



60 YEARS OF SERVICE

2004-05 Analysis

MAJOR ISSUES

Health and Social Services



Better Care Reduces Health Care Costs for Aged/Disabled

- Aged and disabled persons who would benefit the most from receiving coordinated health care have been excluded from many Medi-Cal managed care plans. This group offers the state the greatest opportunity to contain Medi-Cal costs. We recommend the enactment of legislation to gradually shift certain beneficiaries to a managed care setting. (See “Part V” of *The 2004-05 Budget: Perspectives and Issues*.)



“Remodeling” the Drug Medi-Cal Program

- California’s program for substance abuse treatment services for Medi-Cal beneficiaries is a patchwork of services. We recommend an approach which would provide greater authority and resources for community-based treatment services, contain the fast-growing costs of methadone treatment, and integrate a potentially more cost-effective mode of treatment into the program without a net increase in state General Fund resources. (See “Part V” of *The 2004-05 Budget: Perspectives and Issues*.)



Moving Toward a Model Antifraud System

- Although the Legislature has approved significant increases in resources to combat Medi-Cal fraud, fraud remains a major concern. In our analysis, we explain the structure of the Department of Health Services’ (DHS) antifraud program and how it compares to national models of fraud control, identify areas in which the DHS could become more effective in combating Medi-Cal fraud, and offer recommendations to improve antifraud efforts. (See page C-111 of this Analysis.)



Enrollment Caps and Block Grants Raise Concerns

- The Governor proposes to (1) cap enrollments for certain specified health and social services programs and (2) block

grant funds to county for certain state-only programs serving immigrants. We recommend that the Legislature reject (1) the block grant proposal because the programs proposed for transfer are not well-suited for local control and (2) most of the cap proposals because administrative difficulties, equity issues, and other concerns outweigh the potential benefits. (See pages C-37, page C-47, C-147 and C-198 of the *Analysis*.)



Governor's Welfare Reform Proposal May Increase Participation, but Limits County Flexibility

- The Governor's budget proposes to increase CalWORKs participation by imposing further sanctions on non-compliant families and requiring that recipients engage in employment or on-the-job training within 60 days. The administration's assumptions concerning program participation improvement are overly optimistic and the proposal unnecessarily limits county flexibility to find the optimal mix of work, training, and employment activities to help recipients become self-sufficient. (See page C-227 of the *Analysis*.)



Child Care Reforms Moving in Right Direction, but More Work Needed

- The Governor proposes a number of significant reforms to California's subsidized child care system including eligibility restrictions and higher family fees. Although the proposals set priorities for limited child care resources, they lack important policy and implementation details that would help the Legislature weigh state savings against reducing child care services for a significant number of lower-income families. (See page C-19 of the *Analysis*.)



Evaluating the Governor's IHSS Proposal

- The Governor proposes to eliminate the "residual" In-Home Supportive Services (IHSS) program, limit state participation in provider wages, and reduce services to recipients living with relatives. The proposal to limit services for recipients living with family members merits approval because it is a reduction in services that can probably be absorbed by family members. With respect to the other proposals, we make no recommendation. (See page C-267 of the *Analysis*.)

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OVERVIEW

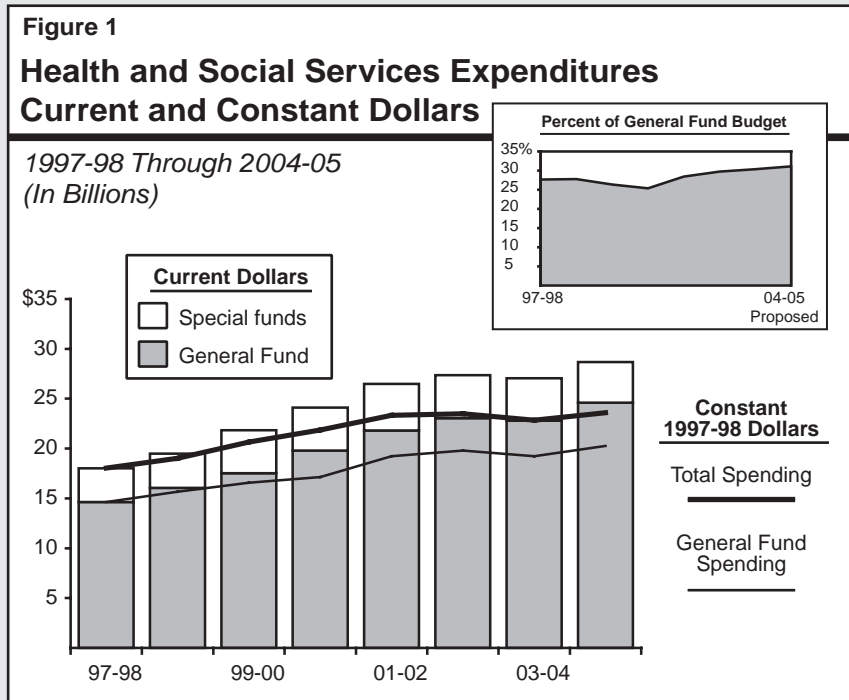
Health and Social Services

Although General Fund spending for health and social services programs is projected to increase by 7.9 percent to \$24.6 billion in 2004-05, this year-over-year increase is misleading because General Fund spending in 2003-04 is artificially depressed by one-time federal funds and accounting savings. After adjusting for these one-time savings, health and social services expenditures are essentially the same between the current and budget years. However, this assumes that the budget avoids increased spending in 2004-05 through a combination of grant and provider rate reductions, eligibility restrictions, and caps on enrollment in certain programs.

EXPENDITURE PROPOSAL AND TRENDS

Budget Year. The budget proposes General Fund expenditures of \$24.6 billion for health and social services programs in 2004-05, which is 31 percent of total proposed General Fund expenditures. Figure 1 (see next page) shows health and social services spending from 1997-98 through 2004-05. The health and social services share of the budget as proposed would increase about 1 percent in the budget year, to just over 31 percent. Although the proposed General Fund budget for 2004-05 is \$1.8 billion (7.9 percent) above estimated spending for 2003-04, nearly all of this increase is attributable to one-time federal fiscal relief and accounting changes which artificially depressed General Fund spending in 2003-04. After backing out these changes, General Fund spending in 2004-05 is virtually identical to the level in 2003-04. Special funds spending for health and social services is proposed to decrease by \$190 million (4.5 percent) to a total of \$4.1 billion.

Historical Trends. Figure 1 shows that General Fund expenditures (current dollars) for health and social services programs are projected to increase by \$10 billion, or 68 percent, from 1997-98 through 2004-05. This



represents an average annual increase of 7.7 percent. Most of this growth (about 85 percent) occurred from 1997-98 through 2002-03.

In contrast, special fund expenditures have been decreasing since reaching a peak of \$4.7 billion in 2001-02. For 2004-05, special fund spending is projected to decrease by \$190 million (4.4 percent) to just less than \$4.1 billion. Most of this decrease is attributable to reduced spending of funds administered by the Children and Families Commission and reduced Proposition 99 funds, both supported by tobacco tax revenues which have been in decline.

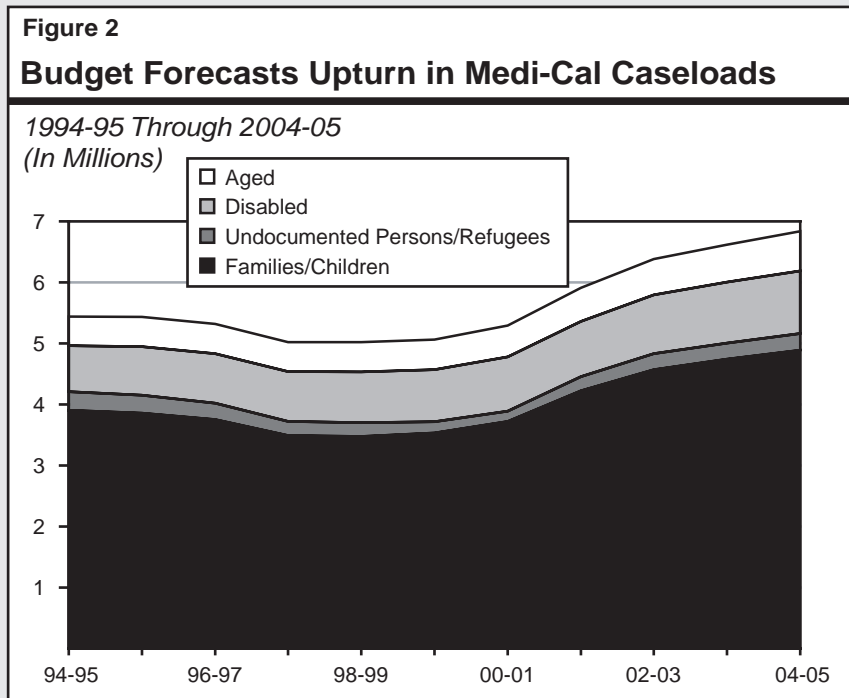
Combined General Fund and special funds expenditures are projected to increase by about \$10.6 billion (59 percent) from 1997-98 through 2004-05. This represents an average annual increase of 6.8 percent.

Adjusting for Inflation. Figure 1 also displays the spending for these programs adjusted for inflation (constant dollars). On this basis, General Fund expenditures are estimated to increase by 38 percent from 1997-98 through 2004-05, an average annual rate of 4.7 percent. Combined General Fund and special funds expenditures are estimated to increase by

31 percent during this same period, an average annual increase of just less than 4 percent.

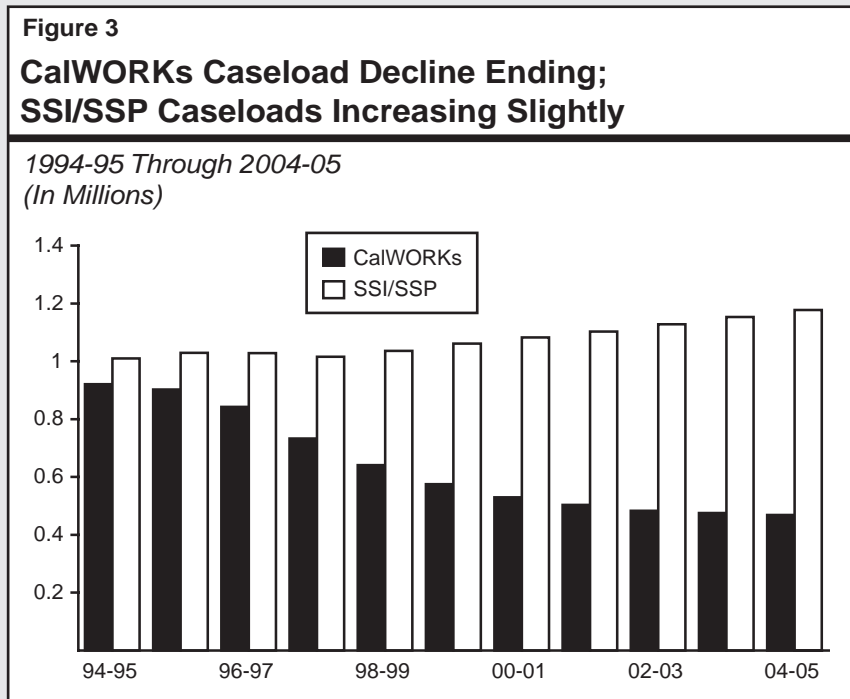
CASELOAD TRENDS

Caseload trends are one important factor driving health and social services expenditures. Figures 2 and 3 (see next page) illustrate the budget's projected caseload trends for the largest health and social services programs. Figure 2 shows Medi-Cal caseload trends over the last decade, divided into three groups: families and children (primarily recipients of California Work Opportunity and Responsibility to Kids [CalWORKs], 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.



Medi-Cal Caseloads. As shown in Figure 2, the Governor's budget plan assumes that a modest increase in caseload will occur during the budget year in the Medi-Cal program. Specifically, the overall caseload

is expected to increase by about 220,000 average monthly eligibles (3.3 percent). This would continue a growth trend, although at a slightly slower pace, that has occurred in prior years.



The caseload projections for 2004-05 take into account the following budget proposals and assumptions that would increase the caseload: (1) new procedures to help transfer children receiving screening and immunization services under the Child Health and Disability Prevention (CHDP) program into more comprehensive Medi-Cal coverage and (2) an assumption of rapid growth (6.8 percent) in 2004-05 in the caseload of medically needy aged, blind, and disabled persons. These increases would be partially offset by the following proposals and assumptions that reduce the caseload: (1) a proposal to limit the number of recent immigrants and undocumented persons who can receive nonemergency services, starting January 1, 2004; (2) a measure adopted last year for mid-year reporting of eligibility for certain adults; and (3) another measure adopted last year to require counties to process annual eligibility redeterminations in a more timely manner.

Healthy Families Caseload. The Governor's budget plan assumes that the entire caseload for the Healthy Families Program will be limited

commencing January 1, 2004, and further assumes that this enrollment cap would continue at least through the end of 2004-05. Only about 5,000 infant children who would be shifted to Healthy Families coverage from their present health coverage under the Access for Infants and Mothers program would be exempted from the enrollment limits.

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 slightly more *persons* in the CalWORKs program—about 1.21 million compared to about 1.17 million for SSI/SSP. (The SSI/SSP cases are reported as individual persons, while CalWORKs cases are primarily families.)

As Figure 3 shows, the CalWORKs caseload peaked in 1994-95 (after the recession of the early 1990s). Since then, the caseload has declined steadily for several years, essentially bottoming out in 2002-03, with slight decreases estimated for 2003-04 and 2004-05, mostly attributable to the proposed grant reduction and stricter work participation requirements.

As discussed in our annual *California's Fiscal Outlook* report, the CalWORKs caseload decline was due to various factors, including the improving economy, lower birth rates for young women, a decline in legal immigration to California, changes in grant levels, behavioral changes in anticipation of federal and state welfare reform, and, since 1999-00, the impact of CalWORKs program interventions (including additional employment services). The recent end to the caseload decline may be attributable to the composition of the remaining caseload and the extent to which it includes adults who face 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 (about 1.5 percent per year). This component accounts for about 30 percent of the total caseload. The larger component—the disabled caseload—grew rapidly in the early 1990s, but more recently has experienced steady moderate growth of about 2.5 percent since 1997-98.

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 percent each year.

SPENDING BY MAJOR PROGRAM

Figure 4 shows expenditures for the major health and social services programs in 2002-03 and 2003-04, and as proposed for 2004-05. As shown in the figure, three major benefit payment programs—Medi-Cal, CalWORKs, and SSI/SSP—account for a large share (about 69 percent) of total spending in the health and social services area.

As discussed earlier, much of the increase in 2004-05 reflects making up for the loss of one-time savings (federal funds and accounting changes) which artificially depressed General Fund spending in 2003-04. As Figure 4 shows, General Fund spending is proposed to increase in most health programs (though not as much as is required by current law), while four of the five largest social services programs (CalWORKs, In-Home Supportive Services [IHSS], Foster Care, and Child Welfare) will experience budget reductions. In-Home Supportive Services is proposed for the largest reduction in percentage terms (13 percent).

MAJOR BUDGET CHANGES

Figures 5 and 6 (see page 14 and 15) illustrate the major budget changes proposed for health and social services programs in 2004-05. (We include the federal Temporary Assistance for Needy Families [TANF] funds for CalWORKs because, as a block grant, they are essentially interchangeable with state funds within the program.) Most of the major changes can be grouped into five categories: (1) funding most caseload changes, (2) suspending cost-of-living adjustments (COLAs), (3) grant and provider rate reductions, (4) capping growth in certain programs and shifting the immigrant-related portion of these programs to counties, and (5) other policy restrictions.

Caseload Changes. With the exception of proposed caps on enrollment discussed below, the budget funds caseload changes in the major health and social services programs.

COLA Suspensions and Grant Reductions. The budget proposes to suspend statutory COLAs for CalWORKs and SSI/SSP, and does not provide the discretionary COLA for Foster Care and related programs. Also, the budget proposes to not “pass-through” the federal SSI COLA. In addition, the budget proposes no inflation adjustment for county administration of CalWORKs, Foster Care, Food Stamps, and Child Welfare Services. In addition to the COLA suspensions, the budget achieves significant savings from a 5 percent grant reduction in CalWORKs.

Figure 4
Major Health and Social Services Programs
Budget Summary^a

(Dollars in Millions)

	Actual 2002-03	Estimated 2003-04	Proposed 2004-05	Change From 2003-04	
				Amount	Percent
Medi-Cal					
General Fund	\$10,554	\$9,765	\$11,569	\$1,804	18.5%
All funds ^b	29,790	29,215	31,216	2,002	6.9
CalWORKs					
General Fund	\$2,078	\$2,060	\$1,995	-\$64	-3.1%
All funds	5,869	5,421	4,866	-555	-10.2
Foster Care					
General Fund	\$511	\$487	\$426	-\$60	-12.4%
All funds	1,645	1,744	1,723	-21	-1.2
SSI/SSP					
General Fund	\$3,004	\$3,144	\$3,346	\$202	6.4%
All funds	7,549	8,116	8,284	168	2.1
In-Home Supportive Services					
General Fund	\$1,086	\$1,033	\$897	-\$137	-13.2%
All funds	2,813	3,215	2,763	-452	-14.1
Regional Centers/Community Services					
General Fund	\$1,511	\$1,671	\$1,779	\$108	6.5%
All funds	2,299	2,554	2,709	154	6.0
Developmental Centers					
General Fund	\$345	\$365	\$370	\$5	1.4%
All funds	647	715	690	-25	-3.5
Healthy Families Program					
General Fund ^c	\$24	\$294	\$306	\$11	3.8%
All funds	693	803	839	36	4.5
Child Welfare Services					
General Fund	\$588	\$628	\$610	-\$18	-2.8%
All funds	1,952	2,013	2,058	45	2.2
Children and Families Commission					
General Fund	—	—	—	—	—
All funds	\$533	\$755	\$566	-\$189	-25.1%
Child Support Services					
General Fund	\$432	\$434	\$463	\$29	6.7%
All funds	1,075	1,129	1,167	38	3.4

^a Excludes departmental support.

^b Includes some costs for other departments and miscellaneous funds.

^c Some program costs temporarily shifted to Tobacco Settlement Fund in 2002-03.

Figure 5

Health Services Programs Proposed Major Changes for 2004-05 General Fund

Medi-Cal	Requested: \$11.6 billion
	Increase: \$1.8 billion (+18.5%)

- + \$958 million due to the 2003-04 shift from accrual to cash
 - + \$655 million to offset the loss of one-time federal funds
 - + \$253 million for a net increase in costs for pharmacy benefits
 - + \$164 million for rate increases for certain clinics and hospitals
-
- \$341 million from a provider rate reduction and other rate changes
 - \$279 million from shifting some provider payments into 2003-04 and \$144 million from delaying some payments until 2005-06
 - \$184 million due to prior actions to reduce costs for drugs, medical supplies, and services

Department of Developmental Services	Requested: \$2.2 billion
	Increase: \$115 million (+5.6%)

- + \$105 million net increase from the transfer of habilitation services
-
- \$100 million from establishing statewide standards for the purchase of services in Regional Centers

Healthy Families Program	Requested: \$306 million
	Increase: \$11 million (+3.8%)

- \$32 million from imposing a cap on program enrollment

Department of Mental Health	Requested: \$911 million
	Increase: \$32 million (+3.6%)

- + \$28 million to prepare to open Coalinga State Hospital in 2005-06
-
- \$20 million to eliminate Children's System of Care

Figure 6

Social Services Programs Proposed Major Changes for 2004-05 General Fund

CalWORKs	Requested: \$2 billion
	Decrease: -\$64 million (-3.1%)

- + \$136.5 million for child care and automation costs associated with the Governor's welfare reform
 - + \$94.4 million for TANF transfers to achieve General Fund savings in other programs
-
- \$132.5 million from the full-year impact of proposed 5 percent grant reduction effective April 2004
 - \$162.9 million from grant savings attributable to Governor's welfare reform
 - \$67.8 million because welfare-to-work match obligation is satisfied
 - \$53.7 million for grant savings associated with more adults reaching their five-year time limit

SSI/SSP	Requested: \$3.3 billion
	Increase: \$202 million (+6.4%)

- + \$238.1 million to replace one-time federal fiscal relief funds
 - + \$57.9 million for caseload increase
-
- \$62.5 million from not "passing through" the federal COLA

In-Home Supportive Services	Requested: \$897 million
	Decrease: -\$137 million (-13%)

- + \$147.4 million for caseload increase
 - + \$61.4 million to replace one-time federal funds
-
- \$277 million net savings from the full-year impact of eliminating the residual (state-only) program
 - \$98 million from limiting state participation in provider wages to the minimum wage, rather than \$10.10 per hour

Enrollment Caps and County Block Grant

Enrollment Caps. The Governor's budget proposes to cap enrollment for some or all caseloads in the following health and social services programs: Medi-Cal Healthy Families, AIDS Drug Assistance Program, the Breast and Cervical Cancer Treatment Program, California Children's Services (CCS), the Genetically Handicapped Persons Program (GHPP), state mental hospitals, the Cash Assistance Program for Immigrants (CAPI, state-only SSI/SSP), the California Food Assistance Program (CFAP, state-only Food Stamps), and CalWORKs for post-August 1996 immigrants. The budget scores savings of about \$60 million in 2004-05 from these enrollment caps.

County Block Grants. The budget plan proposes to achieve additional savings by restructuring and consolidating some of these capped programs into a single block grant to counties. Affected by this proposal are the following programs which serve legal immigrants: CalWORKs, CFAP, CAPI, and Healthy Families. The budget assumes savings of \$6.6 million (5 percent of the proposed block grant) from efficiencies associated with county block grant administration.

Other Policy Changes

IHSS. The budget includes several proposals which restrict services, eligibility, and provider wages. Specifically, the Governor proposes to (1) eliminate the residual program, which is funded exclusively with state and county dollars; (2) limit state participation in provider wages to the minimum wage (that is \$6.75, rather than the \$10.10 per hour currently authorized); and (3) reduce services for recipients living with able-bodied relatives.

CalWORKs. The Governor proposes state welfare reforms including (1) a 25 percent grant reduction for cases in sanction status, (2) stricter work requirements for recipients and applicants, and (3) a 25 percent grant reduction for families who have reached their five-year time limit and are unemployed.

Child Care. The budget proposes several changes to state child care programs including increases in family fees, reductions in payments to providers, eligibility limits, and an elimination of dedicated funding for child care for families who have been off cash assistance for three years or more.

Medi-Cal. The Governor's budget proposal reflects the continuation into the budget year of various reductions that were proposed to begin in the current year (but that have not been enacted at the time this analysis was written). These proposals would reduce the reimbursement rates paid

to specified providers, which were already set to decrease by 5 percent, by a total of 15 percent; impose the enrollment caps discussed above; and eliminate funding earmarked to increase pay for nursing home workers. Additional reductions proposed in the spending plan to commence in the budget year would reduce Medi-Cal expenditures by delaying payments to providers by one week; establishing a “quality improvement fee” for managed care health plans; and reducing the reimbursements paid to certain clinics and hospitals.

The administration also proposes to pursue a federal waiver to achieve additional ongoing Medi-Cal savings in 2005-06 by simplifying eligibility standards, imposing copayments for services, modifying benefit packages for certain optional populations, expanding managed care plans, and implementing other changes.

Department of Developmental Services (DDS). The January budget plan dropped administration proposals presented in November to cap caseloads for Regional Center (RC) community services. Funding is provided for a shift of habilitation services from the Department of Rehabilitation to DDS that was adopted last year. Also, the budget reversed an earlier proposal to end certain community services, such as respite care. State savings would be achieved in 2004-05 through such steps as establishing copayments to families of certain children receiving services and standardizing statewide the services that are provided in the community. The administration is also proposing to pursue the development of additional cost-saving measures for implementation in 2005-06, including an expansion of copayments, statewide standardization of the rates paid for the major services purchased by RCs, and implementation of a proposed waiver program to cap individual allowances for client services while giving them increased client control over their services.

The administration intends to proceed with closing Agnews Developmental Center and indicated it will review whether additional facility closures are warranted.

Healthy Families Program. The budget plan continues into 2004-05 the proposal first outlined by the administration in November to cap caseloads and reduce provider rates for various programs starting in 2003-04. Benefits for recent immigrants would become part of a block grant to counties (as discussed above). The premiums and benefits provided for children of families with higher incomes would be modified to establish a “two-tier” program structure by 2005-06.

Public Health. The budget proposes a series of program reductions. All TANF funding for the Community Challenge Grant program to reduce the number of teenage and unwed pregnancies and to promote responsible parenting would be eliminated. Allocations for the CHDP pro-

gram would decline dramatically as clients are shifted to the Medi-Cal and Healthy Families programs. A provider rate reduction comparable to the one imposed for Medi-Cal would be imposed for CCS, CHDP, and GHPP, so that a 5 percent rate cut for these programs that was enacted in the *2003-04 Budget Act* would increase to a total of 15 percent under the Governor's spending plan. The administration proposes to again suspend the state's annual contribution to the County Medical Services Program.

Department of Mental Health. State funding would be provided in the budget year for the staffing needed to open a new state hospital primarily to house Sexually Violent Predators in Coalinga early in 2005-06. A series of measures are proposed to limit the population of certain criminal offenders to the state hospital system, and counties (rather than state hospitals) would henceforth be responsible for holding individuals who were being considered for commitment to the state hospital system as Sexually Violent Predators after their parole from state prison. Funding for mental health services for certain children in the Medi-Cal Program would grow significantly, but all funding for the state-supported Children's System of Care program would be eliminated.

Senate Bill 2. No resources are provided in the budget for any state agencies to commence the implementation of Chapter 673, Statutes of 2003 (SB 2, Burton), a measure expanding health insurance coverage.

Department of Alcohol and Drug Programs. The Office of Problem and Pathological Gambling, a newly created state office to help gambling addicts that is funded with Indian gaming revenues, would be abolished.

CROSSCUTTING ISSUES

Health and Social Services

CHILD CARE

The Governor's budget proposes a number of significant reforms to California's subsidized child care system. These proposals effectively prioritize limited child care resources. However, the Governor's proposals lack important policy, implementation, and administrative details that would help the Legislature weigh state savings against reducing child care services for a significant number of lower-income families. We evaluate the proposals' effect on children, families, and the state budget, and present some alternative approaches.

BACKGROUND

California's subsidized child care system is primarily administered through the State Department of Education (SDE) and the Department of Social Services (DSS). A limited amount of child care is also provided through the California Community Colleges. Figure 1 (see next page) summarizes the funding levels and estimated enrollment for each of the state's various child care programs as proposed by the Governor's 2004-05 budget.

As the figure shows, the Governor's 2004-05 budget proposes about \$3 billion (\$1.8 billion General Fund) for the state's child care programs. This is a decrease of about \$60 million from the estimated current-year level of funding for these programs. About \$1.4 billion (49 percent) of total child care funding is estimated to be spent on child care for current

or former California Work Opportunity and Responsibility to Kids (CalWORKs) recipients. The total proposed spending level will fund child care for approximately 684,100 children statewide in the budget year.

Figure 1**California Child Care Programs**

2004-05
(Dollars in Millions)

Program	State Control ^a	Estimated Enrollment	Governor's Budget
CalWORKs			
Stage 1 ^b	DSS	89,000	\$510.4
Stage 2 ^b	SDE	93,500	546.2
Community Colleges (Stage 2)	CCC	3,000	15.0
Stage 3	SDE	57,000	368.8
Subtotal		(242,500)	(1,440.4)
Non-CalWORKs			
General Child Care	SDE	86,100	\$593.4
Alternative Payment Programs	SDE	29,800	182.3
Pre-School and After-School	SDE	308,500	511.0
Other	SDE	17,200	225.1
Subtotal		(441,600)	(1,511.8)
Totals—All Programs		684,100	\$2,952.2
^a Department of Social Services (DSS); State Department of Education (SDE); California Community Colleges (CCC).			
^b Includes holdback of reserve funding which will be allocated during 2004-05 based on actual need.			

CalWORKs Child Care System

State law requires that adequate child care must be available to CalWORKs recipients receiving cash aid in order to meet their program participation requirements (a combination of work and/or training activities). If child care is not available, then the recipient does not have to participate in CalWORKs activities for the required number of hours, until child care becomes available. The CalWORKs child care is delivered in three stages:

- **Stage 1.** Stage 1 is administered by county welfare departments (CWDs) and begins when a participant enters the CalWORKs

program. In this stage, CWDs refer families to resource and referral agencies to assist them with finding child care providers. The CWDs then pay providers directly for child care services.

- **Stage 2.** The CWDs transfer families to Stage 2 when the county determines that participants' situations become "stable." In some counties, this means that a recipient has a welfare-to-work plan, or employment, and has a child care arrangement that allows them to fulfill their CalWORKs obligations. In other counties, stable means that the recipient is off aid altogether. Stage 2 is administered by SDE through a voucher-based program. Participants can stay in Stage 2 while they are in CalWORKs and for two years after the family stops receiving a CalWORKs grant.
- **Stage 3.** In order to provide continuing child care for former CalWORKs recipients who reach the end of their two-year time limit, the Legislature created Stage 3 in 1997. Recipients timing out of Stage 2 are eligible for Stage 3 if they have been unable to find other subsidized child care. Assuming funding is available, former CalWORKs recipients may receive Stage 3 child care as long as their income remains below 75 percent of the state median income (SMI) level and their children are below age 13.

Non-CalWORKs Child Care System

As discussed above, CalWORKs recipients are guaranteed child care in certain programs that are reserved for current and former CalWORKs recipients. In contrast, non-CalWORKs child care programs (primarily administered by SDE) are open to all low-income families at little or no cost to the family. Access to these programs is based on space availability and income eligibility. This is because child care for low income non-CalWORKs families is not fully funded and waiting lists are common.

Families receive child care subsidized by SDE in one of two ways, either by (1) receiving vouchers from the Alternative Payment (AP) program providers that offer an array of child care arrangements for parents or (2) being assigned space in public or private child care centers or "family child care homes" that contract with SDE to provide child care. (Family child care homes provide care in the home of the provider.)

Current-Year Child Care Reforms

As part of the 2003-04 budget package, the Legislature approved a number of child care reforms that affected both CalWORKs and non-CalWORKs child care. These changes to eligibility and provider reimbursement rates are described below.

Elimination of Child Care Eligibility for 13-Year Olds. Budget trailer bill provisions eliminated child care services for 13-year olds. This age group could previously receive subsidized care if they were in families with incomes below 75 percent of the SMI level.

Elimination of Child Care Eligibility for “Grandfathered” Families. In 1997, the Legislature reduced the family income eligibility requirements for subsidized child care from 100 percent to 75 percent of the SMI, adjusted for family size pursuant to Chapter 270, Statutes of 1997 (AB 1542, Ducheny). However, Chapter 270 specified that children from families with incomes between 75 percent and 100 percent of SMI that were already receiving subsidized care could maintain (be grandfathered in) their right to such care as long as their family income did not exceed 100 percent of SMI. The 2003-04 budget package eliminated this eligibility exception.

Changes in Regional Market Rates. The state reimburses AP child care providers based on the regional market rate (RMR). The RMR is a survey of what child care providers charge in each region. This information is used to determine the maximum reimbursement rate the state will pay providers in any given region. Separate rates are calculated depending on provider type, age of children, and time in care. The Legislature lowered the maximum reimbursement rate from the 93rd percentile to the 85th percentile of the RMR. This means that under the new policy, the state will fully reimburse about 85 percent of regional providers, and will not fully reimburse the 15 percent of providers with the highest costs.

GOVERNOR’S BUDGET PROPOSES ADDITIONAL REFORMS

Figure 2 compares the Governor’s child care reform proposals to current law. The Governor’s budget proposes a number of reforms to the CalWORKs and non-CalWORKs subsidized child care systems including changes in program eligibility, family fees, and provider reimbursement, which we describe below.

Eligibility Restrictions

The Governor’s budget proposes several child care eligibility changes. The administration estimates that these changes would result in combined savings of about \$84.8 million and approximately 20,000 children losing eligibility for subsidized child care. (The Governor’s budget assumes that the 11 and 12 year olds that lose eligibility for subsidized child care

Figure 2

Administration’s Child Care Proposals Compared to Current Law/Current Practice

	Current Law/Current Practice	Administration’s Proposal (and Budget-Year Impact)
Eligibility		
Income Eligibility	Family income up to 75 percent of the SMI (for a family of four).	Implement a three-tiered eligibility structure. Maximum income eligibility in “high” cost county would remain the same. Income eligibility in “medium” and “low” cost counties would decrease. Annual adjustments based on CNI. (\$9.3 million savings; 1,900 children lose eligibility.)
Age Eligibility	Children up to age 13 are eligible for both CalWORKs and non-CalWORKs child care.	Eliminate eligibility for 11 and 12 year olds if after-school programs are available (for which they would receive priority placement). (\$75.5 million savings; 18,000 children lose eligibility and move to after-school programs.)
Stage 3 Child Care	Former CalWORKs participants are eligible for Stage 3 as long as they meet income and age eligibility. Current practice prevents families from applying for non-CalWORKs child care while receiving aid.	Limit Stage 3 child care to one year (in addition to two years in Stage 2). Families currently in Stage 3 would receive one additional year. CalWORKs families could sign up for non-CalWORKs care as soon as they have income. (No impact in the budget year.)
Eligibility for Nonworking Parents	No time limit as long as families remain eligible.	Limit eligibility to two years. (No savings scored; caseload impact unknown.)

Continued

Other Proposals		
Reimbursement Rates	Providers are reimbursed at up to 85 th percentile of the RMR.	Creates a six-level reimbursement rate structure that reimburses providers between 40 th and 85 th percentile of the RMR ^a , depending on licensure, training, and whether they serve private pay clients. (\$57.7 million savings; 95,592 children impacted.)
Family Fees	Families with income over 50 percent of SMI pay fees up to 8 percent of their gross income.	Families with income over 40 percent of SMI ^b pay fees up to 10 percent of gross income. (\$22.3 million savings; fees increased for 77,250 children.)
Totals		
Savings (All Funds)		\$164.8 million
Children Losing Eligibility		20,000 <i>(including those children switching to after-school care)</i>
Children Subject to Increased Fee		77,250
^a	RMR=Regional Market Rate.	
^b	SMI=State Median Income.	

would receive after-school care under the proposal.) The proposed eligibility restrictions achieve savings by eliminating the funding associated with the “freed-up” child care slots that are vacated due to eligibility restrictions rather than redirecting the savings to fund child care for children on waiting lists. We summarize the proposals, describe the impact of the proposed eligibility changes on children and families, and offer issues for legislative consideration.

Income Eligibility

The Governor’s proposal to create a three-tiered child care eligibility structure reflecting the cost-of-living differences among counties has merit. The proposed eligibility structure would, however, lower the income eligibility threshold for subsidized child care in medium- and lower-cost counties, resulting in an estimated 1,900 children losing

eligibility for subsidized child care programs for a state savings of \$9.3 million in 2004-05. While the proposal lowers the eligibility threshold, it does maintain eligibility for families with the lowest income.

Proposal Creates a Three-Tiered Income Eligibility Structure. Under current law, income eligibility (last increased in September 2000) for child care is based on the SMI (adjusted for family size). The administration proposes creating a three-tiered income eligibility structure that reflects the differences in cost of living among counties. Current eligibility levels for families in “high-cost” counties would remain the same, while eligibility for families in all other counties would be reduced. Figure 3 shows the proposed income eligibility levels for subsidized child care. As the figure shows, a family of three in a “medium-cost” county with monthly income above \$2,729 would no longer be eligible for subsidized child care.

Figure 3

Proposed Maximum Monthly Subsidized Child Care Income Eligibility^a

	Family Size				
	1 and 2	3	4	5	6 or More
High cost county ^b	\$2,730	\$2,925	\$3,250	\$3,770	\$4,290
Medium cost county ^c	2,606	2,792	3,102	3,599	4,095
Lower cost county ^d	2,482	2,659	2,954	3,427	3,900

^a Current income eligibility is the same as the high cost county figures.
^b High cost counties: Marin, San Francisco, and Santa Clara.
^c Medium cost counties: Alameda, Contra Costa, Los Angeles, Monterey, Napa, Orange, San Diego, San Luis Obispo, Santa Barbara, Santa Cruz, Solano, Sonoma, and Ventura.
^d Lower cost counties: All other counties.

The Governor’s budget proposes basing income eligibility thresholds on the fixed dollar amount shown in Figure 3 beginning in October 2004. This amount would be adjusted annually in accordance with changes in the California Necessities Index (CNI). The income eligibility changes would result in an estimated 1,900 children losing eligibility for child care for a total state savings of \$9.3 million.

Child Care Costs Vary by Region. Like the cost of living, child care costs vary across the state. A recent study done by the Public Policy Institute of California and the SPHERE Institute showed that both family-

based care and center-based care was significantly more expensive in the Bay Area, with the highest statewide costs in Santa Clara, San Francisco, and Marin Counties. Furthermore, the study showed that child care costs varied across the state.

Conclusion. We believe that an income eligibility system that takes regional cost of living into account has merit because a family living in a high cost region of the state will, on average, need to spend more on housing, child care, food, and other necessities.

In considering the administration's proposal, the Legislature should first evaluate the merits of a differential income eligibility system, and then determine the level of savings it would want to achieve with such a policy. The administration has devised a differential income eligibility system by adopting the current income eligibility threshold as the eligibility ceiling in high cost counties and then lowering eligibility thresholds in low and medium cost counties. As a result, the administration's proposal generates General Fund savings. Alternatively, a state income eligibility system that recognizes differences in regional costs of living could be developed in a fiscally neutral way.

Age Eligibility

The administration proposes to eliminate subsidized child care for 11 and 12 year olds, except when after-school programs are not available to serve these children. Under the proposal, 11 and 12 year olds would be given priority in after-school programs. Although we believe that the proposal is reasonable given the state's fiscal constraints, our analysis indicates that the administration has significantly overestimated savings resulting from this proposal. In addition, the proposal lacks key details regarding the definition of "available" as it applies to after-school programs, as well as important implementation details.

Proposal Restricts Eligibility for 11 and 12 Year Olds. Under current law, children age 12 or below from families with incomes below 75 percent of the SMI are eligible for child care. The administration proposes to eliminate child care eligibility for 11 and 12 year olds when after school programs are available for an estimated savings of \$75.5 million. The administration estimates that about 18,000 children ages 11 and 12 would lose subsidized child care eligibility and obtain after-school care.

Governor's Proposal Lacks Detail. The proposal lacks key details that are necessary to evaluate both the number of children that might be affected by this proposal as well as projected savings. For example, the administration's policy states that 11 and 12 year olds will lose child care eligibility *only if* after-school programs are available to the child. How-

ever, it is unclear what constitutes “availability.” After-school programs typically operate for only a limited time period, often no later than 7:00 p.m., and usually not on the weekends and during the summer. About 70 percent of the working adults receiving CalWORKs are employed in the service or retail trade industries that often require nontraditional work hours. The administration’s policy is unclear as to whether or not the definition of available would include a standard that after-school programs be available to CalWORKs participants even on nights and weekends.

Another area needing clarification is how the proximity of after-school programs to the child’s residence or a parent’s employer would be factored into determining availability. For example, some families may face transportation or other barriers that prevent them from accessing after-school programs.

Availability of Current After-School Programs. The state and federal governments currently fund two major before and after-school programs—the After School Education and Safety Program and the 21st Century Community Learning Centers—for K-12 students in California. The Governor’s budget includes \$121.6 million (Proposition 98) for the After School Education and Safety Program to serve about 133,000 students. At some time in the future, Proposition 49 (passed by the voters in November 2002) will require an additional \$429 million annually for the program. (Please see the discussion below.) Federal 21st Century Learning Centers also provide before- and after-school services. In the current year, California received about \$76 million in federal funds to serve about 79,000 students.

Although schools currently offer an array of after-school programs, it remains uncertain whether these programs have the capacity to accommodate the 18,000 11 and 12 year olds estimated to lose child care eligibility under the Governor’s proposal. In some areas, there may be waiting lists for after-school programs. If the programs have the capacity, these additional students would in effect displace generally younger students currently being served by the program. This is because the 11 and 12 year olds would have priority in publicly supported after-school programs under the Governor’s proposal.

Estimated Savings Not Likely to Be Achieved. The administration’s stated intention is that either 11 and 12 year olds should receive care in after-school programs, or when after-school programs are not available, through the existing subsidized child care system. Yet, the administration’s savings estimate assumes that *all* 11 and 12 year olds will be eliminated from the child care system. We believe that this expectation is unrealistic given that many CalWORKs recipients work in industries often requiring

nontraditional work hours, when traditional after-school programs may not be available.

Conclusion. The Governor's proposal to eliminate subsidized child care eligibility for 11 and 12 year olds when after-school care is available, significantly overestimates savings and lacks important details the Legislature needs to evaluate the proposal.

Stage 3 Eligibility Limits

The Governor's budget proposes to limit Stage 3 CalWORKs child care to one year (in addition to two years in Stage 2) once a family has left cash aid, and allow CalWORKs families to sign up for a slot in the non-CalWORKs child care system as soon as they begin to earn income. Those families currently in Stage 3 child care would have one more year of eligibility. Given limited child care resources, we believe the proposal is reasonable because it addresses the differential treatment of working poor families and families previously in CalWORKs. However, limiting eligibility for Stage 3 child care creates a transition problem for families currently in Stages 2 or 3 of the CalWORKs child care system. We offer two options that would help address this transition problem.

Proposal Would Limit Stage 3 Child Care to One Year. Generally, families are eligible for Stage 3 child care after they have been in Stage 2 child care for two years. Under current budgeting practices, families may remain in Stage 3 until their income exceeds 75 percent of the SMI or until their children are 13 years old or older. The Governor's budget proposes restricting the amount of time that a family can receive Stage 3 child care to no more than one year after they have left cash aid and have exhausted their two-year transitional eligibility in Stage 2. Under the proposal, families who began receiving Stage 3 services on or before June 30, 2004 and meet other eligibility standards will be allowed to continue receiving services until July 1, 2005. As a result, the administration estimates that budgetary savings and Stage 3 caseload reductions will not be realized until 2005-06.

Proposal Allows CalWORKs Families to Apply for Non-CalWORKs Child Care as Soon as They Have Income. Current practice generally prohibits CalWORKs families from signing up on a waiting list for non-CalWORKs child care until they no longer receive CalWORKs aid. The Governor's budget proposes to allow CalWORKs families to apply for such care as soon as they have some income, even while they are still on aid. This change is intended to help ensure that these CalWORKs families would not be disadvantaged in accessing child care once they leave CalWORKs.

Stage 3 Reforms May Disadvantage Certain Current and Former CalWORKs Families. This proposal would disadvantage some current and former CalWORKs families because these families would not have had the benefit of putting their names on a non-CalWORKs child care waiting list at the time they started earning income. Generally, the lowest-income families on a non-CalWORKs child care waiting list are given priority for available child care slots. These current and former CalWORKs families may have higher incomes than other families on a child care waiting list and, therefore, they may be given lower priority for available child care slots. Also, current Stage 3 families may simply have less time to move up the waiting list.

We view the disadvantages for current Stage 2 and 3 families as a transition problem that the Legislature may want to address. If the Legislature decides to accept the administration's proposal to limit Stage 3 to one year, it may want to consider the following options that would help to mitigate some of the barriers to child care that some families might experience as a result of the proposed Stage 3 reforms.

- **Allow Families in Stages 2 and 3 Child Care to Remain Eligible.** This option would allow current CalWORKs families to sign up for non-CalWORKs child care immediately, but remain eligible for Stage 3 eligibility until they are able to find a slot in the broader subsidized child care system. Under this option the Governor's one year limit on Stage 3 only applies to future Stage 3 families. This option would assist CalWORKs families, but would lower out-year savings.
- **Allow Families in Stage 2 and 3 Child Care to Remain Eligible for Up to Three Years.** As a variation of the above option, for three years after implementation of the proposed change CalWORKs families would maintain Stage 3 eligibility, after which time they would not be able to extend their time in Stage 3, regardless of whether or not they secured other arrangements. Again, this option would smooth the transition to regular subsidized child care for CalWORKs families, but would lower out-year savings, compared to the Governor's budget.

Although the above alternatives reduce out-year savings, they also reduce the potential that families will return to CalWORKs to obtain needed child care. In addition, these alternatives would reduce future Stage 3 child care costs once the respective transition periods conclude.

Conclusion. The current child care system provides differential eligibility for CalWORKs and non-CalWORKs families. Specifically, families that leave CalWORKs receive child care until they are no longer income or age eligible, while working poor families receive subsidized child care

only if space is available. The Governor's Stage 3 proposal addresses this differential treatment. Accordingly, we believe that the Governor's proposal is reasonable. However, we do recognize that there is a transition issue for families currently in Stage 2 or 3 child care, and provide two options to address that circumstance.

Eligibility Limits for Nonworking Parents

The administration proposes to limit eligibility for families who are eligible for child care based on their participation in education and training activities to two years. All families would receive two additional years of eligibility after the policy is implemented. Given limited child care resources, we believe this proposal is reasonable.

The administration proposes to limit eligibility for families who are eligible for child care based solely on their participation in education or training-related activities to two years. Currently, there is no time limit on eligibility for this group. Upon implementation of the proposed change, families would receive an additional two years of eligibility regardless of how many years they had been receiving child care. The administration does not anticipate out-year savings because it will make the vacated child care slots available to other families.

The administration was unable to provide information on the number of children who are eligible for subsidized child care based solely on parental participation in education and training activities. Similarly, the administration was unable to estimate how many children would be impacted by this change. Given limited child care resources, however, we believe that it is reasonable to limit eligibility for families that are not working, but participating in education and training activities.

Weighing the Costs and Benefits of Restricting Child Care Eligibility

As the Legislature considers whether to adopt the child care eligibility changes contained in the Governor's budget proposal, it should examine the impact on the state budget, families, and children. The state is facing a difficult financial situation that may necessitate limiting the level of service provided through public programs. The proposed child care eligibility restrictions are estimated to save \$164.8 million (all funds), which could help address the budget shortfall or be used for other legislative priorities.

On the other hand, research has shown that access to reliable, affordable child care is an important part of employment stability for low-income families. Eliminating eligibility for child care for some low-income

families may make them more susceptible to employment disruptions that could increase their likelihood of needing CalWORKs and other income dependent public aid programs. This is especially relevant beginning in 2005-06 under the budget plan, as transition funding would end and Stage 3 families would lose their CalWORKs child care eligibility. The Governor's budget does not propose any additional non-CalWORKs child care spending related to his proposed child care reforms. Under the Governor's proposals, children who had formerly received care through the CalWORKs child care system would begin moving into the non-CalWORKs system in 2005-06. This could result in increased demand for child care in a system that often has waiting lists for eligible families. As a result, additional families may not be able to secure subsidized child care, which could result in additional employment disruptions for some families.

Provider Reimbursement

While we believe the policy objective is sound, we withhold recommendation on the administration's proposal to create a tiered-provider reimbursement rate structure pending additional detail from the administration regarding health, safety, and education standards as well as implementation and administration issues.

Proposal Creates a Tiered Reimbursement Rate Structure. Generally, AP providers are reimbursed under current law up to the 85th percentile of the rates charged by other providers in the area offering the same type of child care. Figure 4 (see next page) shows the administration's proposed reimbursement rate structure. The Governor's proposal creates a six-tiered child care reimbursement rate structure that reimburses providers from the 40th to 85th percentile of the RMR, depending on licensing and accreditation, health, safety, and childhood development training, and the mix of subsidized or unsubsidized families served. This means that under the proposed new structure, licensed exempt providers without specialized education or training will be reimbursed by the state at a rate no greater than the 40th percentile of the rate charged by child care providers in the region. At the other end of the proposed reimbursement rate structure, licensed, accredited providers with specialized training will be reimbursed by the state at a rate up to the 85th percentile of the rate charged by regional child care providers.

We believe that the policy of basing reimbursement rates on a provider's level of training, education, and other factors has merit in that it (1) reflects the reimbursement structure in the nonsubsidized child care market and (2) better reflects the cost of providing care.

Legislature Needs Additional Detail to Evaluate Merits and Impact of Proposal. The administration's proposal does not provide adequate detail that would allow the Legislature to fully evaluate how the proposed changes will affect child care providers, families, and quality of care. The administration includes a provision that SDE and DSS, in consultation with the Department of Finance (DOF) shall establish a standardized process for documenting a provider's early childhood education, health and safety training, and accreditation for purposes of determining a reimbursement limit. However, the true impact of the proposal on families, counties, and state finances cannot be fully evaluated until the Legislature receives more information regarding these and other details such as rate determination and the oversight process.

Figure 4**Proposed Child Care Provider Reimbursement Schedule**

Provider Type	Maximum Reimbursement Rate
Licensed	
Accredited: specialized education and/or training; serve subsidized and unsubsidized children.	Up to 85 th percentile of RMR ^a
No specialized education and/or training; serve subsidized and unsubsidized children.	Up to 75 th percentile of RMR.
Accredited: specialized education and/or training; serve only subsidized children.	Up to 75 th percentile of RMR.
No specialized education and/or training; serve only subsidized children.	Up to 50 th percentile of RMR.
License Exempt	
Specialized education and/or training.	Up to 50 th percentile of RMR.
No specialized education and/or training.	Up to 40 th percentile of RMR.
^a RMR=Regional Market Rate.	

Analyst's Recommendation. We believe the policy of tying reimbursement rates to the level of training, education, and other factors has merit. However, we withhold recommendation on the administration's proposal to create a tiered child care provider reimbursement structure given uncertainties regarding important definitional, implementation, and administrative details.

Family Fees

The administration proposes to lower the income threshold at which a family must begin paying fees, raise the maximum amount a family would have to pay for child care, and limit fee deferral for certain children at risk for neglect or abuse. The combined policy changes would result in state savings of about \$22.3 million and would increase fees for about 77,250 children. In considering this proposal the Legislature may want to examine linking the amount of family fees paid to the provider's cost of providing care, level of training, licensure, and other factors.

Proposal Increases the Number of Families Required to Pay a Fee and Increases Maximum Amount of Fees. Currently, families are required to pay a fee for child care once their income reaches 50 percent of the SMI. The fees are not to exceed 8 percent of their total income. The administration's proposal would instead require families to pay a fee once they exit cash aid—approximately 40 percent of the SMI—in an amount not to exceed 10 percent of family income. For example, under the Governor's proposal a family of three with an annual income of about \$25,000 would pay about \$56 more for child care each month. Figure 5 (see next page) shows the proposed new fee schedule.

The Governor's budget further proposes that families pay the family fees directly to providers to achieve administrative simplicity. Currently, counties have some flexibility in the way fees are collected. In most counties fees are collected through an AP Program or county agency which then reimburses providers. In some counties, fees may also be collected directly by providers. In most cases, the administration's proposal will shift the burden of collecting the fees from the counties to child care providers. To the extent that providers are unable to collect these fees, it would effectively result in a provider rate reduction.

Fee Limitation for CWS Referred Kids. Under the Governor's proposal, families receiving a referral for child care services from Child Welfare Services (CWS) because the child is considered to be at risk for neglect or abuse are exempt from family fees for no more than one year. Currently they are exempt indefinitely. Children who are considered at

risk and are referred by a non-CWS professional will be exempt from family fees for no more than three months.

Weighing the Costs and Benefits of Fees. Increasing family fees will allow the state to fund child care for more children at the same level of state funding. Although the Governor's proposal recognizes the ability of families to pay for child care through its sliding scale fee structure, increasing fees puts an additional financial burden on relatively low-income families.

Figure 5

**Family Child Care Fees^a
Administration's Proposed New Monthly Fee Schedule**

Full-Time Care			Part-Time Care		
Income	Fee	Percent of Income	Income	Fee	Percent of Income
\$1,564	\$22	1%	\$1,564	\$9	1%
1,994	100	5	1,994	40	2
2,216	151	7	2,216	60	3
2,438	210	9	2,438	84	3
2,659 ^b	266	10	2,659 ^b	106	4
2,792 ^c	279	10	2,792 ^c	112	4
2,925 ^d	293	10	2,925 ^d	117	4

^a Family of three full-time care.
^b Income limit for lowest cost counties.
^c Income limit for high cost counties.
^d Income limit for highest cost counties.

Linking Fees to Cost of Care. When considering this proposal, the Legislature may also wish to consider basing the fee structure on the cost of care, thereby enabling families to make decisions about the type of care they utilize related to the amount they pay. Requiring families in the subsidized child care system to pay a portion of the cost of care more accurately reflects the reimbursement arrangements they will be subject to once they leave the subsidized system.

Conclusion. The administration's child care fee proposals would increase fees for about 77,250 children. As the Legislature considers this proposal, it may want to also consider linking the amount of family fees

paid to the provider's level of training, licensure, the cost of providing care, and other factors.

PROPOSITION 49: AFTER SCHOOL EDUCATION AND SAFETY PROGRAM

We find that, based on the Governor's proposed budget and our fiscal forecast, Proposition 49 would not trigger an increase in funding for the After School Education and Safety Program until 2007-08. In part, the exact timing of when Proposition 49 will require additional spending depends on (1) how the state solves the structural imbalance between General Fund expenditures and revenues and (2) future growth in General Fund revenues.

As approved by voters in 2002, Proposition 49 requires that the state appropriate additional funding for the After School Education and Safety Program beginning as early as 2004-05. The state must increase funding for the program from the \$121.6 million provided in 2003-04 to \$550 million (a \$428.4 million increase) when certain conditions are met, which we describe below. The funding for Proposition 49 is "continuously appropriated" (that is, there is no need for annual legislative action to appropriate funds). When additional funds are provided for the program, they will be "on top of" the state's minimum guarantee funding requirement for Proposition 98 for that year (referred to as an "overappropriation").

When Will Proposition 49 Trigger?

Proposition 49 requires the state to provide additional funding for the After School Education and Safety Program when specified General Fund spending reaches a required level. The Proposition 49 "trigger" funding level is determined by (1) establishing a base year between 2000-01 and 2003-04 in which the "nonguaranteed General Fund appropriation" level was the highest and (2) adding \$1.5 billion to that base year funding level. Our interpretation of the initiative is that nonguaranteed General Fund appropriations are non-Proposition 98 General Fund appropriations plus any over-appropriations of the Proposition 98 minimum guarantee.

