. Recommend denial of request for additional funding to activate beds at two state hospitals that will not be needed until 2003-04 at the earliest.

C-156 ■ **New Prison Facility May Face Delay.** The opening of a new mental health facility at Salinas Valley State Prison may be delayed for at least five months. Recommend DMH and CDC report at budget hearings on the savings that should result if its activation is postponed.

C-157 ■ **Budget Should Be Realigned.** About 20 percent of state hospital positions are vacant and a number of factors make it unlikely that most will ever be filled. Recommend that the Legislature carefully review a pending study of these vacancies and direct the Department of Finance to realign DMH's budget request to more closely reflect its actual workforce and expenditures.

Analysis Page

C-159 ■ **AB 3632 Program. Reduce Item 4440-295-0001 by $47.9 Million. Shift Funds to New Item 4440-104-0001.** Recommend Legislature set-aside funding for the AB 3632 mandate—"Services to Handicapped Students"—pending development of a new categorical program to support county mental health services to special education pupils.

C-165 ■ **Cost of New Services Almost Double Prior Estimate.** The cost of expanding therapeutic behavioral services to troubled children and older youth is almost double on a cost-per-client basis than the estimates presented to the Legislature last year. Withhold recommendation on the request for a $16 million expansion pending an explanation from DMH at budget hearings on why the cost is so much higher than indicated last year.

Employment Development Department

C-167 ■ **Workforce Investment Act Discretionary (WIA) Funds.** The Governor's budget proposes to use most of the available WIA discretionary funds to support existing programs. We review the history of budgeting WIA funds and comment on the Governor's proposal.

C-169 ■ **Use WIA Funds to Offset Employment Services Costs. Reduce Item 5100-001-0185 by $4,600,000**. Recommend using $4.6 million in unbudgeted federal WIA state discretionary funds to replace Employment Development Department (EDD) Contingent Fund support for the Employment and Employment Related Services Program. This action results in an identical General Fund savings.

C-170 ■ **Assessing the Faith-Based Initiative**. For 2002-03, the Governor proposes $4 million to continue a competitive grant program that engages faith-based and community-based organizations in the delivery of social services. We review the program's implementation in 2000-01 and 2001-02.

C-180 ■ **Recommendations for Improving the Faith-Based Initiative**. If the Legislature elects to continue this program in 2002-03, recommend that EDD (1) require potential grantees to explain how they will avoid pervasively sectarian service delivery as

Analysis Page

part of the application process and (2) incorporate unannounced site visits into their monitoring program. Further recommend that the Legislature clarify in statute that the EDD should focus the majority of the resources on organizations which have had limited opportunity to obtain government funds to provide welfare-to-work services.

Department of Rehabilitation

C-183 ■ **Budget Suspends Statutory Rate Adjustment**. The department is statutorily required to adjust rates for Work Activity Program providers every two years. The Governor proposes to suspend the July 1, 2002, rate adjustment, for an estimated General Fund cost avoidance of $3.8 million in 2002-03.

C-184 ■ **Legislature Needs More Information on Proposed Savings in the Habilitation Services Program.** Withhold recommendation on proposed savings pending review of a more detailed proposal which should be submitted by the department prior to budget hearings.

Department Of Child Support Services

C-185 ■ **Penalty Elimination Assumption Creates Substantial Budget Risk.** The assumption that California's child support automation penalty will be eliminated by congressional legislation creates a substantial budget risk—$181 million General Fund in 2002-03.

C-186 ■ **Increased Revenues Not Reflected in Budget. Increase General Fund Revenues by $4,100,000**. Increase General Fund revenues by $4,100,000 because the budget does not account for anticipated collection increases in the Franchise Tax Board's child support collections program.

C-187 ■ **California Child Support Automation Project.** Withhold recommendation on redirection of $4.2 million pending receipt of additional information demonstrating the difference between Department of Child Support Services' and Franchise Tax Board's project oversight activities.

Analysis Page

Department of Social Services CalWORKs Program

Caseload and Grants

Time-Limits

Maintenance-of-Effect (MOE) Spending Requirement

Analysis Page

C-198 ■ **Count Additional Spending Toward MOE Requirement.** Recommend that the department count toward the CalWORKs MOE requirement General Fund expenditures for (1) supplemental cash payments to disabled adults and children, (2) nonemergency health services for certain immigrants and (3) subsidized child care for certain families. We estimate such countable expenditures to be in the range of $30 million to $100 million. Counting such expenditures would increase legislative flexibility in allocating General Fund monies for CalWORKs.

Other Budget and Policy Issues

C-200 ■ **Budget Proposes Redirecting County Performance Incentives.** The Governor's budget proposes to redirect $189 million in unspent county performance incentives in 2001-02 and 2002-03.We comment on the advantages and disadvantages of this proposal.