Figure 6 (see next page) shows the calculation of the nonguaranteed General Fund appropriation level that would trigger the additional \$428 million in spending on after-school programs. The figure shows that 2001-02 is the base year, and that the base appropriation level is \$54.7 billion. This means that the state would not have to spend additional dollars to meet the proposition's requirement until nonguaranteed General

Fund appropriations in any year exceeded this amount. At such time, all spending above the base amount would go to after-school programs until the \$550 million cap was reached. In 2004-05, the Governor's budget proposes a nonguaranteed appropriation level of \$49.3 billion, \$5.4 billion less than the trigger level.

Figure 6**What Is the Proposition 49 Trigger?***(In Billions)*

	2000-01	2001-02	2002-03	2003-04
Non-Proposition 98 appropriations	\$47.9	\$47.2	\$48.6	\$44.8
Proposition 98 appropriations above minimum	0.5	6.1	—	—
Nonguaranteed appropriations	\$48.3	\$53.2	\$48.6	\$44.8
"Add-on" amount	1.5	1.5	1.5	1.5
Potential Trigger Amounts	\$49.8	\$54.7	\$50.1	\$46.3

^a As the highest amount during the four base years, this amount would serve as the "trigger" level.

Based on our revenue forecast and assuming implementation of the Governor's budget, we estimate that the state would not be required to augment after-school spending until 2007-08. However, when the initiative will actually trigger will depend largely on two factors:

- ***Solution to the Structural Deficit in 2004-05 and Beyond.*** The Governor has proposed to solve the 2004-05 structural imbalance between General Fund expenditures and revenues through a combination of expenditure reductions, a property tax shift from local governments, borrowing, and deferrals. To the extent the final budget resolution involves less expenditure reductions, the state would trigger the Proposition 49 appropriations sooner.
- ***Growth in the Economy.*** If General Fund revenue grows faster than either the LAO or the Department of Finance have forecasted, the augmentation requirements could trigger earlier than 2007-08.

HEALTH AND SOCIAL SERVICES ENROLLMENT CAPS

MOST ENROLLMENT CAP PROPOSALS FLAWED

The Governor's budget plan proposes to establish limits on enrollments ("caps") for certain specified health and social services programs. We recommend that the Legislature consider the Governor's enrollment cap proposal on a case-by-case basis, weighing the potential fiscal benefits of capping each identified health and social services program against the complexities and issues relating to the creation of caseload caps. Based upon such an analysis, we recommend that nine be rejected, propose one be approved with some modifications, and make no recommendation regarding one cap proposal.

Governor's Proposal

The Governor's spending plan assumes the continued implementation in 2004-05 of a proposal in his mid-year budget reduction package to impose enrollment limits for specified health and social services programs. His proposal, which is summarized in Figure 1 (see next page), is anticipated to result in General Fund savings of about \$1.2 million in the current year and almost \$60 million in the budget year.

The caseload caps would affect selected programs and, in some cases, selected groups of individuals within programs operated by four agencies—the Department of Health Services (DHS), the Managed Risk Medical Insurance Board (MRMIB), the Department of Mental Health (DMH), and the Department of Social Services (DSS). For DHS, the affected programs are the AIDS Drugs Assistance Program (ADAP), the Breast and Cervical Cancer Treatment Program, California Children's Services (CCS), the Genetically Handicapped Persons Program (GHPP), and Medi-Cal (for legal immigrants and undocumented immigrants). Certain populations of forensic patients served by DMH would be capped, as would be

Figure 1 Proposed Health and Social Services Enrollment Limits

(Dollars In Thousands)

Department, Program, and Enrollees Affected	General Fund Savings		Capped Enrollment	2004-05 Effect On Recipients
	2003-04	2004-05	Level ^a	
DSS:				
CalWORKs for legal immigrants	—	—	5,200	No effect because caseload expected to remain below limit.
California Food Assistance Program	—	\$100	10,230	Caseload 273 fewer by 6/30/05.
Cash Assistance Program for Immigrants	\$153	4,175	8,645	Caseload 984 fewer by 6/30/05.
DHS:				
Medi-Cal (full-scope services for recent legal immigrants)	—	\$5,631	113,139	Average monthly waiting list of 11,439.
Medi-Cal (nonemergency services for undocumented immigrants)	—	9,770	794,700	Average monthly waiting list of 65,900.
Breast and Cervical Cancer Treatment Program ("state-only" patients)	—	1,781	1,658	Average monthly waiting list of 525.
California Children's Services ("CCS-only" children)	\$121	1,895	37,594	Average monthly waiting list of 1,256.
AIDS Drug Assistance Program	275	550	23,891	Waiting list of 1,392 by 6/30/05.
Genetically Handicapped Persons Program (GHPP) ["GHPP-only" participants]	245	194	842	Average monthly waiting list of 3.
MRMIB:				
Healthy Families Program (all populations)	—	\$31,523	732,344	Waiting list of 159,374 by 6/30/05.
DMH:				
State hospitals (Only Not Guilty by Reason of Insanity and Incompetent to Stand Trial forensic admissions)	\$361	\$3,745	2,045	42 fewer hospital admissions by 6/30/05.
Totals	\$1,155	\$59,364		

^a Administration estimate as of November 2003. Most caps would be based on January 1, 2004 caseload.

all enrollment of children in the Healthy Families Program administered by MRMIB. The DSS programs that would be affected are the Cash Assistance Program for Immigrants (CAPI), the California Food Assistance Program (CFAP), and the California Work Opportunity and Responsibility to Kids (CalWORKs) program (for legal immigrants).

As Figure 1 indicates, most components of the Governor's proposal limit participation in these programs for recent immigrants and undocumented persons whose benefits may not qualify under federal law for federal reimbursement. However, the Governor's plan also would affect nonimmigrant children and adults, including children in the Healthy Families Program whose health coverage is eligible for federal matching funds. (The Governor's budget plan does not include a November mid-year budget reduction proposal, which was withdrawn in December, to limit the enrollment of persons with developmental disabilities in community services provided by regional centers.)

The proposed enrollment limits were all to have gone into effect during the first part of calendar 2004, with the first caps proposed to take effect in January and the last intended to take effect in April. At the time this analysis was prepared, however, the Legislature had not taken action regarding the Governor's proposals, and thus no caps had gone into effect.

Caseload Limits a Standard Practice

In concept, there is some merit to the approach of addressing part of the state's serious fiscal problems by imposing limits on caseloads. Such a strategy could be less disruptive to program beneficiaries than other approaches (for example, eliminating entire eligibility categories and service categories) for achieving state savings. Also, if the caps are ongoing, they would generally be effective in addressing the state's structural budget problem. We discuss these issues in more detail below. Such caps are already commonplace in other states and for other California programs, although federal law limits a state's ability to apply caps to programs funded with federal Medicaid reimbursements.

Other States and Programs Limit Caseloads. The concept of capping enrollments in public programs is not a new idea. For example, the number of subsidized child care slots provided is effectively capped by budget allocations. With the exception of CalWORKs recipients, low-income families are placed on waiting lists for child care. Families with the lowest income levels are prioritized for subsidized child care slots when they become available.

Such limits on participation are less common for health and social services programs, but others do exist. For example, unlike California,

Illinois limits the availability of community services for persons with developmental disabilities in accordance with the state's resources available for their support. Illinois residents are placed on waiting lists when resources run short, with residential services prioritized for those who are in crisis situations, wards of the state approaching the age of 22, and individuals who reside in state institutions.

Six of the 35 states with separate State Children's Health Insurance Programs (the equivalent of the Healthy Families Program in California) have frozen enrollments because of budgetary problems. Two of the six closed their program rolls to new applicants, while the other four established waiting lists of applicants. Most of the states provide some limited exceptions to their enrollment caps, such as for children who automatically lose their Medicaid eligibility as they grow older.

California has already imposed some limits on services. The Managed Risk Medical Insurance Program operated by MRMIB, a program which provides affordable health coverage for individuals who have been denied coverage in the private insurance market, limits its admissions to stay within the program's annual General Fund appropriation.

Federal Law Limits Cap Options. One reason such limits are less common for publicly supported health programs is the constraints imposed on this approach under federal Medicaid rules. Medicaid, the main state-federal health program for the poor (known as Medi-Cal in California), is a source of financial support for a variety of specialized health-related programs, including drug treatment, mental health, nursing homes, and in-home supportive services, in addition to regular health care services.

In order to be eligible for federal reimbursement under Medicaid, federal law generally requires that all eligible persons receive any medically necessary services. Thus, waiting lists are generally precluded, except for federal waiver programs that permit states to cap the number of individuals receiving the specific services included under the waiver.

Notably, the Governor's proposals for capping enrollment do not involve any programs or Medi-Cal services that would risk the loss of federal Medicaid reimbursement. The caps affecting Medi-Cal services only limit those services that are provided on a "state-only" basis without any federal Medicaid match. For example, only nonemergency services, such as long-term care and family planning services, are capped for undocumented immigrants; no change is made for emergency services for undocumented persons, for which federal reimbursement is permissible. The Governor's budget plan similarly would only cap full-scope Medi-Cal services for legal immigrants who are not deemed "federally qualified" for federal reimbursement under Medicaid.

Less Impact on Current Recipients. In one respect, the Governor's proposal to achieve savings through the imposition of caps could be less disruptive than other approaches to achieving state savings in health and social services programs. The nature of enrollment caps is that no one currently receiving services through that program would be at risk of losing them so long as they complied with eligibility and other program rules. Such continuity of benefits obviously could be important for persons who are in the midst of medical treatment or who are temporarily relying on state assistance for the support for their family.

Fiscal Effect of Caps Would Grow Over Time. The imposition of caseload caps could help address the state's long-term structural budget problem by providing an ongoing budget solution that would probably grow in its fiscal impact over time.

We would note that this may not be the case for each program affected by the Governor's enrollment cap proposal. For example, growth in one of the two populations of forensic patients in state hospitals that would be capped (known as Not Guilty by Reason of Insanity, or NGI commitments) has been fairly flat so far in 2003-04. That is also the situation for the proposed limit on CalWORKs assistance for legal immigrants.

However, a number of the other programs have caseloads that have grown significantly in the past or are likely to accelerate in the future. One example is the Healthy Families Program, which is projected to increase by 16 percent in 2004-05 if an enrollment limit is not adopted.

While the CAPI caseload would remain relatively stable in 2004-05 without a cap in place, state law makes it likely that a surge in the number of persons receiving assistance will occur beginning in September 2006 as immigrants reach the end of a ten-year "deeming period" that has the effect of making many individuals ineligible for cash assistance due to a presumption that they are supported by their sponsors. Previous administration estimates suggest that the future cost to the state for their cash benefits could be in the tens of millions, and could eventually exceed \$100 million annually. The state stands to avoid a significant increase in the cost of these programs if their enrollment is limited at this time. However, these post-2006 cost increases could also be avoided by further extending the deeming period, the approach taken by the Legislature in 2001.

Capping Enrollments Raises Issues

The Governor's enrollment-cap proposal raises a number of significant issues. Specifically, these include questions pertaining to the equity of enrollment limits, their administrative cost and difficulty, the poten-

tial for offsetting costs that could negate the intended savings, risks to the implementation of program changes previously enacted by the Legislature, and an inaccurate savings estimate.

A detailed discussion of the effect of the enrollment caps for the Healthy Families and DMH hospitals can also be found, respectively, in the MRMIB and DMH sections of this chapter of the *Analysis*. We discuss some of the more general issues relating to health and social services program caseload limits in more detail below.

Equity Issues. In one sense, enrollment caps are equitable, in that all persons on waiting lists would be treated alike. However, such caps also put in place an “all or nothing” approach to providing services, in which individuals or families who meet the same eligibility requirements are treated unequally. Some get services because they qualified first, while others just like them do not.

The Governor’s budget proposal raises several equity issues, in particular. It relies upon a “first-come, first-served” approach in determining which individuals on waiting lists would be enrolled as current program enrollees drop off the rolls and “room” is created for new applicants. Those who were poorer and therefore with fewer resources to seek alternative assistance, or with a more serious need for services, would not be prioritized for services. The choice of programs subject to enrollment caps also raises equity questions. For example, the Governor’s plan proposes to cap “state-only” CCS, a program for children who are generally the sickest and most medically fragile, while not limiting services for other children with less intensive medical needs.

The Governor’s proposal also creates “gaps” in coverage that raise equity concerns. For example, some children in poorer families may have to wait for months to obtain Healthy Families coverage while children in families with higher incomes might be able to obtain coverage without delay in counties participating in the Children’s Health Initiative Matching Fund (CHIM) program which is not subject to a cap. Similarly, young children in poor families who are automatically disenrolled from Medical as they grow older would not be allowed to shift immediately to the Healthy Families Program, but would go on waiting lists, while children in higher-income families in CHIM counties would retain coverage.

Administrative Cost and Difficulty. In general, the imposition of enrollment caps makes programs somewhat more costly and difficult to administer. For example, procedures for the establishment of waiting lists, and for dealing with disputes with program applicants over the disenrollment and reenrollment in a program, can be a complex process to administer.

The savings expected from some of the enrollment caps are fairly minor when compared to the overall program costs. For example, the budget assumes savings of \$194,000 in 2004-05 from limiting enrollment in the \$49 million GHPP program. Moreover, the administrative cap proposed for the CalWORKs for Immigrants program would result in no savings at all while generating costs. Likewise, the enrollment limit for CFAP would save an estimated \$100,000 from a denial of benefits to a total of 188 persons during the budget year.

Also, several of the programs proposed for enrollment caps are affected by a separate administration proposal to transfer funding in certain programs for services for immigrants to the counties in the form of a block grant. (We discuss the block grant proposal in the “Crosscutting Issues” section of this chapter.) Under the Governor’s budget plan, the state would go through the administrative process of establishing waiting lists for these individuals, only to subsequently eliminate their eligibility for the state program. Making all of these program changes within a matter of months would probably result in extra administrative costs.

In general, the Legislature should consider whether the savings resulting from an enrollment limit are worth the operational problems and administrative costs that such a change could create.

False Economies Possible. In some cases, the savings achieved in the short term directly due to the imposition of a caseload cap risks a result of greater state costs in the long run. This is a risk inherent in the proposal to cap participation in ADAP. Delaying assistance to low-income individuals with the HIV virus could result in their inability to purchase expensive “AIDS cocktail” medications. If their medical condition subsequently deteriorated because of AIDS to the point where they became disabled, they would become eligible for Medi-Cal coverage and might need costly inpatient hospital care. These additional costs over time might offset or exceed the savings from the enrollment cap.

Cap Places Program Changes at Risk. Establishment of an enrollment cap places at risk the implementation of program changes previously enacted by the Legislature. These policy impacts could be significant. For example, limiting enrollment for children in the Healthy Families Program could jeopardize prior federal approval of a future expansion of the program to eligible parents authorized by the Legislature. It could also hinder the implementation of a new effort to establish a “gateway” to shift children in the Child Health and Disability Prevention (CHDP) program to more comprehensive coverage in the Medi-Cal and Healthy Families programs.

Savings Estimate May Be Understated. The ADAP enrollment limit appears likely to have a larger effect and result in greater savings than

the administration has estimated in its budget plan. Instead of impacting 1,392 individuals, this change appears likely to affect 2,100 and the state savings from the cap in 2004-05 would likely be about \$2 million, rather than the \$550,000 figure assumed in the Governor's plan.

Analyst's Recommendation

We recommend that the Legislature consider the Governor's enrollment cap proposal on a case-by-case basis, weighing the potential fiscal benefits of capping each identified health and social services program against the issues relating to that program that we have identified in this analysis. Based upon our own such analysis, we: (1) recommend that nine of the enrollment caps be rejected, (2) propose that one be approved with some modifications by the Legislature, and (3) make no recommendation regarding one cap proposal. We believe caps are a reasonable approach for the Legislature to consider for CAPI and DMH state hospitals, although alternative approaches to achieving savings warrant consideration and are feasible.

Figure 2 summarizes our reasons for our recommendations. In most cases, we recommend rejection because we found equity problems, risks to the implementation of policy changes previously approved by the Legislature, administrative costs and complexity, and the likelihood that savings would be offset by other costs. In the case of the state hospitals, we believe the proposed cap for selected populations is a reasonable interim step but that additional actions should be considered to prioritize the use of expensive inpatient beds for patients who are amenable to treatment. We discuss this issue in more detail in our discussion of the DMH budget request in this chapter of the *Analysis*.

In regard to CAPI, we have concluded that the enrollment cap is a policy call for the Legislature, given the state's fiscal difficulties. The Legislature must resolve the fundamental question as to whether limiting participation for these services is an appropriate public policy. If it determines it does not wish to adopt such an approach, we believe there are alternative approaches to containing future growth in the program, such as the option discussed above of modifying its deeming policies for such immigrants.

We recommend that the Healthy Families and Medi-Cal enrollment limits be rejected. The inequitable gaps in coverage that such limits would create, as well as the conflicts with the CHDP gateway and other prior legislative decisions, would be problematic and difficult to resolve. In our view, there are better alternatives for achieving program savings that we believe warrant legislative consideration. We identify these in this

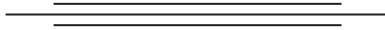
Figure 2

LAO Recommendations on Governor's Enrollment Cap Proposals

Department, Program, and Enrollees Affected	Recommendation/Comments
DSS:	
CalWORKs for Legal Immigrants	Reject. No savings would be achieved to offset administrative costs.
California Food Assistance Program	Reject. Minor savings achieved from caseload cap probably not worth increased administrative costs and operational problems.
Cash Assistance Program for Immigrants	No recommendation. A reasonable option to consider but raises fundamental policy question about limiting services for this population. There are alternatives for containing the cost of this program.
DHS:	
Medi-Cal (full-scope services for recent legal immigrants)	Reject. Could be difficult to administer and would create inequitable gaps in coverage.
Medi-Cal (nonemergency services for undocumented immigrants)	Reject. Could be difficult to administer and would create inequitable gaps in coverage.
Breast and Cervical Cancer Treatment Program ("state-only" patients)	Reject. Savings from caseload cap could be offset by increased future costs for treatment services.
California Children's Services ("CCS-only" children not also in Medi-Cal or Healthy Families)	Reject. Would create inequitable situation in which CCS children with intensive medical needs would lack coverage while children needing only routine care would have coverage.
AIDS Drug Assistance Program	Reject. Savings from caseload cap could be offset by increased future costs for treatment services.
Genetically Handicapped Persons Program (GHPP) ["GHPP-only" participants not also in Medi-Cal]	Reject. Minor savings achieved from caseload cap probably not worth increased administrative costs and operational problems.
MRMIB:	
Healthy Families Program (all populations, including recent legal immigrants)	Reject. Would create inequitable gaps in coverage and conflict with implementation of policy changes, such as the CHDP "gateway."
DMH:	
State Hospitals (Only Not Guilty by Reason of Insanity and Incompetent to Stand Trial forensic admissions)	Approve as interim step to prioritize use of inpatient beds for persons amenable to treatment.

Analysis (including within the “Medi-Cal” and “MRMIB” sections of this chapter) and in *The 2004-05 Budget: Perspectives and Issues*.

Should the Legislature choose to proceed with enrollment caps for these programs, we would recommend that the Legislature examine alternative approaches that would make them more workable. For example, the Legislature may wish to consider allowing targeted exceptions to the enrollment limits, such as allowing poor children who are disenrolled from Medi-Cal as they get older to be enrolled in Healthy Families. Administrative costs might be reduced if certain programs were closed to new enrollment without the establishment of waiting lists. If waiting lists are to be established, the Legislature could establish criteria to prioritize the enrollment of individuals with the lowest incomes or greatest need for medical care or public assistance. Finally, if the Legislature chooses to adopt the CAPI and ADAP enrollment limits, it should increase the ADAP savings to \$2 million.



COUNTY BLOCK GRANT PROPOSAL

PROGRAMS PROPOSED FOR BLOCK GRANT WOULD BE A POOR FIT FOR COUNTIES

The Governor proposes to consolidate into a single block grant, funding for state-only programs which serve immigrants, and transfer these programs to the counties effective October 1, 2004. The proposal assumes that counties will achieve administrative efficiencies, so proposed block grant funding has been reduced by 5 percent. We recommend that the Legislature reject the proposal because the programs proposed for transfer to the counties are not well-suited for local control.

Key Features of the Governor's Proposal

The Governor's 2004-05 budget plan proposes to consolidate into a block grant about \$132 million in state spending and programs for immigrants, and transfer funding and program responsibility to counties. Figure 1 (see next page) summarizes the programs and funding levels for the programs affected by the block grant proposal. Key features of this proposal include:

Enrollment Caps. All of the programs proposed for the county block grant would have their enrollments capped in the first part of calendar year 2004 (although program responsibility would remain with the state until October 1). For the Healthy Families Program (HFP) for immigrants, the cap is proposed to take effect on January 1, 2004. For the Cash Assistance Program for Immigrants (CAPI), California Work Opportunity and Responsibility to Kids (CalWORKs) for legal noncitizens, and the California Food Assistance Program ([CFAP] state-only Food Stamps for immigrants), the cap would take effect April 1, 2004. (For a more detailed discussion of the proposed enrollment caps for health and social services programs, please see the "Crosscutting Issues" section of this chapter.)

Figure 1**Programs for Immigrants
Governor's Block Grant Proposal**2004-05
(In Thousands)

Program	Proposed Block Grant Funding	Assumed Administrative Savings
Cash Assistance Program for Immigrants	\$59,837	\$3,148
CalWORKs for legal immigrants	45,847	2,414
California Food Assistance Program	8,995	320
Healthy Families for legal immigrants	16,118	850
Totals	\$130,757	\$6,732

Block Grant. As of October 1, 2004, the Governor proposes to consolidate all funding for the above referenced programs for immigrants into a single block grant for transfer to the counties. Subject to some restrictions noted below, counties would have freedom to move funds among the existing programs and to restructure benefit and eligibility rules. Counties could have the greatest degree of discretion with the CAPI and the Healthy Families (for immigrants) components, because there are no federal requirements and any state requirements could be eliminated through the state legislation creating the block grant. With respect to all programs, counties would be free to continue the enrollment caps established earlier in the year, or they could fund caseload increases through benefit and service reductions or the addition of their own resources.

The Governor's budget summary indicates that the May Revision is likely to include a proposal for a combined appropriation for these programs. As shown in Figure 1, the total block grant for counties would be about \$131 million reflecting nine months of services in 2004-05. (In 2005-06, the first full fiscal year of block grant implementation, the total amount of transferred program funds would be about \$174 million.) The proposal is silent with respect to how funds will be allocated among counties, but it is our understanding that the starting point for the allocation discussion would be the respective caseloads within each county.

Five Percent Reduction for Assumed Efficiencies. The proposal assumes that counties will be able to achieve efficiencies in delivering block

grant programs to legal immigrants. To account for these efficiencies, state expenditures have been reduced by 5 percent (\$6.7 million) compared to the amount that would have been budgeted for the transferred programs from October 2004 through June 2005. The proposal does not indicate how counties would achieve the assumed efficiencies.

Some Federal and State Requirements Remain. Although counties would have some flexibility to restructure the programs and move funding among the programs, certain state and federal restrictions would remain. For example, the CalWORKs program is California's version of the federal Temporary Assistance for Needy Families (TANF) program. Under the TANF program, states must meet specified work participation requirements and are subject to a maintenance-of-effort (MOE) spending requirement. Under the block grant proposal, counties would be required to expend the funds associated with CalWORKs in accordance with federal law so that the expenditures would count toward the MOE. For this to work, counties would have to expend the funds on low-income families with children in ways that are consistent with the state TANF plan, and would need to meet federal reporting requirements. For technical reasons, some of the funds for CFAP would also be "required expenditures" because they are used to satisfy the TANF MOE requirement.

Stakeholders Group to Work on Details. As noted above, the proposal lacks many details including (1) how much flexibility counties will have to restructure programs and move funding among programs in accordance with county priorities, (2) the allocation of the block grant funds among counties, and (3) how counties will achieve budgeted efficiencies so as to not further reduce benefits and services for immigrants. Another open question is how the amount of the block grant would be adjusted in future years. Although the proposal is silent in this regard, the fact that these programs are subject to proposed enrollment caps suggests that future adjustments to the block grant would not reflect caseload growth. Whether to adjust for inflation is another key issue for the Legislature to consider. Given the complexity of the proposal, the administration has indicated it will establish a stakeholders group to discuss its details.

Evaluating the Governor's Block Grant Proposal

Compared to the total amount of resources now spent for the programs affected by the proposal, the Governor's block grant plan would achieve some state savings. If the administration's intention is not to adjust block grant levels in the future to keep pace with continued caseload growth for these services, the level of savings could grow significantly in future years.

However, our analysis of the block grant plan indicates that there are some significant policy concerns about the measure that the Legislature may wish to consider. We discuss these policy concerns in more detail below.

Income Redistribution Programs Should Usually Be at State Level. The CAPI, CalWORKs for legal immigrants, and the CFAP are essentially income support programs for low-income immigrant Californians. As these programs are cash (or cash equivalent) programs, the state has an interest in maintaining uniformity in benefit levels. Otherwise, variation in benefit levels could lead to migration effects, whereby one county's reduction in benefits spurs others to reduce benefits in order to avoid becoming a benefit "magnet." Given the state's interest in uniform benefits for income redistribution programs, the CAPI, CFAP, and CalWORKs for immigrants are poor candidates for transfer into a block grant and should be left as state responsibilities.

Achieving Administrative Efficiencies Will Be Difficult. As noted above, the proposal does not explain how counties will achieve administrative efficiencies equal to 5 percent of the proposed block grant. Our review suggests that counties are unlikely to achieve the assumed savings administratively, and will probably need to reduce services or benefits to stay within the proposed block grant amount. Listed below are specific concerns with the affected programs:

- ***Healthy Families.*** Currently, the state administers the HFP and contracts directly with insurance plans for coverage of children, including the immigrant children affected by this block grant proposal. The counties' role in the program is minimal. Counties choosing to continue health coverage for these children comparable to what they are now provided under the HFP would have to develop a new program infrastructure that would result in added administrative costs. In addition, because such counties would be arranging for health coverage for a much smaller group of children than the state, the cost per child for the purchase of this coverage would probably be much greater than the rates to insurers through Healthy Families.
- ***CAPI.*** Counties currently administer CAPI and have already formed consortia in order to more efficiently deliver cash benefits through automated systems. There is nothing in the Governor's proposal to suggest that further county control will lead to more administrative savings.
- ***CalWORKs for Immigrants.*** Like CAPI, CalWORKs is currently administered by the counties. CalWORKs funding for administration, welfare-to-work services and child care are part of an existing block grant to counties. As noted above, this spending is

counted toward the TANF MOE requirement. As such, counties would be required to expend these funds in a manner that is consistent with the federal TANF program and meet federal reporting requirements. In summary, block granting CalWORKs for immigrants does not materially increase county flexibility and would be unlikely to result in administrative savings.

- **CFAP.** Currently, the state purchases food stamps coupons through an existing agreement with the federal government. It is unlikely that the federal government would agree to 58 separate agreements, so counties would need to continue operations under the existing state agreement. Accordingly, putting CFAP funds in a block grant would not appear to increase county flexibility, again making administrative savings unlikely.

For the reasons stated above, the proposal appears to provide little in additional county flexibility and is therefore unlikely to result in administrative savings. We believe that counties are most likely to reduce services or benefits in order to stay within the proposed block grant amount. In other words, the proposed 5 percent reduction is more likely to result in a reduction in services to low-income immigrants, rather than administrative streamlining in the delivery of these services.

Analyst's Recommendation

We believe there is merit generally in the concept of reexamining which programs now operated by the state could be more effectively and efficiently operated by shifting greater responsibility and authority to local governments. In the past, and again this year, we have offered a number of proposals for restructuring state programs (such as substance abuse treatment services) that we believe would improve the quality of the public services provided while also reducing state costs.

However, we recommend that the Legislature reject the proposed county block grant for immigrant programs because the programs are not well-suited for local control. Counties are unlikely to achieve the administrative efficiencies assumed in the Governor's proposal. The 5 percent savings proposed to be achieved through the block grant (\$6.7 million) represent a further reduction in services or benefits for low-income immigrants.

In order to offset the loss of the savings associated with the block grant proposal, the Legislature may wish to consider other options and recommendations for reducing state program costs that are presented in *The 2004-05 Budget: Perspectives and Issues* as well as in the "Health and Social Services" chapter of this *Analysis*.

QUALITY IMPROVEMENT FEES

ADDITIONAL FEDERAL FUNDS AND STATE SAVINGS POSSIBLE THROUGH PROVIDER FEE MECHANISM

The Governor's budget plan offers a modified proposal for a "quality improvement assessment fee" on Medi-Cal managed care health plans to enable the state to draw down additional federal funds for support of the program. We recommend approval of the Governor's proposal to impose such a fee for Medi-Cal managed care health plans. In addition, we recommend that the Legislature explore the option of extending such a fee to mental health managed care.

Background

Unique Fee Mechanism Generates Additional Federal Funds. Federal Medicaid law permits states to impose fees on certain health care service providers and in turn repay the providers through increased reimbursements. Because the costs of Medicaid reimbursements to health care providers are split between states and the federal government, this arrangement provides a mechanism by which states can draw down additional federal funds for the support of their Medicaid programs. These funds can then be used to offset state costs.

The Governor's 2004-05 budget plan proposes to impose such a charge, which it terms a quality improvement assessment fee, for Medi-Cal managed care health plans. (A similar proposal for Medi-Cal managed care was enacted as part of the *2003-04 Budget Act*, but the Department of Health Services (DHS), has indicated that technical problems will prevent its implementation this year.) The administration estimates that the current proposal will result in net state savings of \$75 million in 2004-05 while also providing additional reimbursements to health plans. (The fees are also commonly called "quality improvement" or "quality assurance" fees.) We will discuss the Governor's fee proposal later in this analysis.

Under federal law, the fees must be imposed on all members of that class of providers. For example, a fee on hospitals must apply to all public and private hospitals, and not just psychiatric hospitals. Such a fee mechanism was adopted and is already being successfully implemented by DHS in regard to Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs) in order to generate an estimated \$17.5 million in savings for the state. More than a dozen other states have also imposed such fees for various types of medical providers in keeping with the provisions of federal law.

Federal Laws Limit Use of Fees. Federal Medicaid law recognizes a state's authority to levy such assessments on a broad range of Medicaid providers. These providers are: (1) inpatient hospital services; (2) outpatient hospital services; (3) nursing facility services; (4) services of ICF/DDs; (5) physicians' services; (6) home health care services; (7) outpatient prescription drugs; (8) services of a Medicaid managed care organization; and (9) other services as established by federal regulation. The policy of federal authorities has been to limit such fees to 6 percent of provider payments.

Federal statute identifies a number of conditions that must be met by a state in order to qualify such a provider fee for federal reimbursement under the Medicaid Program. For example, under federal rules, all providers that deliver the same class of services must be assessed the fee. The fee must be "broad-based," meaning that it is applied to all Medi-Cal and non-Medi-Cal payments going to the same provider. Also, all providers must be assessed the fee uniformly—a 2 percent fee cannot be assessed to some providers while a 6 percent fee is assessed to others.

Finally, federal law does not allow the state to guarantee to the providers subject to a quality improvement fee that they will be compensated with a rate increase sufficient to "hold them harmless" from any net increase in costs. In effect, the imposition of the fee and the authorization of any increases in reimbursements to providers must be handled as separate actions.

How Does the Fee Mechanism Work? Figure 1 (see next page) provides a simplified explanation of how such fees can be structured to draw down additional federal funds, reduce state costs, and provide additional resources to medical providers to improve the quality of health care.

In our example, a state imposes a 6 percent quality improvement fee on the gross revenues of certain health care providers who currently are reimbursed at a rate of \$100 per day (Step 1). As a result, the state collects about \$6 in revenues for each \$100 of revenues received from the providers subject to the fee. These fee revenues would be deposited in the state's General Fund. Continuing with our example, the state, in turn, agrees to

Figure 1

Example of How Quality Improvement Fees Can Benefit Both a State and a Medicaid Provider

	Federal Government	State Medicaid Program	Medicaid Provider
<p>1. State Charges Fee. The state charges and collects a 6% fee from a provider on its gross revenues of \$100 per day.^a</p>		+ \$6	← - \$6
<p>2. Provider Receives Offsetting Rate Increase. The cost of the fee is added to the rates paid to the provider, bringing its total reimbursements to \$106 per day, an increase of \$6. Because Medicaid costs are split 50-50 between the state and the federal government, half of the additional money (\$3) comes from the state and the other half (\$3) comes from the federal government.</p>	- \$3		→ + \$3
		- \$3	→ + \$3
<p>3. Provider Receives Further Rate Increase. At this point, the state has a net gain of \$3 (It collected \$6, but paid only \$3 toward provider rate increase). The state chooses to use part of its revenue gain (\$1) to provide a further rate increase for providers which is matched by \$1 more from the federal government. The state uses the remaining \$2 gain in revenue to help offset state costs for the Medicaid program.</p>		- \$1	→ + \$1
	- \$1		→ + \$1
<p>4. Financial Gain. The net result—the state and the Medicaid provider have a net \$2 financial gain, while more funding (\$4) is drawn down from the federal government.</p>	- \$4	+ \$2	+ \$2

^aTo simplify our example, the amount of fee revenues depicted here does not include a small additional amount of revenues that would be received by the state (48 cents) as a result of applying the 6% fee to additional revenues of \$8 per day that would be received by providers.

increase its Medicaid reimbursements to \$106 per day. Under this scenario, a Medicaid provider would receive a new, higher reimbursement rate for its services that equals the cost of the fee (Step 2).

The state benefits from this transaction because the federal government shares in the cost of the Medicaid program. The split between California and the federal government in 2004-05 for Medi-Cal Program costs is expected to be 50-50. Thus, in our example, the state would pay only half the additional cost of the reimbursements for providers (\$3 per day of health care services) and the federal government would pay the other half of these costs (also \$3 per day). This leaves the state with \$3 of the \$6 that it collected originally.

States have generally chosen to use part of their financial gain—\$3 in our example—from such transactions to invest in improvements in the quality of health care provided under their Medicaid programs. In our example (Step 3), the state does so by increasing rates for providers subject to the fee by the equivalent of \$2 per day, bringing their total reimbursement rate to \$108. The state uses \$1 of its \$3 revenue gain, plus a \$1 match in federal Medicaid funds—to pay the \$2 rate increase. This leaves the state with a net revenue gain of \$2.

To sum up our example, (1) additional federal funding is drawn down that was not previously available, (2) the state experiences a net financial gain by receiving new quality improvement fee revenues that exceed the state cost of the rate increases it authorizes for Medicaid providers, and (3) the providers experience a net financial gain due to rate increases that exceed their new fees.

As noted earlier, our explanation of how the fee mechanism works in this analysis has been slightly simplified. Our example slightly understates the potential gain to a state and slightly overstates the gain to providers.

Implementation Procedures. The DHS must complete a number of complex steps before such fees can be imposed. These procedures include the review and, if necessary, modification of a state's federally-approved Medicaid plan to ensure that it allows a quality improvement fee to be assessed. In some cases, state law changes may be necessary. The DHS must also draft and publish new regulations, policies, and procedures to collect a new provider fee, including procedures to address any fee payment disputes, and, in some cases, coordinate these arrangements with affected state departments.

Fees Can Create “Winners” and “Losers.” In our example above, we showed how a Medicaid provider could be held harmless, or actually receive a rate increase, through the simultaneous imposition of a quality

improvement fee and rate increases. Notably, the fee now being imposed in California for operators of ICF/DDs almost entirely affects providers who are already participating in the state's Medi-Cal Program. Operators of ICF/DDs will pay a 6 percent quality assurance fee but receive an 8.8 percent rate increase.

However, quality improvement fees can also be imposed in a way that affects medical providers who are not participating in the Medi-Cal Program. Because federal law requires that such a fee apply to all providers within a defined class of providers, any providers within that class that do not provide services to Medi-Cal beneficiaries would not benefit from an increase in funding allocations that was made possible with the state's receipt of new fee revenues. The imposition of charges on providers who will not receive any offsetting benefit would probably constitute a tax increase under state law. Thus, this approach raises important tax policy issues.

When such a fee is imposed across a class of medical service providers, any non-Medicaid providers, in effect, indirectly share part of the burden of caring for Medicaid beneficiaries through their fee payments. While some would contend that it is only fair that the burden of providing health care for the poor be shared in this way, other providers are likely to object to such an arrangement. Ultimately, it is a policy call for the Legislature whether such a tax is an appropriate source of revenue to help support the Medi-Cal Program, or whether more general sources of revenue, such as the income or sales tax, are a more appropriate basis for providing financial support of health care for the poor.

The imposition of fees in such circumstances could be advantageous to the state in at least one other respect: Such fees could provide a greater incentive for providers who are not doing so to accept Medi-Cal beneficiaries. Overall access to services for beneficiaries could improve as a result.

The Governor's Managed Care Fee Proposal

As noted earlier, the *2003-04 Budget Act* included a proposal to implement a quality improvement fee on Medi-Cal managed care plans beginning January 2004. The fee was expected to result in net financial gain to the state of \$37.5 million in 2003-04 and \$75 million in 2004-05.

The Governor's 2004-05 budget plan proposes to delay the implementation of the fee (now called a "quality improvement assessment fee") until July 2004. The delay relates to as-yet unresolved technical issues affecting how the fee would be imposed on managed care health plans.

As noted earlier, federal law requires that quality improvement fees be “broad-based,” and applied to all members of a class of providers, including both those participating in Medi-Cal and those who are not. Some large managed care plans provide services to both Medi-Cal and to commercial beneficiaries within the same business entity. At the time the Legislature adopted the fee proposal last year, DHS believed it would be possible to assess the fee only on the Medi-Cal part of their business. However, we are advised that federal authorities indicated in subsequent discussions with DHS that any fees would have to be imposed on their entire line of business in order to receive federal approval.

The 2004-05 budget plan addresses this objection of federal authorities by proposing that all Medi-Cal managed care plans establish a separate business entity for their Medi-Cal line of business. Some plans are already structured in this way, and DHS has indicated that all plans could do so by 2004-05. At the time this analysis was prepared, DHS was continuing to discuss these implementation issues with managed care plans.

LAO Comments. Our analysis indicates that the DHS proposal would probably result in fee revenues and a net General Fund gain to the state of the magnitude indicated in the Governor’s 2004-05 budget plan. Specifically, the budget plan assumes that the imposition of a 6 percent fee on managed care plans would result in about \$300 million in revenues that would be deposited in the General Fund. It further assumes that these providers would receive rate increases of about 9 percent that would increase Medi-Cal Program expenditures by about \$225 million. The end result would be a net financial gain to the state of about \$75 million annually. These net state savings would be ongoing and would change over time in accordance with managed care plan revenues.

State Has Opportunity to Expand on Fee Strategy

Greater State Financial Gain Possible. Our analysis indicates that it may also be possible for the state to impose quality improvement fees on mental health managed care plans to achieve a net General Fund financial gain for the state of as much as \$70 million annually while providing a net increase in resources available to counties for mental health care of as much as \$23 million.

We would note that our estimate is presented for illustrative purposes only. The financial gains which can result from drawing down additional federal funds through quality improvement fees could be split differently between the state and providers than the figures we have presented in this analysis.

Currently, the state Department of Mental Health (DMH) contracts with county entities, identified in state law as Medicaid managed care plans, to provide specialty mental health services for certain groups of children and adults specified in state law. These contracts are a voluntary arrangement for counties. Were a county to decline to contract with the state for this purpose, DMH would contract instead with other private or public entities to provide specialty mental health services within that jurisdiction. At present, however, nearly all counties are serving as the managed care plans for their respective jurisdictions.

About \$2.6 billion would be available for counties from a combination of federal, state, and county funds for specialty mental health services in 2004-05 under the Governor's budget plan. This includes services both for Medi-Cal beneficiaries and others not eligible for Medi-Cal. Our estimate assumes that a 6 percent quality improvement fee could be imposed on the total expenditures for this entire class of services provided by the counties. Our estimate also assumes that the state would use part of its fee revenue to increase the separate allocations that the state provides for mental health managed care plans by about 45 percent. This increase in state funding would be matched by an increase in matching federal funds. Thus, counties would collectively receive an additional amount of mental health managed care funds that would more than offset the quality improvement fees they would collectively pay to the state.

While our estimate assumes that mental health managed care allocations would generally be increased to offset the cost of the fee, other approaches are possible. For example, the additional funding provided by the state could be targeted to improve the mental health services provided to specific Medi-Cal populations.

One implementation issue warrants further study to determine if our approach is feasible. Based on our initial discussions of the quality improvement fee concept with DMH and DHS, it is not clear at this time whether any of the counties would have to restructure their mental health managed care operations to separate out the provision of specialty mental health services from the other health services provided within that jurisdiction. Some restructuring of such operations might be necessary to formally establish mental health managed care plans as a separate class of providers of services under federal law.

Analyst's Recommendations

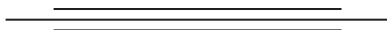
In order to draw down additional federal funds to offset the cost to the state of the Medi-Cal Program, we recommend approval of the

Governor's modified proposal to establish a quality improvement assessment fee for Medi-Cal managed care plans. Our analysis indicates that, while DHS was unable to implement such a fee in the current fiscal year, progress is being made in structuring the fee program so that it will obtain federal approval in time for implementation in the budget year.

Given the state's serious fiscal problems and the growing cost of the Medi-Cal Program, we further recommend the Legislature explore the option of imposing a quality improvement fees on mental health managed care plans. Specifically, we recommend that DHS and DMH report at budget hearings on the feasibility of imposing quality improvement fees for these providers, the potential revenues that could be generated from such fees, and any significant operational issues that would affect their implementation.

A similar quality improvement fee proposal for In-Home Supportive Services (IHSS) is discussed in our analysis of the IHSS program later in this chapter.

Such fees are also possible for other classes of medical services provided as part of the Medi-Cal Program.



SENATE BILL 2

BUDGET LACKS FUNDING TO IMPLEMENT HEALTH INSURANCE EXPANSION MEASURE

The Governor's budget proposal does not include funding to implement recent legislation creating a "pay or play" system to expand health coverage for employees and, in some cases, their dependents. The legislation went into effect on January 1, 2004, but was put on hold by a pending referendum that is now expected to be decided by voters in a November 2004 statewide election. We recommend that the administration provide the Legislature with information at budget hearings on the funding and personnel that might be needed in 2004-05 to implement the new law.

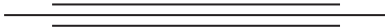
Background. In 2003, the Legislature approved and the Governor signed SB 2 (Chapter 673, Burton), which enacted a pay or play system of health coverage for certain employers. Under the measure, specified California employers would be required to pay fees to the state commencing in 2006 to provide health insurance for their employees and, in some cases, for their dependents. Alternatively, the employer could choose to arrange directly with health insurance providers for coverage for these individuals. The measure would also establish a state program to assist lower-income employees to pay for their share of health care premiums.

Senate Bill 2 took effect on January 1, 2004. However, opponents of the measure collected and submitted signatures for a referendum that would put SB 2 to a statewide vote of the public. Supporters of SB 2 contested the legality of the referendum in court. In January, a state appellate court ruled that the referendum effort was valid and placed the measure on the November 2004 ballot. (At the time this analysis was prepared, an appeal of that decision remained a possibility.) Because the referendum qualified for the ballot, SB 2 was put "on hold" and will take effect only if subsequently upheld by voters. If it were approved by voters, SB 2 would take effect immediately.

Advance Activities Required to Implement Legislation. Our analysis indicates that three state agencies—the Managed Risk Medical Insurance Board, the Department of Health Services, and the Employment Development Department—bear major administrative responsibilities related to the implementation of SB 2. Although some components of the new programs established by the measure would not commence operation until 2006, these agencies would require resources during 2004-05 for work related to establishing new information technology systems, program regulations, and staffing in order to implement a number of provisions of SB 2.

Senate Bill 2 does not include an appropriation for these administrative activities, and the Governor's budget plan also does not provide funding to any state agency for this purpose. The administration has indicated it did not include funding for SB 2 in the budget because of the referendum.

Analyst's Recommendation. Because it is possible that SB 2 will go into effect during the budget year, the administration should be directed to provide the Legislature with information at budget hearings regarding the funding and personnel that might be needed in 2004-05 for administrative activities to implement the new law.



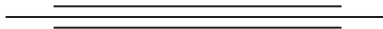
INDIGENT ADULT PROGRAM

Medically Indigent Adult Program And the Vehicle License Fee (VLF)

We recommend that the Legislature approve the administration's proposal to retain the current vehicle license fee depreciation schedule and preserve revenue support for locally realigned programs.

In 1991, the Legislature approved a realignment of funding and responsibilities for various health and social services programs from the state to counties, supported in part with a transfer of increased VLF revenues. A September 2003 appellate court ruling relating to the Medically Indigent Adult Program, one of the programs transferred to counties, could trigger a loss of \$1.5 billion in VLF realignment revenues. The administration has proposed a statutory change to prevent the loss of these funds for the support of realigned programs.

We discuss the so-called “poison pill” provisions of realignment that could affect VLF revenues in our discussion of “Tax Relief” (Item 9100) provisions of the budget plan in the “General Government” chapter of this *Analysis*.



DEPARTMENTAL ISSUES

Health and Social Services

DEPARTMENT OF AGING (4170)

The California Department of Aging (CDA) administers funds allocated to California under the federal Older Americans Act (OAA). These funds are used to provide services to seniors, including supportive services, nutrition programs, employment services, and preventive health services. In addition, CDA administers a range of programs, supported by state and federal funds, that provide noninstitutional services for older Californians and functionally impaired adults, including the Multipurpose Senior Services Program, Linkages, Adult Day Health Care, and the Alzheimer's Day Care Resource Centers. Finally, CDA administers the Foster Grandparent, Senior Companion, Respite Purchase of Services, Respite Registry, and Brown Bag programs.

The budget proposes total expenditures of \$185.3 million for 2004-05 (\$33.4 million General Fund, \$139.5 million federal funds, \$9.2 million in reimbursements, and \$3.3 million from special funds) which is unchanged from the current year. General Fund spending is proposed to be \$33.4 million in 2004-05, a reduction of \$1.7 million (4.7 percent) compared to estimated expenditures in 2003-04. This reduction is primarily due to the proposal to convert all funding for local assistance into a block grant and reduce the block grant by 5 percent.

Consolidating Local Assistance Into Single Block Grant

Currently, the Department of Aging oversees the administration of Older Americans Act (OAA) programs and Community Based Services Programs (CBSP). Area Agencies on Aging (AAAs) deliver services to California seniors at the local level. The budget proposes to (1) eliminate the requirements for CBSP, (2) consolidate funding for both CBSP and the OAA programs into a single block grant for the AAAs, and (3) reduce the proposed block grant by 5 percent. We recommend approval of the consolidation proposal and make no recommendation on the proposed 5 percent reduction.

Background. The CDA operates the OAA programs and the CBSP. The OAA programs authorized by federal law are: Supportive Services, Congregate Nutrition, Home Delivered Meals, National Family Caregiver Support Program, Preventive Health, Senior Employment, and Ombudsman/Elder Abuse Prevention. Total General Fund support for OAA programs is \$16.4 million in 2003-04. The CBSP authorized in state law are: Foster Grandparent, Brown Bag Network, Senior Companion, Linkages, Alzheimer's Day Care Resource Centers, Respite Registry, and Health Insurance Counseling and Advocacy Program. General Fund support of CBSP is \$15 million in 2003-04. Although state legislation establishes standards and goals for the CBSP, these programs could be operated by the existing AAAs under the authority of the OAA.

Governor's Proposal. The Governor proposes to (1) make CSBP optional, (2) consolidate all funding for OAA programs and CSBP into one block grant to the AAAs, and (3) reduce funding for the block grant by 5 percent. Because the consolidation will reduce administrative overhead at CDA, the budget proposes to eliminate 1.5 positions in administrative support and achieves General Fund savings of \$107,000 in state operations. Eliminating the requirement to operate the CSBP should provide some administrative relief at the local level (in the form of reduced accounting and reporting requirements). We note however, that the administrative relief is likely to be less than the proposed 5 percent reduction in the block grant.

Proposal Makes CBSP a Local Option. Although the proposal would delete the requirement that AAAs operate the CBSP, all of the individual programs that make up CBSP may be operated under the authority of the supportive services programs within the OAA. Whether to continue the CBSP would be a local decision under the proposal.

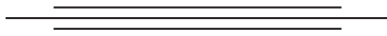
Comments on the Governor's Proposal. The consolidation and 5 percent reduction proposals present the Legislature with two issues. First is

the fiscal question of whether funding for California's programs for senior citizens should be reduced by 5 percent. Second is the policy question of whether the decision to operate CBSP should be devolved to the local level.

Fiscal Considerations. Whether to reduce funding for the consolidated funding stream by 5 percent is a question of fiscal priorities for the Legislature. We believe that the proposal will relieve the AAAs from some accounting and reporting requirements specifically associated with the CSBP, but such savings are likely to be less than the \$1.6 million (5 percent) reduction. As a point of reference, we would note that total funding for the CDA peaked at \$189 million in 2002-03 (compared to \$185 million proposed for 2004-05). In contrast, General Fund support for CDA has decreased substantially from its peak of \$60 million in 2000-01 to the \$33 million proposed for 2004-05. The General Fund decrease is attributable to program eliminations and budget reductions made during the current period of fiscal distress. Increases in federal funds have offset most of the General Fund reductions over the past few years.

Consolidation Proposal Has Merit. The consolidation proposal would eliminate the legislative mandate to operate CSBP. We think the proposal has merit because it increases local flexibility to structure programs for senior citizens in ways that reflect local priorities. In general, this proposal would provide local governments greater ability to adjust programs to meet the needs of their communities and experiment to determine which efforts improve program outcomes. In general, local governments are in a better position than the state to discern what works in their community and preserve the programs yielding the best outcomes during tight fiscal times. Accordingly, we recommend approval of the block grant proposal.

We would further note that this proposal stands in sharp contrast to the county block grant proposal discussed in the "Crosscutting Issues" section of this chapter. The proposed consolidation of aging programs does not involve income maintenance where devolution of such programs raises concerns about intercounty migration effects if counties establish varying grant levels. In addition, the CBSP consolidation proposal provides the AAAs with real flexibility to modify programs to meet local priorities, whereas the county block grant proposal does not contain such flexibility.



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 DADP estimates that its treatment system will provide services to approximately 396,000 clients in 2004-05. The DADP administers the Drug Medi-Cal Program, which provides substance abuse treatment services for beneficiaries of the Medi-Cal Program. It also allocates other 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.

Governor's Budget Proposal. The Governor's budget proposes \$598 million from all fund sources in the current fiscal year, with \$233 million in General Fund support. That is slightly below the level of state spending authorized in the *2003-04 Budget Act*.

The budget plan for 2004-05 for DADP proposes \$591 million in spending from all fund sources. General Fund support for DADP programs, including about \$120 million in funding appropriated by Proposition 36, would be budgeted at a total of \$238 million. That amounts to an increase of about \$4.6 million, or 2 percent, above the revised expenditure plan for the current fiscal year proposed by the Governor.

The proposed increase in General Fund spending on alcohol and drug treatment programs in the budget year is primarily the result of revised estimates for the Drug Medi-Cal Program. This includes caseload and utilization changes in substance abuse treatment services, and the phase-

out of one-time federal funding that had temporarily increased the share of program costs borne by the federal government. The budget plan also reflects a proposed one-time rollback in the rates paid to Drug Medi-Cal providers in 2004-05 to 2002-03 levels.

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 Governor's budget plan requests authority to spend about \$3.5 million in federal grant funds for a new program, known as Screening, Brief Intervention, Referral, and Treatment, which would attempt to reduce substance abuse through intervention with individuals who have been brought to medical facilities, including emergency departments and trauma centers.

Finally, the budget plan proposes to eliminate the Office of Problem and Pathological Gambling, a program established last year with a \$3 million allocation of Indian gaming funds. The office had been established to assist individuals who are addicted to gambling.

Federal Funding Requirement May Not Be Met

Current-year expenditures for community treatment services now appear likely to fall short of the level that would be required to satisfy a maintenance-of-effort requirement imposed on the state as a condition of receiving certain federal grant funds. As a result, the state is at risk of being penalized with the loss of as much as \$3.2 million in federal grant funds in the future.

State Has Maintenance-of-Effort (MOE) Obligation. The Governor's budget plan for DADP reflects a proposed decrease in General Fund spending for substance abuse treatment programs in the current fiscal year of about \$2.2 million below the amount appropriated in the *2003-04 Budget Act*. This reduction in current-year spending is the result of (1) reductions in state administrative spending mandated by Control Section 4.10 of the act, (2) technical budget adjustments that reflect the state's receipt in 2003-04 of one-time federal funding that temporarily increased the federal share of support for Drug Medi-Cal services and reduced General Fund expenditures, and (3) downward adjustments in caseload and costs in the Drug Medi-Cal Program.

Primarily as a result of these budget changes, the Governor's revised 2003-04 spending plan now appears likely to be insufficient to meet the state's obligation under a federal grant program to maintain a specified level of state support for community substance abuse treatment programs.

The DADP calculations that we have reviewed indicate that, were the proposed current-year level of spending to stand, the state would fall short by about \$3.2 million in the current fiscal year of meeting 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 in the future for every state dollar they spend below the required MOE level.

In this case, then, the state is at risk of subsequently losing \$3.2 million of its future SAPT allocation. We would note that, under the Governor's budget proposal, the state would exceed the MOE funding requirement in 2004-05.

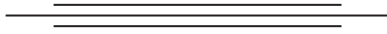
Situation Could Change in May. The DADP has indicated that it will review this situation prior to the May Revision to determine whether the state is still at risk of violating the SAPT MOE requirement. It is possible, for example, that unanticipated increases in the caseload in the Drug Medi-Cal Program would prompt the administration to seek additional General Fund spending authority in the current fiscal year. Depending on the amount of additional funding involved, the potential federal sanctions could be reduced or even eliminated if the Legislature concurred in such a budget change.

The DADP also indicates that it could seek federal relief from the MOE requirement on the grounds that is "within material compliance" with the MOE rule. However, it is not certain that federal authorities would actually agree to waive the MOE requirements. We will continue to monitor the situation and will provide the Legislature with information about the matter at the time of the May Revision.

"Remodeling" the Drug Medi-Cal Program

California's program for substance abuse treatment for Medi-Cal, known as Drug Medi-Cal, provides a patchwork of services with an inconsistent level of support for different modes of treatment and for different treatment populations. Based on our analysis, we recommend an approach for addressing these concerns which would provide greater authority and resources for community-based services, contain the fast-growing costs of methadone treatment, and integrate a new and potentially more cost-effective mode of treatment into Drug Medi-Cal that does not require a net increase in state General Fund resources.

The *Supplemental Report of the 2002-03 Budget Act* directed the Legislative Analyst's Office to examine the operations of the Drug Medi-Cal Program. Our analysis was to include, but was not limited to, an examination of what barriers exist to broaden provider participation and beneficiary access to Drug Medi-Cal, as well a review of the options and recommendations available to the Legislature to maximize federal financial participation for its support. Our analysis of the program can be found in "Part V" of *The 2004-05 Budget: Perspectives and Issues*.



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 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. The California Medical Assistance Commission negotiates contracts with hospitals and health plans for the provision of Medi-Cal services. Other state agencies, including 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 oversees the program to ensure compliance with federal law.

Proposed Spending. The budget for DHS proposes Medi-Cal expenditures totaling \$31 billion from all funds for state operations and local assistance in 2004-05. The General Fund portion of this spending (\$11.6 billion) increases by \$1.8 billion, or 19 percent, compared with estimated General Fund spending in the current year. The remaining expenditures for the program are mostly federal funds, which are budgeted at a level

(\$17.8 billion) that is about 3 percent more than estimated to be received in the current year.

More than half of the overall increase in General Fund spending is due to the inclusion in 2003-04 of a program accounting change that reduces program costs on a one-time basis. In addition, one-time savings result from increased federal funds in 2002-03 and 2003-04. Adjusting for these one-time savings, underlying General Fund expenditures for Medi-Cal are projected to grow by \$191 million, or about 2 percent, in 2004-05. These additional costs are proposed to be more than offset by spending reductions.

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 \$4.7 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, 42 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 (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 that 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 determined eligible for Medi-Cal benefits (Medi-Cal “eligibles”) receive a Medi-Cal card, which they use to obtain services from providers. 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 (3.3 million of the total of 6.4 million Medi-Cal eligibles in July 2003) are enrolled in managed care plans. 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 are 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 shows, for each of the major Medi-Cal eligibility categories, the maximum income limit for eligibility for health benefits, the estimated caseload, and the annual benefit cost per person for 2003-04. 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**

2003-04

	Maximum Monthly Income Or Grant ^a	Asset Limit Imposed?	Spend Down ^b Allowed?	Enrollees (Thousands)	Annual Benefit Costs Per Person ^c
Aged, Blind, or Disabled Persons					
Welfare (SSI/SSP)	\$1,419	✓	—	1,301	\$7,938
Medically needy	954	✓	✓	247	7,355
133 percent of poverty equivalent	1,419	✓	✓	— ^d	— ^d
Medically needy—long-term care	Special Limits	✓	✓	64	43,843
Families					
Welfare (CalWORKs) ^e	\$1,150	✓	—	1,479	\$1,459
Section 1931(b)-only ^f	1,624	✓	—	2,605	1,531
Medically needy	1,190	✓	✓	— ^g	— ^g
Children and Pregnant Women					
200 percent of poverty— pregnancy service and infants	\$3,157	—	—	203	\$3,488
133 percent of poverty— ages 1 through 5	2,130	—	—	117	1,260
100 percent poverty— ages 6 through 18	1,624	—	—	111	1,005
Medically indigent— ages 6 through 18	1,190	✓	✓	221	1,329
Medically indigent adults— all services	1,190	✓	✓	6	12,001
Emergency Only					
Undocumented immigrants may qualify in any category and are limited to emergency services (including labor and delivery and long-term care)				822	\$1,231
<p>^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).</p> <p>^b Indicates whether persons with higher incomes may receive benefits on a share-of-cost basis.</p> <p>^c Combined state and federal costs.</p> <p>^d Enrollment and costs included in amounts of Medically Needy Aged, Blind, or Disabled persons.</p> <p>^e Income limit to apply for CalWORKs (including a \$90 work expense disregard). After becoming eligible, the income limit increases to \$1,903 (family of four) with the maximum earned-income disregard.</p> <p>^f Includes Transitional Medi-Cal, which extends coverage for families who leave CalWORKs or 1931(b)-only for up to 12 months.</p> <p>^g Enrollment and costs included in amounts for Section 1931(b) family coverage.</p>					

Aged, Blind, or Disabled Persons. About 1.6 million low-income persons who are (1) at least 65 years old or (2) blind or disabled of any age receive Medi-Cal coverage. This group constitutes about 24 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 (80 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 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 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, blind, 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.

More than 900,000, or about 56 percent, of the aged or disabled Medi-Cal eligibles are also beneficiaries of Medicare—the federal health insurance program for persons 65 and older and for younger persons with disabilities who cannot work. Medi-Cal generally pays the Medicare premiums and any copayments or deductibles for these “dual eligibles,” and Medi-Cal pays for services not covered by Medicare, such as prescription drugs and long-term care. Medi-Cal also provides some limited assistance to a small number of dual eligibles with incomes somewhat higher than the medically needy standard.

The number of Medi-Cal eligibles in long-term care is small—only 64,400 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 12 percent, of total Medi-Cal benefit costs.

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 39 percent of all Medi-Cal eligibles are 1931(b)-only and medically needy families. Although these families 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 are children or able-bodied working-age adults, who generally are relatively healthy. Similarly, CalWORKs welfare recipients who receive Medi-Cal account for 22 percent of all Medi-Cal eligibles and only 9 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 about \$36,800 for a family of four).

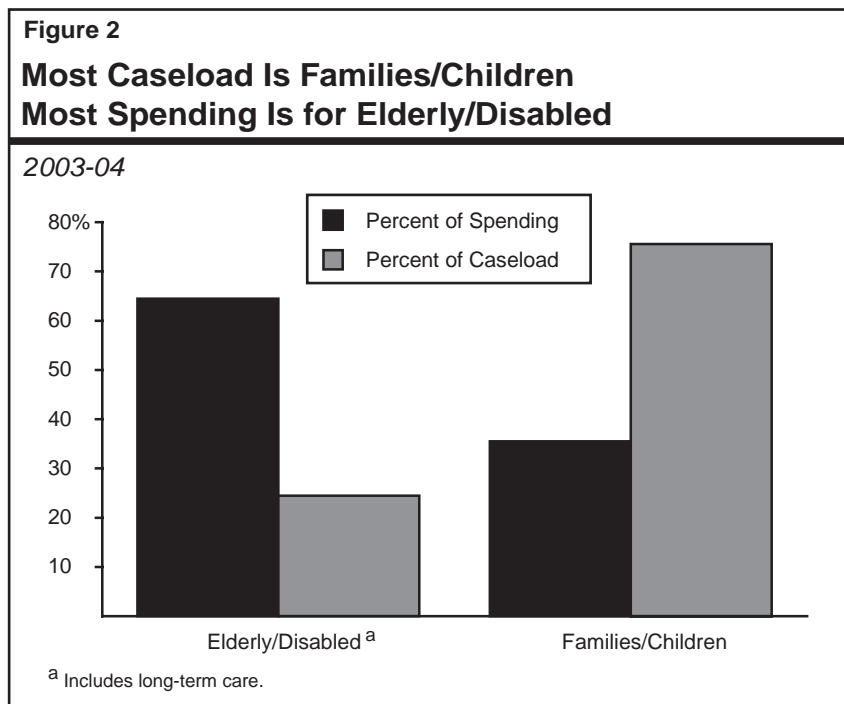
The medically indigent category also covers children and young adults under age 21. Several special categories provide coverage without a share-of-cost or an asset limit to children in families with higher incomes—200 percent of the FPL for infants, 133 percent of the FPL for children ages 1 through 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 incomes 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. The Governor’s mid-year reduction proposal included changes in eligibility for certain immigrants that are discussed later in this section.

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.



MEDI-CAL EXPENDITURES

Further Decrease in Current-Year Spending

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

The budget estimates that for the current year the General Fund share of Medi-Cal local assistance costs will decrease by about \$789 million (7.5 percent), compared with 2002-03. The bulk of this decrease is for benefit costs, which will total an estimated \$9 billion in 2003-04.

Figure 3					
Medi-Cal General Fund Budget Summary^a					
Department of Health Services					
<i>(Dollars in Millions)</i>					
	Expenditures			Change From 2003-04	
	Actual 2002-03	Estimated 2003-04	Proposed 2004-05	Amount	Percent
Local Assistance					
Benefits	\$9,941	\$9,082	\$10,825	\$1,743	19.2%
County administration (eligibility)	509	592	631	39	6.6
Fiscal intermediaries (claims processing)	103	91	113	22	24.5
Totals, local assistance	\$10,554	\$9,765	\$11,569	\$1,804	18.5%
Support (state operations)	\$92	\$95	\$104	\$9	9.9%
Caseload (thousands)	\$6,380	\$6,620	\$6,840	\$220	3.3%

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

General Fund Reduction in 2003-04. The 2003-04 Budget Act decreased General Fund spending from 2002-03 by about \$602 million (5.7 percent) with the inclusion of significant one-time savings such as shifting the budgeting for Medi-Cal benefits from an accrual to a cash basis of accounting. The act also included a temporary increase in the federal share of support for the program that reduced General Fund costs in 2003-04 by nearly \$570 million.

Mid-Year Reduction Proposals. As noted earlier, a package of mid-year budget reductions proposed by the Governor would result in addi-

tional Medi-Cal savings in the current year of nearly \$207 million General Fund.

The Governor's budget plan would reduce by 10 percent the rates paid for physician services, pharmaceuticals, dental services, managed care plans, home health care, medical transportation, and certain other medical services. This rate reduction also affects certain non-Medi-Cal programs, including the California Children's Services Program; the Family Planning, Access, Care and Treatment Program; the state-only Family Planning Program; the Genetically Handicapped Persons Program; and the Breast and Cervical Cancer Early Detection Program. The proposed change is expected to reduce state costs by about \$160 million in the current year. This rate reduction would be in addition to the 5 percent rate cut included in the *2003-04 Budget Act*, and would result in a total rate reduction of 15 percent if adopted. The Governor has also proposed the elimination of a special rate increase for long-term care providers to achieve an estimated state savings of \$46 million.

The savings from the two reduction proposals discussed above would be partly offset by a mid-year reappropriation of \$60 million General Fund from 2000-01.

The Governor's mid-year reduction package also included several proposals to cap the number of undocumented immigrants, as well as legal immigrants living in the country for less than five years, that receive services from Medi-Cal and the Breast and Cervical Cancer Treatment Program. The budget plan assumes that this proposal will not result in state savings until 2004-05.

January Proposals to Reduce Current-Year Costs. The Governor's January budget plan includes various proposals to achieve a net reduction of \$40 million General Fund in the current year. Most of the savings, about \$351 million, are attributable to four proposals that are one-time in nature.

The first is a reduction in the amount paid to the Department of Mental Health for mental health services provided to Medi-Cal children and youth, due mostly to the shift from accrual to cash budgeting in 2003-04, but also due to a modest caseload reduction. The second reduction results from the Governor's proposal to modify and delay from 2003-04 to the budget year the imposition of a quality improvement fee on managed care plans. Third, the Governor proposes to achieve savings from the recovery of inappropriate payments to the federal government for certain providers. Finally, the budget reflects larger overall savings than expected from the shift in accounting from accrual to cash.

The remainder of the proposals are ongoing in nature. These include a reduction in the interim rate paid to certain hospitals, a change in the methodology used to set rates for clinics, and various rate reductions. Savings of about \$26 million would be achieved in the current year, with increased savings expected in 2004-05.

Increased Caseload and Other Costs. The proposed savings discussed above are partially offset by several factors. One of these factors includes greater-than-anticipated growth in the number of children and youth who are participating in Medi-Cal because of the Child Health and Disability Prevention program “gateway” to Medi-Cal, which commenced operation in July 2003 and which is expected to increase costs by more than \$39 million.

Other increases in Medi-Cal benefit costs in the current year are due to an increase in the utilization of nursing facilities that is expected to increase state costs by about \$20 million and the settlement of three federal audits related to inpatient hospital psychiatric claims that will require the state to repay the federal government about \$16 million in 2003-04.

Prepayment of Checkwrite Increases Costs. The Governor proposes that the payments to Medi-Cal providers scheduled for July 1, 2004 be paid instead on June 30, 2004. While this action increases General Fund costs in the current year by \$135 million, it would result in one-time savings of \$8.5 million in 2004-05. That is because the shift allows the state to take advantage of the temporary increase in federal Medicaid funding that will end in June 2004. The federal government will pay nearly 53 percent of Medi-Cal Program costs until June 30, but will only pay 50 percent of costs as of July 1.

Unrealized Savings Increase Costs. The Governor’s budget anticipates that about \$91 million in savings from cost-containment activities assumed in the *2003-04 Budget Act* will not be realized. If it were not for the current-year reduction proposals there would have been a deficiency in the current year.

The DHS has determined that the delay in the enactment of the *2003-04 Budget Act* and the mid-year elimination of budgeted positions have delayed the implementation of certain cost-containment activities, thereby increasing state costs for Medi-Cal services in the current year. Specifically, about \$59 million was added to 2003-04 spending because of an anticipated erosion of savings from efforts to reduce fraud, contract for durable medical equipment and lab services, closely manage the care of certain persons, and implement other strategies to recover funds that have been paid inappropriately. The cost increases also include \$32 million in savings assumed in the budget act from the addition of staff to resolve

aged drug rebate payment disputes. An additional \$29 million in anticipated savings in dental services are not expected to be achieved because of a legislative decision to alter a new requirement for X-rays for dental restorations.

Budget-Year Expenditure Reduction

The Governor's proposed budget estimates that total General Fund spending for Medi-Cal local assistance will be about \$11.6 billion in 2004-05, a net increase of \$1.8 billion, or 19 percent, above the estimated spending in the current year. About \$1.6 billion of the General Fund increase in spending reflects the budget-year effect of the shift from accrual to cash accounting (\$958 million) and the temporary increase in the level of federal funding in 2003-04 (\$655 million). Without these one-time savings in 2003-04, the 2004-05 increase in Medi-Cal expenditures from the previous year would be much smaller—\$191 million or 2 percent, rather than the much larger increase shown in Figure 3.

Additional increases in expenditures are the result of increases in the price and utilization of services and caseload growth. The budget plan also takes into account an increase in the Medi-Cal caseload in 2004-05 of about 220,000 average monthly eligibles (3.3 percent). This would bring the total number of individuals receiving assistance to 6.8 million—roughly 19 percent of the state's population. These spending increases are partly offset by a series of proposals to reduce program costs through cuts in rates and services and certain one-time savings. Figure 4 summarizes the major components of the change in benefit costs, which we discuss below.

Increased Price and Utilization of Services. In line with a continuing trend that has significantly bolstered Medi-Cal Program expenditures in recent years, the 2004-05 budget plan assumes an increase in the cost of pharmaceuticals of \$253 million.

The Governor's budget also includes about \$164 million for rate increases for certain clinics and hospitals that offer services to Medi-Cal patients, including the final of a series of rate increases to hospitals that provide outpatient services to fulfill a 2001 legal settlement.

Medi-Cal "buy-in" payments for Medicare premiums would also continue to grow. The Medi-Cal Program 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 so-called buy-in payments will increase by \$109 million in 2004-05.

Figure 4	
Medi-Cal Benefits	
Major General Fund Spending Changes	
Governor's Budget	
<i>2004-05</i> <i>(In Millions)</i>	
One-Time Increases	
Funding shift to counties to reduce costs	\$958
Reduction in federal share of Medicaid funding	655
Increases in Price and Utilization of Services	
Increased pharmacy costs	\$253
Various rate adjustments	164
Increased cost for Medicare and Medicare HMO premiums	109
Nurse to patient ratios	31
Caseload Increases	
Caseload shift due to implementation of the Child Health and Disability Prevention program "gateway" to Medi-Cal	\$110
Ongoing Savings From Proposals	
Additional 10 percent provider rate reductions, revised rates for clinics, and reduced interim rate for some hospitals	-\$341
Increased savings from various 2002 and 2003 proposals to reduce costs for drugs, supplies, and services	-184
Quality improvement fee for managed care plans (net savings to General Fund)	-75
One-Time Savings	
Checkwrite prepayment in 2003-04	-\$278
Checkwrite prepayment in 2004-05	-144

Chapter 945, Statutes of 1999 (AB 394, Kuehl), requires hospitals to maintain specific staffing levels (established by DHS) for various hospital units, such as critical care units, beginning January 1, 2004. The budget plan includes about \$31 million to offset the cost of the mandate for hospitals that provide services to Medi-Cal patients.

In addition to the cost increases identified in Figure 4, costs are also expected to go up for some of the health programs that are passed through the DHS Medi-Cal budget but actually administered by other state departments. Notably, the cost of mental health services administered by the Department of Mental Health, including children's services provided

under the Early and Periodic Screening, Diagnosis and Treatment Program, are expected to increase by about \$126 million. The increase is due partly to continued growth in program caseload and costs, as well as to technical adjustments related to the shift in Medi-Cal accounting and the anticipated end of a one-time increase in the federal share of cost for the Medicaid Program.

Caseload Increases. The Governor's budget plan anticipates that caseload costs would increase in 2004-05 by \$110 million due to the implementation of a program in July 2003 that will preenroll children in Medi-Cal and the Healthy Families Program who are screened for medical problems through the Child Health and Disability Prevention program.

Some of these costs would be offset by the continued effect of steps taken last year to tighten eligibility procedures. Last year's budget plan included provisions intended to reduce caseloads by (1) ensuring that county workers completed redeterminations of Medi-Cal eligibility on a timely basis and (2) establishing a process that requires adult beneficiaries to report on their eligibility for Medi-Cal or be disenrolled from services.

Also, the Governor's mid-year reduction proposal to impose caps on caseloads for various immigrant programs as discussed earlier is expected to result in savings of \$23 million in the budget year.

Ongoing Savings From Proposals to Reduce Costs. The spending plan takes into account the estimated ongoing effect of several reductions proposed to reduce rates paid to Medi-Cal providers in the current year and budget year that would achieve combined savings of \$341 million in 2004-05.

As discussed above, the Governor's mid-year reduction plan included a 10 percent rate cut in the current year on selected providers in addition to the 5 percent provider rate cut imposed in the *2003-04 Budget Act*. The mid-year proposal would achieve a total of \$460 million in state savings in 2004-05—\$300 million more than the \$160 million in savings to be achieved in 2003-04—because they would be in effect for the full fiscal year.

Also included in the Governor's \$341 million in proposed savings are two other actions that would reduce rates. One would modify the reimbursement rates for certain clinics that provide services to Medi-Cal patients to achieve estimated savings of \$28 million. The proposal would base rates on audited cost reports from 1999 and 2000 rather than on unaudited cost reports from 2000. The budget plan also assumes a 10 percent reduction in the interim amount initially paid to noncontract hospi-

tals that serve Medi-Cal patients (the amounts paid to hospitals are later adjusted to reflect actual costs) for an estimated savings of \$13 million.

Additional state savings of \$184 million are expected to result from the full-year implementation in 2004-05 of various strategies adopted in the 2002-03 and 2003-04 Budget Acts to reduce costs and utilization for prescription drugs, durable medical equipment, and medical supplies.

The Governor's budget plan proposes to levy a quality improvement fee on managed care health plans. The fee would generate additional revenues of \$300 million that would be offset by a \$225 million increase in Medi-Cal expenditures to provide a rate increase to health plans, for a net savings to the state General Fund of \$75 million. This proposal is a modification of a measure in the 2003-04 Budget Act that the administration indicates could not be implemented in 2003-04 because of federal restrictions.

One-Time Savings. The budget plan assumes significant General Fund savings from one-time actions that shift the timing of payments to providers. One proposal, discussed above, is to shift the provider payment ordinarily made on July 1, 2004 to June 30, 2004 to take advantage of a greater federal Medicaid cost-sharing ratio that expires on the latter date. This shift in payments would have the effect of reducing state expenditures in the budget year by \$278 million.

In a separate, but similar action, the Governor's budget plan proposes to delay all other checkwrites to providers during the budget year by one week. Since Medi-Cal is now budgeted on a cash basis, this change would result in one-time state savings of \$144 million in 2004-05 because the last checkwrite of the fiscal year would be shifted to 2005-06. The extra week would also allow the department additional time to review the payments to detect fraudulent claims.

MEDI-CAL COST AND CASELOAD TRENDS

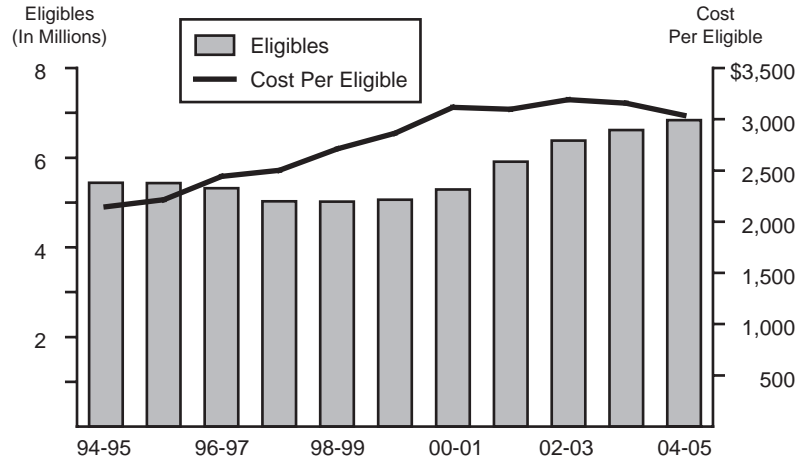
Figure 5 (see next page) illustrates how the Medi-Cal caseload and per-eligible costs have changed since 1994-95, along with projections of these measures for 2003-04 and 2004-05 based on the budget estimates.

Budget Forecasts Caseload Increase 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. The increase in caseload and decline in the cost per eligible for the program is projected to continue in the budget year.

Figure 5
Medi-Cal Caseload Would Increase
And Costs Decline Under Budget Plan

1994-95 Through 2004-05



Caseload. Between 1994-95 and 1996-97, the Medi-Cal average monthly caseload was relatively constant, averaging about 5.4 million eligibles. The Medi-Cal caseload subsequently dropped by almost 300,000 eligibles (5 percent) in 1997-98. The change in the Medi-Cal caseload roughly paralleled changes in the CalWORKs welfare caseload. The 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 2000-01, 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.

The caseload began to grow rapidly during 2001-02 and 2002-03 primarily due to a variety of eligibility expansions and simplified eligibility processes. Growth in eligibles is expected to continue in 2003-04 and 2004-05, but at a slower rate.

Cost Per Eligible. 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 1994-95 through 2004-05. This is greater than the rate of general inflation during this period (nearly 2 percent) as measured by the Gross Domestic Product deflator.

While the caseload has gone up and down over the past decade, the cost trend per eligible had been almost steadily upward until 2001-02. While the number of families on welfare in the Medi-Cal population declined during this period, the proportion of relatively higher-cost aged and disabled beneficiaries had increased, driving up the average cost per eligible for the Medi-Cal population as a whole.

The turnaround in the trend seen since that time appears to be partly 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 compared to other beneficiaries, such as the aged, blind, and disabled.

Based on the Governor's budget plan, these costs would decrease by about 1 percent in the current year and further decrease by nearly 4 percent in the budget year. This decrease can be partly attributed to the Governor's proposals to phase in additional provider rate reductions in the current year and budget year.

Overall Caseload Estimate Reasonable

We find that the budget's overall estimate for the Medi-Cal caseload is reasonable, but believe that there is both upside and downside risk to the estimate. While it is possible that the population of aged beneficiaries will be greater than budgeted, it is also possible that the population of nonwelfare families and children will be less than assumed in the Governor's budget plan. We will monitor caseload trends and recommend appropriate adjustments at the time of the May Revision.

Figure 6 (see next page) shows the budget's forecast for the Medi-Cal caseload in the current year and 2004-05. The majority of the projected Medi-Cal caseload increase occurs in the families and children eligibility categories. The budget plan estimates that the caseload for this group

will increase by 4 percent in the current year and an additional 3 percent in the budget year. Nonwelfare families account for most of the changes in Medi-Cal eligible families and children. The budget estimates that the caseload of Medi-Cal eligible nonwelfare families will increase by about 7 percent in the current year, and then increase by 6 percent in the budget year.

Figure 6
Medi-Cal Caseload
Governor's Budget Estimate

(Eligibles in Thousands)

	Change From 2002-03				Change From 2003-04		
	2002-03	2003-04	Amount	Percent	2004-05	Amount	Percent
Families/children	4,572	4,741	169	4%	4,890	148	3%
CalWORKs	1,549	1,479	-70	-5	1,453	-26	-2
Nonwelfare families	2,434	2,605	171	7	2,769	164	6
Pregnant women	203	208	5	3	215	6	3
Children	386	449	63	16	453	4	1
Aged/disabled	1,549	1,617	68	4%	1,679	62	4%
Aged	584	616	31	5	650	34	6
Disabled (includes blind)	965	1,001	37	4	1,029	28	3
Undocumented Persons	259	262	3	1%	271	10	4%
Totals	6,380	6,620	240	4%	6,840	220	3%

Some of the projected current-year and budget-year growth in the nonwelfare families and children caseload is the result of the implementation of a “gateway” in the Child Health and Disability Prevention (CHDP) program. The Governor’s budget estimates that efforts to expedite the enrollment of CHDP children into more comprehensive health care coverage will result in nearly 146,000 eligibles being added to the Medi-Cal Program in 2004-05. Additional caseload growth is expected to result from the enactment of two laws in 2003 that simplified eligibility processes for children who receive free meals through the National School Lunch Program or are eligible for Food Stamps.

The overall projection of nonwelfare families and children caseload growth is consistent with past trends. However, the effect of ongoing changes in the Medi-Cal Program is hard to predict and there could be significant revisions to the projection for various reasons. For example, these changes include modifications of eligibility determination proce-

dures adopted in the *2003-04 Budget Act* with the intent of reducing caseloads and implementation of the CHDP gateway.

Caseloads for the aged, blind, and disabled are expected to grow by about 68,000 beneficiaries or 4 percent in the current year and by an additional 62,000 beneficiaries or about 4 percent in the budget year. The growth in the current year is due to underlying caseload growth trends as well as a projected increase in caseload due to a Superior Court ruling in a case known as *Craig v. Bonta*. This ruling requires DHS to provide Medi-Cal benefits to persons terminated from the federal SSI/SSP program retroactively to June 30, 2002.

Caseload increases for the aged are being driven primarily by those aged individuals who qualify as medically needy. This eligibility category is expected to grow by 29,100 or nearly 18 percent to 191,900 in 2004-05. This is a substantially larger year-to-year caseload growth increase than the 7 percent increase that is estimated will occur between 2002-03 and 2003-04. The most recent data that we have reviewed suggest that caseload in this category may be growing even faster than projected and that the current-year and budget-year estimate may understate funding requirements for these eligibles. However, in discussions with DHS, the department has indicated that the most recent data may be skewed by the effect of *Craig v. Bonta* and that updated information would be provided at the time of the May Revision.

Potential Risks to Accuracy of Caseload Projections and Cost Estimates. The accuracy of the department's caseload projections and cost estimates are dependent upon a number of other more general factors not discussed above. Among the factors that could cause the Medi-Cal program's caseload and costs to vary from the projections are:

- ***Federal actions*** such as a continuation of the temporary increase in federal funding relief or the potential effect of the enactment of federal legislation such as the recent Medicare bill on the Medi-Cal program.
- ***Further changes in state laws and regulations*** adopted by the Legislature and the Governor or through the initiative process. For example, state law was changed to expand health insurance coverage for employees and dependents of certain employers, a step which would eventually have an effect on Medi-Cal Program caseloads.
- ***Effect of Lawsuits on the Governor's Budget Proposals.*** As discussed earlier, the *2003-04 Budget Act* included a proposal to reduce certain provider rates by 5 percent. However, a preliminary injunction issued by a federal district court has blocked, at least

for now, part of the rate reduction that was to take effect on January 1, 2004. If the rate reduction is prevented from occurring, the state could lose hundreds of millions of dollars in savings and it would be less likely that the additional 10 percent rate reduction proposed by the Governor could be imposed.

Analyst's Recommendation. In summary, we do not recommend any specific budget adjustment for caseload at this time because we believe that there is both upside and downside risk to the estimate. While it is possible that the population of aged beneficiaries will be greater than budgeted, it is also possible that the eligibility determinations and CHDP gateway implementation will result in fewer eligibles than assumed in the Governor's budget plan. Given this situation, we will continue to monitor the Medi-Cal caseload trends and the Legislature's actions on the Governor's mid-year proposals, and will recommend appropriate adjustments at the time of the May Revision.

We will address various aspects of the Governor's estimates of program costs later in this analysis.

ASSESSING THE GOVERNOR'S 2004-05 BUDGET PROPOSALS

As discussed above, the Governor's 2004-05 budget plan proposes a series of actions to help address the state's fiscal problems and operate the Medi-Cal Program. We discuss his proposals to reduce program costs through the establishment of a quality improvement fee for managed care health plans and to cap enrollment for certain groups of immigrant beneficiaries in the "Crosscutting Issues" section of this *Analysis*. Our assessment of his proposal to transfer eligibility determinations for the Breast and Cervical Cancer Treatment Program to the counties is discussed in the "Public Health" section of this *Analysis*. Finally, our assessment of his proposals to reduce reimbursements for various Medi-Cal providers, reform the Medi-Cal Program, and increase staff to process prior authorizations for prescription drugs and medical services are discussed below.

Litigation Places Savings From Some Rate Reductions in Doubt

The Governor's budget plan proposes a 10 percent rate cut for certain providers in addition to a 5 percent cut enacted in the 2003-04 Budget Act for combined current-year and budget-year state savings of \$960 million. There is a significant risk whether the state would achieve

this level of savings because of ongoing litigation over the issue. As it considers the Governor's proposal for deeper rate cuts, we recommend that the Legislature examine alternative approaches that would strike a balance between concerns over how such reductions would affect access to care and quality of care for Medi-Cal beneficiaries and the need to address the state's serious fiscal problems.

Further Reductions Proposed. As discussed earlier in this analysis, the 2003-04 Budget Act and related budget legislation adopted a 5 percent cut in the rates paid for physician services, pharmaceuticals, dental services, managed care plans, home health care, medical transportation, and certain other medical services delivered to Medi-Cal beneficiaries. The rate cut, which was to have taken effect on January 1, 2004, was expected to reduce state costs by about \$103 million in the current year. The savings in 2004-05 from full-year imposition of the 5 percent reduction would have been roughly \$237 million.

As shown in Figure 7 (see next page), the Governor's mid-year budget reduction package includes a proposal to reduce rates by another 10 percent, bringing the total rate reduction to 15 percent and the total savings assumed in the current fiscal year to \$263 million. The Governor's 2004-05 budget plan assumes that the full 15 percent reduction would continue at least through the end of 2004-05 and generate \$697 million in savings in 2004-05. The rate reductions would be in effect until January 2007. Thus, the Governor's budget plan, if adopted by the Legislature and upheld by the courts, would result in combined current-year and budget-year savings amounting to \$960 million.

Ruling Blocks Implementation of First Rate Reduction. Litigation initiated by the state's Medi-Cal providers means it is possible that the state will achieve only some of the savings assumed to result from provider rate reductions.

A preliminary injunction issued by a federal district court in December has partly blocked, at least for now, the implementation of the first 5 percent reduction in rates for providers who serve fee-for-service patients. The decision was based on a claim that the rate cuts violated a federal law requiring that the rates paid to Medicaid providers be adequate to ensure quality care and access to care for beneficiaries. The court held that DHS had failed to analyze the potential effects of the rate cut in regard to these factors. The ruling means it is almost certain that legal action will be brought challenging the Governor's proposal to reduce rates an additional 10 percent.

The December court ruling did not apply to all providers who were subject to the 5 percent rate reduction; the cut enacted for managed care health plans was allowed to remain in effect. Thus, as things now stand,

Figure 7				
Provider Rate Reductions: Proposed General Fund Savings				
<i>(In Millions)</i>				
	Total	Pharmacy	Managed Care	All Other
2003-04				
5 percent	\$103	\$46	\$31	\$27
10 percent	160	92	9	59
Totals	(\$263)	(\$137)	(\$40)	(\$86)
2004-05				
5 percent	\$237	\$99	\$62	\$76
10 percent	460	199	99	162
Totals	(\$697)	(\$299)	(\$160)	(\$238)
Two-Year Savings				
	\$960	\$436	\$200	\$324
Detail may not total due to rounding.				

the state would still be able to achieve General Fund savings from managed care rate cuts of at least \$40 million in 2003-04 and an additional \$160 million in 2004-05 if the Governor's proposal for a full 15 percent rate reduction were adopted by the Legislature. However, managed care plans have filed a "notice of dispute" with DHS challenging the department's rate calculation methodology which, if successful, would jeopardize the potential savings.

The state appealed the court's decision in early January in its entirety, and has also taken steps to attempt to win the immediate reinstatement of at least part of the savings by submitting to the court a DHS analysis of the adequacy of Medi-Cal pharmacy rates that had been completed in 2002. The court is expected to rule on the issue within 60 days of the filing of the appeal. As shown in Figure 7, restoration of the 5 percent rate reduction for pharmacies, and adoption of the Governor's proposal for an additional 10 percent rate reduction for pharmaceutical providers, would enable the state to achieve savings of nearly \$436 million over two years.

At the time this analysis was prepared, the Legislature had not yet acted upon the Governor's mid-year reduction proposal, which was to have taken effect in January 2004. Even if the department ultimately pre-

vails on any portion of the litigation and the injunction is lifted, some of the savings assumed in the mid-year proposal from the 10 percent cut would be lost. Federal and state rules do not permit rates to be cut retroactively when providers have not received advance notice of such a change. However, since advance notice was given to providers regarding the 5 percent rate reduction, the savings could be achieved retroactively to January 1, 2004, if this reduction were subsequently permitted by the courts.

Analyst's Recommendation. In our February 2001 report, *A More Rational Approach to Setting Medi-Cal Physician Rates*, we took note of evidence from health research conducted nationally indicating that the rates paid to medical providers can affect the quality of care and access to care provided to Medicaid patients. We also acknowledged, however, that there is no simple formula that relates rate levels to health care access and quality.

The rate reductions proposed by the Governor, in our view, are likely to have significant effects on the operation of the Medi-Cal Program. The Legislature, however, faces the difficult choice of balancing these concerns against the state's serious fiscal problems.

We would recommend that, as the Legislature examines the Governor's rate cut proposal, it also consider some alternatives that would enable it to strike a balance between these competing concerns. The Legislature could moderate the size of the rate reduction; apply it selectively to certain providers and moderate the impact on others, depending on the available evidence as to how quality of care and access to care might be affected; or further limit by statute the time period the rate reductions would be in effect.

Any of these approaches would diminish at least somewhat the level of savings proposed by the administration from rate reductions. Thus, if it were to reject or significantly modify the Governor's plan, the Legislature should also consider ways to achieve alternative budgetary solutions in order to address the state's fiscal problems. Our office has identified a number of options and recommendations for reducing state costs or increasing state revenues in *The 2004-05 Budget: Perspectives and Issues* and this *Analysis*. Such a review of alternative budget solutions may prove necessary, in any event, if the state is unable to overcome legal challenges now pending that could prevent a portion of the provider rate reductions from taking effect.

Reject Staff to Process Authorization Requests, But Provide Necessary Flexibility on Workload

We recommend rejection of the Governor's request for 36 additional positions to process treatment authorization requests (TARs) because our analysis shows that increasing the number of staff who process TARs is not the most cost-effective way to address the growth in TAR volume. We propose instead steps to give the Department of Health Services the authority it needs to better manage its TARS workload and to improve the TARS process. (Reduce Item 4260-001-0001 by \$1 million.)

Governor's Budget Proposal Would Add Staff. State law requires Medi-Cal providers to submit TARs to obtain authorization for reimbursement for specific procedures and services. Some of the services that require TARs include certain prescription drugs, long-term care claims, and inpatient hospital claims. The volume of TARs has increased significantly during the past three years. The number of TAR reviews conducted by DHS increased 17 percent in calendar year 2002, and another 17 percent in 2003. The department anticipates the upward trend in TARs reviews will continue, primarily driven by a surge in the number of TARs submitted for drug prescriptions.

The Governor's 2004-05 budget plan would increase by 36 the number of staff that review prior authorizations for certain prescription drugs and medical services for Medi-Cal patients. The additional staff are expected to cost \$4 million (\$1 million from the General Fund) in 2004-05. These additional resources would bring the total budget for TARS reviews to roughly \$70 million (\$20 million General Fund) and the total staffing level to 685.

The budget plan also proposes statutory language that would give DHS the discretion to examine a sample of TARs for medical services and prescription drugs, instead of the current requirement that every such request be reviewed.

Recent Study Found Significant Problems With TARs Processing. A study commissioned last year by the Medi-Cal Policy Institute (which recently became part of the California Healthcare Foundation), a non-profit group which studies Medi-Cal and other state health programs, found significant problems with the Medi-Cal TAR process. Among the study's findings:

- ***Relatively Larger State Staff.*** The DHS uses a relatively larger staff than private health plans to process TARs. This may be partly justified by Medi-Cal's sicker and older patient population, which is more likely to require services subject to prior authorization.

Nevertheless, the program's staff positions for this function appear to be excessive.

- **Lack of Cost-Benefit Evaluations.** The DHS does not conduct routine cost-benefit evaluations to determine if requiring prior authorization for specific services and drugs helps to contain overall program costs. For example, state law requires that any prescription for drugs exceeding the limit of six per month be subject to a TAR. This requirement is a major factor driving up the TAR workload. However, DHS has not determined if this limit reduces prescription drug costs for the state. Given that only 10 percent of such TARs are disallowed, and that drugs addressing chronic conditions are routinely approved, it is possible that requiring TARs for selected drugs and medical services might be a better approach.
- **Inconsistent Decision Making.** The study also found that decision making on TARs is inconsistent and often lacking formal criteria. An Internet-based system called Service Utilization Review Guidance and Evaluation (SURGE), now in development by DHS, should result in faster TAR decisions, uniform criteria for decision making, and a reduction in the number of DHS staff needed to process TARs. The DHS indicates that the technology and data systems are now available to implement the system for pharmacy TARs, but that the department has not implemented the system for this purpose. It is not clear from our discussions with the department why this is the case. The state would also benefit if SURGE were placed in service to process medical claims. However, it will most likely be a couple of years before the necessary data systems for such an effort would be available.

Proposed Language and Other Steps Could Reduce TAR Volume. As we noted above, the Governor's budget plan proposes statutory changes to give DHS greater flexibility in terms of how many TARs must be reviewed for certain services and drugs.

Our analysis indicates that this language would be effective in helping the department to better manage its workload. For example, under the proposal DHS could choose to review only a sample of certain drugs, such as over-the-counter drugs, that generate a high volume of prescriptions but that are low-cost and low-risk to patients. Similarly, DHS could spend less staff time reviewing hemodialysis or other services that have high TARs approval rates and are less likely to be abused.

While the legislative changes sought by the administration appear to be warranted, our review of the DHS request for 36 additional personnel indicates that it does not fully take into account the potential reduction

in workload and staffing needs that could result from adoption of the statutory changes.

Analyst's Recommendation. Based on our analysis, we believe that DHS could better address the increasing volume of TARs by focusing initially on actions that reduced its workload rather than by increasing the number of staff who process TARs. Accordingly, we recommend that the Legislature adopt the statutory changes proposed by the administration giving the department the discretion it needs to manage this workload more effectively, but deny at this time the request for additional positions. The Legislature could reconsider the request next year after the effect of the statutory changes on TARs workload trends had been determined.

We also recommend that the Legislature direct DHS to take additional steps to reduce its TAR workload. For example, the Legislature may wish to consider directing DHS to conduct routine analyses of the various types of claims subject to TAR reviews based upon such criteria as the medical risks for patients and the costs and benefits of the reviews to the Medi-Cal Program. The DHS should also be directed to implement the SURGE system for pharmacy claims on a statewide basis by the end of the 2004-05 fiscal year.

AN AGENDA FOR LONG-TERM REFORM OF THE MEDI-CAL PROGRAM

Proposals to Reform Medi-Cal Should Be Pursued

The Governor's budget plan offers a package of proposals for long-term reform of the Medi-Cal Program that it estimates would achieve General Fund savings of \$400 million beginning in 2005-06. In general, the proposal warrants careful consideration by the Legislature given our projections of continued caseload and expenditure growth in the program and the state's fiscal difficulties. However, some key details of the proposal are still lacking. We recommend that the Legislature direct the Department of Health Services to present more detailed information about the reform plan at budget hearings so that it will be in a better position to assess the policy implications and savings that would actually be achieved by the administration's plan. We also recommend changes to (1) the request for staffing and funding to develop the proposal and (2) managed care enrollment procedures.

Governor Proposes Sweeping Reforms

Two Major Components. The Governor's budget plan presents two major proposals to reform the Medi-Cal Program for the stated purpose of providing the state with the flexibility to meet the essential needs of program beneficiaries at costs that are affordable to the state. The budget plan requests \$3.2 million (\$1.5 million from the General Fund) for additional resources for DHS to initiate such a reform effort, including 15 positions and funding for two contracts. No savings from the adoption of the proposal are anticipated in the budget year, but the Governor's budget plan estimates that the proposal would result in state savings of \$400 million in 2005-06.

We summarize the Governor's two major proposals as follows:

- Restructuring the program to allow for a multitiered eligibility and benefits structure with components that more closely resemble private health coverage.
- Expanding managed care coverage on a mandatory basis for families and children into additional counties where these services are now provided primarily on a fee-for-service basis, and also encouraging additional aged, blind, and disabled beneficiaries in these counties to volunteer for enrollment in managed care.

We describe the Governor's proposals in more detail below. However, we note that the administration proposals, at this point, represent only broad and conceptual options for legislative consideration. The budget plan offers few details to explain many aspects of the Governor's plan, indicating instead that these are to be developed by the administration in consultation with the Legislature and "stakeholders" with an interest in the operation of the Medi-Cal Program, such as beneficiaries and providers. In our discussion below, we provide background information that may assist the Legislature in assessing the Governor's plan once more details are forthcoming.

Restructuring Medi-Cal Eligibility and Benefits

Some Federal Provisions Can Be Waived. The Centers for Medicare and Medicaid Services (CMS), the federal government agency that administers the Medicaid Program, has the authority to grant to states waivers of certain Medicaid statutes to enable them to explore innovative service delivery and financing approaches to providing health care services. Under the Governor's proposal, the DHS would obtain a Section 1115 Medicaid Demonstration Waiver that would allow the state to implement changes in the structure of Medi-Cal.

While the changes proposed in such waivers can be sweeping, they are subject to renewal every five years and states must be able to demonstrate that the changes will not increase federal government costs for the Medicaid program. Some states have already obtained waivers comparable in many respects to the one proposed by the administration.

Medi-Cal Eligibles Could Be Divided Into Categories. The DHS indicates that one element of its waiver request may be to split Medi-Cal eligibles into three categories.

One category would include beneficiaries who are guaranteed eligibility for Medicaid services under federal law. This category would presumably include children and adults who are eligible to receive CalWORKS cash grants and persons who receive SSI/SSP benefits.

A second, separate group could be Medi-Cal eligibles who are mandated to get coverage under federal law except for the fact that their income slightly exceeds federal eligibility standards.

The third category could be “medically needy” eligibles—both children and adults in families to whom the state at its option has chosen, without any federal requirement, to expand health coverage. This category could include families who do not qualify for CalWORKS cash assistance but nevertheless have relatively low incomes.

Benefits Could Vary by Eligibility Category. The administration has suggested that it might seek to create a three-tiered benefit structure that would provide varying levels of benefits for the three categories of eligibles described above. Beneficiaries who received coverage entirely at the state’s option, for example, might receive a more restricted package of benefits that more strongly resembled private insurance and that included financial limits on the services covered by the state. Eligibles for whom the federal government mandates health coverage would presumably receive a more elaborate package of Medi-Cal benefits.

Additional Waiver Features Possible. The administration has indicated that it also contemplates an effort through the waiver to simplify and align eligibility standards for Medi-Cal with other programs that assist low-income persons. Another possible waiver component identified by the administration is the implementation of more effective requirements that patients contribute copayments to partly offset the cost of certain services, such as a provision allowing a physician to require a copayment as a condition of receiving nonemergency medical services. The administration is also proposing to seek a federal waiver which would allow it to redefine federal requirements for Early and Periodic Screening, Diagnosis and Treatment, which have been interpreted to require a broad and costly array of services for children and youth.

Costs and Savings From Implementation. The budget plan requests ten additional staff positions for DHS in 2004-05 at a cost of about \$700,000 (\$350,000 General Fund), as well as an additional \$250,000 in funding (\$125,000 from the General Fund) for professional consultants, as well as \$4.3 million (\$1.5 million General Fund) to make changes to existing information technology systems to help prepare this component of the waiver request and to begin to implement a multitiered structure for the Medi-Cal Program. The Governor's proposal indicates that additional resources may be needed for these purposes in 2005-06 and subsequent years. The administration anticipates that these costs will be more than offset by future savings from the implementation of the reforms.

Expansion of Managed Care

From 22 Counties to 36. Under the Governor's reform proposal, the DHS would also seek to expand enrollment for parents and children in the Medi-Cal managed care system into 14 additional counties that currently operate under the fee-for-service system. This would bring the total number of counties operating under the Medi-Cal managed care system to 36 and result in the transition of about 414,000 beneficiaries from fee-for-service into managed care. Henceforth, enrollment of these families into managed care would become mandatory upon enrollment in the Medi-Cal Program.

This geographic expansion of managed care would require modification of various federal waivers, federal approval of the state's plan, the execution of contracts with additional managed care health plans, and efforts to resolve concerns with the various groups affected by such a change, including beneficiaries and providers.

Costs and Savings From Implementation. The budget plan proposes to increase DHS staff by five to implement this expansion at a cost of \$400,000 (\$200,000 General Fund), as well as \$250,000 (\$126,000 General Fund) in additional funding for a state contractor that enrolls Medi-Cal beneficiaries in managed care plans.

The 2004-05 budget plan assumes that no savings would result from the adoption of this proposal in the budget year, due to the time needed to develop a plan, to subsequently secure federal approval of the modification of existing waivers to permit the expansion, and to obtain state and federal approval of nonbid contracts with managed care plans.

Implementation would be phased in beginning in 2005-06. Net savings of \$16 million (\$8 million from the General Fund) are projected for 2005-06, with annual ongoing savings of \$33 million (\$16.5 million from the General Fund) anticipated in 2006-07 and thereafter. These savings

are based on the assumption that the state will pay capitation rates to health plans equivalent to 95 percent of what it would cost the state to provide medical services to these beneficiaries under the fee-for-service system. The budget plan also assumes some funding would be set aside for a contractor who would be responsible for enrolling beneficiaries in managed care.

In addition to expanding mandatory managed care to families and children, the administration indicates that it will develop a strategy to encourage the voluntary enrollment of additional aged, blind, and disabled persons into Medi-Cal managed care plans.

Managed Care Proposal Raises Some Concerns

While we believe the Governor's proposals for expansion of managed care warrant consideration by the Legislature, we do have concerns about three aspects of this proposal.

Some Positions Not Needed Yet. Our review of the Governor's proposals indicates the administration is requesting full and immediate staffing to address a workload that will actually phase in more gradually over the budget year and 2005-06. Specifically, we believe that three of the five positions will not be needed until after DHS has obtained the necessary federal approvals for the expansion and has entered into new contracts with managed care plans. The DHS does not expect these steps to be completed until 2005-06. Deletion of the three unneeded positions from the 2004-05 budget would reduce the DHS request by \$200,000 (\$100,000 General Fund).

Some Existing Managed Care Plans in Trouble. At least two of the existing Medi-Cal managed care plans (both County Organized Health System [COHS] plans) have indicated that they face serious financial problems. It appears likely that other COHS plans may also encounter problems in the future. At the same time that the administration examines an expansion of managed care, it should also consider what steps the state should take to ensure that the existing managed care system remains financially stable. We discuss this issue and our recommendations to the Legislature in more detail later in this section of our *Analysis*.

Contractor Costs for Enrollment Could Be Reduced. As noted earlier, the Governor's reform plan would increase funding for the state contractor that enrolls Medi-Cal beneficiaries in managed care. The current three-year contract is scheduled to expire as of September 2004.

The DHS has the option of authorizing three one-year extensions of the contract at an estimated cost of about \$50 million per year (\$25 million General Fund). The Governor's proposal to expand Medi-Cal man-

aged care into additional counties assumes that this contract will be extended for several years, and further assumes an increase in the cost of the contract of about \$7.5 million (\$3.8 million General Fund) in 2005-06.

Under the current process that exists in certain counties, a person who enrolls in Medi-Cal is given up to 30 days after enrollment to choose a managed care plan. To assist the enrollee in making this decision, the enrollment contractor mails each participant a package containing information about the health plans in that county at a cost of about \$5 per mailing. An identical second enrollment package is sent out later in the month. The state currently spends about \$8 million on such mailings each year.

Our analysis indicates that the state could achieve significant savings on the costs of these mailings by allowing new enrollees who have already decided on a health plan to enroll in that plan at the time they apply for Medi-Cal benefits. Such a change would reduce the contractor's mailing and enrollment processing costs and expedite the enrollment of beneficiaries into managed care health plans. We estimate the state would achieve savings in the low millions of dollars annually from such a change.

Analyst's Recommendations

In general, the administration's proposal to reform the Medi-Cal Program warrants careful consideration by the Legislature, given our projections of continued caseload and expenditure growth in the program and the state's fiscal difficulties. However, many of the details the Legislature needs to fully understand and assess the proposals were not available at the time this analysis was prepared. Consequently, we cannot say at this time whether the proposal will achieve the overall savings level of \$400 million in 2005-06 that was estimated in the budget plan. This is also the case in regard to the proposal to establish a multitiered restructuring of eligibility and benefits as part of a federal waiver. For this reason, we withhold recommendation at this time on the request for funding to implement this component of the reform package until more information is available.

According to the administration, additional information about this proposal will be provided to the Legislature at the time of the May Revision. We recommend that DHS be directed instead to present more detailed information about its reform plan at budget hearings prior to the May Revision so that the Legislature will be in a better position to assess its policy implications and the savings that would result from adoption of the administration's plan. The May Revision timeline proposed by the administration is so late in the budget process it may not provide the Legislature with sufficient time to examine the proposal and, if warranted, consider modifications and improvements to the suggested approach.

We also recommend that the Legislature modify the administration's proposal for funding and staffing to expand managed care to delete three of the five positions and \$200,000 (\$100,000 General Fund) associated with these positions because, as we discussed earlier in this analysis, these resources will not be needed until 2005-06.

We further recommend that the Legislature direct DHS to modify its current arrangements with its managed care enrollment contractor. Specifically, individuals applying for Medi-Cal in managed care counties who have decided on a health plan should be able to enroll in a plan at the same time that they apply for Medi-Cal. The DHS should estimate the potential savings from this change, so that the Legislature can enact an appropriate and corresponding reduction to the Medi-Cal Program budget.

Additional Opportunities for Reform Worth Considering

In addition to the concepts proposed by the Governor for reforming the Medi-Cal Program, we believe that the Legislature should consider other opportunities that we have identified to improve the program and achieve savings. These include providing coordinated care to the aged and disabled, simplifying eligibility for families by combining Medi-Cal and Healthy Families coverage, improving the eligibility determination process, studying the impact of Medicare legislation, and advocating for federal changes in the Medicaid Program.

Broader Reform Approach Warranted. The Governor's approach for longer-term reform of Medi-Cal addresses some of the key factors affecting the quality of services and the continuing growth in the cost of the program. Our analysis indicates that this concept, while substantive, does not fully address all of the major problems which affect the operation of Medi-Cal and all of the major "cost-drivers" that are increasing state expenditures for these benefits.

The Legislature may wish to consider a more comprehensive approach to reform that examines other opportunities that we have identified to improve the program and to achieve state savings. These proposals, which are discussed in more detail below, include:

- Providing coordinated care to aged and disabled (including the blind) persons to reduce costs.
- Restructuring Medi-Cal and Healthy Families into a family coverage model.
- Improving county eligibility determinations.

The Legislature should also consider the impact of federal Medicare legislation enacted this fall in its deliberations over how to reform Medi-Cal and consider advocating for federal government changes to the Medicaid Program that could result in a reduction in state costs.

Coordinating Care for the Aged and Disabled to Reduce Costs. The Legislature may wish to consider the concept of expanding enrollment in managed care plans to the group of Medi-Cal beneficiaries who would probably benefit the most from a shift away from fee-for-service coverage—the aged or disabled.

In our companion document to this *Analysis, The 2004-05 Budget: Perspectives and Issues*, we describe the current Medi-Cal health care delivery system and evaluate its strengths and weaknesses in regard to addressing the health care needs of these beneficiaries. We identify which additional groups of aged or disabled Medi-Cal beneficiaries are good candidates for an expansion of managed care, and offer recommendations to improve the operation of the existing Medi-Cal managed care system that could facilitate their shift from fee-for-service medicine to a more coordinated system of care. Our proposal would go beyond the Governor's plan which proposes to expand managed care chiefly by extending such coverage to families in additional counties.

Restructure Medi-Cal and Healthy Families Into a Family Coverage Model. As the Legislature considers the Governor's reform proposal, it may also want to consider opportunities to combine and restructure the Medi-Cal and Healthy Families programs into a new family health plan that would unify coverage. Many families who are eligible for these programs are not enrolled in them because of their complex and confusing eligibility requirements and procedures. Furthermore, the current structure of the programs often results in situations in which parents and children within the same family must be enrolled in separate programs with differing program requirements and choices of health care providers. We presented a model approach for addressing these concerns in our June 1999 report, *A Model for Health Coverage of Low-Income Families*.