C-202 ■ **Budget Expands County Block Grant But Proposed "Hold-Back" Is Disruptive.** The Governor proposes three significant changes to the CalWORKs budgeting system. These changes include (1) funding county administrative and employment services costs at their current-year levels, (2) substantially expanding the county block grant, and (3) retaining up to 5 percent of the county allocations to pay for potential cost increases for assistance payments. We recommend that the Legislature (1) build on the Governor's county block grant proposal by including additional Temporary Assistance for Needy Families (TANF) allocations in this block grant but (2) reject the proposed 5 percent "holdback" and instead establish a larger TANF reserve to pay for the potential program cost increases.

C-203 ■ **CalWORKs Needs Long-Term Budget Plan.** Absent legislative action, funding pressures in the CalWORKs program will continue to erode the program's welfare-to-work component (employment services and administration). Accordingly, the Legislature faces difficult policy choices in determining the appropriate level of CalWORKs funding. We present policy

Analysis Page

considerations for the Legislature in developing a long-term budget plan for CalWORKs.

C-209 ■ **Eliminate CalWORKs Grant Payments Under $150. Reduce Item 5180-101-0890 by $37 Million.** Recommend eliminating grant payments for families with incomes (including earnings and benefits) of at least 122 percent of the federal poverty level. Such families currently receive relatively modest grant payments (up to about $150 monthly). Removing these families from cash assistance would preserve their time on aid for future periods during which they may become unemployed, and would result in program savings of approximately $37 million.

C-210 ■ **Reinstate Senior Parent Deeming. Reduce Item 5180-101-0890 by $11 Million.** Recommend that a senior parent's income be counted for the purpose of determining financial eligibility of a minor parent's child for CalWORKs assistance. This would result in savings of approximately $11 million.

C-211 ■ **The CalWORKs Child Care Program.** As part of systemwide child care reforms, the Governor proposes to eliminate the Stage 3 "set-aside" designed to provide former CalWORKs families with child care beyond the two-year guarantee for such services. We review the Governor's child care reform proposals and their impact on the CalWORKs program.

C-213 ■ **No Penalty for Cash Management Violation.** As directed by the U.S. Department of Health and Human Services, California will return unspent TANF funds drawn down in violation of the Cash Management Improvement Act, along with interest earned on the advance draw-down funds, but will incur no penalties.

C-214 ■ **Withhold Recommendation on Impact of Federal Eligibility Changes.** Withhold recommendation on the estimated cost of recent federal eligibility changes, pending review of the Governor's May Revision of the budget.

Analysis Page

Community Care Licensing

Foster Care

Food Stamps Program

Analysis Page

Supplemental Security Income/ State Supplementary Program

C-242 ■ **Governor Proposes to Suspend State Cost-of-Living Adjustment (COLA)**. By proposing to suspend the statutory COLA, the budget achieves General Fund savings of $127 million compared to current law.

In-Home Supportive Services

C-245 ■ **Maximize Federal Funds Through Eligibility Changes. Reduce Item 5180-111-0001 by $35,000,000.** Recommend enactment of legislation that (1) requires recipients to elect nonrelative caregivers and (2) eliminates the advance payment option. These changes result in General Fund savings of approximately $35 million.

C-247 ■ **Governor Proposes to Suspend State Participation in Wage Increase.** By suspending the In-Home Supportive Services revenue "trigger" for state participation in higher wages for providers, the Governor's budget achieves a General Fund cost avoidance of $26.7 million.

Child Welfare Services

C-248 ■ **Maximize Federal Funds by Drawing Down Title IV-E Funds for Case Management. Increase Item 5180-151-0001 by $38,300,000 and Reduce Item 4300-101-0001 by $69,900,000**. Recommend (1) replacing Temporary Assistance for Needy Families (TANF) funds with General Fund monies for the purpose of drawing down Title IV-E federal funds, (2) using the freed-up TANF funds to offset General Fund costs in the Department of Developmental Services, and (3) redirecting $2.9 million of these savings to the counties to hold them harmless from this budget change. Together, these actions result in net General Fund savings of $31.6 million. Further recommend that the Department of Social Services report at budget hearings on the potential to draw down more Title IV-E funds in both the current and budget years.

Analysis Page

Health Insurance Portability and Accountability Act Compliance

C-251 ■ **Budget Would Reduce Current-Year Funding for Health Insurance Portability and Accountability Act Compliance (HIPAA) Compliance.** The *2002-03 Governor's Budget* would reduce current-year funding by $74 million ($19 million General Fund) and interrupt some HIPAA activities that departments have begun. The Office of HIPAA Implementation (OHI) should take the lead in ensuring that departments continue to view HIPAA compliance as a priority and OHI should report at budget hearings on the steps it is taking to ensure departments' progress with HIPAA compliance.