The model of coverage that we describe in our report could result in increased state costs because there would be an overall increase in the number of persons receiving health benefits. However, this model could be designed so that it would be cost-neutral or result in net savings if the Legislature combined some of its components with some of the strategies for reform that the administration has proposed, such as a multitiered eligibility and benefits package. For example, aligning the health care benefit package that Medi-Cal beneficiaries receive with the benefits offered under Healthy Families coverage, and imposing copayments and premiums for certain beneficiaries, would reduce state costs.

County Eligibility Determinations: Options Exist for Savings. In our discussion of Medi-Cal expenditures in the *Analysis of the 2003-04 Budget Bill*, we identified significant problems with the present system by which counties administer determinations of program eligibility with funding provided by the state. Our analysis raised concerns about the growing cost to the state of eligibility activities and about the performance of these functions by the counties.

We proposed in that analysis that the Legislature examine several options for reform of this aspect of the Medi-Cal Program, such as centralizing eligibility determinations at the state level using the Internet-based system called Health-e-App. We found that such an approach might significantly reduce the cost of eligibility determinations and ensure greater uniformity in the processing of applications.

Federal Medicare Prescription Drug Reform Act. In December 2003, the President signed the Medicare Prescription Drug Reform Act, a measure that will take full effect on January 1, 2006. The act will result in major changes in both the Medicare and Medicaid programs. Most significantly, the new federal law will require the Medicare program to pay some of the pharmaceutical costs for dual eligibles (that is, Medicare-eligible persons who are also enrolled in Medicaid). Until then, state Medicaid programs, including Medi-Cal, will be responsible (with the help of federal Medicaid matching funds) for the cost of prescription drugs for dual eligibles. The measure also implements a number of other significant program changes, including requirements that state Medicaid programs contribute some state funding to the federal government after drug coverage shifts to Medicare. The measure also increased the premiums charged to persons enrolled in Medicare, which, in some cases, are paid for by Medi-Cal.

Because of the complex and interacting effects of the different provisions of the new federal legislation, its net fiscal effect on the Medi-Cal Program is not clear at this time. We are advised that DHS is now conducting a detailed analysis of how its provisions will affect California. The results of that review and the effect of the law on the way the Medi-Cal Program is operated should be taken into account as reform of the Medi-Cal Program is considered by the Legislature.

Options for Federal Medicaid Reform. Our analysis indicates that reforms could be implemented at the federal level in the Medicaid program which, if adopted, could eventually reduce state Medi-Cal costs by as much as hundreds of millions of dollars annually.

For example, one of these potential changes directly relates to the Governor's Medi-Cal reform proposal to encourage the voluntary enrollment of aged and disabled persons (which may include dual eligibles)

into Medi-Cal managed care plans. Currently, the state is somewhat limited in its ability to manage the care of dual eligibles because of the difficulty in coordinating the Medicaid and Medicare programs. Both the federal and state governments might reduce their future Medicaid costs if the federal government changed its rules to allow states to share in savings they were able to achieve through better coordination of care for dual eligibles, such as through disease management services. Because states like California have no way now to share in the savings from such activities, they have little financial incentive to implement such changes.

Analyst's Recommendation. The Governor's plan to reform the Medical Program intends to address some of the key factors affecting the quality of services and the continuing growth in the cost of the program. In reviewing the Governor's proposal, we believe that the Legislature should also consider other opportunities that we have identified to improve the program and achieve savings. These include providing coordinated care to the aged and disabled, simplifying eligibility for families by combining Medi-Cal and Healthy Families coverage, and improving the eligibility determination process. The Legislature should also consider studying the impact of Medicare legislation, and advocating for federal changes in the Medicaid Program.

FAILURE OF COUNTY ORGANIZED HEALTH SYSTEMS WOULD INCREASE STATE COSTS

The Governor's budget plan assumes that the Health Plan of San Mateo (HPSM), which provides services to roughly 50,000 Medi-Cal beneficiaries, will not be in operation in 2004-05. The HPSM is one of the County Organized Health System (COHS)—a form of managed care—that contracts with Medi-Cal in eight counties. At least two of these plans reportedly face financial problems and others may in the future. The failure of HPSM or other COHS plans could prove costly to the state. Accordingly, we recommend that the Legislature initially reject the administration proposal to budget for the phase-out of HPSM and direct the Department of Health Services to explore alternatives that would permit it to remain in operation. The Legislature should also consider several options to address the COHS plan's financial problems in order to avoid an increase in General Fund costs and the other serious consequences of their loss for Medi-Cal beneficiaries.

Background

COHS Model of Managed Care. The first Medi-Cal managed care system to be organized was the COHS model. (The other two systems are known as the Geographic Managed Care [GMC] model and the Two-Plan model.) The COHS model allows a county to establish a county-controlled health plan to arrange for the provision of medical services, utilization control, and claims administration for Medi-Cal beneficiaries. About 550,000 Medi-Cal beneficiaries received care from COHS plans in 2003. This accounts for nearly 9 percent of all Medi-Cal enrollees and about 16 percent of Medi-Cal managed care enrollees. The COHS model operates in eight counties (Monterey, Napa, Orange, San Mateo, Santa Barbara, Santa Cruz, Solano, and Yolo).

The COHS counties are different from the counties that operate the other two types of Medi-Cal managed care systems in that enrollment in a COHS plan is mandatory for nearly all the Medi-Cal beneficiaries residing in that county. This includes families, children, and aged, blind, and disabled persons. In contrast, enrollment in managed care in the counties that operate the GMC and Two-Plan models is voluntary for aged, blind, and disabled persons but mandatory for families and children. Because the aged, blind, and disabled populations are much more likely to utilize high-cost medical services, COHS plans receive higher capitation rates, on average, than health plans in the other two systems of Medi-Cal managed care.

Some Plans Facing Financial Problems. The COHS plans are subject to licensure under the Knox-Keene Health Care Service Plan Act (Act) by the Department of Managed Health Care (DMHC). In addition, under the Act, COHS plans are obligated to meet certain state requirements meant to ensure their continued financial stability and solvency in order to continue in operation. Generally, these requirements obligate a health plan to demonstrate that it can achieve a positive cash flow from its operations and can show fiscal soundness by assuming full financial risk during its history of operation. If these requirements are not met, DMHC ordinarily would conduct a detailed examination of the health plan and recommend steps that should be taken to ensure the plan's continued operation.

A couple of COHS plans have reported recently to the state that they face a risk of fiscal insolvency within the next several years. One COHS in particular, HPSM, has indicated that it is near to falling out of compliance with DMHC's cash flow requirement. The health plan has proposed to close several times and most recently reported that it will remain open only until the summer of 2004. The Santa Barbara Regional Health Au-

thority (SBRHA) has also reported that it might be unable to meet DMHC's requirements in the near future.

The Governor's Budget Proposal. The Governor's 2004-05 budget plan assumes that HPSM will cease operation at the end of June 2004 and that the county would revert to the fee-for-service system for the delivery of Medi-Cal services in the budget year. This health plan was one of the first Medi-Cal managed care plans and has been serving Medi-Cal patients since 1982. As a result, the approximately 50,000 enrollees would no longer receive services from the managed care plan, but would receive services from fee-for-service providers. We estimate that costs would increase by no more than \$30 million (\$15 million General Fund) under this proposal because it is more expensive to provide health care services in a fee-for-service system.

Why Are COHS Plans in Bad Fiscal Health?

We have identified several factors that have likely contributed to the COHS plans' fiscal challenges. These include an outdated capitation rate-setting methodology, capitation rates that we are advised have not kept pace with inflation, the redirection of Medi-Cal "profits" to serve persons and provide services outside of the Medi-Cal system, rates paid to health care providers that are greater than Medi-Cal fee-for-service rates, and DHS' failure to adequately monitor COHS plans' finances.

Rate-Setting Methodology Is Outdated. The methodology DHS uses to determine capitation rates is outdated in that it is based on historical fee-for-service rates rather than any current information about the actual cost of health care services being provided by health plans to individuals in a managed care environment. This means that rates are based on a mix and utilization rate of medical services that may not reflect those of Medi-Cal beneficiaries receiving care from COHS plans. As a consequence, rates could be too high for some beneficiaries and too low for others. The DHS is in the process of changing its rate-setting methodology. However, this may prove difficult, because Medi-Cal data systems do not collect accurate and complete information about the cost and utilization of health care services by COHS patients. These data are critical to setting appropriate rates for COHS plans.

Capitation Rates Reportedly Lagging Inflation. Although COHS plans' rate data are confidential and not available for our review, we have been advised by some plans that their capitation rates have not kept pace with inflation. Thus, COHS plans might be facing financial challenges because they serve large numbers of aged, blind, and disabled Medi-Cal beneficiaries for whom medical costs are generally growing the fastest. These

patients are most likely to be heavy prescription drug and hospital users—two of the most rapidly growing components of health care spending.

“Profits” Used for Services and Persons Outside of Medi-Cal. A number of COHS plans have generated some level of excess revenue or profits because, for some years, the cost of the medical services they provided was less than the Medi-Cal capitation rates they received from the state. Some of these profits have gone into COHS plans’ reserves and were used to shore up their operations during periods when their expenditures exceeded revenues. However, some plans have also used their profits to expand health coverage to low-income uninsured persons who are not eligible for Medi-Cal, as well as to provide services beyond those ordinarily covered by Medi-Cal. While using Medi-Cal revenues for these purposes is permitted under state rules, it may have resulted in some COHS financially overextending themselves.

Rates Paid to Health Care Providers Are Greater Than Fee-for-Service Rates. Some COHS plans have used the profits that have resulted from high capitation payments to reimburse providers at rates greater than the amount the same provider would have been paid under fee-for-service Medi-Cal. For example, HPSM and SBRHA reimburse providers at 120 percent of Medi-Cal fee-for-service rates. This policy has helped these plans entice additional providers into participation in the Medi-Cal Program and improved access to medical care for Medi-Cal beneficiaries. However, this approach also appears to be creating cost pressures that are contributing to the financial instability of these plans.

Lack of Monitoring of COHS Finances. Another factor that appears to be contributing to the problems now facing some COHS plans is the state’s lack of an adequate system to monitor the plans’ financial condition for Medi-Cal-specific operations. At present, DHS does not require plans to provide detailed supplemental financial reporting for Medi-Cal activities that would enable the state to fully understand why some of the plans are in financial trouble and to what extent Medi-Cal rates contribute to the problem. The DHS also does not conduct financial examinations and on-site reviews to determine when financial problems exist or the proper remedies when problems are discovered. Under state law, plans are not required to provide such financial reporting and DHS is not required to conduct such in-depth reviews. These types of intensive monitoring activities would also go beyond the current role of DHS and DMHC for regulating the basic financial solvency of health plans.

What Would Happen if COHS Plans Ceased Operation?

If COHS plans were, for some reason, to discontinue operation, we have concluded, based upon our analysis, that the resulting shift of Medi-

Cal patients from COHS plans to a fee-for-service system would have a negative fiscal impact on the state, could also reduce the access to care for patients, and would eliminate the monitoring of the quality of patient care.

Our analysis focused on a shift to a fee-for-service system, rather than to some other form of managed care, because significant barriers exist to shifting patients to another system of managed care in nearly all COHS counties. These barriers include the lack of other managed care plans in such counties and federal restrictions on the operation of managed care plans absent a federal waiver allowing expansion that could be difficult and time-consuming to secure.

Medi-Cal Program Costs Would Increase. Our analysis indicates that net state costs for the Medi-Cal Program would probably increase if COHS plans stopped operating and, as a result, Medi-Cal beneficiaries in those counties received their care instead from fee-for-service providers.

Enrolling Medi-Cal beneficiaries in COHS plans instead of fee-for-service for their health care has resulted in significant savings to the state. The DHS estimates that Medi-Cal beneficiaries typically receive health care services from a COHS plan at about 81 percent of the cost of fee-for-service providers. These savings would presumably erode if the COHS plans were terminated and replaced with a fee-for-service system. We estimate the closure of HPSM would result in an increase in state costs of \$15 million. If all COHS plans ceased operation, the net cost to the state could be as much as \$300 million (\$150 million General Fund).

The COHS plans save money for the state because the capitation rates paid to them result in an average cost of care per Medi-Cal beneficiary that is less than the equivalent cost of fee-for-service coverage. The plans provide health care services for a lower cost and stay within their capitation rates in part by better coordinating patient care, such as offering prenatal care that subsequently saves on emergency room costs, and by providing preventative care, such as tobacco cessation programs. The COHS plans also help to control the duplicative or unnecessary use of medical services. The fee-for-service system, in contrast, generally allows patients to receive care from any number of providers as frequently as they wish, and does not necessarily ensure that the health care services they do receive are the ones that are medically necessary.

Access to Providers Could Be at Risk. As we noted earlier, the closure of COHS plans would result in a shift of Medi-Cal beneficiaries to fee-for-service health care providers. Our analysis indicates that such a change could reduce their access to doctors and hospitals and in some cases increase the period of time that they would have to wait to receive care.

In some counties, COHS plans reimburse providers at rates that exceed Medi-Cal fee-for-service rates for the same medical services. Upon the closure of such a COHS plan, some providers may be unwilling to treat Medi-Cal patients at fee-for-service rates that were lower than those they previously received for these same patients from a COHS plan. If a significant number of providers opted out of providing care for Medi-Cal patients, access to care could become more difficult for participants in the program.

There is additional evidence (although not necessarily specific to COHS plans) that suggests that a Medicaid managed care approach can increase access to care for Medi-Cal beneficiaries that shift from fee-for-service medicine. One recently published national study found that disabled and aged patients receiving care from fee-for-service providers wait longer for appointments and must travel further to obtain care than those enrolled in managed care. Another recent California study found that patients who are enrolled in Medicaid managed care subsequently experience improved access to care and become less reliant on emergency rooms for routine care.

Several factors help to explain why enrollment in a COHS plan often equates to better access to care for patients than under a fee-for-service system.

First, under program rules, Medi-Cal patients enrolled in managed care (including COHS plans) must be ensured access to a network of primary care and specialist health care providers. Providers participating in the Medi-Cal Program on a fee-for-service basis are not subject to these provisions. Second, health plans licensed by the state (including COHS plans) are required to comply with various state standards to ensure timely patient access to care. Third, federal law requires that Medicaid managed care plans (including COHS plans) take specific steps to help potential enrollees in Medicaid to understand their health care benefits. For example, health plans must make available free interpretation services for enrollees who are not fluent in English, and to publish health plan information in the prevalent non-English language in the area.

Monitoring of Quality of Care Would End. A shift of patients from COHS plans to a fee-for-service system would mean that the state would no longer monitor the quality of their health care.

The DHS, as part of its oversight responsibilities for Medi-Cal managed care plans, including the COHS plans, conducts annual external quality reviews to measure health plan performance in regard to the quality of health care services provided to Medi-Cal beneficiaries. These studies include the measurement of more than 40 individual quality indicators. A summary of health plans performance in regard to these mea-

tures is publicly reported annually by DHS. In addition to this process, Medi-Cal managed care plans are rated by the DMHC on their quality (together with their commercial plans) and the results are included in an annual *Quality of Care Report Card* that is made available to the public on the Internet.

The DHS does not comparably attempt to measure the quality of care that is delivered by fee-for-service health care providers. The state, in effect, assumes that if Medi-Cal beneficiaries do not like the quality of care they receive from one fee-for-service provider, they will seek out another. However, this assumption does not take into account the possibility that the number of fee-for-service providers participating in the Medi-Cal Program could be insufficient to give Medi-Cal beneficiaries a real opportunity to change providers in response to problems in the quality of their services.

Options for Addressing COHS Plans' Financial Problems

There are some strategies counties could pursue on their own to address their financial problems. For example, some COHS plans have indicated that they could improve their fiscal condition through such actions as reducing rates paid to health care providers and pharmacies, and diversifying their revenue sources by providing coverage for other patients in addition to Medi-Cal beneficiaries. To diversify their revenue sources these plans might be able to contract, for example, with counties to provide health care coverage for county employees.

There are other options the Legislature may wish to consider to help address the financial crisis that some of the COHS plans could face in the near future. We would note that the options outlined below are not mutually exclusive. One or more of them could be implemented together. In addition, several of the options would result in additional costs. These costs, however, should be viewed in the context of an even greater cost to the state from the potential failure of COHS plans.

Improve Outdated Rate-Setting Methodology. The capitation rates that COHS plans are paid are an important component of ensuring their financial stability. One option is to ensure that DHS reforms its process for setting rates for capitation payments paid to COHS plans, particularly for their aged, blind, and disabled populations. This would require modifying DHS data gathering systems to collect accurate and complete information about the cost and utilization of services provided to COHS members. To obtain this information, DHS could provide incentives to encourage the plans' submission of complete and accurate data to the

state. The DHS could use the improved data to develop appropriate capitation rates.

Given the inadequacy of the data now collected by the state, it is not clear at this time whether these changes would result in a net increase or decrease in Medi-Cal capitation rates.

Reduce the Financial Risk of COHS Plans. One option for helping to ensure the continuation of the COHS plans would be to modify the COHS model to reduce their financial risk. For example, the state could decide that COHS plans would no longer be financially responsible for the cost of some or all prescription drugs, or certain other fast-growing medical costs.

Such a shift in financial responsibilities would result in a reduction in costs for COHS plans and an increase in costs for fee-for-service Medi-Cal expenditures. The exact fiscal impact of such a change is unknown.

Limit COHS Plans Use of Profits for Non-Medi-Cal Activities. As we noted earlier, the state has been allowing Medi-Cal managed care plans, including COHS plans, to use Medi-Cal profits to cover services not available under Medi-Cal and to provide services to persons not eligible for Medi-Cal. To some extent, this issue is dwindling as COHS plans become less able to generate excess revenues. The DHS could be asked to examine whether the state could achieve savings by prohibiting this practice.

Monitor Health Plan Financial Condition. Oversight of COHS plans and other plans that participate in Medi-Cal managed care could be increased in two respects. First, legislation could be enacted that would direct managed care health plans that contract with Medi-Cal to provide supplemental financial reporting for Medi-Cal. Second, legislation could be enacted that would require DHS to conduct regular and thorough independent examinations of the financial condition of these plans. This examination could include on-site, in-depth reviews of health plans, in regard to their administrative efficiency, and operational cost-effectiveness. As we noted above, the DHS does not conduct such reviews at this time. The information obtained by DHS through detailed financial reports and examinations could be used to ensure that problems are corrected before they affect the financial health of COHS plans and the quality of care received by Medi-Cal beneficiaries.

Analyst's Recommendation

The state should encourage COHS plans to develop their own solutions to their financial problems. However, as our analysis indicates, the loss of COHS plans could result in a significant net increase in state expenditures once clients in failed COHS plans reverted to more expensive fee-for-service coverage. As we have discussed, there could be other con-

sequences too for Medi-Cal beneficiaries—including less access to providers, and an end to regular monitoring of the quality of their care.

As a first step to address this issue, we recommend that the Legislature initially reject the administration proposal to budget for the phase-out of the Health Plan of San Mateo (HPSM). Instead, the Legislature should direct DHS to explore cost-effective alternatives that would permit the HPSM to remain in operation. The DHS should report back to the Legislature regarding the outcome of these efforts prior to the May Revision.

We recommend that the Legislature also consider the options for state actions to help mitigate the financial problems affecting HPSM and other COHS plans. These options include directing DHS to improve its rate-setting methodology for COHS plans, reducing the financial responsibility of COHS plans, directing DHS to examine the plans' practice of using profits for non-Medi-Cal activities, and enacting legislation to increase the state's financial oversight of COHS plans. The Legislature may wish to conduct hearings examining the financial problems of HPSM and the other COHS plans in the appropriate health policy committees, and direct DHS to comment at those hearings on the various options we have identified for addressing these issues.

MOVING CALIFORNIA TOWARD A MODEL ANTIFRAUD APPROACH

During the past four years, the Legislature has approved significant increases in resources to combat fraud in the Medi-Cal Program. While these actions have resulted in increased savings and allowed the state to avoid some additional program costs, fraud remains a major concern in the Medi-Cal program. In this analysis, we explain the structure of the Department of Health Services' (DHS) antifraud program and how it compares to national models of fraud control in fee-for-service Medicare and Medicaid. We identify areas in which the DHS could be more effective in combating Medi-Cal fraud and offer recommendations as to how DHS could better manage and structure its antifraud efforts. We also review the Governor's 2004-05 budget proposals for expansion of antifraud efforts and recommend changes. Reduce Item 4260-001-0001 by \$2,354,000.

Background

Defining Medi-Cal Fraud. Medi-Cal fraud occurs when either Medi-Cal providers or beneficiaries engage in activities that result in the wrong-

ful expenditure of Medi-Cal funds. Beneficiary fraud generally results when individuals provide false information to become eligible for Medi-Cal or when they otherwise obtain benefits improperly. Provider fraud generally occurs when Medi-Cal providers deliberately misrepresent themselves or intentionally deceive the Medi-Cal program for their own financial gain.

Estimates vary on the amount of fraud in the national health care system and in Medi-Cal. One national expert on the subject has estimated the level of provider fraud in the fee-for-service portion of California's Medi-Cal Program to be roughly 10 percent. This estimate is consistent with those of the U.S. General Accounting Office in regard to the pervasiveness of fraud generally in government health care programs. If that 10 percent estimate were correct, provider fraud in fee-for-service Medi-Cal would total about \$1.8 billion dollars in 2003-04, with a loss of about \$850 million to the General Fund, before any savings and cost avoidances achieved by DHS through its antifraud efforts were taken into account.

Most indicators point to provider fraud as being a larger concern in terms of its current fiscal impact on the Medi-Cal Program than beneficiary fraud. Provider fraud schemes typically include over-billing, double-billing, billing for services not provided, false claims, and falsification of diagnoses to support billing for unnecessary medical services. In fact, the range of Medi-Cal fraud schemes that have come to light as a result of increased scrutiny during the past few years is extensive. The state has responded with a significant expansion of its antifraud efforts, and has focused mainly on provider fraud.

Federal Requirements. Under federal law, the single state agency administering the Medicaid program, which is DHS for California, is required to conduct investigations of possible fraud and abuse. Where fraud is suspected, DHS is also required by federal law to refer cases to the state's chief prosecutory agency, which in California is the Attorney General. The state is also required by federal law to maintain a separate entity to conduct criminal investigation and prosecution of Medi-Cal fraud, which in California is the State Medicaid Fraud Unit in the Attorney General's office.

The Centers for Medicare and Medicaid Services (CMS), which oversees the Medicaid program at the federal level, issues reports to states providing them guidance and information on "best practices" to follow in their fraud control efforts, and reviews and reports on state antifraud activities. In addition, the Office of Inspector General in the U.S. Department of Health and Human Services assesses and reports on the annual performance of state Medicaid fraud control units.

Antifraud Approaches in Fee-for-Service and Managed Care System. Medi-Cal provides health care services through two basic types of arrangements—fee-for-service and managed care. Fee-for-service is the traditional arrangement for health care in which providers are paid for each examination, procedure, or other service they furnish. The providers bill the state Medi-Cal system for their services and are paid by the state through a state contractor, which is often called a “fiscal intermediary.” Most states have focused their antifraud efforts on the fee-for-service part of the Medi-Cal program.

Under managed care, health care plans, primarily Health Maintenance Organizations, contract with the Medi-Cal Program and receive a monthly “capitation” payment or a predetermined monthly amount per-person. The health plans in return assume financial risk for providing a defined package of health care benefits to beneficiaries.

Under this arrangement, physicians and other health care providers are directly paid by the managed care health plans, not the state, as is the case in fee-for-service Medi-Cal. Thus, this arrangement has the effect of shifting most of the burden for detecting and eliminating provider fraud from the state to the managed care plans. A health plan that failed to control provider fraud would place itself at risk of becoming unprofitable, because the state payments to them for beneficiaries are set in advance. We discuss managed care fraud and strategies for addressing this problem in more detail later in this analysis.

Antifraud Program Expansion. As recently as 1999-00, DHS had 89 staff performing functions related to provider overutilization, provider education, and audits for recovery. As can be seen in Figure 8, the state significantly increased its antifraud efforts since that time, beginning in 2000-01.

Figure 8
Department of Health Services
Medi-Cal Antifraud Staffing

Positions	2000-01	2001-02	2002-03	2003-04 ^a	2004-05 ^a
Change	192.2	-9.0	40.0	130.5 ^b	61.0
Totals	233.2	224.2	264.2	394.7^b	455.7

^a Governor's 2004-05 budget proposal.
^b Reflects position reductions resulting from the implementation of Control Section 4.10 of the 2003-04 Budget Act.

The most recent expansion, authorized as part of the 2003-04 budget plan, added 161.5 new positions and \$16.5 million (\$8.1 million General Fund) to DHS for this effort. However, we are advised by the Department of Finance that 31 antifraud positions have been eliminated in response to Control Section 4.10 of the *2003-04 Budget Act*, leaving a net gain of about 131 positions in place. The department is currently in the process of filling these positions. At the time this analysis was prepared, DHS reported that 47 positions had been filled and that hiring offers had been extended to candidates for most of the remaining unfilled positions.

The Governor's proposed 2004-05 budget plan proposes to consolidate 20 auditor positions from the State Controller's Office into DHS to continue ongoing antifraud activities currently performed by an inter-agency agreement. In addition, 41 more positions would be added to increase the number of field audits of hospitals and related billings. Finally, the Governor's budget plan would convert 15 previously approved limited-term positions that would otherwise expire to permanent status. (We discuss the Governor's proposed expansion in more detail below.)

How DHS Antifraud Efforts Are Organized. The DHS' complement of antifraud staff is distributed among several separate offices and divisions within the department. Most are assigned to the following organizations: (1) the payment systems division; (2) the managed care division; (3) the office of legal services; (4) the licensing and certification division; (5) the Medi-Cal fraud prevention bureau, and (6) the audits and investigations division.

Audits and investigations is the central coordination point for anti-fraud activities. It tracks fraudulent providers and beneficiaries involved in various fraud schemes, gathers referrals of cases for investigation, analyzes data, audits providers, conducts antifraud investigations, and coordinates antifraud activities with other governmental agencies. It also serves as the central referral point for suspected Medi-Cal fraud to the Department of Justice, the Federal Bureau of Investigation, and other agencies.

State Contracts Out Some Antifraud Activities. In addition to DHS's antifraud staff, the state contracts out some antifraud functions to three separate vendors. Electronic Data Systems (EDS) is the state's Medi-Cal fiscal intermediary, performing the claims processing function. Included in EDS's contract is funding for the EDS's provider review unit that performs antifraud functions. The EDS contract contains an incentive clause that allows EDS to keep 10 percent of the program savings that it generates through its antifraud efforts.

The DHS contracts with Delta Dental, a managed care health plan which processes Medi-Cal dental claims and treatment authorization re-

quests (TARs) for certain dental services, and maintains a surveillance and utilization review unit.

Finally, the DHS also contracts with the MEDSTAT Group, a firm which has developed a database of Medi-Cal claims from all the entities that pay Medi-Cal claims, such as EDS, county mental health, and the Child Health and Disability Prevention (CHDP) program. The MEDSTAT Group uses its database to conduct checks on the existing claim systems and to look for overpayments to providers that may be due to fraud.

“Cost Avoidances” and “Savings.” One of the primary measures used by DHS to gauge the effectiveness of its antifraud efforts is the amount of cost avoidances and savings that these efforts generate. A cost avoidance is deemed to have resulted primarily when new providers who are potentially fraudulent are prevented from enrolling in the Medi-Cal Program. Savings are deemed to occur when providers already enrolled in the program are found to be engaging in fraud or abuse and their activities are stopped.

The DHS estimates that cost avoidances amounting to \$316 million for the General Fund will be achieved in 2003-04 as a result of the anti-fraud efforts implemented since 2000-01. These cost avoidances for the General Fund are projected to increase by \$93 million in 2004-05 to a total of \$409 million. Similarly, General Fund savings are estimated to reach \$371 million in 2003-04 as a result of antifraud efforts undertaken since 2000-01, and these savings are expected to grow by \$203 million in 2004-05 to \$574 million. (Later in this analysis, we discuss whether the savings and cost avoidance estimates are reliable.)

Toward a Model Fraud Control Strategy

Although the DHS Medi-Cal antifraud program has grown rapidly in recent years, our analysis indicates that these resources have not always been allocated in the most efficient or cost-effective manner. In part, as we will discuss further in this analysis, this is due to a lack of information regarding the pervasiveness of fraud in various aspects of the Medi-Cal program—information critically necessary to targeting fraudulent activity.

California is not alone in the fight against fraud, however. Other states and national experts have studied the problem and identified a number of “best practices” for addressing the provider fraud problem which, as referenced earlier, appears to be the most significant fraud problem at this time. Below we describe a model fee-for-service fraud control strategy, and compare DHS’s antifraud efforts with these best practices.

Characteristics of a Model Fraud Control Strategy

Professor Malcolm K. Sparrow from Harvard's John F. Kennedy School of Government, one of the nation's leading experts on health care fraud, has outlined a model fraud control strategy with seven main components for fee-for-service programs. We summarize these seven components below.

Measure the Prevalence of Fraud. Sparrow indicates that routine and systematic measurement is the foundation of a model fraud control strategy. This requires: (1) the selection of a statistically valid sample of claims; (2) an audit of each claim; and (3) rigorous external validation of the claim information sufficient to identify any fraudulent claims. The important measure is the proportion of total claims paid that are fraudulent—which is assumed to roughly represent the proportion of program costs lost to fraud.

Allocate Resources Based Upon Measurement of the Problem. Under the model fraud control strategy, the amount of resources and personnel dedicated to antifraud efforts should be directly related to the size of the problem as determined by measurement. Under this approach, the state would cease adding resources at the point at which the state would achieve a diminishing return on its antifraud expenditures. In the absence of measurement, Sparrow indicates, antifraud resources are typically based on “best guess” estimates of the size of the problem and the workload increases generated by fraud-detection and referral systems. Neither of these factors necessarily indicates the amount of resources warranted to address the fraud problem.

Clearly Designate Who Is Responsible for Fraud Control. Sparrow indicates that one entity should have overall responsibility for and command of the state's antifraud efforts. A loosely coordinated effort between separate departments and divisions will not result in a coherent antifraud strategy, in his view. Without an overall coordinated approach, he indicates, the state will miss opportunities to achieve efficiencies and in some cases engage in redundant activities. If these functions are dispersed, one governmental division may be unaware that the same work is being done in another division.

Take a Problem-Solving Approach. Sparrow advocates adopting a “problem-solving” approach to fraud control that places emphasis on fraud control rather than on functions such as investigation and detection. Instead of measuring output in terms of caseload, the problem-solving approach focuses resources on the most critical fraud control problems. For example, if a new type of fraud scheme were discovered, the conventional approach might be to focus on detecting additional cases and prosecuting those who were caught. In contrast, under the problem-

solving approach, once a specific fraud scheme is identified, the fraud control team's focus would be on developing preventative measures and controls that would make it impossible to continue the fraud scheme and to ensure that it could not be successful in the future. Under this approach, what Sparrow terms the "unit of work" changes from measuring fraud control in terms of caseload, to looking at the overall problem and developing broad-based, permanent solutions. This more flexible approach to fighting fraud is intended to facilitate efforts by state agencies to seek out and identify new and emerging fraud schemes.

Focus on Early Detection. The problem-solving approach allows for early detection and intervention before too much damage is done by fraud schemes. The objective is to discover emerging fraudulent practices so that the control operation can counteract them in their early stages of development. This proactive approach makes identifying emerging problems and taking preemptive action a priority, as opposed to permitting fraud problems to become endemic and antifraud efforts to be reactive in nature.

Strengthen Prepayment Controls. Sparrow indicates that an effective strategy must provide controls that help prevent the loss of state funds in payments to fraudulent providers. This involves, at a minimum, automatic suspension of large payments (above a predetermined amount) pending review of suspicious claims. Providers would also be monitored for sudden increases in the amount of their claims as well as for claim totals that exceed the reasonable norms for their medical specialty. Also, a small proportion of claims should routinely and randomly be selected for validation.

Every Claim Should Face Risk of Review. According to Sparrow, payment systems should be established so that every claim should be at some risk of review regardless of its dollar amount, its nature, or the reputation of the claimant. When prepayment inquiries can be conducted which can show a claim to be suspicious, and can do this quickly, the fraud-control team can then suspend all claims pending from the same source and place them under intense scrutiny. This reduces the vulnerability of payment systems to large-scale computerized billing schemes.

A Report Card for the State's Fee-for-Service Antifraud Efforts

Some Components Missing. How does California's fee-for-service Medi-Cal antifraud effort compare with the model for fraud control described above? Our analysis indicates that the state's existing program contains some of its specific components, but that others are missing or incomplete. Our findings are summarized in Figure 9 (see next page).

Figure 9
LAO's Comparison of California's Antifraud Efforts to a "Model" Program

	Implemented	Under Implementation
Commitment to routine systematic measurement.		✓
Resource allocation based on the seriousness of the problem. ^a		✓
Clear designation of responsibility for fraud control.		✓
Adoption of a problem-solving approach to fraud control.	✓	
Deliberate focus on early detection of new types of fraud.	✓	
Prepayment, fraud-specific controls.	✓	
Some risk of review for every claim.	✓	

^a Contingent on implementation of routine systematic measurement.

One of the key antifraud components that DHS is now implementing is an effort to measure the extent of fee-for-service provider fraud within Medi-Cal. Part of the 2003-04 expansion of antifraud activities was for funding and staff positions to conduct an "error rate study" in order to estimate the extent of fraudulent claims through a random sampling process. Since the enactment of the budget plan, the state has received an additional \$601,000 in federal funds from CMS to participate in an effort to determine by November 2004 how much of the state's fee-for-service provider payments for health care are not legitimate.

The DHS currently does not have a system to allocate resources based on the seriousness of the problem. However, once the results of the error rate study are available, the DHS will have the information necessary to allocate resources more efficiently. In addition, the DHS currently does not have a clear designation of responsibility for all fraud control activities within the department, according to a recent Bureau of State Audits (BSA) report.

We are advised by the department that it is currently working to implement all the identified components of the model strategy for fraud control. However, until the ongoing study of the prevalence of fraud within the Medi-Cal Program is completed in November 2004, DHS will not have all of the data it needs to implement all components of a model program.

Combating Fraud in Managed Care

The Model Fraud Control Strategy and Managed Care. The model fraud control strategy outlined above applies primarily to fee-for-service Medicaid programs. However, Sparrow indicates that some components of the strategy apply equally well to managed care plans. For example, the idea that fraud-control resources should be allocated in accordance with measurements that objectively determine the size and seriousness of the problem is equally as true in managed care as it is for fee-for-service medicine.

Some differences in approach, however, are necessary. In traditional fee-for-service cases, Medi-Cal provider fraud investigations typically focus on the overutilization of services and fraudulent billings. Fraud in managed care typically involves the unwarranted delay of care or denial of care to beneficiaries, practices that encourage the underutilization of services. In essence, this is an intentional violation of the managed care company's contract with the state to provide specified health services. To ensure that the managed care organizations are fulfilling their contractual obligations, the DHS already has some measures in place to monitor whether managed care providers are promptly delivering appropriate care. However, the state does not collect reliable encounter data—records of the health care services provided to beneficiaries that managed care plans are required to report. The data now being collected from health plans are often incomplete.

Fraud can also be committed against the managed care organization by providers or beneficiaries that, as we noted earlier, can negatively affect the health plan's profitability. The health plans thus have a strong incentive to control this type of fraud in order to remain profitable. However, this does not mean that the health plans will necessarily be effective in controlling fraud within their own organizations, nor does it mean that they will not commit any fraud themselves.

Effectively Targeting Managed Care Fraud. The CMS, the federal agency that oversees state Medicaid programs, has identified six broad areas in which fraud and abuse pose a risk for managed care systems. These are: (1) improper procurement of managed care contracts; (2) misleading consumers to get them to enroll in managed care programs while inappropriately disenrolling high-cost beneficiaries; (3) causing an underutilization of services by making them unduly difficult for legitimate beneficiaries to obtain; (4) the submission of improper claims and improper billing procedures; (5) fee-for-service type fraud by providers against health plans; and (6) embezzlement and theft.

None of these schemes involves the submission of false claims directly to the state, as is typically seen under fee-for-service fraud. Thus, many of the detection and investigative strategies and techniques developed to combat fee-for-service fraud are largely ineffective against the abuses that are more typical in a managed care setting.

Some Antifraud Controls in Place. There are currently some measures in place to ensure that health plans fulfill their contractual obligations to provide care. Medi-Cal managed care health plans are obligated to report information about the quality of the services they are providing to beneficiaries according to a commonly used Health Plan Employer Data and Information Set standards. The DHS conducts the Consumer Assessment of Health Plans Survey to assess Medi-Cal members' satisfaction with their health coverage. In addition, most Medi-Cal managed care plans are Knox-Keene licensed and regulated by the state's Department of Managed Health Care.

More Could Be Done. As noted earlier, fraud in managed care typically involves the unwarranted delay of care or denial of care to beneficiaries. The DHS does monitor managed care organizations through the measures described above. However, a recent BSA report recommended that the DHS complete an assessment (now under way) of how it can use encounter data to monitor managed care plan performance and identify areas where it should conduct more focused studies to investigate potential plan deficiencies. Our analysis indicates that, without reliable encounter data, DHS does not have sufficient information to adequately determine whether or not managed care providers are promptly delivering appropriate care.

According to federal guidelines for addressing fraud in Medicaid, accurate and complete encounter data should be used to monitor utilization of health care, access to care, and the quality of care. In addition, encounter data can be used as a management tool to monitor whether managed care companies are in compliance with their contract terms.

A Systematic, Coordinated Antifraud Approach

The state's antifraud program has periodically expanded during the past four years in reaction to growing concern about the level of fraud in the Medi-Cal Program. A recent examination by the BSA concluded that antifraud activities are not adequately coordinated within DHS. As described above, antifraud functions are spread across several units at DHS and require coordination with other state, local, and federal agencies. Notably, the DHS was unable to provide an organization chart identifying specific positions dedicated to antifraud activities within various DHS

units. Thus, we agree with the BSA report and believe the lack of coordination is partly due to the rapid expansion of the program. Given the size of the program and the potential magnitude of the fraud problem, the state should consider a systematic, coordinated, and long-term approach to curtailing Medi-Cal fraud in keeping with legislative intent and the recommendations of national experts and federal agencies.

Strategic Planning Necessary. The approach we propose would be in accord with CMS guidelines, which suggest that each state Medicaid agency should identify all of the state's fraud and abuse prevention and detection activities, its key partners and stakeholders, and their respective roles and responsibilities. The CMS guidelines indicate that antifraud measures should apply to both fee-for-service and managed care coverage; should include clearly defined, measurable goals and outcomes for antifraud activities; and should include systems to measure and assess areas of vulnerability to fraud and ways to address them. These CMS guidelines are intended to ensure that the state's antifraud efforts are comprehensive, coordinated, and that any future increase in funding and positions are at appropriate levels. The "model fraud control strategy" we described above is aligned with CMS guidelines.

Savings as a Measurement of Effectiveness. The DHS currently measures the effectiveness of its antifraud efforts in terms of savings and cost avoidances. Effective antifraud efforts do result in savings and an avoidance of costs. However, the recent BSA audit found the DHS estimates are unreliable and, in some cases, potentially overstate actual savings.

Instead of measuring the effect of antifraud efforts just in terms of savings, the effectiveness of antifraud activities should also be measured on an ongoing basis against the overall extent of fraud.

Specifically, the performance of a fraud control unit could be measured by its success in lowering or suppressing the level of fraudulent claims the system pays, a factor which could be measured periodically. A target level for prevalence of fraud within a particular part of the Medi-Cal Program could be set, and lowered over time.

Fight Against Fraud Requires Realistic Expectations. Increasing resources to combat Medi-Cal fraud will not usually produce overnight results, but is more likely to pay off in the long run. For example, the expansion of 161.5 antifraud positions approved by the Legislature last year is projected to generate \$20 million in General Fund savings in 2003-04, but is expected to provide more than triple that level of state savings—about \$75 million—in 2004-05.

Savings can take time to achieve because of the sometimes lengthy process involved in hiring additional staff, training the staff, and placing

them in the field where they can begin to have an effect on fraud. For this reason, expansion of antifraud activities does not tend to have a significant immediate impact, and expansions should be carefully planned and considered based on their long-term impact on the Medi-Cal Program.

Achieving several hundreds of millions of dollars in additional anti-fraud savings annually from such efforts may be an appropriate long-term goal for the Medi-Cal Program. But it is highly unlikely that such an outcome could be achieved as a short-term solution to the state's current fiscal difficulties. Later in this analysis, we make recommendations as to how the state could improve the overall effectiveness of its efforts by taking a systematic and coordinated long-term approach to addressing the fraud problem.

The Governor's 2004-05 Antifraud Proposal

Nine New Antifraud Initiatives Proposed. The Governor's 2004-05 budget plan includes nine initiatives to combat Medi-Cal fraud. Three of these would provide an increase in resources for DHS, either through shifts of personnel from other departments, adding staff and funding, or the conversion of limited-term positions that would otherwise expire to permanent status. The proposals are as follows:

- Under the budget plan, 15 limited-term positions currently assigned to provider fraud prevention activities would be converted to permanent positions. This would not require an increase in funding above current-year expenditures. Absent this change, the positions would expire and state expenditures for these positions would decrease by \$464,000.
- Six auditor positions at the State Controller's Office (SCO) that currently perform Medi-Cal antifraud functions would be eliminated, and 20 more would be transferred from SCO to DHS. The budget plan assumes that fewer auditors would be required to handle the same workload because DHS would no longer have to expend resources for the review of work by an outside state agency.
- The budget plan would add 41 auditors to the DHS staff to examine the claims of hospitals serving Medi-Cal beneficiaries at an estimated \$2.4 million cost to the General Fund. The DHS estimates that these positions will generate net General Fund savings of \$1.5 million in 2004-05 in excess of the cost of the positions and \$12.9 million in net General Fund savings in 2005-06.

Five additional antifraud initiatives proposed in the 2004-05 spending plan are to be accomplished within DHS' existing resources. These include:

- Enhancing Medi-Cal estate recoveries by closing a loophole used by middle income persons to prevent the state from recovering assets from their estates to help offset the cost of their medical care. Savings from this action are unknown.
- Contacting Medi-Cal providers with suspicious billing patterns. This effort is projected to result in decreased billings from those providers for a savings of \$2.5 million to the General Fund in 2004-05.
- Confirming with beneficiaries through mail or on-site visits that they actually receive services and products that Medi-Cal has been billed. This activity is projected to result in savings of \$1 million General Fund in the budget year.
- Restricting billing for certain neurological tests to specialists who have received specialized training to perform these tests. This is expected to result in \$625,000 General Fund savings in 2004-05.
- Delay checkwrites to Medi-Cal providers by one week to allow DHS additional time to investigate potentially fraudulent claims before checks are issued. This change is expected to result in one-time General Fund savings of \$144 million in 2004-05 due to the shift of some Medi-Cal payments to 2005-06. The additional savings from a reduction in fraud have not been identified.

In addition to these antifraud efforts that would be implemented during the budget year, the Governor's budget plan proposes to implement counterfeit-proof prescription pads in 2005-06 to reduce forgery and altering of prescriptions. The significant lead-time to implement this change means that it is projected to result in no savings in 2004-05, but savings to the General Fund in 2005-06 are expected to range between \$7 million and \$14 million.

Hospital Auditing Positions Appear to Be Premature. We believe all but one of the Governor's antifraud proposals warrant approval by the Legislature at this time. The exception is the proposal to add 41 auditors to the DHS staff in 2004-05 to conduct additional reviews of hospital claims.

As noted above, the Legislature authorized a total of 161.5 additional positions for antifraud activities for 2003-04. At the time this analysis was prepared, we were advised that DHS was still recruiting and filling many of these positions. As a result, we believe it would be premature to

approve further expansion of the DHS audits and investigations unit before the department has fully implemented the sizable expansion approved for the prior year and demonstrated that it can achieve the savings that were to have resulted from these additional positions. This further expansion should also wait until the error rate study is completed that will shed light on which types of antifraud activities warrant a greater focus.

Analyst's Recommendations

Our analysis has identified areas in which the Department of Health Services (DHS) could improve the overall effectiveness of its antifraud efforts by taking a systematic and coordinated long-term approach to addressing the fraud problem. Based on these principles we recommend: (1) denial of the Governor's proposal to increase staffing for audits of hospitals; (2) that DHS report at budget hearings regarding how encounter data could be used to prevent managed care fraud; and (3) increased legislative oversight of DHS antifraud efforts through additional reporting requirements.

Specifically, we recommend the following actions:

Governor's 2004-05 Antifraud Initiatives. We recommend that the Legislature deny the Governor's proposal to expand hospital audits at this time. Any significant increase in DHS staffing to expand the audits and investigations unit, in our view, should await the outcome of the error rate study which will allow the DHS to identify specific fraud problems and target resources in the most cost-effective manner. At that time, the Legislature will have the additional data it will need to determine whether further expansion of the state's antifraud program is justified or whether resources already provided for the overall antifraud effort should be redirected within the program to expand audits of hospitals.

We recommend approval of all of the Governor's other budget proposals.

Improved Encounter Data Could Help Reduce Fraud in Managed Care. We recommend that DHS be directed to report at budget hearings regarding how it could improve the accuracy and completeness of encounter data from managed care plans, and how that data could be used to monitor the performance of managed care and prevent fraud.

Improve Legislative Oversight to Ensure Strategic Planning. We recommend that the DHS be directed to report to the Legislature by January 2005 regarding: (1) the results of the error rate study, (2) its proposed fraud reduction targets established in response to the data from the error rate

study, (3) the proposed timeframe for achieving these targets, (4) the cost-effectiveness of ongoing antifraud activities, and (5) DHS' progress towards implementing the components of a model fraud control program.

Adoption of the following supplemental report language is consistent with this recommendation:

The Department of Health Services (DHS), shall report to the Chair of the Joint Legislative Budget Committee and the chairs of the fiscal committees for both houses of the Legislature, information regarding the state's Medi-Cal antifraud program. The DHS shall include, but not be limited to (a) the results of the error rate/payment accuracy measurement study, (b) fraud reduction target(s) that have been established based on the data from the error rate/payment accuracy study, (c) the time frame for achieving the target(s), (d) the cost-effectiveness of antifraud activities, and (e) progress towards implementing the components of a "model fraud control program." The department's findings shall be reported to the Joint Legislative Budget Committee and the fiscal and policy committees of both houses of the Legislature by January 1, 2005.

OTHER BUDGET AND POLICY ISSUES

Additional Oversight Needed for Data Systems Contract

A Department of Finance (DOF) audit has raised significant concerns about how the Department of Health Services (DHS) is managing a more than \$230 million a year contract for Medi-Cal claims processing activities. Although DOF's audit unit presented recommendations to address the weaknesses identified by its review, our analysis indicates that there has been insufficient follow-up efforts to ensure that DHS implements the necessary changes. We recommend that the Legislature take steps to ensure that DHS is held accountable and that the problems identified in the audit are fully addressed.

Background. The DHS contracts with a private firm, EDS, for claims processing services and other Medi-Cal Program functions related to the management of the Medi-Cal Program. An audit was conducted by the Office of State Audits and Evaluations (OSAE), a DOF auditing unit, last year because of concerns about the growing scope, size, complexity, and cost of the California Medicare/Medi-Cal Information Systems (CA-MMIS), the information technology system maintained and operated by EDS to carry out these functions.

State payments to EDS have risen about 23 percent a year during each of the last five years. Total payments to EDS are expected to be \$232 million (\$69 million General Fund) in 2004-05.

OSAE Audit Findings. An audit completed in June 2003 by OSAE raised significant concerns with regard to DHS' management of the EDS contract. The audit found weaknesses in DHS' oversight of the contract that, in our view, raise a concern that the state could potentially overpay the contractor for the services it provides. Some of the key audit findings were as follows:

- **State IT Processes Sidestepped.** The DHS incorporated information technology (IT) systems with little or no connection to the Medi-Cal Program into EDS' Medi-Cal contract to sidestep normal IT development and procurement procedures. By adding these projects into the EDS contract, DHS sidestepped the preparation of Feasibility Study Reports which would have helped to determine if DHS was choosing the most cost-effective alternative to develop these systems. In doing so, DHS also circumvented the competitive procurement process without explicitly obtaining an exemption, making it difficult to ensure that the state received the best price and "best value" for the development of these systems.
- **Expenditure Information Not Provided.** As changes to CA-MMIS were authorized by DHS, DOF budget staff were not provided timely or adequate information about the expenditures being made for these modifications. The DHS did not separately track the cost to the state of the specific changes that were being made to the CA-MMIS system. Thus, there was no way for the state to determine whether these modifications were cost-effective.
- **Lack of Oversight.** No internal audit function existed within DHS to ensure that EDS is complying with the terms of the contract and that CA-MMIS is operating as intended.
- **No Payment Resolution Process.** In the event that EDS disagrees with the amount paid to it by the state for its services, there were no procedures in place to resolve disputes with the contractor.

DHS Has Taken Some Steps, But More Are Needed. The DHS submitted to OSAE its response to the audit in December 2003. The response indicates that DHS is in agreement with the findings and recommendations, and identifies some steps that it will take to comply with the audit's recommendations. However, in respect to many of the recommendations, DHS generally notes its agreement but does not indicate what specific steps it will take to implement the recommendation.

At the time our analysis was prepared, OSAE had not required DHS to submit a corrective action plan or reports about its progress towards implementing the recommendations, an approach we understand is cus-

tomary for most OSAE audits. The DOF has indicated that it will instead monitor DHS' management of the contract through the state budget process. The DHS also has indicated that it does not intend to develop a corrective action plan on its own.

We are concerned that this approach will prove insufficient to ensure that DHS corrects the problems identified in the audit and is held accountable for achieving progress in these efforts. For example, absent the preparation of a corrective action plan, DHS will lack a standard management tool to guide its audit compliance activities and to ensure that the department's strategy to implement the recommendations has been thoughtfully developed and therefore more likely to be successful. In addition, the lack of such a plan or any regular reporting on audit compliance activities we believe prevents OSAE and DOF budget staff from being able to effectively monitor DHS' progress toward implementation of the OSAE recommendations.

Analyst's Recommendation. The OSAE audit indicated that, absent corrective action, the state is at risk for overpaying EDS for Medi-Cal Program activities. Accordingly, we recommend that the Legislature adopt supplemental report language directing DHS to develop and submit a corrective action plan to OSAE and the Legislature, and submit reports to OSAE and the Legislature every six months, beginning July 1, 2004, regarding its progress towards implementation of the audit recommendations. In addition, we recommend that the Legislature request BSA to conduct a follow-up audit by July 2005 to assess DHS' progress towards improving the management of its contract with EDS.

The following supplemental report language is consistent with this recommendation:

It is the intent of the Legislature that the Department of Health Services (DHS) develop and submit a corrective action plan to the Department of Finance's Office of State Audits and Evaluations and to the Legislature that identifies the actions it plans to take toward implementing the recommendation described in the report entitled, "Final Audit Report—Examination of the Department of Health Services Fiscal Intermediary Contract With Electronic Data Systems for Medi-Cal Claims Processing." It is also the intent of the Legislature that on July 1, 2004, January 1 and July 1, 2005, that DHS submit semiannual reports to the Office of State Audits and Evaluations and to the Legislature regarding its progress towards implementation of the audit recommendations. The legislative reports shall be provided in writing to the Chair of the Joint Legislative Budget Committee and the chairs of the fiscal committees of both houses of the Legislature.

Contract to Monitor Los Angeles County Health Care System Terminated

Los Angeles County has been receiving additional funding from the state and federal government under a federal waiver project to help financially stabilize the county's health care system. The Legislature provided funding to the Department of Health Services (DHS) for an independent contractor to monitor the project. However, this contract was recently terminated. We recommend that the Legislature take steps to ensure that DHS will continue to adequately monitor the project.

Background. At the start of the 1995-96 fiscal year, Los Angeles County faced a \$655 million budget deficit in health services operations and the potential collapse of its medical "safety net" programs. Basically, these programs provided health care services to low-income individuals who were also uninsured. State, federal, and county officials collaborated to develop a five-year plan to address the crisis by financially stabilizing the county health system and, over time, moving it away from expensive hospital-based services toward community-based primary care and preventative services. The federal government approved the plans as a Medicaid demonstration project that was to end during 1999-00.

The project was renewed for another five years for the period of 2000-01 through 2004-05 and included \$900 million in federal funds that would be phased out over the five-year extension period, \$150 million in state funds, and \$400 million in county funds.

According to the county, it has met many of the reform objectives. However, without a further extension of the demonstration project or alternative revenues, the county anticipates its public health care system will face future budget shortfalls. The county estimates its health services budget will have a positive balance in the current year through 2005-06, but will incur shortfalls beginning in 2006-07 that will grow to \$655 million by the end of 2007-08.

State Monitoring Effort Reduced. Unlike the previous waiver, the most recent waiver required the state to provide a General Fund contribution estimated to be about \$30 million annually. Given the state's financial commitment and vested interest in the county's success in establishing a more cost-effective and efficient health care system, DHS committed to hiring an independent contractor to measure Los Angeles County's compliance with the waiver goals.

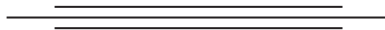
To date, the contractor has submitted two draft annual reports to DHS for fiscal years 2000-01 and 2001-02. It is anticipated that these two reports will be finalized within the next 60 days, at which time they will be made available to the Legislature. In addition, DHS expects to receive

one additional status report. However, no further activities by the contractor will occur, we have been advised, because DHS has terminated the contract as of November 2003 as part of an overall response to a requirement in Section 4.10 of the *2003-04 Budget Act* for reductions in state program operations.

Lack of Oversight Could Place State at Risk. The threat of growing deficits for the Los Angeles County health care system beginning in 2006-07, and the anticipated phase-out of hundreds of millions of dollars in annual federal subsidies puts the state at risk of being called upon to provide substantial financial assistance to the county after the waiver program expires. The DHS has indicated that, despite its termination of the monitoring contract, it intends to use its own staff to conduct limited monitoring of the county's demonstration project activities. The DHS indicates that this will involve reviewing documents, participating in conference calls about the project, and attending oversight committee meetings.

However, it is not clear that this level of oversight will be adequate or as rigorous as the Legislature had intended when it approved funding for the contractor. For example, the contractor had been expected to monitor the county's procedures for ensuring that health care providers have adequate training and qualifications. It does not appear that DHS will perform these more detailed monitoring activities.

Analyst's Recommendation. It appears likely that the termination of the contract will reduce the state's oversight of the Los Angeles County project. Given the state's major stake in the county's success in transitioning to a financial stable health care system, we recommend that the Legislature take steps to ensure that DHS continues to adequately monitor these efforts. Specifically, we recommend that DHS be directed to report at budget hearings on the findings of the final monitoring reports prepared by the contractor. The Legislature should also direct DHS to provide more detailed information on the specific monitoring activities it will carry out during the remainder of the project to help ensure that the goals of the restructuring effort are met.



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 10 percent (\$293 million) decrease from the previous year. The budget proposes \$485 million from the General Fund in the budget year, a 4 percent (\$22.6 million) decrease from the current year. This decrease is largely due to the administration's proposals that would cap enrollment and reduce provider rates and expenditures for various public health programs.

BUDGET PROPOSALS

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

Community Challenge Grant Program (CCG): Elimination. The CCG provides grants to community-based organizations for programs intended to reduce the number of teenage and unwed pregnancies and to promote responsible parenting. In the past, federal Temporary Assistance for Needy Families funds to support CCG have been included within the budget of the Department of Social Services (DSS) and subsequently transferred to DHS for the operation of the program. The proposed 2004-05 DHS budget, however, does not include the \$20 million in federal funding to continue the CCG.

Child Health and Disability Prevention Program (CHDP): Gateway Implementation. The CHDP provides preventive health, vision, and dental screens to children and adolescents in families with incomes at or below 200 percent of the Federal Poverty Level (FPL). The Governor's bud-

get proposes \$4.2 million (\$3.9 million General Fund) in total expenditures for CHDP. This is a 76 percent decrease in all funds and a 48 percent decrease in General Fund expenditures from the previous year. This dramatic reduction is primarily due to the implementation of the CHDP “gateway” program. Later, in this section of the *Analysis*, we provide more details regarding this proposal.

California Children’s Services (CCS): Enrollment Cap and Rate Reduction. The CCS program provides diagnostic and treatment services, medical case management, and medical and occupational therapy services to eligible children and young adults under 21 years of age. The Governor’s budget includes \$142 million (\$67 million from the General Fund) in funding for the CCS. This reflects a 3 percent decrease in all funds and a 10 percent decrease in General Fund expenditures compared to the previous year.

The budget plan includes two measures intended to decrease expenditures in the CCS program. The administration has proposed to cap enrollment in the CCS program for “CCS-only” children—those who are not eligible for benefits under Medi-Cal or the Healthy Families Program—at the January 2004 caseload level. The enrollment cap is projected to total 37,600 children and result in approximately \$1.9 million in state savings. The administration projects that on average the enrollment cap would result in a monthly waiting list of 1,256 children in 2004-05. Clients on the CCS waiting list would be served on a “first-come, first-served” basis once the cap has been reached and existing clients leave the program. The administration has also proposed comparable caseload limits for other health and social services programs. We provide a more detailed analysis of enrollment caps as an approach to reducing state costs in the “Crosscutting Issues” section of this chapter of the *Analysis*.

Additionally, the administration has proposed a provider rate reduction of 10 percent, which in addition to the previous 5 percent provider rate reduction included in the *2003-04 Budget Act* would result in approximately \$5.4 million in savings (\$2.7 million from the General Fund).

Genetically Handicapped Persons Program (GHPP): Enrollment Cap. The GHPP provides health coverage for Californians 21 years of age and older who have certain specific genetic diseases, including cystic fibrosis, hemophilia, and certain neurological and metabolic diseases. The GHPP also serves children under the age of 21 with GHPP-eligible medical conditions who are not financially eligible for CCS. Although there are no maximum income eligibility requirements, families with incomes exceeding 200 percent of the FPL pay program fees based upon their family size and income.

The Governor's proposal provides \$49.5 million for GHPP (\$49.3 million from the General Fund) in 2004-2005, which reflects a 13 percent decrease compared to the previous year. As in the CCS program, the administration has proposed to cap enrollment for GHPP-only clients and reduce provider rates by 10 percent in GHPP. The proposal would cap enrollment at the January 2004 caseload level (estimated to be 842 clients) and is projected to result in approximately \$194,000 in savings. The administration projects that on average the enrollment cap would result in a monthly waiting list of three clients in 2004-05. Additionally, the Governor's budget includes the implementation of a GHPP copayment structure. Under this proposal, the copayment would be deducted from the amount that the state pays the provider for each service. The provider in turn would collect the copayment from the patient. Clients would be required to pay \$10 per service providing approximately \$576,000 in savings to the General Fund.

AIDS Drug Assistance Program (ADAP): Enrollment Cap. The ADAP is a drug 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. Currently, clients with incomes up to 400 percent of the FPL (about \$36,000 for a single childless adult) pay no copayment or premium, while individuals with incomes above that level pay a "sliding scale" copayment that increases with a client's income level.

The budget proposes about \$207 million for ADAP (\$64 million from the General Fund) in 2004-05. While this would provide a \$8.3 million increase in overall funding for the program over the previous year, General Fund support for the program would decrease by \$550,000.

The spending plan would cap enrollment of ADAP clients at about 24,000 individuals beginning January 2004. Individuals applying for ADAP benefits once the cap has been reached would be placed on a waiting list and served on a first-come, first-served basis as existing clients left the program. The administration estimates that the waiting list would total 1,392 by the end of the budget year. The administration estimates that the cap would result in savings totaling \$550,000 in the budget year.

California Nutrition Network for Healthy, Active Families: Increased Federal Funds. The California Nutrition Network for Healthy, Active Families is a broad-based marketing campaign that focuses on encouraging low-income Californians to adopt healthy eating and physical activity patterns.

Currently, \$15.6 million is provided for the support of the network, with this funding provided on a one-time basis. The Governor's budget

proposal would permanently increase the funding level by \$39.7 million with federal funds awarded by the U.S. Department of Agriculture to the DSS.

Expansion of Federally Funded Bioterrorism Efforts. In response to the September 11, 2001 terrorist attacks and a heightened threat of bioterrorism, the federal government authorized funding through the Centers for Disease Control and Prevention and the Health Resources and Services Administration to support state and local activities that would strengthen states' public health systems and improve the coordination of emergency response in the event of bioterrorist acts or outbreaks of infectious disease.

The Governor's budget plan includes an additional \$66 million in the current year and \$77 million in the budget year in federal funds to complete a number of threat assessment, planning, and preparedness activities at the state and local levels. About \$29 million of the additional 2004-05 funds would be appropriated for state operations and \$47 million would be distributed as local assistance to counties and other local government entities.

Proposition 99: Declining Resources. The Tobacco Tax and Health Protection Act (Proposition 99, enacted by voter initiative in 1988) assessed a \$0.25 per pack tax on cigarette products that is allocated for specified purposes. These include various tobacco education and prevention efforts, tobacco-related disease research, environmental protection and recreational resource programs, and health care services for low-income uninsured Californians. The success of anti-smoking initiatives, including tax increases on cigarette purchases, has resulted in a 44 percent decline in Proposition 99 revenues—from the \$573 million received in 1989-90 to an estimated \$321 million in 2004-05.

The Governor's proposed budget would align 2003-04 and 2004-05 expenditures with this anticipated revenue. For 2003-04, the administration has proposed reductions totaling \$4.9 million in the anti-tobacco media campaign (\$2.2 million), tobacco cessation competitive grants (\$1 million), and the California Healthcare for Indigents Program known as CHIP (\$1.7 million). The Governor's proposal for 2004-05 includes a total reduction of about \$23 million affecting the anti-tobacco media campaign (\$3.7 million), tobacco cessation competitive grants (\$3.7 million), certain local contracts for tobacco control activities (\$3.7 million), CHIP (\$5.9 million), and the Breast Cancer Early Detection Program (\$6.1 million).

County Medical Services Program (CMSP): General Fund Suspension. 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 Medical Program and reside in one of 34 participating small California coun-

ties. 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, with the amount capped at \$20.2 million. The General Fund appropriation for CMSP was suspended in 1999-00, and in subsequent fiscal years. The Governor's budget proposes legislation to again suspend in 2004-05 the state's General Fund appropriation of \$20.2 million to CMSP.

Cancer Treatment and Research Programs: General Fund Reductions. The budget plan reflects a reduction of \$4.3 million in General Fund support for a prostate cancer treatment program, as well as the elimination of the remaining \$3.1 million for cancer research activities. Both of these reductions were accomplished in response to requirements in Control Section 4.10 of the *2003-04 Budget Act*.

Repeal of Prior Legislation. The administration indicated that it will propose a repeal of various statutory requirements for DHS activities for which no new funding would be provided in the 2004-05 budget. The legislation that would be repealed include the following measures:

- ***Stem Cell Guidelines.*** This statute, Chapter 506, Statutes of 2003 (SB 322, Ortiz), requires DHS, on or before January 1, 2005, to develop guidelines for stem cell research and would require the Director of Health Services to establish a Human Stem Cell Research Advisory Committee, comprised of specified members, for purposes of developing these guidelines.
- ***Donor Consent Forms.*** This statute, Chapter 464, Statutes of 2003 (SB 617, Speier), requires tissue banks to revise existing informed consent forms and procedures to advise donors that tissue banks work with both nonprofit and for-profit tissue processors and distributors, and that the donated tissue may be used for cosmetic or reconstructive surgery purposes. Additionally, the statute requires DHS to report to the Legislature by January 1, 2004, on the status of regulations governing the administration and enforcement of new regulations pertaining to tissue donor consent forms.
- ***HIV Testing Information.*** This statute, Chapter 749, Statutes of 2003 (AB 1676, Dutra), requires DHS, in consultation with other

specified organizations, to develop, by December 31, 2004, culturally sensitive informational material concerning HIV testing to assist medical care providers. The statute would require that the materials provide information on available referral and consultation resources of experts in prenatal HIV treatment.

- **Tobacco Sale Licensure.** This statute, Chapter 890, Statutes of 2003 (AB 71, Horton), provides for the licensure by the State Board of Equalization of manufacturers, distributors, wholesalers, importers, and retailers of cigarette or tobacco products that are engaged in business in California. The statute would require DHS to provide training on tobacco control laws to noncompliant retailers.
- **Multiyear Spending Authority.** Budget trailer bill language adopted last year provided DHS the authority to use appropriations from Proposition 99 over multiple fiscal years. Repeal of these provisions would mean that unspent allocations of Proposition 99 funding would become available for other programs at the end of the fiscal year.
- **Local Government Mandates.** These state mandates for local government require that coroners notify local health officers within 24 hours of a Sudden Infant Death Syndrome (SIDS) death, (Chapter 453, Statutes of 1974 [AB 409, Crown]), and that local health officers immediately contact the family of a child who has died of SIDS to provide follow-up services, (Chapter 268, Statutes of 1991 [AB 362, Boatwright]). Both of these mandates were suspended in 2003-04.

BREAST AND CERVICAL CANCER TREATMENT PROGRAM

Transfer of Eligibility Work to Counties Would Be More Expensive

The 2004-05 budget plan proposes to transfer eligibility determinations for the Breast and Cervical Cancer Treatment Program to the counties effective January 1, 2005, and to increase funding for the program to address a backlog in processing applications for these benefits. We recommend that the Legislature reject the administration's proposal and adopt a less costly approach that would maintain this function within the Department of Health Services.

Background. The 2001-02 Budget Act and related legislation established two new state programs for individuals who have a diagnosis of

breast or cervical cancer. The two programs together are known as the Breast and Cervical Cancer Treatment Program (BCCTP).

The first new program expanded Medi-Cal eligibility to specified women who were previously ineligible for these benefits. Specifically, full-scope services became available for women under age 65 with no other health coverage, who are in need of treatment for breast and cervical cancer, and whose incomes are below 200 percent of the federal poverty level (FPL). Federal matching funds equal to about 66 percent of the cost of these services are used to match state funds.

The second step was the expansion of existing state programs to provide a comparable “state-only” breast and cervical cancer treatment program for individuals who did not qualify for Medi-Cal. The state-only program provides *only* cancer treatment and cancer-related services that are limited to 18 months of coverage for breast cancer treatment and 24 months of coverage for cervical cancer treatment. Women and men of any age including undocumented persons who may or may not have another source of health coverage, and whose incomes are below 200 percent of the FPL, are eligible for the state-only program.

The new Medi-Cal program is unusual in that most applicants are granted immediate, temporary Medi-Cal eligibility from the doctor’s office through an internet-based application and eligibility determination process administered by Department of Health Services (DHS) staff. (The same process is also followed for the state-only program.) In contrast, most eligibility determinations for Medi-Cal are administered by the counties with funding provided by the state.

The Governor’s 2004-05 Budget Proposal. The budget plan proposes to transfer BCCTP eligibility determinations for both components of the program to the counties effective January 1, 2005, because the caseload for both is much higher than originally anticipated—almost triple the estimate initially used to determine the staffing needs. As a result, there are now insufficient state staff to complete eligibility determinations on time.

As we noted earlier, some BCCTP applicants were supposed to receive only temporary admission (two months) to Medi-Cal, with a subsequent determination during that period to assess whether they were eligible for ongoing Medi-Cal benefits. However, some applicants have remained in this “temporary” status for more than a year, even though they may not be eligible to do so. In addition, ongoing regular redeterminations of eligibility are not being completed for these Medi-Cal beneficiaries as required by federal law. The state is at risk of disallowances of claims for federal Medicaid reimbursements because it is not complying with these and other federal eligibility rules.

The DHS currently has 12 staff dedicated to completing BCCTP eligibility determinations and redeterminations at a cost of about \$1 million (\$480,000 General Fund). The administration proposal is to eliminate one of these positions beginning January 2005 and to strike all but two of the remaining positions by June 30, 2005. The budget plan estimates that this would result in General Fund savings of \$20,000 in the budget year, increasing significantly to about \$800,000 (\$400,000 General Fund) in 2005-06.

The administration further proposes to increase Medi-Cal program spending for county eligibility activities by \$2.4 million (\$1.2 million General Fund) in 2004-05 and by \$5.4 million (\$2.7 million General Fund) in 2005-06 due to the shift to counties of the BCCTP workload. The state would continue to operate and financially support the Internet-based application system, so that signed applications for BCCTP benefits could be forwarded to counties for completion of the eligibility process.

Governor's Proposal Increases State Costs More Than the Addition of State Staff. The DHS indicates that if eligibility determinations are not shifted to the counties, it would need at least 11 new positions to manage the BCCTP workload at an estimated cost of \$460,000 in 2004-05 and \$920,000 in 2005-06. Combined with the annual cost of the existing staff, this would bring the total cost to DHS for administering BCCTP eligibility to \$1.5 million (\$710,000 General Fund) in 2004-05 and about \$1.9 million (\$940,000 General Fund) in 2005-06.

The Governor's proposal, however, to shift most eligibility processing activities for BCCTP to the counties would be more expensive. The total cost (including the retention of some DHS activities) would be \$3.3 million (\$1.7 million General Fund) in 2004-05 and \$5.6 million (\$2.8 million General Fund) in 2003-04.

A comparison of the cost of the two alternatives is shown in Figure 1 (see next page). The Governor's proposal would cost nearly \$1.9 million more (about \$950,000 General Fund) in 2004-05 and about \$3.6 million more (\$1.8 million General Fund) in 2005-06 than adding DHS staff for the same purpose.

Trend in Caseload Growth Is Uncertain. The DHS' estimates of the additional staff persons it will need to manage the BCCTP workload could be either too high or too low.

The estimate of the Medi-Cal and state-only program caseload of 6,400, as of June 2003, is at risk of being in error because of the present backlog of eligibility determinations and redeterminations. Once this backlog is resolved, the BCCTP caseload numbers could change abruptly, as some individuals were granted ongoing eligibility in Medi-Cal and others were removed from the program because they were determined to

Figure 1
Retaining State Eligibility Process for
BCCTP Costs Less Than Shift to Counties

(In Thousands)

Eligibility Process	2004-05		2005-06	
	General Fund	Total Funds	General Fund	Total Funds
State Staff^a				
Current staff (12 positions)	\$480	\$1,000	\$480	\$1,000
Additional staff (11 positions)	230	460	460	920
Total costs	\$710	\$1,460	\$940	\$1,920
Governor's Proposal^b	\$1,660	\$3,310	\$2,780	\$5,560
Net Savings From Keeping Eligibility Work at DHS	-\$950	-\$1,850	-\$1,840	-\$3,640

^a Current process.

^b Shift eligibility process to the counties. For comparison purposes, includes cost of staff that would be retained by the state after the shift.

be ineligible. The caseload growth trend is also at a significant risk of projection error because the program is new. As we noted, the demand for services so far has been much higher than originally anticipated.

Analyst's Recommendation. We recommend that the Legislature not adopt the Governor's proposal to shift BCCTP eligibility determinations to the counties because, as we have discussed above, this approach is more costly than the alternative of increasing DHS staff for this same purpose. Accordingly, we recommend that the proposed increase in the Medi-Cal budget for county eligibility activities be deleted. Because the existing DHS staff is clearly insufficient to handle the BCCTP workload, we recommend that the Legislature instead approve 11 additional staff. This would require an augmentation to the DHS operations' budget of \$460,000 (\$230,000 General Fund) for 2004-05.

We estimate that the adoption of our proposal would result in net savings to the state General Fund of \$950,000 (\$1.9 million all funds) in 2004-05 in comparison to the Governor's budget proposal.

We further propose that any new DHS positions for BCCTP be established as two-year limited-term positions. During the next two years, DHS should be able to complete the processing of the backlog of BCCTP eligi-

bility determinations and redeterminations and to more clearly assess the caseload growth trend for the program. At that point, DHS and the Legislature would be in a better position to assess whether more or fewer DHS staff are needed to administer BCCTP.

CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

Background

Medical Screens and Immunizations Provided. The state CHDP program was established by Chapter 1069, Statutes of 1973 (AB 2068, Brown), to provide preventive health, vision, and dental screens to children and adolescents in low-income families who do not qualify for Medi-Cal. The CHDP program reimburses 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 the state 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.

State Implements CHDP Gateway. Almost all children receiving CHDP services are eligible to enroll either in the Medi-Cal or Healthy Families programs, unless they are ineligible for these programs, most often because they are undocumented immigrants. The *2002-03 Budget Act* provided the initial funding and staffing to DHS to improve CHDP's role as a "gateway" to move children into Medi-Cal and Healthy Families. This was done by establishing an Internet-based system to more systematically identify and bill the Medi-Cal and Healthy Families programs for services to children who are already enrolled in those programs.

The gateway program also "preenrolls" in Medi-Cal any child who is not already enrolled in Medi-Cal or Healthy Families. For preenrolled children, the costs of the CHDP screen as well as the medical services they receive are partially paid through the Medi-Cal Program using either federal Medicaid or State Children's Health Insurance Program funds. By contrast, if the CHDP health screens and immunizations are paid for under CHDP, the state pays for almost all of these costs.

The gateway program aims to permanently enroll preenrolled children in either Medi-Cal or Healthy Families by providing families with an application for these programs. Children who are determined not to be eligible for coverage in either program would continue to be able to receive CHDP services consistent with the allowable number of doctor's visits. Moreover, the same children are permitted to preenroll again in Medi-Cal each time they receive a CHDP screen.

Governor's Budget Proposal

Budget Plan Reduces CHDP Funding Due to Gateway. The Governor's budget proposes to allocate approximately \$17 million from all fund sources (\$8 million from the General Fund) in the current year for an estimated 300,000 CHDP health screens. For the budget year, about \$4.2 million would be provided from all fund sources (\$3.9 million from the General Fund) for an estimated 71,000 CHDP health screens.

A small part of this dramatic decrease in proposed program expenditures is due to the proposed reductions in reimbursement rates for CHDP providers. The *2003-04 Budget Act* reduced provider rates by 5 percent, and a further 10 percent rate reduction is proposed in the Governor's budget plan.

By far, most of the proposed decrease in the CHDP budget is due to the assumed full implementation of the CHDP gateway in the budget year. We discuss this budget assumption in more detail below.

Major Uncertainties in Gateway Budget Proposal

The budget's assumption of a sharp decline in the size of the CHDP program due to the implementation of the gateway to the Medi-Cal and Healthy Families programs is based largely on preliminary data and assumptions about how this major program change will be implemented. As a result, it is possible that the budget request significantly overestimates or underestimates the funding needed for these programs. Accordingly, we withhold recommendation at this time on the funding requests related to the CHDP gateway, pending receipt of the May Revision.

Budget Assumes the Gateway Reduces CHDP Expenditures. As noted above, the Governor's budget plan assumes that the gateway will shift children from CHDP to the Medi-Cal and Healthy Families programs. Accordingly, the Governor's budget plan proposes to reduce the General Fund budget for CHDP by more than \$54 million in 2004-05.

These savings in the CHDP budget would be more than offset under the Governor's budget plan by increased expenses in the Medi-Cal and Healthy Families programs. The budget would provide \$405 million in additional funds for Medi-Cal (\$197 million in state funds) and \$42 million for Healthy Families (\$15 million in state funds) due to implementation of the gateway. After taking into account previous reductions already incorporated into the CHDP budget, these increases in Medi-Cal and Healthy Families program expenditures result in a net fiscal cost to the state of \$358 million when all fund sources are considered (with a \$122 million net cost in state funds).

Impact of Caseload Shifts Still Uncertain. The administration estimates that about 712,000 children will be temporarily preenrolled in Medi-Cal, about 76,000 children will be enrolled on an ongoing basis in Medi-Cal, and that about 39,000 children will be enrolled in the Healthy Families Program in the budget year as a result of the gateway program.

Because the gateway has only been fully implemented since January 2004, the caseload and funding estimates are based on preliminary data and various assumptions regarding the number and characteristics of the children enrolling through the gateway. For example, the estimates contain significant assumptions about the rate at which parents of children who have received CHDP services will submit an application for their child's permanent enrollment in the Healthy Families or Medi-Cal programs. To the extent that the actual application rate was lower or higher than assumed in the budget, the amount of funding required for the Medi-Cal and Healthy Families programs could be underbudgeted or overbudgeted, potentially in the tens of millions of dollars.

Analyst's Recommendation. As we have noted, the budget plan proposes a substantial reduction in the CHDP program, as well as significant increases in Healthy Families and Medi-Cal, based on largely unproven assumptions regarding the gateway program's impact on caseloads. More information about these impacts will be available to the Legislature in the coming months. Accordingly, we withhold recommendation at this time on the CHDP budget proposal, as well as the proposed budget adjustments related to the gateway in the Medi-Cal and Healthy Families programs, until more information is available to assess how much funding will be needed for these purposes. We will monitor gateway enrollment trends and recommend appropriate adjustments at the time of the May Revision.

GENETIC DISEASE TESTING PROGRAM

Reports on Information System Project Not Submitted

The Department of Health Services (DHS) has not provided to the Legislature reports detailing the costs, schedules, and status of the Genetic Disease Branch Screening Information System Project required as a condition of its approval last year. Since these reports would have provided needed information about the finances and status of the project, we recommend that the Legislature deny a proposal for an additional \$5 million loan from the General Fund for this project unless the reports are submitted and DHS is able to demonstrate its ability to manage the project. (Delete Item 4260-011-0001.)

The budget proposes a \$5 million General Fund loan to the Genetic Disease Testing Fund for the ongoing development of the Genetic Disease Branch Screening Information System (GDB SIS) Project. The purpose of the project is to replace an obsolete automation system used to screen newborns for genetic diseases.

Project Funding. In 2002, the GDB SIS Project was estimated to cost \$32 million (\$17 million for its development and \$15 million to maintain and operate the system over seven years). That same year, the administration increased the fees collected through the Genetic Disease Testing Fund by \$4 per newborn for each screening test to fund the project's costs. Since this special fund did not have a sufficient revenue balance to pay the project's up-front costs, the Legislature approved a \$5.3 million General Fund loan as part of the *2003-04 Budget Act* to help fund the project. The Governor's 2004-05 budget plan proposes an additional \$5 million General Fund loan to pay for additional development costs. By June 2009, it is anticipated that sufficient revenues would be available from the Genetic Disease Testing Fund to repay the two General Fund loans.

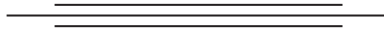
Project and Financial Reports Have Not Been Received. As a condition of approval of the initial loan, DHS is required by law to provide several reports to the Legislature detailing costs, schedule, and status of the GDB SIS Project. At the time the project started in 2003, up-to-date costs and a schedule for the project were unknown. For this reason, the first report, due July 2003, was to provide updated project schedules and cost estimates.

In addition, since DHS has struggled in the past in its management of a number of other information technology projects, the Legislature has been concerned about DHS' ability to manage the project. For this rea-

son, a second set of reports was required to be submitted quarterly to the Legislature, beginning in October 2003, to provide (1) project status and oversight reviews and (2) expenditures, revenues, and the overall fund condition status of the Genetic Disease Testing Fund.

While DHS has shared a report containing some preliminary information about the project's costs and schedule with our office, the Department of Finance has advised us that the report neither represents its decisions on these matters, nor does it constitute a response to the legislative reporting requirements established last year. Thus, the department has not complied with the reporting requirements that were a condition of the loan approved last year by the Legislature.

Analyst's Recommendation. Because the Legislature has not been provided with the information it needs to assess the status of the project and the financial condition of the Genetic Disease Testing Fund, we recommend that the Legislature deny the proposed \$5 million General Fund loan for the GDB SIS Project unless (1) the required reports are submitted and (2) DHS is able to demonstrate in those reports its ability to manage the project.



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 (MRMIP) provides health insurance to California residents unable to obtain it for themselves or their families because of preexisting medical conditions. The Access for Infants and Mothers (AIM) program currently provides coverage for pregnant women and their infants whose family incomes are between 200 percent and 300 percent of the federal poverty level (FPL). The Healthy Families Program provides health coverage for uninsured children in families with incomes up to 250 percent of the FPL who are not eligible for Medi-Cal and, beginning in the budget year, will provide health coverage for certain uninsured infants born to AIM mothers.

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

Budget Proposal. The budget proposes \$1.2 billion from all fund sources (\$314 million General Fund) for support of MRMIB programs in 2004-05, which is an increase of \$35 million or about 3.1 percent (\$10.3 million General Fund) over estimated current-year expenditures.

The relatively small budget increase for MRMIB is due primarily to the administration's proposal to cap enrollment in the Healthy Families Program effective January 1, 2004, and to keep the enrollment cap in place at least through 2004-05. (At the time this analysis was prepared, this

proposal had not been adopted by the Legislature.) Another budget proposal intended to slow Healthy Families spending growth would make the benefits now provided for certain legal immigrants part of a health and social services block grant to counties. Also, the administration has proposed that premiums and benefits provided for Healthy Families children of families with higher incomes be modified to establish a “two-tier” program structure by 2005-06.

The budget reflects the continuation of funding for CHIM at the same level as budgeted for the current fiscal year—about \$154 million (\$54 million in reimbursements from counties and \$100 million in federal funds).

The budget further reflects the implementation of statutory budget language which specifies that infants born to AIM mothers who enroll in the program on or after July 1, 2004, will be enrolled into the Healthy Families Program at birth. Under this new measure, health coverage for the infant’s mother would continue to be provided through AIM.

The budget plan proposes only minor changes in the spending levels for the AIM and MRMIP programs. It also does not contain any proposals to initiate administrative activities to implement Chapter 673, Statutes of 2003 (SB 2, Burton). This measure (1) requires certain employers to pay a fee to the state to support a State Health Purchasing Pool to be administered by MRMIB unless the employer directly provided health insurance coverage for employees or, in some cases, for an employee’s dependents; and (2) establishes a new state program to assist low-income employees with children enrolled in Healthy Families (as well as family members eligible for Medi-Cal) in paying premiums to obtain employer-based health coverage.

We discuss issues relating to the enrollment cap proposal below and also in the “Crosscutting Issues” section of the Health and Social Services chapter of this *Analysis*. We also discuss the block grant proposal and the implementation of SB 2 within the “Crosscutting Issues” section.

HEALTHY FAMILIES PROGRAM

Background

Program Draws Down Federal Matching Funds. 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 previ-

ous limits of their Medicaid programs. Under SCHIP, the federal government provides states with flexibility in designing a program

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, vision, and basic mental health care benefits. The Healthy Families Program also covers more intensive mental health services for children with serious emotional disturbances, which are directly provided through county mental health systems and supported primarily with county and federal funding.

State Implements Program Expansions. The program began enrolling children in July 1998. In 1999, the program was expanded to include children with family incomes 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 January 2002, the state was granted a waiver by the federal government to expand the Healthy Families Program to uninsured parents of children eligible for the Healthy Families or Medi-Cal programs in families with incomes up to 200 percent of the FPL. (State law authorizes the expansion of coverage to parents with incomes up to 250 percent of the FPL, but this further change is not being pursued at this time.) The previous administration had proposed to delay implementation of the Healthy Families parent eligibility expansion until July 2006 due to the state's fiscal problems. The new administration has not proposed any change in this timeline.

Recently, the state initiated additional expansion efforts outside of the state's Healthy Families Program to provide health care coverage for uninsured children. The *2003-04 Budget Act* implemented the CHIM to allow counties to receive federal SCHIP matching funds to provide health coverage on a county-by-county basis to uninsured children living in families earning incomes between 250 percent and 300 percent of the FPL. The implementation of this program is awaiting federal approval. (We discuss the CHIM program later in this analysis.)

The Budget Proposal. As shown in Figure 1, the January budget proposes \$844 million (all funds) in Healthy Families Program expenditures in the budget year. This is an increase of about 4.4 percent over estimated current-year expenditures. The budget proposes \$311 million in General Fund support for the Healthy Families Program, a \$14.3 million increase above the current-year level. The budget proposal represents a relatively modest increase in Healthy Families expenditures in comparison with

six years of much more rapid growth in the program. The slowdown in the rate of program growth can be largely attributed to the Governor’s proposal to cap enrollment in the program beginning in the current year.

Figure 1
Managed Risk Medical Insurance Board
Healthy Families Expenditures

(In Millions)

	2003-04		2004-05 January Budget
	Budget Act	Revised	
Local Assistance	\$800.1	\$803.0	\$839.1
State operations	5.3	5.4	5.2
Totals^a	\$805.3	\$808.4	\$844.3
Tobacco Settlement Fund	—	—	—
General Fund	\$297.1	\$297.0	\$311.3
Federal funds	499.5	504.2	527.1
Reimbursements	8.8	7.3	6.0

^a Detail may not total due to rounding.

Enrollment Cap Proposal Raises Policy Concerns

The Governor’s budget proposal to cap Healthy Families Program enrollment, while feasible and effective in addressing the state’s fiscal problems, raises a number of issues. We recommend against this approach because other alternatives are available to the Legislature to hold down the cost of the Healthy Families Program.

Budget Reflects Capped Enrollment in the Healthy Families Program

Waiting Lists for Applicants. The Governor’s budget plan proposes to cap enrollment in the Healthy Families Program beginning January 1, 2004, at the estimated caseload level for that date, about 732,000 children. Once the program reaches this limit, children applying for Healthy Families coverage would be placed on a waiting list and enrolled on a “first-come, first-served” basis as attrition occurs in the program. The enrollment cap would not apply to infants transferring to the Healthy Families Program from AIM. Children on the waiting lists and in need of

medical care would either access uncompensated medical care through community clinics, emergency rooms, or, in some cases, forgo medical treatment altogether. The proposed enrollment cap would require federal approval as well as state legislative and regulatory changes. Currently, six of the 35 states with separate SCHIP programs (the equivalent of the Healthy Families Program in California) have frozen enrollments because of budgetary problems.

Based on past enrollment trends (including the rate at which children are sometimes disenrolled from coverage for various reasons), the administration projects that the cap would result in a waiting list of approximately 159,000 children by the end of 2004-05. The waiting period for coverage is expected to grow over time, reaching as long as six months by the end of the budget year. Our analysis indicates that the waiting list would grow to approximately 280,000 by the end of 2005-06 and the last child to enroll before June 30, 2006 would not receive coverage until June 2007.

The proposed cap on enrollment would curtail caseload growth in the Healthy Families Program and, subsequently, lower overall state expenditures. The administration estimates that the state would achieve only minor savings from this measure in 2003-04, in part because of one-time administrative costs to carry out the change. But the budget plan assumes it would reduce Healthy Families expenditures by approximately \$86 million (\$32 million from the General Fund) in the budget year.

Governor's Proposal Has Some Advantages

Savings Would Be Realized. The overall administration proposal to cap health and social services program caseloads is discussed generally in the "Crosscutting Issues" section of this chapter. Policy issues of particular importance to the Healthy Families Program are discussed below.

Our analysis of the Governor's proposal indicates that it is technically feasible and would probably generate program savings of the magnitude estimated by the administration. Assuming the cap were maintained, the amount of savings achieved from a freeze on enrollment would grow significantly over time and contribute to addressing the state's structural imbalance between revenues and expenditures.

The administration's approach would also be less disruptive to the ongoing operation of the program than other possible approaches for achieving savings. No child now receiving coverage through the Healthy Families Program would lose his or her benefits. It is also possible that the prospect of long waiting lists would provide additional incentive for parents of Healthy Families children to become more diligent about sub-

mitting annual eligibility documents in a timely fashion, and reduce the high rate of disenrollment of children from the program.

Several Issues Warrant Consideration

The Governor's proposal to cap program enrollment in Healthy Families (as well as comparable caps on other health and social services programs) raises a number of significant policy issues that the Legislature may wish to consider.

Waiting Lists Could Create Inequities. The administration's proposal raises some distinct equity issues. First, children who entered the program before January 1, 2004 would be treated differently than children who applied after that date even though they met the same eligibility criteria. Also, the administration proposal is for a first-come, first-served approach in which the first person on a waiting list would be added to the Healthy Families Program caseload as children were disenrolled and "room" was created for additional children on program rolls. While this approach is equitable—all children on the waiting list would be treated alike—it also raises other questions of fairness, in that children would be added to program enrollment in the future regardless of a child's medical needs or family income level.

Another equity issue pertains to how this cap would be implemented in the context of other publicly supported health programs. For instance, while enrollment would be capped for children in families under 250 percent of FPL in the Healthy Families Program, the Governor's budget plan proposes to continue implementation of the CHIM Fund for counties to use to support their county health initiatives to provide coverage to children in families with incomes between 250 percent and 300 percent of the FPL. Thus, the Governor's budget proposal means that, in some counties, some higher-income children might receive health coverage more quickly through county health initiatives than lower-income children enrolled in Healthy Families who would face a wait of six months or longer for coverage.

Time on Waiting List May Be Underestimated. Another concern is that the waiting time for an applicant to actually receive health coverage could turn out to be longer than the maximum of six months estimated by the administration. That estimate is based on current disenrollment and enrollment trends. To the extent that parents' behavior changed, as discussed above, so that disenrollment rates in the program decreased, the waiting period for coverage could be longer than projected. As noted earlier, the waiting period for enrollees would be likely to exceed one year by June 2006.

Cap Places Program Changes at Risk. Establishment of an enrollment cap places at risk the implementation of the Legislature's previous decisions to (1) authorize the future expansion of the Healthy Families Program to parents, (2) expand health coverage and establish premium assistance through a "pay or play" system of health coverage, and (3) establish a "gateway" from the Child Health and Disability Prevention Program (CHDP) to Healthy Families.

The federal government approved California's waiver request to expand SCHIP-funded coverage for low-income uninsured parents on the condition that the state continue its efforts to enroll low-income uninsured children. The establishment of an enrollment cap and waiting lists may place the previous federal approval of California's parent expansion at risk.

An enrollment cap would also conflict with the provisions of SB 2, which enacted a pay or play system of health coverage commencing in 2006. Among other provisions, SB 2 provides premium assistance and wraparound coverage through the Healthy Families Program for coverage of eligible dependents. Implementation of SB 2 would be complicated by the imposition of enrollment limits that would hinder the expansion of health coverage intended in the measure.

The Legislature provided approximately \$9.7 million (\$3.8 million state funds) in the *2002-03 Budget Act* for information technology and other procedural changes, referred to as a gateway, to expedite the enrollment of children receiving services under the state's CHDP program into Medi-Cal or Healthy Families coverage. However, the proposed Healthy Families enrollment cap and subsequent waiting lists would slow the movement of children through the CHDP gateway to Healthy Families. (The gateway would, however, continue to facilitate the transfer of children into the Medi-Cal Program, except for certain immigrant groups.)

State Would Lose Additional SCHIP Funds. The proposal to cap enrollment in the Healthy Families Program would result in state savings, but also reduce by about \$55 million the amount of federal SCHIP funds being drawn down for health coverage of the uninsured. Since the inception of the Healthy Families Program, California has struggled to fully utilize its federal allotment of SCHIP funds. To date, the state has reverted \$1.1 billion in unspent funds back to the federal government, which was redistributed to other states that were able to expend their allotment within the specified time period. As of May 2003, California had approximately \$1.9 billion in unspent SCHIP funds remaining. We would acknowledge, however, that some other strategies for containing state costs for Healthy Families coverage would also add to the amount of SCHIP funds that would go unspent.

Some Children Would Lose Insurance Coverage. The Healthy Families Program was established to operate in tandem with Medi-Cal to ensure seamless health care coverage for children ages 0 to 19 living in families earning up to 250 percent of the FPL. Due to the income and age-based eligibility structure for both programs, the proposed enrollment cap would place certain children who were enrolled in Medi-Cal at risk of losing insurance coverage. Specifically, upon reaching their first and sixth birthday, children who would traditionally transition to the Healthy Families Program because their families' incomes would no longer qualify them for Medi-Cal would instead be placed on a waiting list for coverage.

Analyst's Recommendation

Other Alternatives Available. . . . After weighing the advantages of imposing an enrollment cap on Healthy Families against the issues discussed above, we recommend against the Governor's proposal because, in our view, other alternatives are available to the Legislature to hold down the cost of the Healthy Families Program. As we will discuss later in this analysis, we believe there are other strategies that could be adopted to reduce program spending that would be more equitable to beneficiaries, more consistent with other state efforts to assist the uninsured, and that would make more effective use of the available federal SCHIP funds.

... But if Proposal Is Adopted. Should the Legislature decide to adopt the Governor's proposal, there are several steps it could take to address some of the issues we have outlined. In that event, we would recommend that the Legislature consider the following actions:

- Modify the first-come, first-served approach to prioritize for Healthy Families coverage the poorest eligible children, and-or those with the most significant medical needs. These actions would partly reduce the savings but ensure that state funds are used for those who are most needy.
- Modify the CHIM program to allow coverage of individuals otherwise eligible for Healthy Families but placed on a waiting list. This could address the inequity by which CHIM children in families with higher incomes would receive coverage quickly, while those in families with lower incomes would remain on waiting lists.
- Adopt supplemental report language directing MRMIB to provide the Legislature with a quarterly report providing a statistical summary of the number of children placed on waiting lists, the period of time applicants must wait for coverage, and the effect of waiting lists on program enrollment rates. This informa-

tion would enable the Legislature to assess the impact of the enrollment caps upon their implementation.

- Direct MRMIB to report at budget hearings on how conflicts with the CHDP gateway, parent expansion of Healthy Families, and SB 2 should be addressed.

Choice of Two-Tier Benefit System Worth Considering

Although our preliminary analysis indicates that the proposal to fund activities to establish a two-tier benefit system represents a reasonable alternative for reducing Healthy Families Program costs to help address the state's fiscal problems, we withhold recommendation on the associated funding request for administrative resources until the administration has fully developed the proposal and provided updated cost and savings estimates to the Legislature.

Higher Premium, Greater Benefits. The Governor's proposal requests \$750,000 in funding (\$263,000 from the General Fund) for administrative activities to implement a two-tier benefit structure for the Healthy Families Program in 2005-06.

Under this proposed approach, children in families with incomes of more than 200 percent of the FPL would henceforth have a choice of two types of health care coverage for their child. (Children in families earning less than 200 percent of the FPL would not be impacted by this proposal.) A family choosing to pay premiums comparable to what they now pay (ordinarily ranging from \$4 to \$9 per month per child) would receive basic medical coverage for their child, but would no longer receive vision or dental coverage. A child in a family choosing to pay a higher premium of about \$15 per month would receive all of the services he or she now receives under the Healthy Families Program, including vision and dental benefits. The proposal would be contingent upon federal approval, require state regulatory changes, and not be implemented until 2005-06.

The administration estimates that its proposal would initially save \$12.2 million (\$6.6 million from the General Fund) beginning in 2005-06 and \$25 million (\$11 million from the General Fund) in 2006-07. The administration has indicated that this estimate is based on a number of assumptions that will need to be modified as the proposal is further refined in budget trailer bill language and the Healthy Families caseload estimate is updated for the May Revision.

A Reasonable Concept. Because the proposal has not yet been fully developed, the Legislature is not in a position at this time to fully assess

the merit of this approach. In concept, however, the Governor's proposal represents a reasonable alternative for reducing Healthy Families Program costs to help address the state's fiscal problems. A two-tier benefit system could result in savings while also providing families with the flexibility to choose the benefit package they need and desire for their child. The proposal is also equitable, in that a higher-income family (earning more than 200 percent of the FPL) whose child qualified for Healthy Families would contribute more toward health care coverage than a lower-income family.

One potential drawback to the proposal is its effect on the health care of some Healthy Families children. Some children might receive vision and dental care less frequently. Because the families affected by this change are those with higher incomes, however, it is also possible that many children would continue to receive the services with out-of-pocket payments for care by their parents.

Analyst's Recommendation. Although our initial analysis indicates that the two-tier benefit proposal has merit in concept, the administration has indicated that the details of the proposal and the cost and savings estimates are still being refined. As such, we withhold recommendation on this approach pending the further development of this proposal.

Alternatives for Reducing Healthy Families Program Costs

The January budget plan proposes several measures to contain the costs of the Healthy Families Program. We recommend that the Legislature also consider alternative approaches to those of the Governor, including program consolidation with Access for Infants and Mothers, changes in premium levels, trimming benefits, or shifting coverage of children in families with higher incomes to county coverage.

The Governor's budget proposes to reduce costs of the Healthy Families Program through an enrollment cap, a block grant for immigrant services, and development of a two-tier benefit structure. Given the state's fiscal difficulties, we recommend that the Legislature also consider alternatives to the Governor's budget proposal. We discuss some of these options below.

Shifting AIM Mothers Into Healthy Families Could Save State Resources

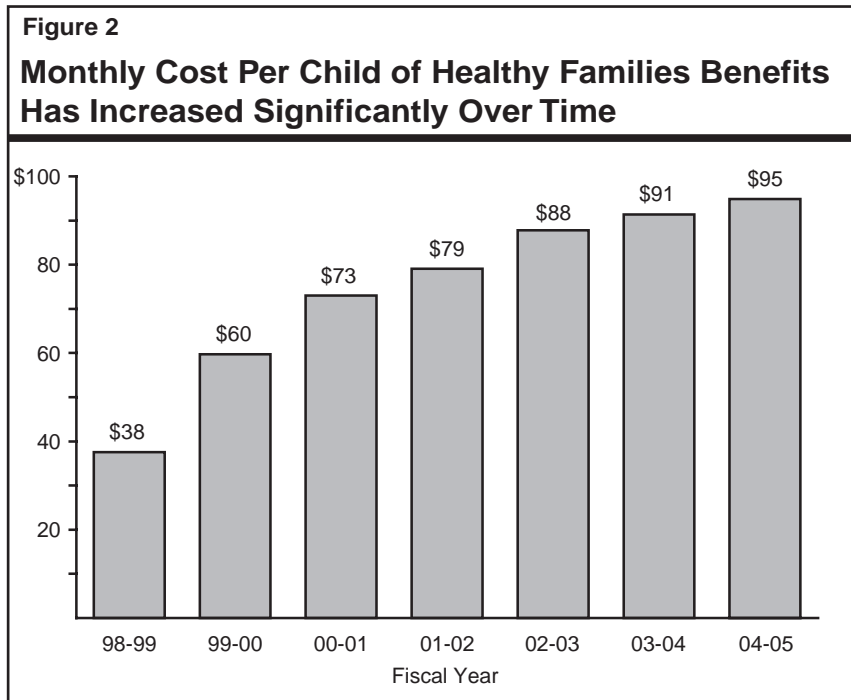
Our analysis indicates that it would be possible for the state to shift some or all of the caseload of mothers in the AIM program to the Healthy Families Program in a way that would maintain their health care while

eventually generating as much as \$42 million in state savings. We describe this alternative in further detail in our discussion of the AIM program later in this chapter.

Family Contributions Could Be Increased

Parent Contributions Unchanged Since Program Began. As noted earlier, families which enroll their child in the Healthy Families Program typically pay between \$4 to \$9 per child each month (with a monthly maximum of \$27 per family) for insurance coverage. The amount paid varies according to a family's income, the region of the state where they reside, and the health plan they selected. The premium levels set for Healthy Families have not changed since the program began in 1998.

However, as Figure 2 indicates, the average monthly cost per child receiving coverage has increased from \$38 in 1998-1999 to a projected \$95 in 2004-05. Within certain limitations in federal law, the state could increase premiums for program enrollees generally to help offset part of the increase in costs. For example, increasing premiums to levels ranging from \$6 to \$12 (varying depending upon income, region, and health plan selected) would result in savings of as much as \$8 million to the state



(\$22 million all funds). In contrast to the Governor's two-tier proposal, which would increase premiums only for higher-income families, this alternative approach would increase premiums across-the-board for most enrollees. To the extent the higher premiums prompted families to discontinue coverage, the state would achieve additional savings.

Currently, several states set monthly premium rates for SCHIP coverage that are significantly higher than the premium levels set in California. As indicated in Figure 3 (see next page), Arizona, Illinois, Texas, and New York have monthly premium levels that range between \$5 and \$11 higher than California's premium rates. Raising California's premiums would bring the state's Healthy Families Program more in line with other states across the country.

Benefits Package Could Be Trimmed

One alternative for reducing state costs for the Healthy Families Program would be to reduce the scope of coverage that all Healthy Families enrollees receive. If this approach were substituted for the Governor's proposed enrollment cap, no eligible child would be denied coverage and placed on a waiting list, but the coverage each child would receive would be reduced in scope. For example, the elimination of vision and dental care across the board for all enrollees would result in state savings of as much as \$75 million in 2004-05.

Some Children Could Be Shifted to County Coverage

The Legislature has the option of reducing costs in the Healthy Families Program by partially or completely reversing the expansion of coverage to higher income families that occurred after the program was initially created and shifting coverage of those children to the CHIM program.

If this alternative were substituted for the Governor's proposed two-tier structure for the program, the existing benefit package, including dental and vision care, could be preserved for all enrollees, but the number of children eligible for the program would be scaled back. In contrast to the Governor's first-come, first-served enrollment cap, this alternative approach would prioritize coverage for poorer families.

This alternative could result in significant state savings. For example, reducing coverage for children in families with incomes above 200 percent of the FPL could save the state as much as \$65 million in 2004-05. The savings to the state would be significantly lower initially if those already enrolled in coverage were permitted to remain in the program. In order to provide an alternative source of health coverage for these chil-

dren in higher-income families, the state could adjust the CHIM program (subject to federal approval) to allow counties to provide coverage for children of families in this income group.

Figure 3
California Premiums Low
Compared to Other States

Comparison of SCHIP Premiums—Fiscal Year 2004

State	Premium or Fee
California	<ul style="list-style-type: none"> • Monthly premium of \$4 to \$9 per month per child depending upon family size and income.^a
Arizona	<ul style="list-style-type: none"> • Income under 150 percent FPL, children do not have a premium. • Income between 150 percent to 175 percent FPL \$10 per month for one child. • \$15 per month for two or more children.
Illinois	<ul style="list-style-type: none"> • \$15 per month for one child. • \$25 per month for two children. • \$30 per month for three or more children.
New York	<ul style="list-style-type: none"> • No premium for children between 0 percent to 160 percent of FPL. • \$9 per child for families between 161 percent to 222 percent of FPL (maximum per family is \$27 per month). • \$15 per child for families between 222 percent to 250 percent of FPL (maximum paid per family is \$45 per month).
Texas	<ul style="list-style-type: none"> • \$15 per month for families between 101 percent to 150 percent of FPL. • \$20 per month for families between 151 percent to 185 percent of FPL. • \$25 per month for families between 186 percent to 200 percent of FPL. • Annual copayment cap set at 1.25 percent of income for families below 100 percent of FPL. • Annual copayment cap set at 2.5 percent of income for families between 151 percent to 200 percent of FPL.

Source: Smith, Vernon K., et al. *SCHIP Program Enrollment: June 2003 Update*. The Kaiser Commission on Medicaid and the Uninsured. December 2003.

^a In general, families below 150 percent of the FPL are charged monthly premiums as low as \$4 per child. Families above 150 percent of the FPL are charged monthly premiums as low as \$6, and no more than \$9 per child.

Block Grant May Not Be Feasible

The Governor proposes to consolidate funding for state-only programs, which serve immigrants into a single block grant for counties effective October 1, 2004. The proposal assumes that counties will achieve administrative efficiencies, so proposed block grant funding has been reduced by 5 percent. We recommend that the Legislature reject the proposal because the programs proposed for transfer to the counties are not well-suited for local control.

The Governor's budget plan proposes to create an Immigrant Services block grant for counties with funding that is currently budgeted for the support of various health and human services provided to certain legal immigrants. Among other programs, the block grant would include approximately \$16.3 million in funding the state would have otherwise spent for health coverage for certain legal immigrant children enrolled in the Healthy Families Program. We discuss this proposal in the "Cross-cutting Issues" section of this chapter.

COUNTY HEALTH INITIATIVE MATCHING FUND

Background

State Established Program for Counties to Access SCHIP Funds. Chapter 648, Statutes of 2001 (AB 495, Diaz), established the CHIM Fund program. Through this program counties would be able to access federal SCHIP matching funds to provide health coverage on a county-by-county basis to uninsured children living in families earning incomes between 250 percent and 300 percent of the FPL. In accordance with Chapter 648, the *2003-04 Budget Act* included about \$150 million to fund the CHIM. As approved by the Legislature, CHIM relies on no state funding but only on federal and county resources—approximately \$54 million in reimbursements from counties and \$100 million in federal SCHIP funds. A portion of these funds (\$280,000) would be used to reimburse the state for its anticipated administrative expenses. In effect, counties would leverage local funds to draw down some of the unspent portion of California's federal SCHIP allotment according to the same 2-to-1 matching rate used by the state. The implementation of this program, however, is contingent upon federal approval of an amendment to the state's SCHIP plan.

The Governor's budget proposes to maintain the current-year level of funding for the CHIM Fund in 2004-05. Specifically, the budget plan includes \$54 million in the CHIM Fund and \$100 million in federal funds.

(As discussed below, the program has not operated in the current year because federal approval is pending.)

Federal Approval of CHIM Still Pending

The implementation of the County Health Insurance Matching Fund is contingent upon federal approval. We withhold recommendation at this time on the Governor's budget proposal to continue the program at its current funding level because a decision by federal authorities on the state's request may be known by this May.

The MRMIB submitted a state plan amendment to the federal government in May 2003 which included the state's proposal to establish the CHIM Fund and specific proposals developed by four Bay Area counties. The administration expects a final decision on its request for approval in May 2004. Currently, four pilot counties are implementing county health initiatives to expand health coverage for children independent of the CHIM, and are awaiting federal approval of the new program, which would allow them to leverage their existing resources by drawing down federal SCHIP funding.

Analyst's Recommendation. We concur with the Governor's budget proposal to continue efforts to take advantage of uncommitted federal funds available through SCHIP to support county health coverage initiatives for children. However, we withhold recommendation on the administration's budget request pending further information on the status of federal approval of the state plan amendment.

ACCESS FOR INFANTS AND MOTHERS

Background

Pregnancy and Postpartum Health Coverage. The AIM program provides comprehensive health care for low-to-moderate income women throughout their pregnancy, delivery, and 60 days after delivery. The program currently also provides health insurance to infants born to women enrolled in AIM until their second birthday. To be eligible for the program, women must be no more than 30 weeks pregnant, have no health coverage for their pregnancy, and have incomes between 200 percent and 300 percent of the FPL. The Medi-Cal Program provides coverage to pregnant women and their infants in families with incomes up to 200 percent of the FPL.

In accordance with statutory budget language adopted last year, infants born to AIM mothers who enroll in the program after July 1, 2004,

will be enrolled in the Healthy Families Program at birth, while the mothers will remain covered through the AIM program. Over time, this shift of new AIM infants into the Healthy Families Program will result in an AIM program consisting only of mothers.

Currently, program participants pay a fee of 2 percent of their family income toward the costs of services received by the mother and an infant up to one year of age. (For example, coverage for an AIM mother and her infant would cost \$449 per pregnancy for a family with an annual income of \$22,450.) Infants born to AIM mothers can continue to receive coverage for a second year through the AIM program for an additional \$100, or \$50 if their recommended one-year vaccinations are up to date. Under the new law, which transfers certain infants to Healthy Families, the family fee for AIM will be reduced to 1.5 percent of family income to reflect the family's new and additional payment of a premium for enrollment of the infant in Healthy Families.

Governor's Proposal

Minor Changes in Spending. As summarized in Figure 4, the Governor's budget proposes about \$118 million from all funds (including \$6.5 million from the General Fund and \$99.5 million in Proposition 99 funds) for the AIM program. This is a small decrease in spending of \$600,000 (or less than 1 percent) from 2003-04. As in the past, the AIM program would be financed primarily with various state fund sources. A relatively small amount of federal funds is currently available to help pay for coverage for infants in their first year in the AIM program.

Figure 4

Access for Infants and Mothers Program Budget Summary

(In Millions)

	2002-03	2003-04	2004-05
Perinatal Insurance Fund (Proposition 99)	\$81.4	\$97.6	\$99.5
General Fund	0.4	7.4	6.5
Tobacco Settlement Funds	3.9	—	—
Federal funds	8.0	13.7	12.1
Totals	\$93.6	\$118.7	\$118.1

Detail may not total due to rounding.

Caseload Shifts. In accordance with the recent changes in statute, the Governor's budget reflects discontinued AIM coverage of infants who will be redirected to coverage under the Healthy Families Program. Figure 5 summarizes the impact this new law is projected to have on AIM caseloads in the budget year.

Figure 5			
Access for Infants and Mothers			
Caseload Summary			
Projected Total Enrollment	2003-04	2004-05	Percentage Change
Women	8,268	8,783	6.2%
First-year infants	84,339	75,562	-14.0
Second-year infants	75,226	88,318	17.4
Totals	167,833	172,663	2.9%

While caseloads for women are expected to increase by 6.2 percent in 2004-05, the number of infants in their first year of AIM coverage is projected to decline by 14 percent. Two factors explain this decline. First, this group of infants consists of those who, in the past, would have received coverage in AIM, but who now would be admitted instead to the Healthy Families Program. (As we noted earlier, infants of mothers who were enrolled before the change takes effect will remain in AIM as long as they are eligible.) Second, program officials indicate that part of the decline in the number of infants in this group is due to prior budget decisions to eliminate funding for outreach activities.

Nonetheless, a temporary increase in caseload of about 17 percent is projected for the budget year for the group of infants who are in their second year of AIM coverage. Because the shift to Healthy Families affects only new admissions to AIM, the number of infants in this second-year group will not be affected by this change until 2005-06. The number of infants in the second-year group is expected to subsequently decline. All infant caseload in the AIM program will be gone by the end of 2006-07 as the children reach age two and are automatically disenrolled from the AIM program.

AIM Mothers Could Also Be Shifted to Maximize Use of Federal Funds

We recommend that the Legislature take steps to shift all new Access for Infants and Mothers-eligible mothers to the Healthy Families Program possibly as soon as the budget year. The Legislature also has the option of shifting this group of enrollees to Medi-Cal coverage. Our analysis indicates that either approach would maximize the state's use of available federal funds and result in significant state savings.

Federal Law Allows Expansions of Care for Pregnant Women. As noted earlier, California's Healthy Families Program implements a federal law, SCHIP, enacted in 1997. This program generally provides funding to states on a 2-to-1 federal/state matching basis.

In September 2002, the Bush administration issued a regulation that permits states to utilize federal SCHIP funding to provide coverage to unborn children (and their mothers) in families with low incomes up to 200 percent of FPL. (States are authorized to submit waiver requests to exceed this income level.) As of September 2003, six states have received federal approval to expand their state's SCHIP-funded insurance programs to include pregnant women and unborn children. The SCHIP statute currently provides states with broad flexibility in defining the services to include under their state plan. Through the new regulation, states have the flexibility to provide expectant mothers services related to pregnancy or conditions that could complicate a pregnancy.

The Medi-Cal Program (the federal Medicaid program in California) provides health care services to low-income persons who meet the program's specific eligibility criteria including special populations of pregnant women and infants. Under longstanding state law, pregnant women in families earning up to 200 percent FPL are eligible under Medi-Cal for no-cost coverage of pregnancy-related health care. Nothing in federal Medicaid law precludes the state from expanding this coverage to include pregnant women up to 300 percent of FPL.

Our analysis indicates that it would be possible for the state to shift some or all of the caseload of mothers who would otherwise remain in the state-funded AIM program to either Healthy Families or Medi-Cal in a way that would maintain their health care while generating significant state savings by drawing down additional federal funds. However, there are significant policy advantages and disadvantages for each approach that the Legislature should consider in authorizing such a change. We discuss these policy tradeoffs in more detail below.

Benefits From Shift to Healthy Families. Merging the population of AIM mothers with Healthy Families would result in both fiscal and programmatic benefits to the state and the persons now enrolled in AIM.

This alternative would help the state to maximize the use of the two-for-one federal matching funds currently available through SCHIP that have gone unused in recent years. (To date, California has reverted approximately \$1.1 billion in SCHIP funds.) Thus, health coverage (at least pregnancy services and possibly more) could be provided for the population of mothers now covered by AIM at a substantially lower cost to the state.

We estimate that the state would eventually draw down as much as \$42 million in additional SCHIP dollars annually for health coverage, resulting in an equivalent net savings to the state. The state could initially achieve net state savings in 2004-05 of as much as \$20 million. The actual savings achieved by the state would depend upon a number of factors, including future state and federal decisions about which AIM mothers, on the basis of their family income, could be transferred to Healthy Families coverage; the timetable for accomplishing this change; and whether the state chose to use some of the savings from this proposal to keep health coverage for mothers under Healthy Families comparable to what they now receive under AIM. (We discuss these health coverage issues in more detail below.) The costs avoided by the state by accomplishing such a shift would grow over time, given the upward trend in AIM enrollment seen in recent years.

The achievement of savings in costs for AIM would free up Proposition 99 funds that could either be (1) used in conjunction with funding for other health programs to help achieve General Fund savings for the state, or (2) used to help preserve funding for Proposition 99 programs which would otherwise face reduction or elimination because of the continued decline in tobacco tax revenues.

Finally, the recommended consolidation of programs would result in programmatic efficiencies over time by combining the administrative responsibilities from two programs into one.

Shift to Healthy Families Has Some Complications. One potential disadvantage of this alternative is that certain nonpregnancy related health care services (such as vision) covered under AIM are not now included in the Healthy Families Program. Additionally, some postpartum medical care is not now covered under Healthy Families. The state could provide such coverage under Healthy Families, but it would reduce the savings the state could achieve from a shift to Healthy Families by approximately \$8 million.

Another concern is that, under federal regulations, the state would ordinarily not be able to draw down SCHIP funding for expectant mothers earning incomes between 250 percent and 300 percent of FPL. The state might either have to keep these mothers in AIM coverage or establish another "state-only" component of the Healthy Families Program (such as now exists for certain legal immigrant children) to provide services for these expectant mothers. The MRMIB, however, has already requested federal approval to use SCHIP funds to cover infants of AIM mothers up to 300 percent FPL. If federal authorities approved this change in coverage for children, the state would be able to draw down federal funds for coverage of all women now eligible for AIM. Such a federal approval would permit the state to achieve the estimated maximum savings of \$42 million annually cited earlier in this analysis.

Benefits and Tradeoffs From Shift to Medi-Cal. Expanding Medi-Cal to include pregnant women up to 300 percent of FPL would likewise maximize the use of available federal funds. This match would result in one federal dollar for each state dollar used to provide coverage for mothers in the income group who would be eligible for AIM. We estimate that the state could eventually draw down additional federal funds of as much as \$25 million annually, and achieve a commensurate amount of state savings. Initial savings to the state of up to \$12 million could be achieved by such a switch in coverage in 2004-05, again depending on a number of key implementation details. For instance, the level of savings would depend on whether the state provided a benefit package that was similar to or less comprehensive than what the pregnant women receive in AIM. If the state were to provide similar coverage as available through AIM, savings would be reduced by approximately \$8 million.

Analyst's Recommendation. After weighing the alternatives, we recommend that the Legislature change state law to permit the gradual shift of some or all mothers in the AIM program to Healthy Families (which could include women up to 300 percent of the FPL depending upon federal approval of the state's plan amendment). Our proposal would not affect anyone now receiving AIM benefits, but would change how coverage for this population is provided in the future.

While a shift of this population to Medi-Cal also has merit, and warrants consideration, the Healthy Families potentially offers greater state savings as well as administrative efficiencies through the consolidation of programs. That is primarily because Healthy Families draws down federal funding at a federal match of two-to-one, whereas coverage under Medi-Cal would result in a one-for-one match of federal dollars to the state's contribution.

The Legislature should also direct MRMIB to report at budget hearings regarding the feasibility, operational ramifications, and potential timetable for implementing this change and the options for covering some or all mothers now eligible for AIM within the Healthy Families Program. The review should include an examination of the options, and cost implications to the state of maintaining postpartum coverage and non-pregnancy services now provided to mothers under the AIM program. In our view, this information would provide the Legislature with the guidance needed to determine whether the state could begin to achieve savings from the implementation of this change in health coverage, as we believe possible, beginning in 2004-05.

Reserve Requirement Unnecessary

We recommend that the Legislature repeal the statutory requirement that the Managed Risk Medical Insurance Board maintain a reserve in the Perinatal Insurance Fund for the Access for Infants and Mothers program, thereby achieving state savings of about \$1 million in Proposition 99 funds. (Reduce Item 4280-111-0232 by \$998,000.)

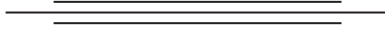
State Law Mandates a Reserve. The Perinatal Insurance Fund is used to receive funding appropriated by the Legislature and subscriber contributions to cover the operating expenses incurred by the AIM program. Under current state law, MRMIB is required to maintain a prudent reserve in the Perinatal Insurance Fund, which is funded from Proposition 99 tobacco tax revenues. Although current law does not specify the level of a prudent reserve, MRMIB has historically been budgeted with a reserve equal to 3 percent of projected program expenditures supported by the fund.

The January budget plan includes a reserve for the Perinatal Insurance Fund totaling \$1 million, equal to roughly 1 percent of program expenditures supported by the fund. The administration has indicated that the customary reserve level was decreased because of the state's fiscal problems.

However, our analysis indicates that there is no need for a separate and special reserve fund for AIM. In the event that AIM program expenditures exceeded the 2004-05 budgeted amount, an alternative source of funding is available to fund unanticipated expenses. Specifically, a separate reserve is maintained for state programs funded through Proposition 99. The Governor's 2004-05 budget plan sets aside \$10.7 million for the Proposition 99 reserve.

Analyst's Recommendation. In light of the state's fiscal difficulties, and the availability of the Proposition 99 reserve for any deficiencies for

the support of AIM, we recommend that the Legislature repeal the state law requiring a separate Perinatal Insurance Fund reserve. The Legislature could then use these funds in coordination with other health programs to achieve an equivalent savings for the state General Fund or to backfill part of the proposed reductions in other Proposition 99 programs.



DEPARTMENT OF DEVELOPMENTAL SERVICES (4300)

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

The Lanterman Act establishes the state's responsibility for ensuring that persons with developmental disabilities, regardless of age or degree of disability, have access to services that sufficiently meet their needs and goals in the least restrictive setting. Individuals with developmental disabilities have a number of residential options. Slightly more than 98 percent receive community-based services and live with their parents or other relatives, in their own houses or apartments, or in group homes that are designed to meet their medical and behavioral needs. The remaining 2 percent live in state-operated, 24-hour facilities.

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

cies. The RCs also purchase services, such as transportation, health care, respite, day programs, and residential care provided by community care facilities. The department contracts with the RCs to provide services to more than 190,000 clients each year.

Developmental Centers (DC) Program. The department operates five DCs, and two smaller facilities, which provide 24-hour care and supervision to approximately 3,500 individuals. All the facilities provide residential and day programs as well as health care and assistance with daily activities, training, education, and employment. More than 7,800 permanent and temporary staff serve the current population at all seven facilities.

Budget Proposal. The budget proposes \$3.4 billion (all funds) for support of DDS programs in 2004-05, which is a 4 percent increase over estimated current-year expenditures. General Fund expenditures for 2004-05 are proposed at \$2.2 billion, an increase of \$114 million, or 5.6 percent, above the revised estimate of current-year expenditures.

The budget proposes \$2.7 billion from all funds (\$1.8 billion from the General Fund) for support of the Community Services Program in 2004-05. This represents a \$108 million General Fund net increase, or 6.5 percent, over the revised estimate of current-year spending primarily as a result of caseload growth, higher utilization rates for services, and other program changes. The increases would be partly offset by proposed reductions in the budget, including policy initiatives to impose cost-containment measures on RC purchase of services and RC operations. (We discuss these policy proposals in more detail later in this analysis.) The 2004-05 Community Services Program includes a net increase of \$104 million in General Fund support due to the scheduled transfer of the Habilitation Services Program from the Department of Rehabilitation to DDS on July 1, 2004.

The budget proposes \$690 million from all funds (\$370 million from the General Fund) for support of the DCs in 2004-05. This represents a net increase of \$5 million General Fund, or 1.4 percent, over the revised estimate of current-year expenditures. The increase in General Fund resources is mainly due to increases for employer retirement contributions and additional funding for employee compensation. However, these increases are largely offset by reductions in DC staffing due to population decline; implementation of Section 4.10, a provision in the 2003-04 Budget Act that mandated reductions in state operations; and the elimination of funding for one-time costs associated with the Bay Area Project, an effort to help move clients at the Agnews DC, which is closing, to relocate to the community.

The budget proposes \$31 million from all funds (\$20 million from General Fund) for support of headquarters. About 60 percent of head-

quarters funding is for support of the community services program with the remainder for support of the DC program.

THE REGIONAL CENTER SYSTEM: SPENDING GROWTH RATE REMAINS A FISCAL CONCERN

The cost to the state of operating regional centers (RCs) for persons with developmental disabilities has continued to escalate at a rapid pace, with General Fund spending more than doubling in the past five fiscal years despite efforts to obtain more federal funds to offset state support. In this analysis, we analyze recent caseload and program spending trends to determine what is driving this growth, review the major initiatives to date to address the situation, consider the Governor's proposal to address these issues, and offer additional approaches for containing RC program costs.

Background

The Regional Center System

Two Types of Expenditures. The RC system provides community-based services to clients through the 21 RCs located throughout the state. The RC budget is mainly comprised of two major types of expenditures. The first major category of RC expenditures consists of *purchase of services*, such as transportation, day programs, and residential care. The Governor's budget proposes \$2.3 billion for RC purchase of services in 2004-05.

The other major category of RC expenditures consists of *RC operations*, which includes eligibility determinations and client assessment, the development of individual program plans for clients, service coordination (also known as case management), as well as associated administrative and personnel costs. The Governor's budget proposes \$420 million for RC operations, although \$23.8 million of these funds represent "pass-throughs" for various contracts, programs, and projects not directly controlled by RCs. Over the past five years, RC operations have comprised about 18 percent to 21 percent of the total RC budget, with RC purchase of services making up most of the remainder.

Fund Sources. The RC budget is supported primarily by the state General Fund as well as by reimbursements that are drawn down under a federal Medicaid waiver program, which is discussed in more detail below. After adjusting for a recent program shift to DDS, General Fund has typically accounted for about 65 percent of the RC budget in recent years, while Medicaid waiver reimbursements are the source of about

21 percent of RC support. Other major sources of funding include: (1) federal Title XX Social Services Block Grant funds; (2) federal Targeted Case Management funds; and (3) other federal funds, mainly related to Early Start services for infants, and various other minor sources of funding.

Home and Community-Based Services (HCBS) Waiver. The HCBS waiver is a federal funding mechanism that allows developmentally disabled persons to live at home or in the community rather than having to live in an institutional setting. Costs for these community-based services are jointly funded by the federal government's Medicaid program (known as Medi-Cal in California) and the state.

Under the HCBS waiver, certain federal Medicaid rules are "waived" to allow states to provide services to persons with developmental disabilities that are not otherwise available to a typical Medicaid recipient. Many services received by RC clients who are enrolled under the waiver are partially paid for in this way by the federal Medicaid program. Unlike some other states, California provides the full scope of RC services to its clients, whether or not they are enrolled under the waiver.

By agreement with federal authorities, enrollment under the waiver is capped. Currently there are about 57,000 RC clients enrolled under the waiver, which is capped at 60,000 RC clients until October 2004. The waiver cap will grow to 65,000 clients in October 2005 and to 70,000 clients in October 2006.

In order to be eligible for the waiver, the client or the client's family must either be Medi-Cal-eligible or be "deemed" eligible for Medi-Cal under special rules that allow an individual to qualify regardless of his or her parent's or spouse's personal income. The client must have a formal diagnosis of a developmental disability and be a RC consumer. Also, the client must undergo an evaluation that determines that, were they not maintained in the community, they could otherwise be placed in a licensed health care facility for persons with mental retardation.

Regional Center Caseload Trends

Growth Trend Still Strong. Between 1999-00 and 2004-05, the RC caseload is projected to grow from about 155,000 to more than 199,000 clients, at an average annual growth rate of about 5.2 percent. For purposes of comparison, however, California's population increased by an average of about 1.7 percent annually during that same period. The caseload trend can be seen in Figure 1 (see next page).

Figure 1			
Regional Center (RC) Caseload Growth			
Fiscal Year	RC Caseload	Year-to-Year Difference	Percent Increase
1999-00	154,962	N/A	N/A
2000-01	163,613	8,651	5.6%
2001-02	172,505	8,892	5.4
2002-03	182,175	9,670	5.6
2003-04 ^a	190,030	7,855	4.3
2004-05 ^a	199,295	9,265	4.9

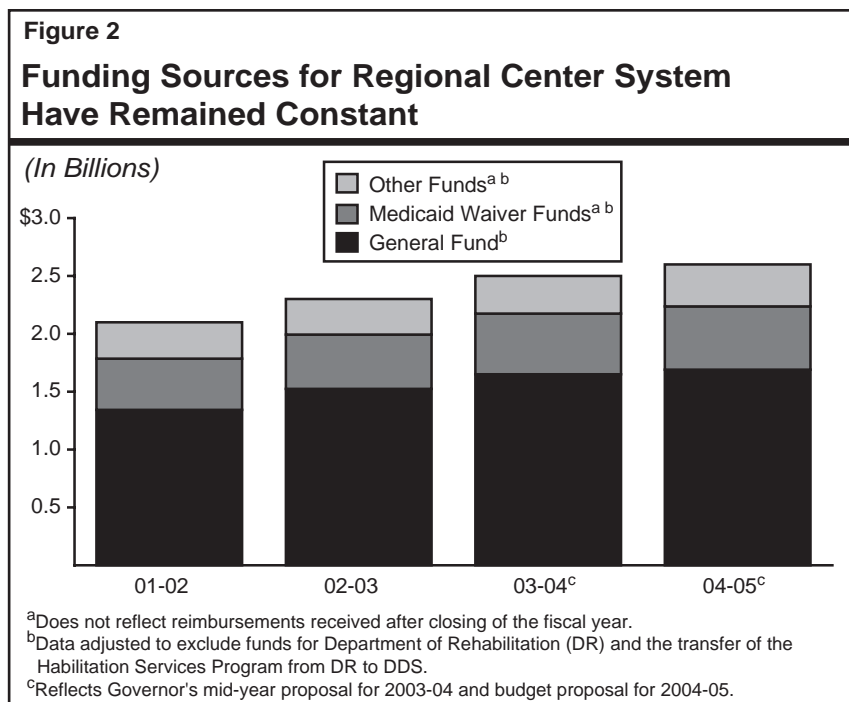
^a Reflects the Governor's mid-year proposal for 2003-04 and budget proposal for 2004-05.

Why Caseload Is Growing. Several key factors appear to be driving these growth trends. Improved medical care and technology has increased life expectancies for the developmentally disabled. It is also possible that medical professionals are identifying more developmentally disabled individuals at an earlier age, and referring more persons to DDS programs. The RC caseload growth also reflects a significant increase in the diagnosed cases of autism, the causes of which are not yet fully understood.

Autism is a neurological disorder characterized by impairments in social relating, language, and by the presence of repetitive and stereotyped behaviors. The caseload for persons professionally diagnosed with full syndrome autism, and excluding children less than three years of age and persons with less common forms of autism, increased between 1998-99 and 2002-03 from about 10,300 to about 20,300 or by almost 97 percent. (During that same period, the caseload of persons with mental retardation increased by 20.4 percent, those with epilepsy increased 16.4 percent, and those with cerebral palsy increased by 15.9 percent.) Other states have reported growth trends in their autistic caseloads similar to those seen in California.

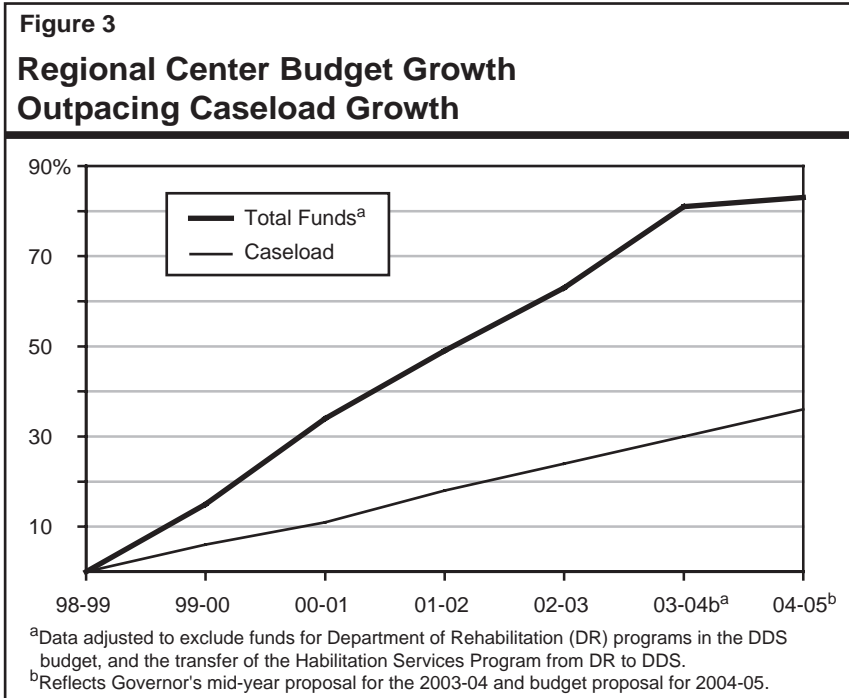
Program Expenditure Trends

Overall Spending and Cost Per Client Growing. Despite recent legislative initiatives to control costs, which we discuss in more detail below, General Fund spending (again, after adjusting for a program shift to DDS) has increased by \$332 million or by 25 percent since 2001-02. As shown in Figure 2, while the overall level of RC spending has increased, the proportion of RC support coming from the General Fund has remained fairly stable in recent years. The proportion of RC funding coming from the federal Medicaid waiver has also remained steady over time.



The average cost per client (including support from all fund sources) has increased steadily between 1998-99 and 2003-04, from about \$9,500 to \$13,400. The Governor's proposed budget, would bring the estimated cost per client in 2004-05 to about \$13,600.

Why Spending Is Escalating. As can be seen in Figure 3 (see next page), total spending for RC services is growing more quickly than RC caseloads. Several factors help to explain why this may be occurring.



One factor is an aging RC client population which requires more intensive and more costly services and supports. Another probable factor pushing costs upwards is the increase in diagnosed autism caseloads discussed earlier, and the comparatively higher costs of treating autistic individuals. Also, as new medical technology, treatments, and equipment become available, the scope of services and supports that DDS is able to provide to developmentally disabled individuals is broadening. In addition, increased spending is, to some extent, a result of rate increases provided for community care facilities that were intended to provide the facilities with sufficient resources to meet federal requirements for quality of care and staffing.

Major Initiatives to Control Costs Show Progress

The Legislature has adopted a series of significant budget actions in recent budget deliberations in an attempt to slow the upward trend in General Fund expenditures for the support of RC programs. These measures include steps to: (1) enhance federal funding for the support of the RC system, (2) impose unallocated reductions and rate freezes; (3) suspend the startup of new community programs; (4) extend intake and

assessment periods; (5) take steps toward expanding parental copayments, and (6) changing program eligibility rules. Several of these actions (although not all) have helped in preventing the significant increases in RC spending from being even greater.

The growth in caseload and costs for RC services has occurred at a time when the state has been experiencing fiscal difficulties. As a result, the Legislature has concurred with a series of changes proposed by the prior administration, and taken other actions on its own, in an attempt to hold down further growth in spending for RC services. Some, although not all, of these actions are proving to be effective in preventing the significant increases in RC spending from being even greater. We discuss these actions in more detail below.

Enhancing Federal Financial Participation. The 2002-03 budget plan adopted proposals to increase the amount of federal financial participation received by the state by enrolling additional RC clients under the HCBS waiver. The DDS was subsequently successful in adding approximately 12,000 additional consumers to the waiver who previously were receiving RC services mainly at General Fund expense. Additional federal funds have also resulted from the reinstatement of some RCs for federal reimbursements. Since 2001-02, the annual amount of federal funding from the HCBS waiver used for support of the RC system has grown by more than \$100 million. The increased level of federal funding is assumed to continue in 2004-05 and subsequent fiscal years.

The 2003-04 budget plan assumed the implementation of several additional proposals to increase federal financial participation for the support of RC services. These steps included: (1) enrollment of additional RC clients under the waiver; (2) increasing the number of contracted services eligible for reimbursement; (3) implementing a system to capture funding for RC waiver administration costs; (4) revising the state's targeted case management rate methodology, and (5) redefining selected services so that they can be added to the waiver.

The DDS originally estimated that this initiative would generate additional federal reimbursements of about \$100 million in 2003-04. However, the department has since revised its estimate downward to about \$87 million due to (1) delays in adding certain services to the waiver, and (2) the determination that some of the additional federal funding sought was already being collected for targeted case management services.

The administration's 2004-05 proposed budget does not contain any new initiatives to increase federal funds under the waiver. The administration has indicated that recent reductions in headquarters staffing has limited the ability of DDS to undertake additional efforts at this time to increase reimbursements from federal funds.

Unallocated Reductions and Rate Freezes. For 2002-03 the administration proposed to achieve \$52 million in General Fund savings by implementing statewide purchase of services standards. (We discuss this approach in more detail later in this analysis.) The Legislature rejected the proposal and instead approved an unallocated reduction of \$52 million. Each RC was assigned a portion of the unallocated reduction and required to submit a plan detailing how it would achieve the savings.

The effectiveness of the 2002-03 unallocated reduction appears to have been limited. Instead of a reduction in overall RC expenditures, the RC system experienced about a \$79 million deficiency in purchase of services in 2002-03. Part of the deficiency—exactly how much is unclear—appears to have been due to the failure by RCs to achieve the savings target.

The administration again proposed the implementation of statewide purchase of service standards for 2003-04, this time with a goal of achieving \$100 million in General Fund savings (it later revised its estimate downward to \$50 million). The Legislature again rejected this proposal and adopted various substitute cost-containment actions. These included setting limits for certain provider rates (for estimated General Fund savings of \$25.9 million), adjustments to service coordinator ratios (\$13.9 million General Fund), elimination of the pass-through of an SSI/SSP rate increase to community care facility providers (\$1.5 million), and an unallocated reduction of \$10 million General Fund for purchase of services.

The Governor's January budget plan generally assumes that these measures will be effective and does not contemplate a deficiency request for additional funding for RC services for the current fiscal year.

Suspension of Startup Programs. The 2002-03 budget as enacted suspended the expenditure of purchase of services funds for the startup of any new RC programs, with the exception of community placement plan programs, unless the expenditure was deemed necessary to protect the consumers' health or safety and had prior authorization from the department. This change was expected to result in savings of \$6 million General Fund. The suspension of the new program startups was continued as part of the 2003-04 budget plan, and a continued suspension is proposed as part of the 2004-05 budget plan.

Intake and Assessment. The 2002-03 budget plan extended from 60 to 120 days the amount of time permitted under state law for RCs to complete the assessment of clients after their initial intake. This was to have resulted in savings of \$4.6 million General Fund. The extension of the assessment period was continued in 2003-04 and is proposed to be maintained in the 2004-05 spending plan.

Parental Copayments. Currently, less than 1 percent of RC clients or their families pay any share of the cost of the services they receive. The Governor's 2003-04 budget plan initially proposed that DDS develop and implement an expanded copayment program to assess and collect reimbursements from the families of developmentally disabled children who live at home and receive certain services purchased by the RCs. The Legislature did not approve the implementation of broader parental copayments in 2003-04, but did adopt budget trailer bill language that directs DDS to submit a plan for implementing parental copayments meeting specific criteria by April 1, 2004. The statutory language specifies that the copayment program cannot be implemented without subsequent statutory authorization by the Legislature. The administration has indicated it is proceeding to develop the proposal for submittal to the Legislature, and is considering additional copayment options. We discuss the Governor's recent copayment proposals later in this analysis.

Change in Eligibility. The 2003-04 budget as enacted contains a proposal to achieve savings of \$2.1 million General Fund by more closely conforming the state's definition of what constitutes a substantial disability to a comparable standard established under federal law. The state's prior definition granted more latitude in determining whether a person was developmentally disabled.

The DDS has estimated that about 400 persons per year would not be eligible for services under the new definition. These would generally be higher functioning individuals with mild mental retardation, or another disability and without severe medical or behavioral needs. While the immediate fiscal impact of the change in definition is relatively small, the cumulative effect may be substantial over the next ten years. The Governor's 2004-05 budget plan assumes continued savings from this action.

Evaluating the Governor's 2004-05 Budget Proposals

The Governor's 2004-05 budget plan for RC community services has several components, including (1) an RC caseload estimate, (2) a proposal to again use federal social services block grant funds to offset state costs for community services, and (3) both budget year and longer term proposals to contain program costs. We explain and evaluate each of these proposals below.

Caseload Assumptions May Be Low

We withhold recommendation on the administration's caseload estimate for regional centers, which assumes a significant slowdown in the rate of growth in the current fiscal year. While recent caseload trends indicate that the Governor's proposal is reasonable, it is not yet clear whether this moderation in caseload growth is an ongoing trend or only temporary. If it turns out to be only temporary, then General Fund support for RC caseload could be underbudgeted by as much as \$20 million in both the current and the budget year.

Caseload Counts Below Budget Target. The DDS budget estimate for 2004-05 is partly based on an assumption that RC caseload in the current year will be 190,030, or 3,070 below the caseload of 193,100 assumed when the 2003-04 budget was approved. This would represent year-over-year growth of 4.3 percent. The Governor's budget plan further assumes that the RC caseload will increase in 2004-05 by 9,265 clients, or 4.9 percent, to a total of 199,295.

If the estimate is accurate, it would reflect a slowdown in caseload growth, although the growth rate would remain significant. The previous caseload projection, presented at the time of the 2003-04 May Revision, assumed a significantly higher year-to-year growth rate of about 6 percent.

The projection of a somewhat moderating rate of caseload growth is reasonable, given the trend seen in caseload and the adoption of cost-control measures adopted by the Legislature in recent years. However, there is not sufficient data available at this time to determine whether the moderation in caseload growth is a temporary change or an ongoing trend. If the previous trend of higher growth were to resume, the Governor's budget plan could be underbudgeted by as much as \$20 million General Fund in both the current and budget year.

Analyst's Recommendation. We withhold recommendation on the Governor's budget proposal at this time. Because of the relatively high degree of uncertainty over the caseload projection, it is possible that the budget proposal may understate the amount of state funding required for the program in both 2003-04 and 2004-05. The administration will update its projections this spring. We will continue to monitor caseload growth trends and recommend adjustments, if necessary, following our review of the May Revision.

Title XX Funding Shift Appears Viable Now

The Governor's budget plan proposes to use \$48 million in federal Title XX Social Services Block Grant funds in place of General Fund for specified regional center expenditures. Although a similar fund switch had been halted in the past because of technical issues, it should be possible to accomplish these General Fund savings in 2004-05.

Title XX Funds Contingent on Copayment Data. The 2002-03 budget plan included provisions intended to achieve General Fund savings by (1) transferring Temporary Assistance for Needy Families funds into the state's federal Title XX Social Services Block Grant, and then (2) substituting block grant funds for General Fund support in the DDS budget for RC programs. The administration subsequently withdrew the proposal and the Legislature agreed to reverse the funding shift to DDS. At the time, the administration cited a lack of data on the income levels of families receiving RC services as a technical flaw inconsistent with federal rules that precluded the shift of these federal funds to DDS.

However, the Governor's 2004-05 budget plan again proposes to accomplish a similar fund switch, this time to generate General Fund savings of \$48 million. The administration believes that income data on the families of RC clients that will be obtained as part of the proposed expansion of parental copayments would resolve this technical flaw, thereby permitting the state to use the Title XX funds to support the RC budget.

Analyst's Recommendation. We concur in the Governor's proposal to accomplish this funding shift in order to achieve General Fund savings. We would note, however, that the success of this proposal is conditioned on a successful effort by DDS to collect and tabulate data that would provide the needed information about client family incomes. We intend to monitor the situation to ensure that the proposed funding shift remains a technically effective solution.

Cost Containment Measures Lacking Key Details

The Governor's budget proposes several cost containment measures that would reduce budget year growth in RC purchase of services by \$100 million in state funds. The Governor's budget also proposes longer-term reforms to contain program costs. We support the Governor's proposals in concept, but withhold recommendation on the reform plan until more details are available. The Legislature should request that these details be provided at budget hearings, rather than at the May Revision, so it can consider their policy implications and determine whether the savings that are proposed will actually be achieved.

2004-05 Budget Proposal. The Governor's budget proposes to reduce growth in 2004-05 RC purchase of services by \$100 million in 2004-05. The administration has identified several general cost-containment strategies that include:

- Implementing statewide purchase of services standards that would regulate RC expenditures.
- Implementing a parental copayment for children 3 to 17 years of age whose parents have the ability to pay for part of the cost of their services.
- Accessing funds that are currently shielded in "special needs" trusts which are established for the care of the RC clients.
- The administration also proposes to make statutory changes that would provide the RCs with the authority and flexibility to achieve the savings and possibly to implement other unidentified actions to constrain RC costs.

Longer-Term Reform. The Governor's budget also proposes to reduce the rate of growth of spending for RC purchase of services in 2005-06 and thereafter by an unspecified amount through three specific cost-containment measures that include:

- Implementing a standardized, statewide rate system for major categories of services purchased by the RCs.
- Implementing a self-directed services model of funding and service delivery commonly known as "self-determination" that will cap individual budgets in exchange for increased client control over services.
- Expanding parental copayments to include families of children from birth to 3 years of age who have an ability to pay.

Below, we provide some general information regarding several of the Governor's cost containment proposals as well as some background information to assist the Legislature in assessing the Governor's plan once more details are forthcoming.

Statewide Purchase of Services Standards

Standards Warranted to Prevent or Reduce Overspending. As we described above, statewide purchase of services standards were proposed in the Governor's January budget proposals in both 2002-03 and 2003-04 but rejected by the Legislature in favor of other approaches. At this point it is not clear how or if the 2004-05 proposal will differ from those proposed by the previous administration. But there is evidence which indi-

cates that such standards are warranted in general to prevent or reduce program overspending.

A recent study commissioned by the state found that five cost-related factors explain why the cost of services for some clients differ from the costs of caring for others. They are the client's (1) age; (2) residence type, such as a community care facility or their home; (3) characteristics, such as whether an individual is autistic; (4) level of mental retardation, if any; and (5) their adaptive behavior, such as their independent living skills and social competence. The study also determined that gender had no relation to purchase of service costs, but that client ethnicity had a small influence on such costs. (At the time this analysis was prepared, a follow-up study was nearing public release that will examine whether other factors account for variations in spending patterns.)

Some Variations Justified. The study compared RC spending patterns and found clear variations in purchase of services expenditures that could not be explained by these five factors. For the five-year period covered by the study, 1995-96 through 1999-00, clients in the three highest spending RCs received more than \$8,700 per capita annually in services, while consumers in the lowest spending regional centers received slightly below \$6,000 in services. The biggest variations were found in out-of-home services, day programs and transportation. These data suggest that there are differences in spending patterns among RCs that could be addressed by statewide purchase of service standards to ensure that RC clients in one region of the state receive services and supports that are comparable to those received by RC clients in other regions.

Some regional variation in the cost of services in RC programs is inevitable and appropriate, given that the RC system was designed and intended to permit community preferences to be taken into account in the delivery of services. Regional factors such as the rural nature of an area or the availability to clients of generic services can also affect costs, such as transportation. We believe these concerns could and should be addressed in the development of statewide standards through the involvement of RC, client advocates, service providers, and other interested parties.

Implementation of Parental Copayments

Last Year's Copayments to Be Implemented, and More Proposed. In our *Analysis of the 2003-04 Budget Bill*, we supported copayments in concept because of the potential fiscal benefit to the state and because we believe it is a reasonable and appropriate policy that those who can afford to do so contribute to the cost of the care provided to members of their family. We did recommend that the Legislature clarify and improve some specific aspects of the plan as it moved forward. We also recom-

mended, among other actions, that the Legislature consider broadening the proposal to include families of children from birth to age 3 as already occurs in some other states.

As discussed above, the Legislature last year directed DDS to submit a plan, by April 1, 2004, for implementing parental copayments that meets specific criteria. The Governor's 2004-05 budget proposal moves forward with the initial expansion authorized by the Legislature, as well as extends copayments to the families of infants.

Fiscal Implications. The DDS's preliminary estimate is that this first copayment expansion (ages 3 through 17) would result in \$29.5 million in additional state revenues during the first full year of implementation. The revenue estimate will be revised after DDS obtains income data on the families of the clients that would be assessed the copayment. In addition to the revenues that would directly result from copayments, however, their implementation would probably decrease the demand for certain RC services. Some families would probably elect to receive fewer services once they were required to help pay for them in order to lower their copayment. As long as they are reasonable in their amount and based on a family's ability to pay them, copayments could help deter excessive use of the available services. Our analysis also indicates that unknown but potentially substantial additional General Fund savings could result from the imposition of copayments on families with infants and the resulting changes in utilization patterns.

Standardizing Rates

Rate-Setting Process Varies. The Governor's budget proposes to implement a standard statewide rate system for major categories of services purchased by regional centers beginning in 2005-06. The rates for residential services purchased by RCs are set at the state level. However, RCs have considerable discretion in determining how much they will pay a vendor for some nonresidential services. The rate-setting methods employed by RCs for nonresidential services vary significantly, according to the type of service. There is also significant variation in the way rates are set for the same types of services, such as for transportation.

Some RC service rates are set competitively while others are not. Some rates are based on historical cost data while others are tied to what other similar vendors are paid, or the rates paid under the state's Medi-Cal health program for the poor, or what the public would pay for the same services. In general, we found the rate-setting approach is often complex, inconsistent, potentially costly to the state, and, in some cases, inequitable to some providers. For example, a provider who has recently con-

tracted with an RC to provide day program services may receive a significantly higher reimbursement rate than another vendor who is providing the identical service, but who signed a contract at an earlier date.

Given the varying methods currently used to determine rates for services purchased by the RCs from their vendors, we believe that the standardization of RC rates contemplated by the administration is feasible in concept and warranted. We would note that while the intent is to constrain costs, changes to rate-setting mechanisms could in theory result either in state savings or costs depending on the details of the specific proposal. Any proposed change to the rate-setting mechanism should be carefully reviewed by the Legislature to ensure that it will in fact result in net savings to the state.

Expansion of the Independence Plus Waiver

More Client Control and Lower Costs. Subject to federal approval, the administration has proposed to implement a waiver that will allow a self-directed services model of funding and service delivery, more commonly known as self-determination, that caps individual budgets in exchange for increased consumer control over services.

In our review of the DDS budget in the *Analysis of the 2003-04 Budget Bill*, we concluded that expansion of self-determination under the proposed waiver represented a potential “win-win” situation for clients and the state. Clients could gain greater control over their services and their life while the state could potentially hold down growth in program costs. During last year’s budget deliberations, the Legislature adopted language that allowed for continuation of the existing self-determination pilot projects in five RCs as well as for expansion to other RCs when consistent with federal approval of the waiver.

Expansion of self-determination is also contingent on the successful implementation of the California Developmental Disabilities Information System (CADDIS), which is necessary to meet federal billing requirements. The CADDIS system, which allows for tracking of individual client budgets, is expected to be fully implemented in all 21 RCs by the end of the current fiscal year.

Reductions in Regional Center Operations

Regional Center Operations Unallocated Reduction. The Governor’s budget proposes an unallocated reduction to RC operations of \$6.5 million to control administration costs. The administration believes that opportunities exist to increase operational efficiencies within the RCs which would allow savings to be achieved without adversely affecting program

administration. Accordingly, under the Governor's plan, DDS will work to develop a long-term strategy to minimize waste and excessive administrative costs.

However, the details of how these efficiencies will be accomplished are not available. Therefore, we are unable to determine at this time how RC administrative functions would be affected and what direct impact, if any, the unallocated reduction would have on the RC's ability to meet their obligation to provide services to their clients.

We would note that several of the administration's cost-containment proposals for 2004-05 and 2005-06 could potentially increase workload for the RCs. Although there are few details available at this point, it is likely that implementation of statewide purchase of service standards, implementation of parental copayments, and an expansion of self-determination projects would create additional administrative workload for the RCs. In addition, in 2004-05 the Habilitation Services Program will be transferred to DDS from the Department of Rehabilitation, a shift which will also generate additional workload, but occur without an increase in RC operations funding.

Analyst's Recommendation

Actual Savings From Governor's Proposals Indeterminable. In concept, the Governor's proposals appear to have merit, given our own past recommendations to the Legislature for reform (see our analyses of the DDS budget in 2002-03 and 2003-04) and the continuation of rapid RC caseload and expenditure growth trends. However, neither the savings estimates for each of the Governor's separate cost-containment proposals for 2004-05, nor detailed information regarding how they would be implemented, was available at the time this analysis was prepared. According to the administration, this additional information will be provided in the 2004-05 May Revision. Details are also lacking regarding the proposals for longer-term reform.

Consequently, we cannot say at this time whether the 2004-05 package will achieve the contemplated savings or provide a full assessment of any of the proposals. Lacking these details, the Legislature is also not in a position to fully assess all of the policy and operational implications of these changes.

Given the complexity of these issues, however, the Legislature should request that the administration present its completed proposals to implement cost-containment measures at budget hearings, and not wait until the May Revision to present these details. An earlier timetable would provide the Legislature with the additional time needed to review, ana-

lyze, and, in some cases, compare alternative approaches to the plans put forward by the administration.

An Agenda for Further Reform

The Governor's budget proposal for a continuing effort to change the way regional center services are delivered in order to improve program accountability and cost-effectiveness represents a reasonable starting point for consideration. There are additional options the Legislature may also wish to consider to broaden the discussion of possibilities for cost containment and program reform, including the improvement of audit functions, clarification of some provisions of the Lanterman Act, modification of the nursing home rate structure, and reductions in certain contracted activities.

In our view, the administration's proposals to study additional cost-saving changes in RC programs and operations constitutes a reasonable initial approach. We believe this discussion should be broadened, however, to include additional opportunities for reform besides those mentioned in the Governor's budget plan. We discuss some of those possibilities below.

State's Auditing Capabilities Could Be Strengthened

Limited State Audit Role. The RC fiscal oversight functions include desk audits in which vendor billings are reviewed for accuracy and completeness or, in some cases, field audits that include a detailed review of some or all of a vendor's records or financial accounts to check their accuracy. In some instances, an RC may request that DDS participate in an audit of a vendor. However, DDS headquarters is neither staffed to perform vendor audits, nor is this one of its regular functions. As a result, there is little chance that a RC vendor will ever face an audit performed by state auditors. One significant exception is vendors who are also Medi-Cal providers, and therefore subject to state reviews related to the state's Medi-Cal antifraud efforts.

Many RC vendors do not participate in the Medi-Cal Program. Although they provide services that are similar or identical in nature to those of Medi-Cal providers, they are not subject to the same statewide, centrally coordinated effort aimed at deterring fraud and abuse to which Medi-Cal providers are subject. We believe this arrangement does not provide an adequate safeguard for the expenditure of very significant amounts of state funds that flow each year through non-Medi-Cal vendor contracts. Our analysis indicates that shifting the responsibility for vendor field audits from the RCs to the state would relieve the RCs of

part of their workload and allow them to focus more on providing high-quality services to RC clients. At the same time it would allow the state to achieve stronger fiscal oversight of the RC vendors and to coordinate these efforts on a statewide basis. Under our suggested approach, the RCs would retain their present oversight responsibilities for conducting desk audits.

Because the existing DDS audit unit is not staffed to perform field audits of vendors, as much as \$2.9 million of the \$4.4 million in funding now provided for RC audit functions could eventually be transferred from the RC operations budget to the DDS headquarters budget for this purpose. Because this change would require modifications of existing RC contracts, it may be necessary to phase in such a funding shift as the contracts are renewed.

Analyst's Recommendation. Accordingly, we recommend that DDS report at budget hearings on the feasibility of shifting the responsibility and funding for field audits of RC vendors from the RCs to DDS. The DDS should also report at that time on whether it would be more cost-effective to contract out the audits, increase headquarters staff to perform the audits, or some combination of these two options. The DDS should also report on the timeline necessary for completing such a shift, and recommend the amount of resources that should be transferred to its headquarters operations for this purpose in 2004-05 to begin phasing in this change.

Lanterman Act Could Be Clarified

Lanterman Act Unclear in Some Respects. The Lanterman Act states the intent of the Legislature to ensure the provision of services to clients and their families be effective in meeting the goals stated in the individual program plan, reflect the preferences and choices of the client, and reflect the cost-effective use of public resources. Services and supports may include, but are not limited to, more than 20 specific services that are listed in the Lanterman Act. The law is specific that the services available must include diagnosis, evaluation, treatment, personal care, day care, speech therapy, education, recreation, camping, and specialized medical and dental care, among others. However, the Lanterman Act is not as specific regarding which services, if any, the state is not responsible for providing to clients. At one time, however, state law was clear that RCs were not obligated to pay for services for a client that parents would typically be responsible for purchasing for any children. This statutory language sunsetted in 2002.

Under the RC system, administrative law judges (ALJs) are empowered to hear appeals of cases in which RCs have denied the provision of

services. In ruling on such appeals, ALJs have recently ordered RCs to fund services and supports for services that are typically paid for by parents of children without developmental disabilities. For example, one RC was required to purchase private swimming lessons even though the RC had determined that group swimming lessons with peers with whom the client could socialize would likely be more beneficial to the client. In another case, an ALJ ordered an RC to pay a portion of the cost for an addition of a bedroom and bathroom to a house. The RC had denied the request because it believed this expense was one which would normally be assumed by the parents of a nonhandicapped child.

Our analysis indicates that the restoration of the language that sunset in 2002 could eventually, although not immediately, result in significant savings to the state. The initial fiscal impact of adopting this language would be relatively modest in terms of reduced RC purchase of services costs—probably less than \$1 million annually. However, the cumulative effect of this change would probably be greater over time, and could potentially reach several million dollars annually. The savings would occur because RCs would have greater authority to control program costs.

Reinstatement of the prior state law could also reduce RC expenditures and workload related to the hearing process to the extent that clarification of the Lanterman Act resulted in fewer appeals of RC decisions to deny payment for services that are appropriately the financial responsibility of their families.

Analyst's Recommendation. For these reasons, we recommend that the Legislature reinstate statutory language that clarifies that parents of children with developmental disabilities, and not state taxpayers, should be financially responsible for the purchase of goods and services that would normally be purchased by the parents of a child without developmental disabilities. Because the impact of this change would be gradual, we recommend no specific budgetary adjustment to the RCs at this time relating to this action.

Nursing Home Rate Restructure Could Increase Federal Funds

Leveraging Federal Dollars Could Reduce General Fund Costs. Our analysis indicates that the state has the option of drawing down additional federal funds to offset the state costs of services provided to residents of Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs). This could be achieved by modifying the ICF/DD rate and implementing other related changes. We estimate that this approach could generate as much as \$50 million annually in additional federal funds that

would allow a commensurate reduction in state General Fund support for these nursing homes.

Federal regulations allow for a broad definition of the services that can be provided in ICF/DDs with reimbursement under the Medi-Cal Program. Other states have been successful in defining their ICF/DD programs more broadly to cover the supports and services for clients with developmental disabilities, thereby increasing their federal reimbursement under Medicaid. However, California continues to maintain a more narrow definition of ICF/DD services than the one permitted under federal law. We believe the state could take the same approach taken by other states to increase its federal reimbursement under Medi-Cal.

Specifically, in order to capture these additional federal funds, the state would have to redefine the ICF/DD program as an “all-inclusive service.” Currently, the ICF/DDs are paid a rate based only on the specific nursing care services they provide. Additional services that a client may receive such as transportation or a day program are generally paid for separately by the RC or provided through a generic service provider. Under this option, ICF/DDs would be redefined to be an all-inclusive service and the responsibility for paying for transportation and day programs and other assistance (in cases where generic services were unavailable) would shift from the RC to the ICF/DDs and would be reflected in the rates paid to the ICF/DDs.

The DDS would have to address several significant programmatic and administrative issues to implement this proposal. Implementation would also likely require regulatory changes and would be contingent on federal approval of an amendment to the State Medicaid Plan. However, no change in statute is believed necessary to move forward with this approach.

Analyst’s Recommendation. Our analysis suggests that recent staffing reductions mean that it would be difficult for DDS headquarters to accomplish the change in ICF-DD rates that we propose without additional positions and resources. Accordingly, we recommend that DDS report at budget hearings on the feasibility, timetable, and staff resources that would be required to proceed with this effort to further maximize the federal funding available to the state for the support of the RC system. The DDS should also specifically report on the state savings, if any, that could be achieved in this manner in the 2004-05 and 2005-06 fiscal years.

Contracted Regional Center Services Could Be Reduced

Missed Opportunity for RC Operational Savings. The Governor's 2004-05 spending plan includes significant proposals for reductions in RC operations. This follows the approval by the Legislature in the 2003-04 budget of a \$13.9 million reduction in RC operations funding through the modification of staffing ratios for case management, supervisory, and clerical personnel.

However, no comparable reductions have been made to various spending items that "pass through" the RC operations budget and do not directly support RC management activities. We believe it would be reasonable to consider reductions to these items given the state's current fiscal condition.

The proposed 2004-05 budget would provide \$22.1 million General Fund for 13 such separate contracts, programs, and projects. A 10 percent reduction in General Fund expenditures would result in General Fund savings of \$2.2 million. We would note that, in most cases, reduction or elimination of these contracts, programs, and projects would require a change in statute, federal approval, or both.

Analyst's Recommendation. We recommend that the Legislature direct DDS to report at budget hearings on the feasibility of achieving a 10 percent reduction in state expenditures for contracts, programs, and projects included in the RC operations budget as "pass-through" items. The DDS would identify the savings that could be obtained within particular pass-through items, the steps necessary to reduce costs, and the effect, if any, on the quality of services provided directly to RC clients.

Conclusion

Even with the recent slowdown that appears to be occurring in caseload growth, it appears likely that RC costs will continue to grow at a significant pace. We believe the Governor's budget proposals offer a reasonable starting point for discussions with the Legislature and other interested parties about how changes could be made in the RC system that would ensure the most cost-effective use of state funding while maintaining high-quality services for RC clients. However, we recommend that discussion be broadened to include some of the additional strategies we have outlined in this analysis.

DEVELOPMENTAL CENTERS PROGRAM

Developmental Centers May Be Underbudgeted

Although the caseload estimate for the Governor's budget plan for developmental centers (DCs) is reasonable, we have identified three factors that make it possible that up to about \$80 million in additional funding will be required for their support. These additional costs could result from (1) the Agnews DC closure plan, (2) the possible federal decertification of Lanterman DC, and (3) the possibility that savings from a proposal to contract out food preparation at the DCs may not be realized.

Caseload Estimate Reasonable. The Governor's budget plan assumes that the DC population will average 3,490 clients in 2003-04, and will continue on the present long-term trend and decrease through the remainder of the current fiscal year and the budget year. Specifically, the DC estimate projects that the average population actually present at any given time in the DCs, including the state's two leased facilities, will be 3,367 for the budget year.

While the proposed budget for 2004-05 reflects savings from the ongoing decline in DC population, these savings are more than offset by increases in retirement costs and other factors, resulting in a net growth in DC expenditures of 1.4 percent in the budget year. Based upon our review of the available caseload data, we believe the Governor's budget estimate for the DCs is reasonable. In any event, the caseload estimate for DCs will be updated at the time of the May Revision.

Our analysis of the budget estimate indicates, however, that three factors could ultimately result in greater expenditures for the DCs in 2004-05 than have been proposed at this time. These factors, which we discuss in more detail below, relate to (1) the Agnews DC closure plan, (2) the possible decertification of Lanterman DC, and (3) the possibility that savings from a proposal to contract out food preparation at the DCs may not be realized.

Funding Request Anticipated for Agnews DC Closure. The 2003-04 budget plan included authorization for DDS to redirect existing resources to form a project team that would begin planning efforts to close Agnews DC by July 2005. The project team is currently developing a master plan for Agnew's closure, and DDS is required to submit a completed closure plan to the Legislature by April 1, 2004.

The administration is expected to submit a 2004-05 funding request during the spring for costs to carry out this closure plan. During the budget year, all remaining Agnews residents would be transferred to other

DCs or placed in the community so that the facility would be shut down by July 2005. During this period, negotiations would also begin for the transfer of Agnews to the Department of General Services as potential surplus property.

In our discussion of the DC closure issue in the *Analysis of the 2003-04 Budget Bill*, we estimated that the state would incur initial costs of \$10 million to \$15 million in the short term related to the closure of Agnews DC. We assume that the administration will probably present a funding request in that range in the spring. The actual costs of closure activity could vary based upon the extent to which Agnews DC clients could be placed in community settings instead of being transferred to the remaining DCs. Our estimate of the additional net funding takes into account: (1) new costs to assess and place DC residents in community programs, (2) costs for relocation of staff, and (3) the savings to DDS operating costs that would result from movement of individuals from DCs to the community or less expensive DCs.

The state would subsequently realize substantial savings from the closure of Agnews—potentially \$30 million to \$40 million annually—that would more than offset these one-time closure costs. In addition to these ongoing savings on state operations, the closure of Agnews would allow the state to avoid an additional \$100 million to \$200 million in costs for capital improvements that would otherwise probably be necessary to continue to operate the facility. Finally, the land value of Agnews offers potential one-time income to the state General Fund of an estimated \$80 million to \$90 million that could be used to offset closure costs.

We would note that our *Analysis of the 2003-04 Budget Bill* recommended that the Legislature initiate the process to also close Lanterman DC in addition to Agnews DC given the projected decline of the DC population. The Governor's budget plan indicates that the administration intends to revisit the issue of whether additional DCs should be closed.

Lanterman Federal Funding at Risk. The federal government periodically conducts surveys of state institutions, including DCs, to ensure that they are being operated in compliance with federal rules and constitutional requirements. A survey conducted at the Lanterman DC in August 2003 concluded that the facility was out of compliance for five of the eight conditions established for the receipt of federal funding for the part of the DC that is licensed as an ICF/DD. About 75 percent of Lanterman clients are cared for in the ICF/DD part of the facility.

If the problems identified in the survey are not remedied before a follow-up survey anticipated to occur by March 2004, the federal Centers for Medicare and Medicaid Services (CMS) may "decertify" the ICF program retroactively to September of 2003. Decertification would result

in a loss of federal funds to the state of approximately \$3.2 million per month—potentially as much as \$32 million in the current fiscal year and \$38.4 million in the budget year. In the past, the state has replaced lost federal funds in the DC program with General Fund support in order to safeguard the health, safety, and welfare of the populations cared for in these 24-hour care facilities.

Contract Savings Depend on Constitutional Amendment. The Governor's spending plan assumes that the state will achieve General Fund savings of \$910,000 in the budget year by contracting out DC food services beginning January 1, 2005. However, our analysis indicates that, while the proposal has merit, some hurdles make it uncertain whether these savings can be achieved.

The five DCs all have large, institutional kitchens where food for the DC residents is now prepared by state personnel. Because of the fragile medical condition of many of the DC residents, and the resulting dietary restrictions, food preparation at the DCs is more complex than is typically the case for other institutions. Many DC residents have special meal plans prepared for them by dietitians and medical staff.

The administration has indicated that it believes contracting-out food preparation will result in more cost-effective and higher-quality service for DC residents. The state currently contracts out for janitorial services at the DCs and has contracted out for food preparation at other state facilities, such as veterans' homes.

However, provisions of the California Constitution and case law limit the practice of contracting-out, especially in regard to programs which already have state staffing in place performing a state governmental function. For this reason, the administration has proposed to place an amendment to the State Constitution on the November 2004 ballot so that this proposal, and other contracting-out efforts affecting other departments, could be implemented within the budget year. The Governor's budget plan assumes both that the Legislature will place such a measure on the November ballot and that it will receive approval by the voters. If either of these actions fails to occur, an additional \$910,000 from the General Fund, beyond the funding now proposed in the budget plan, would be needed for the support of the DCs.

Analyst's Recommendation. We will review the Governor's plan for the closure of the Agnews DC and the anticipated funding request to allow closure of the facility to proceed as the information about these matters becomes available to the Legislature. We will also monitor the Lanterman decertification situation. We recommend no specific actions to the Legislature in regard to these matters at this time, except that we

continue to recommend that the Legislature consider initiating the closure of Lanterman.

We support in concept the Governor's proposal to contract out food preparation in the DCs because of the potential savings from this approach. However, we withhold recommendation pending the outcome of the Legislature's deliberations on the constitutional amendment.



DEPARTMENT OF MENTAL HEALTH (4440)

The Department of Mental Health (DMH) directs and coordinates statewide efforts for the treatment of mental disabilities. The department's primary responsibilities are to (1) provide for the delivery of mental health services through a state-county partnership 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 at Salinas Valley State Prison; and 4) administer various community programs directed at specific populations.

The state hospitals provide inpatient treatment services for mentally disabled county clients, judicially committed clients, clients civilly committed as Sexually Violent Predators (SVPs), and mentally disordered offenders and mentally disabled clients transferred from the California Department of Corrections (CDC).

Budget Proposal Increases DMH Budget Overall. The budget proposes \$2.5 billion from all funds for support of DMH programs in 2004-05, which is an increase of more than \$165 million, or 7 percent, above estimated current-year expenditures. The budget proposes \$911 million from the General Fund, which is an increase of about \$32 million, or 4 percent, above 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 \$134 million, or 9 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 Governor's budget plan reflects a proposed \$245 million increase in EPSDT reimbursements in the budget year compared to the revised current-year level of spending (\$112 million from the General Fund). We discuss the reasons for the augmentation request (including some significant technical adjustments that make program growth appear larger than

is actually the case), describe measures that are being proposed by the administration to partly offset the growth in program costs, and provide our response to these proposals later in this analysis.

The Governor's budget proposes about a \$28 million increase from the General Fund to continue with preparations to open a new state hospital in Coalinga, which is now under construction. This amount includes funding for additional staff, equipment and expenses for the next phases of staffing, and the full-year cost of staff added for activation of the facility in the current year. The administration proposes to open the facility in August 2005.

Budget Proposal Includes Some Reductions. Although the budget plan provides for an overall net increase in General Fund spending, it does reflect some significant reductions in mental health program spending, including proposals to:

- Eliminate all remaining funding for the Children's System of Care (\$20 million) and to reduce funding for the Early Mental Health Initiative (supported with Proposition 98 funds) by \$5 million.
- Defer, for the second year in a row, the payment of more than \$226 million in county claims that have accumulated (as of November 2003) for reimbursement for several state-mandated community mental health programs. The two most significant programs affected are the "AB 3632" services for special education children and a separate mandate for services for seriously emotionally disturbed pupils. (The Governor's proposal, however, does continue to provide \$69 million in federal special education funds within the education budget for these services.)
- Implement a number of measures to reduce the cost of operating the state hospital system, including: (1) placing caseload limits on certain forensic populations, (2) shifting some individuals who are being considered for commitment to state hospitals as SVPs to the local jails while they await their commitment proceedings, and conducting proceedings at an earlier date before such individuals are due to be released from state prisons; (3) restructuring staffing and treatment services to take into account the number of individuals who have been committed as SVPs but are unwilling to participate in treatment; and (4) changing state law to provide for indefinite court commitments of SVPs, instead of two-year commitments that are subject to renewal, in order to reduce the number of evaluations and court commitment proceedings.

We discuss some of these specific proposals in more detail later in this section of the *Analysis*.

STATE HOSPITAL ISSUES

Activation of Coalinga Hospital Could Be Delayed

The Governor's budget requests \$27.7 million to continue the activation of the Coalinga State Hospital. However, our analysis indicates that the state hospital system currently has sufficient capacity to allow the activation of additional beds at Coalinga to be postponed to reduce costs in the budget year. Accordingly, we recommend that the Legislature delay the activation until March 2006 in order to achieve one-time state General Fund savings of up to \$20.1 million. (Reduce Item 4440-011-0001 by \$20,143,000.)

Background

SVP Commitments. In accordance with Chapter 763, Statutes of 1995 (AB 888, Rogan), and Chapter 762 (SB 1143, Mountjoy), California established a new civil commitment category for SVPs. This law requires that certain criminal offenders who have been committed by the courts as SVPs be placed in state hospitals for inpatient treatment, and then eventually released into the community for further supervision and treatment. The law's intent was to ensure that SVPs be confined and treated until they no longer presented a threat to society.

Currently, 535 persons who have either an SVP commitment by a court, or who have been temporarily placed in a state hospital pending the outcome of their commitment hearing, have been placed in the state hospitals. The number of SVP commitments has been growing each year, and only a few persons sent to state hospitals as SVPs have thus far been released to the community.

New State Hospital for SVPs. Beginning in 2000, the state initiated steps to construct a new 1,500-bed secure mental health treatment facility, to be known as Coalinga State Hospital (CSH), to provide DMH with additional capacity to treat patients involuntarily committed under the SVP law. The DMH began construction in 2001, and construction is scheduled to be completed by May 2005. The construction project will be funded by lease-revenue bonds, which are scheduled to be sold in the spring or fall of 2004. To date, the state has committed more than \$380 million for the construction and preliminary staffing of CSH.

In addition to this construction project, the state has taken several steps in recent years to ensure that there is sufficient space in the state hospital system for the treatment of offenders who require high security, such as SVPs. Among other actions, the Legislature provided \$6.9 million in 2001-02 to purchase modular buildings for placement at Patton State Hospital (PSH) and Atascadero State Hospital (ASH) and to convert program areas into temporary patient living space to accommodate up to 500 additional patients. Additional funding for the state hospital system to staff the 500 additional beds has not been provided to date because the overall hospital population has grown significantly less than DMH had previously projected.

Evaluating the Governor's Budget Proposal

CSH Activation Would Continue. The Governor's 2004-05 budget proposal includes \$27.7 million from the General Fund for the continued activation of CSH. This funding consists of (1) \$8.7 million for what are called phases IV and V of staffing; (2) \$12.2 million for operational expenses and equipment; (3) \$3.2 million for recruitment and retention pay differentials and salaries that would exceed standard levels for certain positions at CHS; and (4) a net increase of \$3.6 million to pay the full-year cost in 2004-05 of CSH staff added in 2003-04 to help prepare the facility for its opening. The proposal would add almost 165 new positions for CSH in the budget year. The budget plan also requests an augmentation of about \$770,000 for about 20 additional positions to activate for the first time 147 of the 500 temporary beds at ASH and PSH.

Additional Capacity Not Needed at This Time. Our analysis of the Governor's budget request indicates that the state could delay the activation of CSH and still have more than sufficient capacity to meet the projected need for secure treatment beds in the budget year, and beyond.

According to DMH's own population projections, the number of patients requiring secured housing will not grow, but will instead decline by 47 patients during the budget year as a result of proposals to (1) cap the populations of two groups of forensic patients and (2) divert from the state hospital system persons who have been referred for SVP commitment but have not yet been determined by the court to be SVPs. (We discuss these proposals later in this analysis.)

In light of these projected population estimates, our analysis indicates that DMH will have a surplus of approximately 600 beds in the budget year. The DMH has estimated it will need to house a total of 3,776 secure patients in the state hospitals by June 2005. However, the state hospitals have the capacity to hold up to 4,376 patients in secured treatment settings (including the 500 temporary beds at ASH and PSH) in

2004-05. The anticipated decline in the state hospital populations and the resulting surplus of beds suggest that a delay in the activation of CSH would be possible.

Administration Objections. In our discussions about the possibility of delaying the activation of the facility in order to achieve General Fund savings, the administration has raised several objections.

First, the administration has indicated that delaying the activation of CSH could complicate the sale of the lease-revenue bonds if no date for activation of the facility is specified. Bond underwriters, we are advised, may request that such a date be finalized before bonds could be sold.

Also, the administration has asserted that allowing the facility to sit idle could generate significant new costs by allowing the condition of unused equipment to deteriorate. It has also voiced concern that students who are expected to complete educational programs at a nearby community college in preparation for work at CSH could leave the Coalinga area and obtain employment elsewhere.

Finally, the administration has raised concerns that the use of the temporary beds at ASH and PSH beyond August 2005 may not be permitted by DHS and the State Fire Marshall. The DMH asserts that the continued use of the beds beyond that date could result in licensing violations or require funding to bring the space used for patient care into compliance with licensing, earthquake, and fire safety codes and regulations.

Analyst's Recommendations

Precedents Exists for Facility Delay. In light of the state's budget difficulties, we recommend that the Legislature delay the activation of CSH from August 2005 until March 2006 for a state General Fund savings of up to \$20.1 million. In the past, the Legislature has delayed the activation of state prison facilities, including a new high-security facility in Delano (Kern County), to help address budgetary shortfalls. We believe a similar approach is warranted for CSH, given the considerable resources being requested to bring the facility on line, the severity of the state's current fiscal problems, and our findings that the state hospital system has more than enough secure beds to meet patient needs. We also believe it is possible to address most of the concerns voiced by the administration about a potential delay.

Our approach would fund operating expenses and equipment and staff recruitment costs necessary for a March 2006 opening of the hospital to move ahead in the budget year. Our proposal would also provide the additional funding needed to support the Phase III expansion of staff

already authorized for the current fiscal year to proceed without any disruption. Given that these activities would continue in the budget year at CSH, we see little risk that a seven-month delay in the arrival of patients would result in major costs from the deterioration of any equipment purchased for the facility.

The Legislature could take steps to ensure that the sale of the bonds would proceed. The state recently encountered and resolved a similar issue when it delayed the activation of the Delano II state prison. To ensure that the state's intention to occupy the facility is clear to prospective bondholders, we propose that the Legislature adopt the following budget bill language:

Provision X. In order to address the state's fiscal problems, it is the intent of the Legislature to achieve savings in the 2004-05 fiscal year by delaying some staffing and funding for activation of Coalinga State Hospital until 2005-06. It is further the intent of the Legislature that patients occupy beds at CSH no later than March 2006.

We would acknowledge that a delay in staffing and opening CSH might cause some community college graduates who would otherwise take jobs at the new state hospital to go elsewhere after graduation. However, these nursing and psychiatric technician graduates could be recruited to help address state staffing shortages in these professions, which exist at other state facilities.

We believe it is unlikely that the use of ASH and PSH beds for an additional seven months will pose a serious problem. In 2002-03, DMH itself had proposed to activate these beds for almost as long a period of time (15 months) as we are proposing (20 months). In our view, the department's contention that these beds cannot be used to meet the state's interim needs for secure beds is inconsistent with its prior funding requests for the \$6.9 million; the money that was spent to make these 500 beds available for just this purpose.

If Activation Proceeds, Request Should Be Reduced. Should the Legislature adopt the Governor's proposal and decide not to delay the activation of CSH, we recommend that it reduce the funding request to address several concerns. Specifically, we recommend that the Legislature take the following actions:

- ***Delete Training-Related Travel Funding for New Hospital Police Officers.*** The budget proposal includes \$1.3 million for the cost of staff travel to ASH for the 88 new hospital police officers for CSH. This funding request translates into approximately \$15,000 per new CSH employee, and assumes that every new officer for CSH will require training. This assumption does not appear to be justified, given that some existing staff at ASH and

other state hospitals have indicated an interest in relocating to Coalinga. Therefore, we recommend deletion of the funding in its entirety. The DMH could resubmit a request later this spring for a reduced level of funding for this purpose after it has determined how many new CSH staff will actually be required to travel to ASH for training.

- **Contract Food Service Activities.** Generally under current state law, the state may contract personal services to achieve cost savings when the contract does not cause the displacement of civil service employees. It has already done so for other state facilities, and the administration proposes to expand on this approach next year. Nevertheless, the budget plan would provide \$360,000 in 2004-05 to hire state employees for food service operations instead of contracting for these services at CSH beginning in the budget year. Assuming that contracting resulted in a 10 percent savings, the state could achieve \$36,000 in savings in the budget year, and approximately \$380,000 in annual savings once the hospital is fully operational.

Capping Enrollment and Shifting Some SVPs To Counties Could Make Better Use of Beds

We recommend that the Legislature approve as an interim measure the Governor's proposal to limit the population of two groups of forensic patients in state hospitals. While we find that the proposal has merit, we recommend that legislative policy committees consider as a permanent solution the enactment of statutory changes that would provide the Department of Mental Health (DMH) more authority to prioritize the use of expensive hospital beds for patients who are willing and ready to receive treatment. We also concur with the administration's proposal to shift some individuals who have been referred for commitment as sexually violent predators out of the state hospitals to prioritize the use of beds for patients amenable to treatment.

Background

Judicially Mandated Groups in State Hospitals. Currently, state law provides authority for courts to place certain mentally ill persons in state hospitals. The courts may determine that a defendant who has been accused of a crime is "not guilty by reason of insanity" (NGI) in cases when it finds that the defendant was insane at the time the offense was committed. The courts may also find an individual "incompetent to stand

trial” (IST) when the defendant is unable to understand the nature of the criminal proceedings or assist in their own defense.

In the case of either ruling, the court must direct the defendant to be confined in a state hospital or a public or private treatment facility. In some instances, placement in an outpatient treatment program is also an option. Approximately 1,170 NGI patients and 900 IST patients are currently in the state hospital system—roughly half the entire statewide hospital population. In general, the state and counties share the responsibility for these two populations of defendants in that state law specifies that offenders who have been determined by the courts to be an IST or an NGI can be placed either in the state hospital system or in a local facility (sometimes a jail).

Individuals Referred to SVP Commitments in Hospital Beds. A court determination is required before an individual may be committed to the state hospital system as an SVP. Currently, about 160 of the individuals who are awaiting court proceedings for an SVP commitment are being held in the state hospital system while their cases proceed. Some additional individuals are still being held in state prison as these proceedings occur, while still others who have been released from prison are held in county jails.

A number of components of the SVP law have been determined to constitute a state-mandated program for county governments. Among other costs, counties are reimbursed for the cost of holding any person being considered for an SVP commitment in county jails.

Governor’s Budget Reduction Proposals

The Governor’s budget proposes various measures that would result in General Fund savings totaling approximately \$360,000 in the current year and \$10.4 million in the budget year. Specifically, the proposals would (1) place enrollment limits on certain forensic populations to achieve savings of \$360,000 in the current year and \$2.8 million in the budget year and (2) modify the way the state manages its SVP population to obtain \$7.6 million in state savings in 2004-05.

Governor’s Proposal to Limit Certain Forensic Populations. As part of a mid-year budget reduction package to limit the caseloads of various health and social services programs, the administration has proposed to limit the number of NGI and IST patients at the state hospitals. Specifically, the state would cap the NGI population at approximately 1,200 patients and the IST population at 850 patients effective January 1, 2004. (At the time this analysis was prepared, the Legislature had not approved

this proposal.) The caps would continue at least through the 2004-05 fiscal year.

The administration has indicated that the proposed caps would apply only to new patients, and that existing NGI and IST patients would not be transferred out of the hospital system to conform to the limits. In the event that the hospital population exceeded the cap, admissions of these groups of patients to the hospital system would halt until the census fell to the capped level. In instances where hospital population limits were reached, NGI and IST patients would typically be housed at a county jail at local expense. As a result, adoption of the Governor's proposal for ISTs and NGIs is likely to increase county costs.

Governor's Proposal for Managing the SVP Population. The Governor's budget plan also proposes to shift some individuals who are being considered for commitment to state hospitals (precommitment SVPs) to the local jails while they await their commitment proceedings. The budget plan also proposes to conduct these commitment proceedings at an earlier date before such individuals are due to be released from state prisons in order to reduce the state hospital population. The Governor's proposal relating to SVPs would not increase county government costs, in that, unlike ISTs and NGIs, the entire cost of the SVP population is the responsibility of the state. Counties could obtain reimbursement from the state to offset any additional costs they would incur for holding precommitment SVPs who had been diverted from the state hospital system to county jails.

Measures Would Be Effective in Reducing State Costs. Absent the Governor's proposed cap on NGI patients, this population would potentially grow by 14 patients in the current year and an additional 42 patients in the budget year. Our analysis of caseload trends indicates that the administration's estimates of the caseload reductions and savings due to the NGI cap appear reasonable.

Due to its assumption of a decline in the IST population, the administration budget plan recognized no additional savings as a result of the enactment of a cap on the IST population. However, our review of recent IST caseload trends indicates that the adoption of the cap probably would result in state savings of as much as \$6 million in the budget year. At the time this analysis was prepared, the current IST population exceeded the proposed IST cap by about 39 patients, and further growth in the number of IST patients appeared likely.

Our analysis also indicates that the proposal to shift precommitment SVPs from the state hospitals could have a larger impact on caseloads and achieve greater state savings than estimated by the administration. The Governor's budget plan assumes that the changes that it proposes

would reduce the hospital population by 100 in 2004-05. However, 160 precommitment SVPs are presently in the state hospital system. Thus it is possible that the savings from the Governor's proposed changes to the SVP statute could be greater than estimated in the budget plan.

Using State Beds More Cost-Effectively. The administration has indicated that part of its rationale for capping certain populations and for redirecting precommitment SVPs from the state hospitals is an effort to ensure that the state prioritizes the use of costly inpatient hospital resources for patients who are willing and ready to accept treatment for their mental illness.

The administration has indicated that some NGI and IST patients transferred to the state hospitals by the courts have been unwilling to accept treatment, including medications that could improve their mental condition. Past court rulings have limited the state's authority to provide such medications to individuals against their will. Under these circumstances, placing such individuals in intensively staffed treatment facilities—at a cost of more than \$107,000 per year for each offender—does not appear to be the best use of limited state resources.

To the extent that the imposition of a cap on IST and NGI populations prompted some judges to more carefully consider which offenders it transferred to state hospitals, it is possible that this change could result in the more cost-effective use of state resources. However, our analysis suggests that the establishment of such caps would not fully address this concern. This is because it would not remove from the existing state hospital population individuals who currently are not amenable to treatment, while potentially keeping out of the hospital system individuals who are ready and willing to accept treatment.

The administration's proposal to shift a portion of the precommitment SVPs would have the effect of prioritizing the use of state hospital beds for persons willing to accept treatment. The DMH has indicated that individuals who are awaiting legal proceedings that could result in their commitment as SVPs are generally unwilling to engage in treatment activities. This is because standard therapy for sex offenders often involves efforts to get individuals to discuss and admit their history of sex crimes. As a result, many individuals who are being held in the state hospitals while they await their SVP commitment hearings are not actively engaged in treatment, in effect wasting the expensive treatment resources available to them.

Analyst's Recommendation

Given the state's serious fiscal difficulties, and the merit of limiting the number of NGI and IST patients held at state expense in the hospital system, we recommend that the Legislature concur with the administration's proposal to establish caps on the NGI and IST populations.

However, we recommend that this limit be approved only as an interim action. In our view, such a cap should be imposed only as a temporary step until legislative policy committees can consider the enactment of permanent changes in state law that would ensure that expensive state hospital resources are prioritized for mentally ill patients who are amenable to treatment. For example, the Legislature may wish to consider providing DMH the legal authority to return to the courts, and to transfer out of the state hospital systems back to county custody, NGI or IST patients who have proven over time to be unamenable to treatment. Under such legislation, the courts could then place these individuals in the most suitable and cost-effective setting.

Accordingly, we propose that the statutory provisions of the administration's proposal be adopted with amendments that sunset the enrollment caps as of January 2006. We believe this would provide the administration with sufficient time to pursue a legislative solution to the inefficient use of state hospital resources.

We also concur with the administration's recommendation to shift a portion of the precommitment SVPs to the local jails while they await the verdict on their commitment hearing, and to expedite the commitment proceedings of others before their release from state prison. While the budget plan reflects \$7.6 million in savings to the General Fund from the shift of 100 SVPs to the local level, we estimate that the state could eventually achieve as much as \$5 million in additional savings from the shift of all precommitment SVPs (currently estimated at 160) to the local level.

Finally, we note that there could be some offsets to these SVP-related savings, because more persons would be held in county jails while they were awaiting their commitment hearings in the courts. However, the cost to the state of reimbursing counties for the use of their jail beds would be much lower than the cost of using an equivalent number of state hospitals beds—perhaps as much as 20 percent lower. For this reason, we believe this is a sound fiscal approach.

Additional Funding for SVP Evaluations Not Justified

We believe that the administration's proposal to eliminate the present requirement that Sexually Violent Predator (SVP) commitments be

renewed every two years is a policy matter for the Legislature to consider. However, a request for a \$1.1 million augmentation for a projected increase in SVP evaluations should be rejected because it is not supported by recent caseload trends. (Reduce Item 4440-001-0001 by \$1 million.)

Background

Evaluations Legally Required. State law provides a process by which offenders can be determined by the courts to be SVPs and committed to the state hospital system for treatment. Part of that commitment process involves evaluations by psychiatrists or psychologists to ascertain the mental condition of the criminal offenders. These evaluations are conducted upon the referral of cases to DMH by the state Board of Prison Terms (BPT).

Once an individual has been committed to the state hospital system by the courts, DMH is required to periodically reevaluate whether the individual still constitutes an SVP who warrants confinement in the state hospital system. Under current law, SVPs are committed for a two-year period and cannot be held beyond that time period unless another petition for commitment and relevant evaluations are filed. The *2003-04 Budget Act* provides about \$5.9 million annually for SVP evaluations and related activities.

The state also incurs additional costs to reimburse local governments for the legal proceedings for the SVP commitments, and for subsequent legal proceedings to determine whether these individuals should remain in a state hospital or be released to the community.

Governor's Budget Proposal

Indeterminate SVP Commitments. The Governor's 2004-05 budget proposes to modify state law to eliminate the present requirement that SVP commitments be renewed every two years. Rather, commitments could be made by the courts for an indeterminate period of time. Persons who had been committed as an SVP would be released upon a determination by a court that their mental condition had so improved that it would be appropriate for them to be placed in the community. (The administration proposes, as under current law, that a person confined as an SVP would continue to have the right to petition the courts once each year for his/her release from a state hospital.)

The administration estimates that this change in law would significantly reduce the number of recommitment evaluations that would have to be conducted by DMH-paid evaluators. Also, eliminating the two-year recommitment process would reduce the cost to the state for testimony

in local legal proceedings, and reduce future claims by local governments for reimbursement of their costs for their role in the process. We are advised by DMH that, of the 13 states with SVP statutes, California is the only state with a determinate commitment period. The department has indicated that all other states provide for indefinite initial commitments of SVPs.

Although the budget of DMH was reduced by \$2 million to reflect the effect of these changes in the budget year, the department subsequently has documented a slightly smaller reduction in costs of about \$1.9 million.

Funding Request for Workload Increase. Partly offsetting this proposed reduction in DMH funding is a budget proposal to increase by about \$1.1 million the General Fund resources available for SVP evaluations. The administration cites as justification, among other factors, historical data it has compiled indicating an increasing trend in the number of BPT referrals of SVP cases to DMH, as well as an increasing trend in the number of cases subsequently screened by DMH and assigned to its evaluators.

However, more recent caseload data we have reviewed does not justify the administration request. Data available through the end of calendar year 2003 indicates that the number of BPT referrals, as well as the number of SVP cases being referred to evaluators, is declining, not increasing. If current trends continue, the number of SVP evaluations could stay level or even decrease in the budget year. This data is summarized in Figure 1.

Figure 1			
SVP Referrals and Assignments of Evaluations Are Declining			
	2002	2003	Percentage Change
Referrals of SVP cases from BPT	636	558	-12%
Cases referred for evaluation	352	283	-20

Analyst’s Recommendation

Because the most recent caseload data available to us at the time this analysis was prepared does not support the budget projection of increas-

ing workload for SVP evaluations, we recommend that the Legislature reject the \$1.1 million augmentation proposed by the administration for these activities. We will monitor the trend and, if necessary, recommend any necessary further actions in regard to the budget for SVP evaluations at the time of the May Revision.

We view the Governor's proposal to modify state law to remove the present legal requirement that recommitment evaluations automatically occur every two years for SVP cases as an important policy matter for the Legislature to decide. We would note that, under the administration's approach, a person confined as an SVP would continue to have the right to petition each year for his/her release.

If the Legislature does choose to approve the Governor's proposal to eliminate every two-year redetermination of SVP commitments, we would recommend a minor modification. Since DMH has documented savings of about \$1.9 million related to this proposal, we recommend that this slightly smaller reduction amount be adopted by the Legislature. Together with our recommendation on the evaluation caseload request, such an action would result in a net reduction of \$1 million in General Fund expenditures for 2004-05 relative to the amount of funding provided in the Governor's budget plan.

Budget Includes Beds Missing From CDC Budget

The Governor's budget plan includes a \$2 million increase in reimbursements to the Department of Mental Health (DMH) from the California Department of Corrections (CDC) to purchase additional state hospital beds at Atascadero. However, the General Fund resources needed for CDC to purchase these beds have not been included in CDC's 2004-05 budget request. Without prejudice to the possible merit of this proposal, we recommend that this expenditure authority be deleted from the DMH budget until such time as these resources are added to the spending plan for CDC.

Governor's Proposal. The DMH budget plan requests \$2 million in reimbursement expenditure authority to reflect a proposal by CDC to contract for an additional 25 acute psychiatric beds at the Atascadero State Hospital. However, the 2004-05 CDC budget request does not include funding for these additional beds. The administration has indicated that this funding for CDC may be requested at the time of the May Revision.

Analyst's Recommendation. Without prejudice to the possible merit of allowing CDC to obtain additional beds in the DMH hospital system, we recommend that the DMH expenditure authority be deleted because it will not be needed if these resources are not included in the CDC budget for 2004-05. If such a request for General Fund spending is presented by the administration at the time of the May Revision, and if the Legislature determines that the request is justified, reimbursement authority for this purpose could be restored to the DMH budget at that time.

COMMUNITY PROGRAM ISSUES

EPSDT Costs Still Soaring, but Some Progress in Sight

The Governor's budget plan proposes a significant increase in funding for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) specialty mental health services for children and young adults as well as multiple measures to contain the growth in expenditures of the program. Our analysis indicates that, while the program is still growing significantly, recent efforts to slow the growth in EPSDT expenditures appear to be having some effect. We recommend approval of further efforts to contain program costs by (1) adjusting provider rate limits to better reflect the actual cost of delivering EPSDT services, (2) increasing accountability and oversight through additional auditing of program expenditures, and (3) developing a request for a federal waiver to tighten the definition of what services must be provided by the state.

Background

State Provides Broad Range of EPSDT Services. The EPSDT, a federally mandated program, requires states to provide a broad range of screening, diagnosis, and medically necessary treatment services to Medi-Cal beneficiaries under age 21, even if the treatment is an optional service under a state's Medicaid plan. The requirements apply to mental health as well as physical health.

Historically, the state's expenditures for EPSDT mental health services have grown dramatically—as much as 30 percent annually. In an attempt to slow this growth, state program rules were changed to require counties to be financially responsible for a 10 percent share of the nonfederal cost of program growth. Previously, they were obligated to provide a base level of funding, but bore no share of the cost of the growth of the program. In addition, the Legislature adopted statutory language

in 2002-03 directing DMH to assist counties in implementing managed care principles that would help slow the growth in the program.

Governor's Proposed Budget for EPSDT

Increased Funding, but Additional Measures to Reduce Costs. The EPSDT specialty mental health services are budgeted within the DHS budget, and are budgeted as reimbursements in the DMH budget. These services are supported with General Fund and federal funds. As has been the case since the inception of the program, the Governor's spending plan again proposes significant increases in state spending for EPSDT specialty mental health services.

Due mainly to technical adjustments we will discuss in more detail later, the actual amount of state spending for EPSDT specialty mental health services in the current year will be significantly less than the amount appropriated in the *2003-04 Budget Act*. The initial budgeted level was about \$370 million from the General Fund, but this would be adjusted to \$254 million under the Governor's budget plan, primarily to reflect a technical shift made in 2003-04 from accrual to cash accounting.

State support for EPSDT specialty mental health services would grow to \$365 million in 2004-05 under the Governor's budget proposal, an increase of almost \$112 million or 44 percent. This spending level takes into account some significant technical adjustments, but also results from continued increases in caseload and costs in the program. The proposed budget for 2004-05 also reflects anticipated savings from two proposals that are intended to slow the growth of EPSDT expenditures.

Various Adjustments Distort Actual EPSDT Program Growth. A straight comparison of the projected current year and budget year expenditures suggests that program expenditures would grow by 44 percent in one year. However, various technical adjustments to the budget totals create a somewhat misleading picture of how EPSDT expenditures are changing.

The *2003-04 Budget Act* and related legislation shifted the Medi-Cal Program from accrual to cash basis of accounting. The Governor's budget plan would adjust the 2003-04 spending level for EPSDT to put the program on the same accounting basis as the rest of the Medi-Cal Program. This technical change has the effect, on a one-time basis, of reducing the budget for the program in the current year, and making the amount of funding provided for EPSDT services in the budget year look dramatically larger.

Additionally, the 2004-05 budget reflects a change in the share of costs of the Medi-Cal Program that is supported by the federal government. In

2003-04, a congressional fiscal relief package for the states bumped up the share of costs borne by the federal government for Medicaid. This had the effect of reducing the state cost of EPSDT services in the current year. However, the federal relief package is scheduled to expire at the end of 2003-04. The Governor’s budget plan takes into account that the state share of EPSDT program costs will increase in 2004-05 from the current 50 percent to 53.3 percent. This also has the effect of inflating the 2004-05 spending level for EPSDT services.

Absent these changes, the actual program growth would still be significant, about 22 percent, but not nearly as large as the nominal change in the budgeted amounts of 44 percent. Figure 2 shows how state expenditures for EPSDT services would grow if the spending figures were adjusted to exclude the effects of the accounting shifts and the change in the federal share of costs for the program.

Figure 2			
Adjusted EPSDT Funding Growth Less Dramatic Than Budget Figures			
<i>(In Millions)</i>			
	General Fund Budget		Percentage Change
	2003-2004	2004-2005	
Budget Act amounts	\$254	\$365	44%
Actual program spending after adjustments ^a	349	425	22

^a Figures adjusted to (1) compare fiscal years on an accrual basis and (2) to hold federal share of program costs constant.

Governor’s Proposals for Reducing EPSDT Costs

The Governor’s budget plan includes three proposals to reduce costs in the EPSDT program by (1) adjusting (“re-basing”) provider rate limits to better reflect the actual cost of delivering EPSDT services, (2) increasing accountability and oversight through additional auditing of program expenditures, and (3) tightening the definition of what services must be provided by the state

Re-Basing Provider Rate Limits. The budget plan includes a reduction of \$40 million in General Fund support (a \$60 million reduction in all fund sources) from updating provider rates for EPSDT and other men-

tal health services to correspond with current information about the actual cost of providing these services (a process referred to as re-basing). Based on its initial review of more current cost reports, the administration expects that re-basing would reduce the rate limits for all services.

If the Legislature considers approving the administration's estimated \$40 million in General Fund savings from re-basing statewide maximum provider rates, it should recognize that there are some risks associated with this estimate. Currently, the maximum rates established for EPSDT and other mental health services provided by the counties are based on cost information dating back to 1989-90, which has been adjusted for inflation. The state was to have updated these rates at least every three years by using more current cost information, but has not done so.

The administration is proposing that the statewide rates be re-based for the first time since 1993. Its estimate of \$40 million in state savings is based on a preliminary analysis of 2001-02 cost reports. The actual magnitude of the savings, however, is uncertain and will not be known until a consultant to be retained by DMH has completed extensive re-basing calculations.

Additional Auditing. Additionally, the administration's budget plan assumes that the state will achieve savings of \$6.4 million for the General Fund (\$13 million all funds) from conducting additional audits of counties and their contractors who provide mental health services. The budget plan requests an augmentation of \$844,000 in state funds (\$1.7 million all funds) for this monitoring and oversight activity.

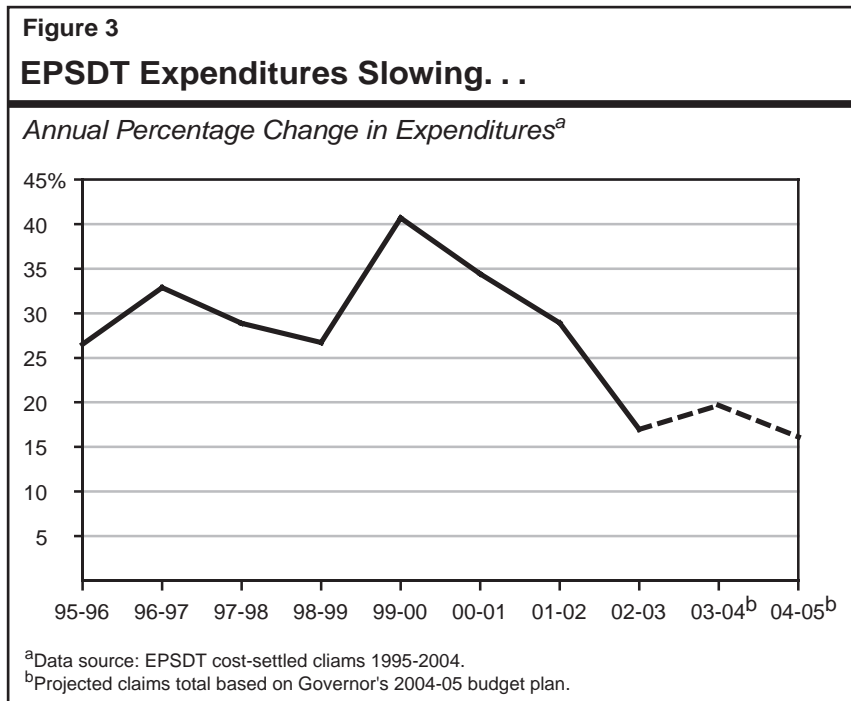
Waiver Proposal. The budget plan also proposes to undertake efforts that are intended to result in additional state savings on EPSDT services beginning in 2005-06. About \$236,000 in state funds (\$472,000 all funds) is requested for additional DMH staff and contract services to develop an application to the federal government for a waiver of federal requirements for EPSDT services. The waiver would not seek to end the provision of such services overall, but would instead allow the state to establish a more formal definition of which EPSDT services were "medically necessary" and therefore necessary to provide to eligible Medi-Cal beneficiaries. Absent such a definition, the administration has indicated, the state is subject to a more vague standard of having to provide any services that "ameliorate" the medical condition of someone with a mental health condition.

Thus far, the administration has not indicated specifically how it would use this more narrow definition of medical necessity to modify the existing EPSDT services to achieve state savings. The administration has proposed that the effort to reform EPSDT be part of a larger federal waiver request to achieve savings in the Medi-Cal Program.

Additional EPSDT Cost-Reduction Efforts Warrant Consideration

Slowing of Expenditures Suggests Progress, but More Effort Needed.

Our analysis indicates that the existing cost containment measures have curbed some of the EPSDT expenditure growth. As can be seen in Figure 3, the rate of growth of state expenditures for EPSDT peaked several years ago and has since begun to decline. This decline suggests that the state is making some progress at containing EPSDT expenditures. However, the total cost of the program continues to grow, as can be seen in Figure 4. Under the Governor's 2004-05 budget proposal, total spending for EPSDT services would surpass \$1 billion once all funding sources for the program have been taken into account.

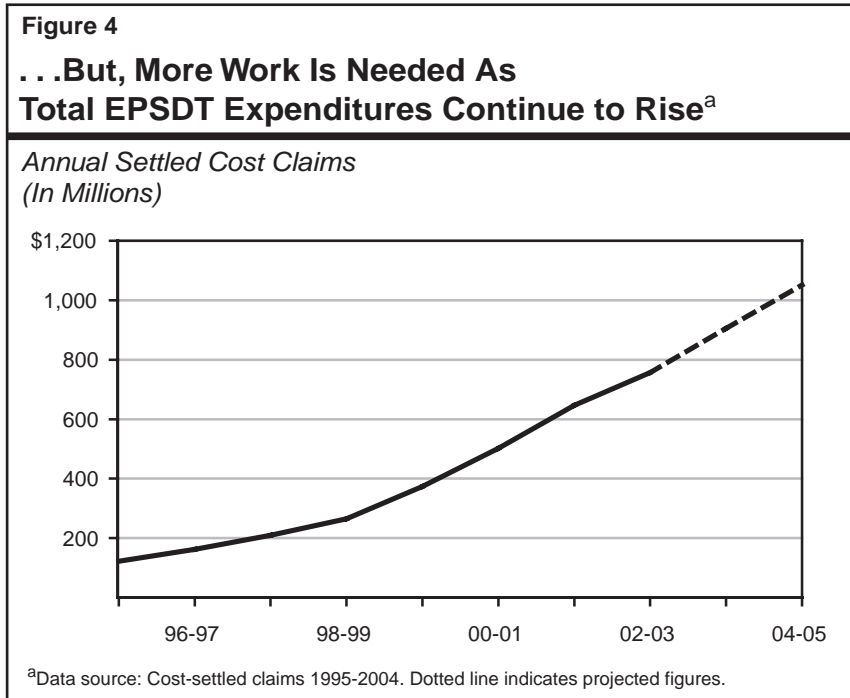


Analyst's Recommendation

We concur with the administration's current estimates of EPSDT expenditures, and recognize that they will be updated by the administration at the time of the May Revision. Given the continuing growth in the cost of EPSDT services, we concur with the administration's request for additional staff and contract funding to initiate steps to rebase provider rates in line with current actual costs, to audit county and contract pro-

viders, and pursue a federal waiver to tighten the definition of what services must be provided.

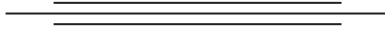
These measures, in our view, would (1) ensure that provider rate limits better reflect actual costs, (2) provide stronger accountability and oversight of EPSDT expenditures at the local level, and (3) promote a more cost-efficient use of state resources only for medically necessary treatment and services.



Additional Federal Funds and State Savings Possible Through Provider Fee Mechanism

The Governor’s budget plan proposes a “quality improvement assessment fee” on Medi-Cal managed care health plans to enable the state to draw down additional federal funds for support of the program. We recommend the Legislature explore the feasibility of establishing such fees for mental health managed care plans to draw down additional federal funds, result in a net financial gain of up to \$70 million annually for the state, and provide as much as \$23 million in additional funding for mental health care programs.

We discuss our proposal to assess a “quality improvement fee” for mental health managed care plans in the “Crosscutting Issues” section of this chapter.



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 Governor's budget proposes expenditures totaling \$1.3 billion from all funds for support of DCSS in the budget year. This is an increase of 3.5 percent over 2003-04. The budget proposes \$499 million from the General Fund for 2004-05, which is an increase of \$30.5 million, or 6.5 percent, compared to 2003-04. Most of the increase is attributable to an estimated increase in the federal penalty and increased expenditures for the California Child Support Automation System (CCSAS).

UPDATE ON REQUIRED BUDGET AND ALLOCATION METHODOLOGY IMPROVEMENTS

In the *2003-04 Budget Act*, DCSS was required to begin making improvements on its county allocation formulas, and its budget methodology and budget display. Since that time, the department has made some progress.

Allocation Workgroup. In the fall of 2003, DCSS convened a large group of stakeholders to examine the current county allocation methodology and recommend changes that would more clearly meet the funding requirements of the counties. As part of the work for those meetings, DCSS undertook a substantial statistical review of the performance and collections data available for each county. Through this review, DCSS was able to connect county performance on some outcome measures to the level of funding provided to counties. They were also able to tie expected

amounts of child support collections to the level of funding available to administer the program.

Next Steps for Allocation Workgroup. At the time this analysis was prepared, DCSS was working on a final allocation methodology, which would tie county performance on state and federal outcome measures to the amount of funding allocated for their local programs. We recommend that DCSS report at hearings on the status of this effort.

Improving Budget Display. The DCSS was also required to begin work on improving the information provided in its budget documents and improving the methods used to build its budget. The child support budget display for 2004-05 shows significant improvement in terms of the information provided. The department has included auxiliary documents in its budget information, which summarize the amount of the federal child support penalty over time, and which illustrate the spending and collection trends over the last three years. Perhaps more significantly, DCSS's budget tables are beginning to display the detailed funding changes for the program in a clear way. In prior years, all administrative costs were included in one basic line; there was no way to determine which aspects of the program were being augmented or reduced in the budgets proposed by the administration for DCSS. However, in the current budget, changes are being clearly displayed. For example, the amounts budgeted for implementing the new collections enhancements are clearly separated from the basic cost of running the program. Similarly, anticipated collections associated with this enhancement are also displayed separately.

GOVERNOR'S BUDGET PROPOSES KEEPING COUNTY SHARE OF CHILD SUPPORT COLLECTIONS

The Governor's budget proposes that counties give up their current 2.5 percent share of assistance collections. This increases General Fund revenues by \$39 million and potentially creates a further disincentive for counties to invest in collecting child support payments for families. We recommend allowing those counties that meet state and federal performance measures to keep their share of the assistance collections.

Background. Most child support collections are paid to the custodial parent. However, a portion of the child support dollars collected by the counties are used to pay back the state, federal, and local governments for the cost of grants provided under the California Work Opportunity and Responsibility to Kids (CalWORKs) and the Foster Care programs. (These grants were paid on behalf of the children whose noncustodial parents are now paying child support.) These are known as assistance

collections. Under current law, 50 percent of those funds are returned to the federal government, 47.5 percent constitute state General Fund revenue, and the remaining 2.5 percent reimburse the counties for their share of the CalWORKS grants. A small portion of the assistance collections reimburse foster care expenses. That sharing ratio is slightly different.

Governor's Budget Proposal. The Governor's budget proposes that the state retain \$39 million in collections that constitutes the counties' share of assistance collections and use it as state General Fund revenue. Along with this \$39 million, the Governor's budget also proposes that counties continue to pay 25 percent of the federal child support automation penalty. The estimated county share of the penalty is \$55 million for 2004-05. Other than this share of the penalty, there is no county share in the child support program.

Analyst's Recommendation. The child support program is driven in large part by state and federal performance measures. States receive federal incentive funds based on their ability to achieve the federal performance measures, and may be penalized for repeated failure of certain measures. Because of the existence of these measurements, we recommend that the Governor's proposal to keep the county share of collections be modified into an incentive for the counties to improve their performance. Under our recommendation, counties that meet all of the established performance measures would be allowed to retain their share of the assistance collections.

Our analysis indicates that based upon current federal performance measures, about 50 percent of the counties have met or exceeded the state-wide average for performance and would therefore be able to retain their share of assistance collections. However, none of the six largest counties is among that group. Adopting this recommendation would reduce General Fund revenue by \$12.4 million in 2004-05. However, by providing the counties with a better performance incentive, it should result in more federal incentive funds coming to the state, which will in part offset the loss of General Fund revenues. Further, stronger county performance should help assure that the state will avoid future federal penalties.

WITHHOLD RECOMMENDATION ON CHILD SUPPORT COLLECTIONS

We withhold recommendation on estimated child support collections pending the release of the Governor's May Revision because the estimate of collections may be overstated based upon the department's new method of projecting collections.

The DCSS has developed a new methodology for estimating the amount of dollars that can be collected based upon the amount of money invested in the program. However, the Governor's budget does not reflect this relationship. Based upon the department's new estimating methodology, the collection estimates may be overstated. This is because the increase in the collections estimate is not proportional to the amount of administrative funding proposed. We therefore withhold recommendation on the budget's estimate of assistance and nonassistance child support collections pending review of the Governor's May Revision estimates.

CALIFORNIA'S CHILD SUPPORT AUTOMATION SYSTEM

Federal law requires states to develop statewide child support automation systems. The CCSAS project is intended to be California's federally required child support system. The CCSAS project is currently estimated to cost \$1.3 billion (\$869 million federal funds and \$459 million General Fund) over ten years. Of these costs, \$801 million is for a contractor to develop and maintain the system with the remainder for associated state costs. The CCSAS project consists of two phases: (1) Phase I, which will provide a centralized data base and reporting system and (2) Phase II, which will provide a statewide child support enforcement system. The state began developing Phase I of the project in 2003.

Project Background

Federal Penalty. Federal law requires states to have completed the development and implementation of statewide child support systems by 1997. Since California did not complete its system by that time, the federal government reduces, in the form of penalties, its share of the costs for administering the state's child support program. Through 2002-03, the state incurred penalties totaling approximately \$562 million. The penalties for the current and budget years are expected to be \$195 million and \$220 million, respectively. Thus, through the budget year, federal penalties will have totaled almost \$1 billion. When CCSAS is fully implemented in 2008, the federal penalties should be eliminated.

State Law Requires Franchise Tax Board (FTB) to Manage Project. Chapter 479, Statutes of 1999 (AB 150, Aroner), requires the FTB to act as the agent for DCSS to procure, develop, implement, and maintain the new statewide system. In 1999, the Legislature required FTB to manage the project because (1) FTB had experience procuring and managing large information technology (IT) projects and (2) DCSS would be focusing on

implementing the state's newly reformed child support program. The FTB and DCSS staff assigned to CCSAS work together in the same DCSS office building.

State's Child Support Program Implemented. Chapter 479 created DCSS as a separate department responsible for the state's child support enforcement program. In addition, administrative responsibility at the local level shifted from county district attorneys to new separate county agencies. The local transition was completed in 2003.

Potential for Improved Accountability

Transferring the California Child Support Automation System from the Franchise Tax Board to the Department of Child Support Services would increase accountability for the project's success. We recommend that the administration report on potential problems and anticipated savings from implementing this option.

Below, we discuss the option of transferring the CCSAS project (including its project management structure) from FTB to DCSS. Such a transfer would offer potential programmatic benefits to both DCSS and FTB. As noted below, a transfer could also offer the opportunity for some budget savings.

Areas of Potential Benefits and Savings

Increase DCSS Accountability. The responsibility for success of the CCSAS project is currently shared between FTB and DCSS. The FTB is responsible for the project's technical and management success and DCSS is responsible for the project's program success. Yet, it is difficult to tell where one area of responsibility ends and another area begins. For example, it will be difficult to determine if any problems are due to complex state program requirements or technical problems in the software. By having only DCSS responsible for the success of the CCSAS project, the Legislature can hold DCSS accountable for any problems that the project may experience. Also, by having only one department responsible for CCSAS, it eliminates possible "finger pointing" between the two departments.

Reduce Project Staff. Since the CCSAS project is shared by two departments, both FTB and DCSS have staff dedicated to the project. For the current year, FTB has 113 staff and DCSS has 58 staff approved to work on the project. From a recent FTB analysis of the CCSAS workload, it appears that some of the DCSS and FTB staff are performing similar and possibly duplicative project tasks. For example, during the project's

design phase, both departments have staff reviewing and analyzing requirements for the system. The only difference in their tasks appears to be that FTB staff *recommends* and DCSS staff *approves* requirements. In most state IT projects, there is no difference between these two tasks. As long as the two departments share responsibility for the project, blurred lines of responsibility are going to result in duplication of effort. If, however, only one department was responsible for the project, workload could be reexamined to increase efficiencies and reduce duplicative staff assignments.

Eliminate Coordination Activities. Both FTB and DCSS have staff coordinating activities between the two departments. For example, FTB staff must keep DCSS staff informed of any budget requests that FTB needs to support the project. After FTB has prepared the request, then DCSS staff must review the request for fund availability and consistency with federal funding requirements. In addition, both FTB and DCSS have staff coordinating technical aspects of the project, such as converting data from the old systems. If the project were transferred to DCSS, these types of coordination activities could be eliminated.

Allow FTB to Focus on Revenue Collections. The FTB's primary responsibility is to administer and collect revenues from the personal income and corporation taxes. The FTB is *not* the state's child support enforcement agency nor does it have any unusual expertise in this program area. To ensure CCSAS project success, FTB's management has had to devote some of its time to the project. By transferring the CCSAS project to DCSS, FTB's management could refocus on its primary mission of administering and collecting taxes.

Transferred CCSAS Project Must Include Current Staff and Project Management

In our view, if the Legislature were to transfer the project, any transfer must include the current FTB project staff and the project management structures that FTB has developed and implemented. One of the reasons that the Legislature designated FTB as the CCSAS project manager was FTB's experience at managing large IT projects and its use of "best practices" in managing and implementing automation efforts. The FTB has attempted to implement those same best practices in the contract and risk management on the CCSAS project. Given that the state's child support program is now established and the CCSAS procurement is complete, FTB has already contributed most of the advantages originally sought by the Legislature in designating FTB as the project leader. Transferring the project should not mean losing the staff experience and management techniques already implemented. Since FTB project staff is

already colocated with DCSS, the FTB staff could be easily integrated into DCSS and its management structure.

Administration Should Report on Project Transfer

Given that the CCSAS project is the state's largest and most complex state IT project, there is some risk in transferring the system. We believe some of this risk would be minimized if the same project staff and best practices are transferred with the project. We do, however, recommend that the Legislature direct FTB and DCSS to analyze the transfer option and report at budget hearings on potential problems or project disruptions that could occur as a result of such a transfer. In addition, we recommend that DCSS analyze the CCSAS workload and report at budget hearings on the potential savings that could be achieved as a result of the transfer.

DEPARTMENT OF SOCIAL SERVICES CALWORKS PROGRAM (5180)

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

The budget proposes an appropriation of \$4.9 billion (\$2 billion General Fund, \$147 million county funds, \$56 million from the Employment Training Fund, and \$2.7 billion federal funds), to the Department of Social Services (DSS) for the CalWORKs program in 2004-05. In total funds, this is a decrease of \$555 million, or 10 percent, compared to estimated spending of \$5.4 billion in 2003-04. This decrease is primarily attributable to savings from (1) a proposed 5 percent maximum grant reduction, (2) proposed changes in work participation and sanction policies, (3) savings from adults reaching their 60 month CalWORKs time limit, and (4) savings from proposed child care reforms.

We note that Congress extended funding for the Temporary Assistance for Needy Families (TANF) block grant through March 31, 2004. The Governor's budget assumes TANF funding will eventually be extended or reauthorized at current funding levels (\$3.7 billion annually for California) at least through state fiscal year 2004-05.

CASELOAD AND GRANTS

Caseload Decline Ends

The California Work Opportunity and Responsibility to Kids caseload has declined significantly since 1994-95. Recent caseload trend data suggest that, absent any policy changes, the caseload would increase by about 1 percent in the budget year. However, the administration estimates that implementation of the Governor's proposed policy changes would result in a 1.3 percent decrease in caseload which would more than offset this baseline 1 percent increase.

Caseload Levels in the Budget Year. Actual caseload data shows that the CalWORKs caseload has declined every year from 1994-95, when caseloads reached their peak, through 2002-03. Since October 2002, the caseload has been relatively flat. Absent any changes to the CalWORKs program, the administration projects that the caseload would increase by about 1 percent in the budget year. However, the Governor's budget anticipates that the caseload will decrease by about 1.3 percent from what it would have otherwise been in the budget year as a result of proposed program changes.

Figure 1 (see next page) compares the administration's current law caseload projections with the caseload that would result under the proposed policy changes. Under current law, the average monthly caseload would be expected to increase slightly in the current and budget years. However, the administration's proposed policy changes are estimated to remove 6,363 cases (1.3 percent) from the caseload by 2004-05.

The caseload reduction is primarily attributable to a proposed 5 percent grant reduction. The proposed grant reduction will eliminate eligibility for about 6,000 average monthly cases in the budget year because lowering the grant levels has the effect of lowering the income threshold at which working families become income-ineligible for cash assistance. As a result, families with relatively high earnings would no longer be eligible and would lose aid.

Child-Only Cases Increasing, While Cases With Adults Continues to Decrease. While the total caseload is projected to remain relatively flat, the composition of the caseload is changing. Under CalWORKs, adults are generally limited to 60 months of cash assistance. Adults began reaching the time limit in January 2003. When a family reaches the time limit, the adult is removed from the assistance unit and the case becomes a child-only case. Caseload trends reflect this shift. The budget estimates that by June 2005, about 57,000 families will have reached the time limit, and be in the safety net.

Figure 1
Projected Average Monthly Caseload^a

	Caseload		
	Actual 2002-03	Estimated 2003-04	Projected 2004-05
Caseload: Current Law	482,736	476,937 ^b	475,175 ^b
Impact of policy changes:			
5 percent grant reduction		-1,531 ^c	-6,059
Work participation reforms		—	-265
Child Support Assurance Project		—	-39
Total Impact		-1,531	-6,363
Percent Change From Current Law Caseload:			
With Governor's Policy Proposals	482,736	475,406	468,813

^a Figures represent average annualized monthly impact.
^b Includes previous policy changes.
^c Reduction only applied to April, May, and June.
^d Numbers may not add due to rounding.

Conclusion. The administration’s monthly caseload projection is consistent with our review of the most recent actual caseload data. 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 Adjustments and Reduces Grant Payments

The Governor’s budget proposes to (1) reduce grant payments by 5 percent and (2) suspend both the October 2003 and July 2004 cost-of-living adjustments. Compared to current law, these proposals result in estimated state savings of \$135 million in 2003-04 and \$408 million in 2004-05.

Cost-of-Living Adjustment (COLA) Suspensions. State law requires that CalWORKs recipients receive a COLA equal to the percent change in the California Necessities Index. The Governor’s budget proposes to suspend the July 2004 statutory COLA, and assumes that the October 2003 COLA will not be granted.

Figure 2 shows the savings in the current and budget years as a result of the proposed grant reductions. Not providing the October COLA results in savings of \$91 million in 2003-04 and \$126 million in 2004-05, compared to current law. Suspending the July 2004 COLA results in additional savings of \$105 million in 2004-05. These savings estimates assume that the October 2003 COLA is required by law. We note, however, that the administration believes that the October 2003 COLA is not part of current law and is arguing the issue in court.

Figure 2		
CalWORKs Savings From Governor's Grant Reduction Proposals		
<i>(In Millions)</i>		
Proposal	2003-04	2004-05
Assume no October 2003 COLA	\$91	\$126
Delete July 2004 COLA ^a	—	105
Reduce grants by 5 percent	44	177
Totals^b	\$135	\$408

^a Savings assume implementation of October 2003 COLA.
^b Detail may not total due to rounding.

CalWORKs COLAs and the Vehicle License Fee (VLF). The state law enacting a VLF rate reduction beginning in 1999 included an accompanying provision stating that from 2000-01 through 2003-04, CalWORKs COLAs would be granted only in fiscal years in which VLF tax relief is granted. In June 2003, the Director of Finance determined that there would be a rate increase for VLF payments due on or after October 1, 2003. Because this tax relief was eliminated, the CalWORKs October 2003 COLA (for 2003-04) was suspended. However, in November 2003, the new administration rolled back the VLF tax rate increase, thereby triggering tax relief and an assumed requirement to provide the October CalWORKs COLA. As noted above, the administration contends that the October 2003 CalWORKs COLA is not required by current law, arguing that the previous administration's action to increase the VLF was not legal, and that in accordance with the statute, no COLA is required since there was no increase in tax relief. At the time this analysis was prepared, the issue was being litigated. Until this issue is resolved by the courts, we assume throughout this analysis that granting the October 2003 COLA is

part of current law. Finally, we note that the October 2003 COLA has thus far not been included in recipients' grant payments.

Grant Reduction. In addition to the COLA suspensions, the Governor proposes to reduce the maximum monthly aid payment by 5 percent, effective April 1, 2004. As shown in Figure 2, compared to current law, this reduction results in state savings of \$44 million in the current year and \$177 million in the budget year. The reduction also results in a caseload decline of about 6,000 cases effective April 2004. As discussed previously, lowering the maximum aid payment levels has the effect of lowering the income threshold at which working families become income-eligible for cash assistance. As a result, families currently receiving a small grant would no longer be eligible for CalWORKs and would lose aid.

Figure 3 shows the maximum CalWORKs grant and food stamps benefits for a family of three under current law, and what the maximum grant and benefits would be under the Governor's reduction proposals.

Figure 3			
CalWORKs Maximum Monthly Grant and Food Stamps			
Current Law and Governor's Proposal			
<i>Family of Three</i>			
<i>2004-05</i>			
	CalWORKs Grant	Food Stamps	Totals
High-Cost Counties			
Current grant: includes June 2003 COLA	\$704	\$301	\$1,005
With October 2003 COLA ^a	728	290	1,018
Current law (2004-05): October 2003 and July 2004 COLAs	749	281	1,030
Governor's proposal: deletes October 2003 COLA and July 2004 COLA, and reduces grants by 5 percent	\$669	\$317	\$986
Change From Current Law	-\$80	-\$36	-\$44
Low-Cost Counties			
Current grant: includes June 2003 COLA	\$671	\$316	\$987
With October 2003 COLA ^a	694	305	999
Current law (2004-05): October 2003 and July 2004 COLAs	713	297	1,010
Governor's proposal: deletes October 2003 COLA and July 2004 COLA, and reduces grants by 5 percent	\$637	\$331	\$968
Change From Current Law	-\$76	-\$34	-\$42
^a October COLA has not been implemented.			

As the figure shows, under the Governor's proposals, in 2004-05 the maximum CalWORKs grant for a family of three in a high-cost county would be \$669, compared to \$749 under current law. The maximum CalWORKs grant for a family of three in a low-cost county would be \$637 under the Governor's proposals, compared to \$713 under current law.

As a point of reference, the federal poverty guideline for 2003 (the latest reported figure) for a family of three is \$1,271 per month. (Federal poverty guidelines are adjusted annually for inflation.) Under current law, the combined maximum CalWORKs grant and food stamps benefits in high-cost counties is \$1,030 per month (81 percent of the poverty guideline). Under the Governor's proposals, combined benefits in high-cost counties would instead be \$986 per month (78 percent of poverty guideline). Combined benefits in low-cost counties would be \$1,010 per month (79 percent of poverty guideline) under current law, compared to \$968 (76 percent of poverty) under the Governor's proposals.

EXPANDING TANF TRANSFERS RESULTS IN GENERAL FUND SAVINGS

State Spending Budgeted at TANF Maintenance-of-Effort (MOE) Floor

The Governor's budget proposes to (1) spend the minimum amount of General Fund monies needed to meet the MOE spending requirement for the CalWORKs program and (2) maintain a \$160 million TANF reserve. Because of the MOE requirement, any net augmentation to the Governor's spending plan would deplete the TANF reserve amount, and/or result in General Fund costs. Any net reduction in program spending will generally result in TANF savings, not General Fund savings because the budget proposes spending at the MOE minimum.

TANF MOE Requirement. To receive the federal TANF block grant, states must meet an MOE requirement that state spending on assistance for needy families be at least 75 percent of the federal fiscal year (FFY) 1994 level, which is \$2.7 billion for California. (The requirement increases to 80 percent if the state fails to comply with federal work participation requirements.) Although the MOE requirement is primarily met through state and county spending on CalWORKs and other programs administered by DSS, state spending in other departments is also used to satisfy the requirement. The Governor's budget includes \$468 million in countable MOE expenditures outside of the CalWORKs program in the budget year.

Effect of Spending Changes. If spending is augmented for CalWORKs above what is proposed in the Governor's budget, it would reduce the budgeted \$160 million TANF reserve and/or decrease the amount of TANF funds that would be available for new transfers outside of the CalWORKs program. Reducing the amount of new transfers would result in additional General Fund spending in the programs that were to receive the TANF transfers absent other budget actions by the Legislature. If CalWORKs spending is augmented beyond the Governor's proposal so that both the reserve and the TANF grant have been exhausted, General Fund spending would need to increase above the MOE floor.

TANF Transfers

The Governor's budget achieves General Fund savings by increasing Temporary Assistance for Needy Families (TANF) transfers to the Title XX Social Services Block Grant (Title XX) by \$41 million in the current year and \$120 million in the budget year. The transferred TANF would be used to offset General Fund costs in In-Home Supportive Services (IHSS), Child Welfare Services (CWS), the Department of Developmental Services (DDS), and Foster Care.

Budget Increases TANF Transfers to Title XX to Achieve General Fund Savings. The Governor's budget proposes a series of TANF expenditure reductions discussed in more detail elsewhere in this analysis, which (1) enable CalWORKs spending to stay at the MOE floor, (2) generates funds for new TANF transfers, and (3) provides a \$160 million TANF reserve. For 2004-05, the budget proposes \$120 million in new TANF transfers outside of the program for the purpose of offsetting General Fund spending. Figure 4 shows the amount of the proposed transfers and General Fund offset by department and program. Specifically, the budget increases TANF transfers to the Title XX Social Services Block Grant by \$41 million in the current year and \$120 million in the budget year. The Title XX funds are then used to offset General Fund costs in In-Home Supportive Services, Child Welfare Services, DDS, and Foster Care.

Based on preliminary information from the administration about the proposal, it appears that the proposed fund transfers are viable options for achieving General Fund savings. (Please see the DDS section of this chapter for a more detailed discussion of implementation issues associated with the proposed transfer.) The federal TANF block grant provisions allow the state to transfer up to 10 percent of its TANF funds to Title XX. The transferred TANF funds must be spent on children or their families with incomes under 200 percent of the federal poverty level. Once transferred, the funds may be used to support any programs that meet the stated Title XX goals, including, achieving economic self-sufficiency,

preventing abuse or neglect, enabling families to stay together, and preventing inappropriate institutional care.

As noted, the new TANF transfers are designed to achieve General Fund savings. Rejecting the TANF transfers would not change the CalWORKs program or the programs to which the funds are transferred absent other policy decisions. Rejecting the transfers would make more resources available for the CalWORKs program, but would result in General Fund costs elsewhere.

Figure 4		
Governor's Proposed New TANF Transfers to Achieve General Fund Savings		
<i>(In Millions)</i>		
	Current Year	Budget Year
Department of Social Services		
In-Home Supportive Services	\$41	—
Child Welfare Services	—	\$16
Foster Care	—	56
Department of Developmental Services		
Community Services Program	—	\$48
Totals	\$41	\$120

BUDGET PROPOSES SIGNIFICANT CALWORKS REFORMS

The Governor’s budget proposes a number of changes to the CalWORKs program, including stricter work requirements and greater sanctions. These program reforms would result in \$167 million in grant savings, partially offset by \$134 million in child care costs and \$2.5 million in automation costs in 2004-05. We discuss welfare reform in California, summarize the Governor’s reform proposals, present a framework for considering the proposals, and offer comments and recommendations.

Welfare Reform in California

The 1996 Federal Welfare Reform Legislation. The 1996 federal welfare reform law ended the individual entitlement to welfare and replaced

it with a block grant (\$3.7 billion annually for California) that gives states significant programmatic flexibility. To receive the block grant, states must meet an MOE requirement that state spending on welfare for needy families be at least 75 percent of the federal fiscal year FFY 94 level, which is \$2.7 billion for California (80 percent, or \$2.9 billion, if the state fails to meet the federal work participation requirement). Federal law holds states accountable for moving families from welfare to work by requiring states to meet statewide work participation rates of 50 percent for all families and 90 percent for two-parent families. Federal law allows states to reduce their required participation rate by applying a caseload reduction credit, which is based on caseload decline since FFY 1995. Failure to meet federal work participation requirements results in a penalty equal to 5 percent of a state's TANF block grant, which would be \$370 million for California. Federal penalties may increase if the state continues to fail to meet participation rates in successive years. Finally, the federal welfare reform legislation set a five-year lifetime limit on an individual's receipt of federally-funded welfare grants or services. The law permits states to exempt up to 20 percent of its cases from the time-limit for reasons of hardship.

CalWORKs Participation and Time Limits. California implemented federal welfare reform by enacting the CalWORKs program. The CalWORKs program requires that adults in single-parent families participate in work or approved education or training activities for 32 hours each week. Two-parent families must participate at least 35 hours a week, with one adult working at least 20 hours. This emphasis on helping people become employed as quickly as possible is often referred to as a "work-first" approach. Noncompliance with participation requirements results in a sanction equal to the amount of the adult portion of the grant. In this situation, the adult is removed from the case, the grant is reduced by the adult portion, and the case becomes a "child-only" case. The CalWORKs program also imposes a time limit on adults. After five cumulative years on aid, a family's grant is reduced by the adult's portion and the case becomes a child-only "safety-net" case.

County Control and Flexibility. Counties have broad flexibility in the design and implementation of the CalWORKs program, including administration, employment services, and child care. Each county has a county-designed CalWORKs plan and is responsible for moving CalWORKs recipients into program participation. Counties also share in 50 percent of any financial penalties the federal government assesses for not meeting federal TANF work participation requirements.

CalWORKs Outcomes. California has met federal work participation requirements each year since CalWORKs was implemented, thus avoiding federal penalties. We note that the state's required participation

rate is significantly reduced by the federal caseload reduction credit. Because California has experienced a significant caseload decline since FFY 1995, the caseload reduction credit reduces the statutorily required level of participation from 50 percent to less than 10 percent. For FFY 2002, California's actual participation rate was 27 percent, which was above the state's FFY 2002 required federal participation level of about 7 percent.

While California has met the federally required participation rate, and increased the number of people working, the overall percentage of adults who are meeting their CalWORKs participation requirements is much lower than one might expect given the work-first approach envisioned in the CalWORKs statute. Figure 5 summarizes the status of work participation in the CalWORKs program. Of particular concern are the 55,500 cases that are neither working, participating in any welfare-to-work activities, nor in sanction or pending sanction status. This 55,500 represents nearly 20 percent of all cases with adults and 28 percent of all cases subject to participation. We refer to these cases as "disengaged."

Figure 5 CalWORKs Participation Status Cases With Adults^a		
	Cases	Percent of Cases Required to Participate
Cases Generally Not Expected to Participate		
Exempt or pending sanction	66,791	NA
On-aid less than two months	21,155	NA
Subtotal	(87,946)	NA
Cases Subject to Participation		
In sanction	50,738	26%
Working:		
More than 20 hours/week	22,920	12
Less than 20 hours/week	51,062	26
Not Working:		
Meeting participation	18,496	9
No participation	55,486	28
Subtotal	(198,702)	(100.0%)^b
Total Cases With Adults	286,648	

^a Based on the Department of Social Services' 2003 Survey Data.
^b Detail may not total due to rounding.

We note that some of these disengaged cases may in fact be complying with program requirements, but are in between activities. Figure 5 also shows that an additional 18,500 cases are not working, but are meeting program requirements through other activities, such as vocational training or substance abuse treatment. (For more information on the disengaged, please see our discussion of CalWORKs participation in the *2002-03 Budget: Perspectives and Issues*.)

As Figure 5 shows, three-quarters (75 percent) of the cases that are expected to participate are working less than 20 hours per week. About 26 percent are working, but less than 20 hours; 28 percent are disengaged from program participation; and 26 percent are in sanction status. These low participation rates are of concern for two primary reasons. First, failure to meet new higher federal participation rates (please see our discussion on federal welfare reauthorization later in this section) could lead to a significant federal financial penalty. Second, low engagement with program activities indicates that some adults who are facing the five-year lifetime limit on cash assistance may not be receiving the services they need to become self-sufficient as quickly as possible.

Framework for Evaluating the Governor's Proposals

The Governor proposes broad reforms to the California Work Opportunity and Responsibility to Kids program designed to increase program participation. In order to assist the Legislature in evaluating these proposals, we summarize the Governor's approach, and offer a framework for assessing specific aspects of the proposal.

The Governor's Approach to CalWORKs Reform. Figure 6 summarizes the Governor's proposals compared to current law. As the figure shows, the Governor's budget includes significant changes to fundamental components of the CalWORKs program. Specifically, the Governor's proposal includes a 25 percent grant reduction (beyond the current law reduction) for families in sanction status more than one month and for nonworking families in which the adult has reached the CalWORKs time limit. The Governor's proposal also narrows the activities that would count towards meeting the first 20 hours of the individual participation requirement. In addition, the Governor proposes to require job search while applications are pending and to require all nonworking cases to have a welfare-to-work plan within 60 days of receiving aid. The administration estimates that these program reforms would result in \$167 million in savings, offset by \$136 million in child care and automation costs in the budget year, for a net savings of about \$31 million.

Figure 6 CalWORKs Current Law vs. Governor's Proposals	
Current Law	Governor's Proposal
Job Search	
Four weeks of job search allowed after aid is granted, unless county determines additional job search is needed.	Requires all applicants to participate in job search while applications for aid are pending.
Welfare-to-Work Plan	
Counties must complete welfare-to-work plan after job search.	Requires all aided adults not meeting work requirements to complete and sign a welfare-to-work plan within 60 days of the receipt of aid.
Allowable Participation Activities	
Counties have broad flexibility in determining participation activities for up to two years.	Requires all nonexempt recipients to engage in 20 hours per week of more narrowly defined "core" work activities within 60 days of entering program.
Sanctioned Case Grant	
Removes the adult portion from the grant.	Reduces grant for cases that have been in sanction status for more than one month by an additional 25 percent.
Safety-Net Case Grant	
Removes the adult who has reached the time limit from the grant.	Reduces grant for safety-net cases with a nonworking adult by an additional 25 percent.

In presenting his proposals, the Governor has offered several reasons why these changes are needed, including (1) increasing work participation and personal responsibility, (2) anticipation of federal welfare reauthorization reforms, and (3) prioritizing funding for core services. In evaluating the Governor's proposals, we believe the Legislature should consider pending federal welfare reform, and how the proposal impacts county flexibility, work incentives and participation, and the state budget.

How Does the Proposal Address Pending Federal Welfare Reform Reauthorization? The 1996 federal welfare reform law authorized the TANF block grant through September 2002. Congress was unable to pass a reauthorization bill before September 2002, and the program is now

being funded through a continuing resolution, which maintains current TANF funding, rules, and regulations through March 31, 2004.

In February 2003, The House passed H.R. 4, its version of TANF reauthorization. In September 2003, the Senate Finance Committee passed its version of H.R. 4, but the full Senate has yet to act on reauthorization legislation. Both the Senate and House versions of reauthorization contain provisions that require stricter work requirements, including a requirement that recipients participate in a minimum number of “core work activities.” Both bills also incrementally increase minimum state participation rates to 70 percent with varying participation credits. If finally adopted by Congress, and taking into account the participation credit, it appears likely that California would ultimately need to reach a work participation rate of at least 50 percent. (Please see our overview of federal welfare reauthorization later in this section.)

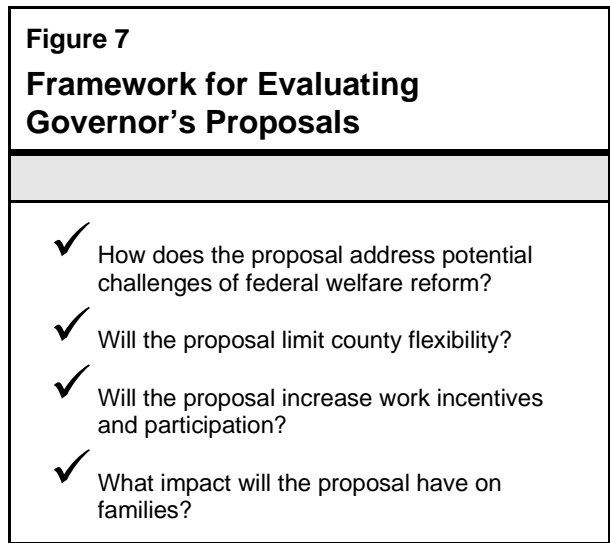
Will the Proposal Limit County Flexibility? When the Legislature created the CalWORKs program, it gave the counties broad programmatic flexibility. The program was designed to allow counties to provide a broad array of welfare-to-work service options in order to help recipients become self-sufficient and to meet federal participation requirements. In considering the Governor’s proposals, the Legislature should determine whether proposed reductions in county flexibility will help achieve statewide program goals.

Will the Proposal Increase Work Incentives and Participation? Moving families into stable employment is a principle goal of the CalWORKs program. The Governor’s proposed policy changes put an even greater emphasis on moving participants into work quickly. The Legislature should consider the extent to which each proposed policy change is likely to increase employment and participation as well as the policy’s impact on the long-term goals of self-sufficiency.

What Impact Does the Proposal Have on Families? The administration’s proposals may result in negative consequences for some CalWORKs families and positive outcomes for others. Designing effective welfare-to-work strategies is difficult because policies can simultaneously have positive and negative impacts on families. For example a sanction for failure to participate should have the positive effect of improving work participation, by presenting families with a negative consequence if they choose not to participate. On the other hand, those families unable or unwilling to comply with a participation requirement will face a reduction in family income, with potential adverse consequences for the children in such a family. The Legislature should consider both the positive impacts of moving families into employment and the potential hardships that grant reductions could have on families.

What Is the Fiscal Impact of the Proposals. The administration estimates that the Governor’s CalWORKs reform proposals would decrease grant costs by \$167 million and increase child care and automation costs by an estimated \$136 million, for a net savings of about \$31 million in 2004-05. Net savings are estimated to increase to about \$90 million in 2005-06. Given the state’s difficult fiscal situation, we believe the Legislature should weigh the state fiscal effects of each proposal against the impact on counties, families, and children.

Our framework is summarized in Figure 7. Below we discuss each of the Governor’s proposals using this framework. We begin by reviewing the Governor’s proposed work participation reforms and then discuss the proposed sanctions.



Work Participation Reforms

In the area of work participation, the Governor proposes (1) requiring an up-front job search while applications are pending, (2) requiring aided adults to sign a welfare-to-work plan within 60 days of the receipt of aid, and (3) limiting the activities that count as participation. Below we review the Governor’s proposals and offer comments and recommendations.

Proposal Requires Job Search While CalWORKs Application Is Pending

The Governor's budget proposes to require applicants to search for a job while their application for California Work Opportunity and Responsibility to Kids aid is pending. Although counties would have broad flexibility in determining job search requirements and verification, this up-front job search would be mandatory for all applicants. We recommend that the Legislature ensure county programmatic and fiscal flexibility by making the policy to require job search as a condition of eligibility, a county option.

Governor's Proposal. Current law prohibits counties from requiring an up-front job search while applications are pending. The administration proposes requiring individuals to participate in job search while their CalWORKs application is pending. The administration has indicated that under the proposal, counties will have broad flexibility in determining the number of hours of job search required, type of search, and required verification. Child care and transportation would be provided to applicants while they are searching for a job.

Proposal May Help to Increase Participation. The extent to which the Governor's proposal helps to increase work participation will largely depend on county policy design and implementation. Requiring job search may, among other things, serve to clearly outline the work-first expectation to participants as they enter the CalWORKs program. We note that such high expectations could also be instilled with an up-front program expectations orientation, as is the practice in Riverside County.

Research Shows Programs Which Include Flexibility in Determining Initial Activities Are the Most Successful. There has been continued debate about the most effective way to help welfare recipients move from welfare to stable employment. Some welfare programs emphasize employment services, while others focus on providing education and training. A 2001 study done by the Manpower Demonstration Research Corporation (MDRC) found that welfare programs that offered a mix of work first for some recipients, and education and training for others were the most successful. This research points to the importance of allowing counties to maintain the flexibility to decide on the best course of action for recipients.

Proposal May Lead to Additional County Costs. The administration's proposal could increase county costs for child care, transportation, and administration. The most recent data show that over 50 percent of all CalWORKs applications were not approved. Under the Governor's proposal, counties could potentially be responsible for paying for child care

and transportation for a significant number of people that do not end up participating in the program. Because the administration's proposal gives counties flexibility in implementation of up-front job search, the extent to which counties would incur new costs will largely depend on the program design and requirements that each county establishes.

Analyst's Recommendation. As research has shown, a flexible approach to providing a mix of employment services (including job search), training, and education may be the most effective way to move individuals from welfare to long-term employment. We recommend that the Legislature give counties the option of requiring job search while an individual's application is pending. This would allow counties to assess what would work best in their communities.

Proposal Requires Aided Adults to Complete A Welfare-to-Work Plan Within 60 Days of Aid

The administration proposes requiring aided adults who are not already meeting program requirements to complete and sign a welfare-to-work plan within 60 days of the receipt of aid. This proposal may help to engage recipients who are not currently participating in program requirements, but may also limit county flexibility to evaluate the needs of the local labor market as they relate to the abilities and barriers of the participant. We recommend that the Legislature consider modifying the Governor's proposal to give counties more flexibility in meeting this potentially beneficial requirement.

Governor's Proposal. The administration proposes to require all aided adults who are not already meeting work requirements to sign a welfare-to-work plan within 60 days of the receipt of aid. A welfare-to-work plan specifies the activities in which a participant will be engaged and what services will be provided to the participant in order to achieve the stated goals. Currently, counties are required to complete a welfare-to-work plan after a four-week job search. However, if the county determines that additional job search would help to secure employment, then job search can be extended. Thus currently, some recipients may go a number of months without a signed plan.

Proposal May Help Increase Work Participation. Requiring a welfare-to-work plan to be completed two months after the receipt of aid may help to increase participation, especially among the caseload that is disengaged from the program. As noted earlier, 55,500 cases are disengaged. For these and other cases, the certainty of a welfare-to-work plan may help case managers keep recipients on a path toward self sufficiency.

Proposal May Not Be the Best Use of Limited County Resources. Currently, a welfare-to-work plan is used to help structure a participant's long-term goals of moving from welfare to work. For many CalWORKs recipients, 60 days would be an adequate amount of time to complete an effective welfare-to-work plan. However, for some individuals, 60 days would not be sufficient time to assess and test the recipient's abilities and barriers, and how those abilities fit with the needs of the local labor market. Requiring a completed welfare-to-work plan within 60 days for all participants who are not already meeting program work requirements may hinder county efforts to use job search and other activities to complete an effective welfare-to-work plan for some recipients. Moreover, hastily completed welfare-to-work plans could limit county ability to decide the most effective mix of up-front services and activities for a participant. This may result in the need for counties to reassess and modify the welfare-to-work plan using limited county resources, or lead to less desirable long-term employment outcomes.

Analyst's Recommendation: Modify the Governor's Approach. The Governor's proposal addresses an important CalWORKs program issue, that a significant percent of the nonexempt caseload is not participating in program requirements. We concur with the goal that all nonworking recipients have a welfare-to-work plan. However, by allowing only 60 days for plan completion, the Governor's proposal restricts the tools that counties have to help determine local labor market conditions, as well as a participant's employment barriers and abilities. This information helps counties develop a plan that moves participants into stable, long-term employment. Accordingly, we recommend that the Legislature modify the Governor's proposal to provide counties with the flexibility to extend the 60-day time frame up to 120 days for certain recipients. This would give counties the time needed to more thoroughly explore the needs of the local labor market and the barriers and abilities of the participant.

Proposal Requires 20 Hours of Core Work Activities

The Governor's proposal narrows the list of activities that would count towards the first 20 weekly hours of required participation. This limits the counties' available options to help participants move from welfare to work. In addition, this requirement is more restrictive than both of the Congressional welfare reauthorization proposals currently being considered. We recommend that the Legislature retain as much county flexibility as possible with respect to participation activities.

Governor's Proposal. The Governor's proposal requires that all nonexempt CalWORKs recipients engage in 20 hours of core work activi-

ties each week in addition to other approved activities to meet the 32 hour (or 35 for two-parent families) a week work requirement. Figure 8 lists the activities that currently count toward meeting participation requirements and the activities that would be defined as core work activities under the Governor’s proposal. After meeting the core work requirements, recipients could meet the remaining weekly requirement with other current law activities, such as education related to employment, vocational training, English as a second language, and substance abuse and mental health treatment.

<p>Figure 8 Qualifying State Welfare-to-Work Activities</p>
<p>Activities That Currently Count Toward Participation^a</p>
<ul style="list-style-type: none"> • <i>Unsubsidized employment.</i> • <i>Subsidized employment (public or private sector).</i> • <i>Work experience.</i> • <i>On-the-job training.</i> • <i>Community service.</i> • <i>Job search and job readiness assistance (limited time).</i> • Provision of child care to community service participants. • Vocational education and training. • Job skills training directly related to employment. • Education directly related to employment. • Secondary school or General Education Diploma course of study. • Appraisal, assessment, or reappraisal. • Grant-based on-the-job training. • Work study. • Supported work or transitional employment. • Domestic violence services. • Mental health services. • Substance abuse services. • Other work activities. <p>^a Bold and italicized activities are considered "core" work activities under the Governor's proposal.</p>

The administration estimates that about 97,000 families will increase their work participation in response to stricter work requirements. The administration also estimates that about 530 eligible families will be deterred from applying for CalWORKs each month as a result of the more stringent requirements. The administration further estimates that the proposal would result in \$120 million in grant savings, partially offset by additional child care costs of \$90 million, for a net savings of about \$30 million.

Proposal Limits County Flexibility. Counties currently have broad flexibility in determining the appropriate mix of work, education, vocational training, and barrier removal activities (such as mental health and substance abuse) that will help a CalWORKs participant move from welfare to work. Under current law, the CalWORKs program allows recipients to participate in work-related activities including barrier removal, education, and training for up to two years after a welfare-to-work plan has been developed. The Governor's proposal would limit the flexibility that counties have to engage a participant in work-related activities, instead requiring nonexempt adults to work 20 hours a week in a core work activity within 60 days of aid. This approach is not likely to be effective for recipients facing up-front employment barriers. For example, about 12,000 cases per month currently receive mental health or substance abuse treatment. Under the Governor's proposal, such participants would only be able to receive these services if they were also working or participating in community service jobs (CSJ) or on-the-job training (OJT) for 20 hours per week. The Governor's proposal thereby limits counties' ability to identify and address these barriers.

Unrealistic Assumptions. The department estimates that its proposal to narrow the activities that would count toward meeting participation requirements would impact about 125,000 recipients (51,000 currently working less than 20 hours per week, 18,000 meeting participation through activities other than work, and 55,500 who are not participating). We believe the administration's assumption that those working less than 20 hours and those that are meeting participation without work will either obtain employment or be able to attend CSJ or OJT is probably somewhat optimistic, but on balance is reasonable.

However, with respect to the 55,500 cases who are disengaged, we believe the administration's assumptions are unrealistic. Specifically, the administration assumed that 82 percent of the disengaged cases would meet the new requirements and 18 percent would be sanctioned. The administration provides no information to support its assumption that such a large percentage of the disengaged cases will begin meeting more rigid participation requirements. Given that this group is already disengaged from program participation, it is unlikely that narrowing the al-

allowable participation activities would result in significantly greater program participation. In summary, we believe the administration has overestimated the potential success of this proposed policy change. This means that child care costs and grant savings due to employment are overestimated, and sanction savings are underestimated.

No Additional Employment Services Funding Included in the Proposal. The administration estimates that about 86 percent (64,000 cases) of adults that had previously not been working will meet the new participation requirements for 20 weekly hours of core work activities within two months. Some of these individuals will obtain unsubsidized employment, however, while others will be unable to find employment and will need OJT or CSJ slots. The budget includes no additional funding to support OJT and CSJ slots. If for example, 5 percent of adults who had previously not been working need OJT and 5 percent need a CSJ slot, it could result in more than \$8 million in additional county costs.

In addition, some of those recipients who obtain employment may be working less than 32 hours and may require some other education or training activity to make up the difference between employment hours and the 32 hour requirement. The budget includes no additional funding for these employment services. We note that some of these costs, and costs for OJT and CSJ noted above, could in part be offset by savings from recipients shifting from training activities to unsubsidized employment.

Proposal Is More Narrow Than Federal Welfare Reform Proposals. Both the House and Senate reauthorization bills include provisions that increase the minimum hours of work required. In addition, the House bill restricts the types of activities that count toward the first 24 hours of participation. However, both bills also include a provision that allows for up to three months (House) and six months (Senate) of barrier removal instead of core work activities within a 24-month period.

Proposal to Narrow Participation Activities Is Flawed. As described above, the proposal to narrow the range of participation activities severely restricts county flexibility to determine which services and activities are most likely to help recipients become self sufficient. The administration has not presented evidence how their proposal will not only increase participation, but will do so within a more narrowly defined set of activities. The disengaged in particular may have barriers to employment that would need to be resolved before they could successfully engage in 20 hours or more of core work activities.

Analyst's Recommendation. We believe that counties are in the best position to identify which activities will help recipients become self-sufficient. Narrowing the list of allowable activities is unlikely to increase

participation among the disengaged to the extent envisioned by the administration. Under current law, counties have a fiscal incentive to ensure that recipients are participating in that they are responsible for sharing in any federal penalty to the extent the state fails to meet the higher participation rates contemplated in pending versions of federal welfare reform reauthorization. We recommend that the Legislature retain as much county flexibility as possible with respect to participation activities.

Our analysis indicates that the Governor's proposal to narrow the activities that count toward meeting individual participation requirements may excessively limit county flexibility. However, given the current number of people who are not meeting program requirements and given that the state shares in any federal penalty for not meeting requirements, the Legislature may wish to consider some changes to work requirements pursuant to federal proposals. For example, the Legislature may want to consider providing the counties with guidelines for managing their caseloads under the potentially more narrow definitions of participation that may be part of federal welfare reauthorization by limiting the number of recipients who can participate in non-core work activities.

Grant Reductions for Sanctioned And Safety Net Cases

The administration proposes to reduce grants by 25 percent for cases that have been in sanction status for longer than one month, and for safety net cases with nonworking parents. We discuss each proposal below.

Proposal Would Reduce Grant for Sanctioned Cases

The administration estimates that reducing child-only grants by 25 percent after one month in sanction status will result in a grant reduction for 26,200 families and will motivate 13,400 families to address and remedy ("cure") their sanction. Although it is likely that an additional grant reduction will result in some sanctioned adults complying with program requirements, research is inconclusive as to the magnitude of such a work incentive. The Legislature should weigh the benefits of higher participation against any potential negative impact of a grant reduction on children.

Governor's Proposal. The administration proposes to reduce grants by 25 percent for families that are in sanction status for more than one month. Currently, a family's grant is reduced (on average) by about \$146 each month when the adult is removed from the case. This proposal represents a further grant reduction of about \$150 per month, leaving the

total monthly grant for a family of three at about \$375 (assuming the Governor's proposed grant reductions). Currently, there are 39,600 cases with sanctions lasting more than one month. The administration estimates that about 26,200 cases (66 percent) will receive the 25 percent reduction and that 13,400 (34 percent) cases will cure their sanction. This policy change is expected to result in grant savings of \$36 million, offset by an estimated \$19 million in grant costs attributable to cases curing their sanction to avoid the proposed 25 percent reduction, and by about \$45 million for additional child care costs, for net increased costs of about \$28 million.

Research Is Inconclusive as to Whether a 25 Percent Grant Reduction Will Motivate Individuals to Avoid and/or Cure Their Sanction. The administration assumes that about 13,350 cases will cure their sanction as a result of the more stringent sanction policy. Research is inconclusive as to how large a sanction must be in order to motivate individuals to remedy a sanction. As noted above, currently a family's grant is reduced (on average) by about \$146 when the adult is removed from the case. Despite this significant reduction, on average, about 4,000 cases are sanctioned each month. Given inconclusive research, it is difficult to predict how many adults will be motivated to avoid or cure their sanction with an additional \$150 grant reduction.

The administration provides no basis for its estimate that 34 percent of the cases subject to sanction will cure their sanction status as a result of the proposed policy change. To the extent that recipients do not cure their sanction as anticipated by the administration, there will be greater net savings because the cost of grants as well as the cost of child care will decrease.

Proposal Unlikely to Increase Federal Work Participation Rates. When a case is sanctioned, the adult is removed from the case and it becomes a child-only case, thereby excluding the case from the state's federal work participation rate. Therefore, a case in sanction status does not negatively impact the state's ability to meet work participation requirements. Once the sanction is cured, the adult portion of the grant is restored and the case will once again be included in the federal participation figure. We assume that formerly sanctioned cases have the same work participation behavior as all other cases. Accordingly, bringing such a case back into the caseload will not change the state's federal participation rate.

Analyst's Comments. The administration's proposal to reduce the grant for sanctioned cases will probably increase the number of adults that cure their sanctions and begin program participation which could help them become self-sufficient. However, the proposal will not help

the state's federal work participation rate because sanctioned cases are currently excluded from the participation rate calculation. The Legislature should weigh the potential increased program participation against the potential negative impact to children as a result of the grant reduction.

Proposal Would Reduce Grant for Safety Net Cases With a Nonworking Adult

The Governor's proposal to reduce grants by 25 percent for safety net cases in which the adult is not working will reduce program expenditures. However, the policy will not help the state's work participation rate because the adults in safety net cases are currently not counted toward the state's work participation rate. The Legislature must weigh the \$29 million savings against the negative impact that the grant reduction may have on families and children.

Governor's Proposal. Under current law, when an adult CalWORKs recipient has reached his/her 60 month time limit, the adult is removed from the assistance unit and the children are moved into the child-only safety net caseload. The administration proposes to further reduce the grant for safety net cases with nonworking adults by 25 percent. On average, this would result in a monthly grant reduction of about \$135 in the child-only grant. The administration indicates that the work requirement could be satisfied with any earnings in a quarter. In addition, it is our understanding that employment would be self-certified, but would require some sort of verification (such as a paycheck stub). Counties would not have the flexibility to set more stringent work or verification requirements.

Proposal Will Not Impact Federal Work Participation Rates. Adults in the safety-net case are not counted toward the state's work participation calculation. As a result, even if adults increased their participation, it would not improve the state's work participation rate.

Minimal Work Incentive. Currently there are 23,600 nonworking safety net cases. The administration assumes that all of these nonworking cases will have their grants reduced by an average of \$135 per month, and that *no* cases will begin work as a result of the grant reduction. This assumption indicates that the expected goal of the policy is grant savings rather than higher levels of employment for adults with children in safety net cases. The administration's estimated \$29 million in savings is probably overstated, in that some recipients may in fact meet the minimal work requirements. Given that the work requirement could be satisfied

with very little work effort, we anticipate that the proposal will result in only a minor increase in the hours of employment.

Analyst's Comments. The Governor's proposal would not directly help the state's federal work participation rate, although it may minimally influence the training, education, and employment decisions of current recipients. Given the proposal's minimal work requirements, we believe that some nonworking adults will meet the new requirements and avoid the grant reduction. Therefore, we believe the administration has overstated savings associated with this proposal, because it assumes no impact on employment behavior. The Legislature should weigh the estimated savings against the potential negative impact to children in families in which the adult is not working and has little or no access to CalWORKs employment support services.

UPDATE: FEDERAL WELFARE REAUTHORIZATION

As of February 2004, Congress had not completed action on federal welfare reauthorization. We describe the major features of the currently pending House and Senate versions of welfare reform and update our fiscal estimates of these measures.

Status of Federal Welfare Reauthorization

The 1996 welfare reform law created the TANF block grant program, replacing the Aid to Families with Dependent Children (AFDC) program. The welfare reform law authorized the TANF block grant through September 2002. Congress was unable to pass a reauthorization bill before September 2002, and the program has been funded through a series of continuing resolutions, which maintain current TANF funding, rules, and regulations. The current continuing resolution expires at the end of March 2004.

In February 2003, the House passed H.R. 4, the "Personal Responsibility, Work and Family Promotion Act of 2003," its TANF reauthorization bill. In September 2003, the Senate Finance Committee passed its version of H.R. 4, but the full Senate has yet to act on reauthorization legislation. Both the Senate and House versions of reauthorization make substantial changes to TANF, health care, and child support. We limit our discussion here to the TANF changes, especially provisions that impose stricter work requirements and higher participation rates.

Major Provisions of Federal Proposals

Common Elements. Figure 9 summarizes the major work participation provisions in current law, and the House and Senate welfare reform proposals. Both the House and Senate proposals maintain current TANF block grant funding levels, state spending requirements, five-year federal time limit, and the 20 percent caseload time-limit exemption option. The proposals share other common elements that differ from current law. Both proposals require a self-sufficiency plan (welfare-to-work type plan) within 60 days of enrollment and increase the state's participation rate. In addition, both proposals make significant changes to allowable work activities and increase the hourly work requirement.

Figure 9		
TANF Reauthorization Proposals		
Major Work Participation Provisions		
Current Law	House Passed Bill	Senate Finance Bill
Statewide Participation Rates		
<ul style="list-style-type: none"> • 50 percent of single parent and 90 percent of two-parent families must meet work requirements. 	<ul style="list-style-type: none"> • Incrementally increases participation requirements to 70 percent for both one- and two-parent families. 	<ul style="list-style-type: none"> • Same as House.
Caseload Reduction/Employment Credit		
<ul style="list-style-type: none"> • Statewide participation rate requirements are reduced by the percentage point decline in a state's caseload since FFY 1995. 	<ul style="list-style-type: none"> • Recalibrates credit so that it is eventually based on caseload decline over the most recent four-year period. 	<ul style="list-style-type: none"> • Replaces caseload credit with an employment credit that is eventually capped at 20 percent.
Exclusion From Participation Rate		
<ul style="list-style-type: none"> • States may exclude single-parent cases with a child under 12 months of age from the participation rate calculation. 	<ul style="list-style-type: none"> • Current law plus: Allows states to exclude cases in the first month of assistance. 	<ul style="list-style-type: none"> • Current law plus: Allows states to exclude the first month of assistance, and families with a child under 1 year of age.
Participation Hours		
<ul style="list-style-type: none"> • 20 hours per week for single parents with a child under age 6; 30 hours for single parents with older children; 35 hours for two-parent families. No credit for partial participation. 	<ul style="list-style-type: none"> • Requires all families to participate 40 hours. Partial credit for partial participation. 	<ul style="list-style-type: none"> • Requires single parents to work for 24 hours if they have a child under 6 and 34 hours if children are over 6. Two-parent families are required to work 39 hours (more if they receive subsidized child care). Partial credit for partial participation.
<i>Continued</i>		

Key Differences. While sharing some common elements, the House-passed welfare reform proposal differs significantly from the version passed by the Senate Finance Committee. In general, H.R. 4 proposes more stringent work requirements and sanction policies, and less flexibility in participation rate credits and exclusions. Below we discuss key features of the two proposals and their potential impact on the CalWORKs program.

State Participation Rates

Current Law. Figure 10 (see next page) shows the required state participation rates under the House and Senate proposals. Under current

Current Law	House Passed Bill	Senate Finance Bill
Participation Activities		
<ul style="list-style-type: none"> • “Priority” activities must account for at least 20 hours per week. Remaining work hours may be met through “core” activities, job skills training, or education related to employment. 	<ul style="list-style-type: none"> • Requires 24 weekly hours of priority work activities. Excludes job search and vocational education as countable priority activities. Gives states broad flexibility to count any state-approved activity toward the remaining hours. 	<ul style="list-style-type: none"> • Requires 24 weekly hours of priority work activities. The remaining hours may include broader activities including barrier removal and job search.
Universal Engagement		
<ul style="list-style-type: none"> • After 24 months of aid, every family must participate for some hours in welfare-to-work activities. 	<ul style="list-style-type: none"> • Requires states to establish a welfare-to-work plan for every aided adult within 60 days of receiving aid. 	<ul style="list-style-type: none"> • Requires states to establish a welfare-to-work plan for every aided adult within 60 days of receiving aid.
Flexibility Period		
<ul style="list-style-type: none"> • No provision. 	<ul style="list-style-type: none"> • Allows three months in any 24-month period to be spent in substance abuse treatment, rehabilitation services, job search, or work-related education. (May be extended by one month in some circumstances.) 	<ul style="list-style-type: none"> • Same as House, but may be extended an additional three months in some circumstances. Job search can count for up to 12 weeks.
Sanctions		
<ul style="list-style-type: none"> • States have flexibility in determining whether to impose a full or partial sanction on noncompliant families 	<ul style="list-style-type: none"> • States are required to impose a full family sanction for continued noncompliance. 	<ul style="list-style-type: none"> • Maintains current law with small change in state plan requirement and mandates that self-sufficiency plan is reviewed before sanction is imposed.

law, states must meet a statewide work participation rate requiring that 50 percent of single-parent families and 90 percent of two-parent families are meeting hourly work participation requirements. California, like many other states, has moved its two-parent caseload into a separate state program that is not subject to the 90 percent participation requirement.

	Federal Fiscal Year				
	Year 1	Year 2	Year 3	Year 4	Year 5
Figure 10					
TANF Reauthorization Proposals^a					
Projected Impact on California's Work Participation Rates					
House Version					
Work participation requirement	50%	55%	60%	65%	70%
Less caseload reduction credit	-43	-22	—	—	—
Effective rate	7%	33%	60%	65%	70%
California's estimated participation rate under new provisions	34%	34%	34%	34%	34%
Participation Gap	—	—	26%	31%	36%
Senate Version					
Work participation requirement	50%	55%	60%	65%	70%
Less employment credit	-21	-21	-21	-21	-20
Effective rate	29%	34%	39%	44%	50%
California's estimated participation rate under new provisions	34%	34%	34%	34%	34%
Participation Gap	—	—	6%	10%	16%
^a Source: the Department of Social Services, using FFY 2002 data.					

Federal law reduces the required participation rate by applying a caseload reduction credit. This adjustment is based on the percentage decline in each state's welfare caseload since FFY 1995. California, like most states, has experienced a significant caseload decline since FFY 1995. Consequently, the FFY 2002 required participation rate for California was about 7 percent. In addition, single-parent cases with a child under 12 months of age may be excluded from the participation rate calculation.

H.R. 4. The House bill increases the states' minimum work participation requirement by 5 percent each year from 50 percent to 70 percent

five years later. The caseload reduction credit is changed so that when fully implemented, the reduction credit is based on caseload decline over the most recent four-year period. Assuming that the caseload remains relatively flat, this would mean that California would not receive a caseload credit after four years (full implementation).

Senate. Like the House bill, the Senate bill also increases the state’s minimum work participation requirement by 5 percent each year from 50 percent to 70 percent five years later. The Senate bill replaces the caseload reduction credit with an employment credit that gives states credit for individuals who are diverted from receiving welfare, leave welfare for a job, or find a higher paying job. The credit is capped at 40 percent for the first year, and is reduced to 20 percent over the next five years.

Work Participation Requirements

Current Law. Figure 11 shows work participation requirements under current law, the House proposal, and the Senate proposal. Current federal law requires that single parents with a child under age 6 work for at least 20 hours per week and those with older children work for at least

Figure 11
Weekly Work Participation Requirements

	Single Parent		
	Children Under 6	Children Over 6	Two-Parent Families
Current Law	20 hours	30 hours	35 hours
House^a			
Full credit	40 hours	40 hours	40 hours
Partial credit	Pro-rated for 24-40 hours	Pro-rated for 24-40 hours	Pro-rated for 24-40 hours
Senate^b			
Full credit	24 hours	34 hours	39 hours ^c
Partial credit		.675 credit for 20-23 hours .75 credit for 24-29 hours .875 credit for 30-33 hours	.675 credit for 26-29 hours .75 credit for 30-34 hours .875 credit for 35-39 hours

^a The House proposal requires 24 hours of "core" activities, the remaining 16 are up to state discretion. After 24 hours, pro-rated partial credit.

^b The Senate proposal requires 24 hours of core activities, the remaining hours include a broader list of activities. Extra credit given for families exceeding required hours.

^c 55 hours if family receives subsidized child care.

30 hours per week. Two-parent families must work at least 35 hours per week. No credit is given for partial participation. California law requires single-parent families to participate in 32 hours per week and two-parent families to participate 35 hours per week.

House Proposal. H.R. 4 increases the number of hours that parents are required to work to 40 hours a week for all families. The two-parent family work participation rate is eliminated. A pro-rated partial credit is given for families that participate in core activities for at least 24 hours a week.

Senate Proposal. The Senate bill increases the number of required work hours from 20 to 24 hours per week for single parents with a child under age 6 and 30 to 34 hours per week for single parent families with children over age 6. Two-parent families are required to work 39 hours, which is increased to 55 hours per week if the family receives subsidized child care. Partial credit is given for single parents who participate for at least 20 hours and for two-parent families that participate for at least 26 hours per week.

Work Activities

Current Law. Under current law there are nine core work activities which must account for at least 20 hours of required work participation. These core activities are: unsubsidized employment, job search, vocational educational training, work experience, community service, private subsidized employment, public subsidized employment, OJT and childcare for community service participants.

House Proposal. The bill increases the number of required core work activity weekly hours from 20 to 24 and narrows the set of allowable core work activities. The allowable core work activities are: unsubsidized employment, subsidized employment, on-the-job training, supervised work experience, and supervised community service. H.R. 4 no longer allows job search/job readiness or vocational education to count towards the first 24 hours of participation. However, H.R. 4 does allow participation in substance abuse and rehabilitation treatment, job search, and other activities as defined by the state to count toward the core work requirement for up to three months in a two-year period.

While H.R. 4 restricts allowable core work activities, it provides additional flexibility to states to define work activities above the 24 hours of core work activities.

Senate. The Senate bill requires 24 weekly hours of priority work activities. The remaining hours may include broader activities including job search, barrier removal, substance abuse, and education.

Universal Engagement

Current Law. Adults are required to participate in work activities within 24 months on aid. Work activities are defined by the state. It is a state option to develop an individual responsibility plan for recipients. California currently requires the completion of a self-sufficiency plan (welfare-to-work plan) following the completion of the four week job search. Counties can extend job search (and the welfare-to-work plan) if the county determines that additional job search would help to secure employment. The completion of the welfare-to-work plan starts the 18 or 24 month time limit in work-related activities such as education and vocational training.

House Proposal. The House proposal requires states to develop a self-sufficiency plan, that includes detail on planned work activities for all adults within 60 days of welfare enrollment. A federal sanction may be imposed on states that fail to comply.

Senate Proposal. The Senate proposal also requires a self sufficiency plan within 60 days of welfare enrollment. The Senate bill specifies what the plan should contain, including detail about how the recipient intends to engage in work or other sufficiency activities, steps to promote child well-being, and information about support services the state will provide. A federal sanction may be imposed on states that fail to comply with the self-sufficiency plan requirement.

Sanctions

Current Law. Federal TANF law directs states to sanction clients for failure to participate in work and other program requirements. States that do not sanction noncompliant recipients are subject to a federal financial penalty. Current federal law gives states flexibility to determine the structure of its sanctions policies. However, federal law prohibits states from penalizing a single parent with a child under age 6 if childcare is not available.

California implemented a sanction policy that impacts only the adult portion of the grant, unlike many other states that impose a full family sanction, or cut the entire family grant. In California, when someone has been sanctioned for the first time, benefits are reinstated as soon as the person comes into compliance, known as curing the sanction. A second instance of noncompliance results in a sanction of at least three months

or until the sanction is cured. A third and subsequent instance of noncompliance results in a sanction being imposed for a minimum of six months or until cured.

House Proposal. The House bill requires that states terminate assistance to all family members (full family sanction) if any adult is not meeting program requirements for more than two months. It also requires that the state plan must describe how it will provide services for noncompliant families. Any state funds expended for cases in sanction status more than two months may not be counted toward the state's MOE spending requirement.

Senate. The Senate bill largely maintains current law. However, it requires that the state plan include strategies the state will take to address services for noncompliant families and requires the state to review the noncompliant persons self-sufficiency plan before imposing the sanction.

Child Care

Current Law. Currently, states receive a total of \$2.7 billion annually in Child Care Development Funds for child care. California's share of these funds is about \$520 million. California law requires that adequate child care be available to all CalWORKS recipients receiving cash aid in order to meet their program participation requirements (a combination of work and/or training activities).

House Proposal. The House bill proposes increasing mandatory (required) child care funding by \$1 billion over five years. These funds would require a federal match set at the current federal Medicaid assistance percentage (FMAP) match. The proposal also includes increasing discretionary funding by \$1 billion over five years. The discretionary funds are subject to appropriation.

Senate. The Senate bill also increases mandatory spending by \$1 billion and discretionary spending by \$1 billion over five years.

Impact on the CalWORKs Program

Both H.R. 4 and the Senate Finance bill contain new provisions that will have significant fiscal and programmatic effects on the CalWORKs program. As discussed above, the bills differ in several key areas including the caseload reduction/employment credit, full family sanction requirement, required recipient participation rate, and allowable core work activities. However, the proposals share a number of similar provisions including, an increase in the state participation rate, an increase in the

number of required hours, and a universal engagement requirement. Below we discuss the potential impacts of these expected federal policy changes on the CalWORKs program.

Federal Proposals Likely to Result in Participation Rate “Gap”

Both the House and the Senate proposals impose a significant increase in both the number of hours for which families must participate each week, and the percentage of families who must participate.

Changes to Definition of Participation. California’s actual participation rate under current law was 27 percent (FFY 2002). The DSS has estimated that under both the House and the Senate proposals, the state’s participation rate would increase to 34 percent. Most of the increase is due to provisions allowing partial credit for partial participation, and the elimination of a separate two-parent rate, which will allow California to move two-parent families (who have higher participation rates) back into the federal participation rate calculation. Currently, no credit is given for those who are participating, but not fully meeting requirement.

We note that the Congressional Research Service estimates that California’s actual participation rate will be higher under the Senate proposal than the House proposal. This is largely because under the Senate version, partial credit begins at 20 hours, rather than 24 hours, and work participation requirements are lower for single-parent families. Our own preliminary analysis also suggests that the Senate proposal may result in somewhat higher participation rates than the House version for the reasons noted above. Nevertheless, we have used the somewhat more conservative DSS estimates for purposes of estimating the participation gap.

Participation Gap. Taken together, the work requirement and state participation rate provisions would result in a significant “gap” between California’s estimated participation rate and the effective participation rate requirement. Figure 10 shows the DSS estimates of California’s “effective” participation requirement (participation rate less caseload reduction/employment credit) under both the House and Senate proposals compared to the state’s current participation rate. As the figure shows, under current state law California would be significantly below the required participation rate under the House bill by the third year of implementation and under the Senate proposal by the fourth year. If the state does not meet its federal participation requirement, it is subject to a significant federal penalty.

Update on the State Fiscal Impact

Estimated Fiscal Impact of H.R. 4. In September 2002, we estimated that once fully implemented, the then pending House version of welfare reform authorization would result in annual state costs of about \$750 million above current expenditures. (For more information, please see our report *Fiscal Effect on California: Congressional Welfare Reform Reauthorization Proposals*, August 29, 2002.) From a fiscal impact perspective, H.R. 4 as passed by the House in February 2003 is not significantly different than the version passed by the House in 2002. Based on the same methodology we used in 2002 (with updates for caseload, child care utilization, and county welfare-to-work allocations) we estimate that when fully implemented, H.R. 4 would result in additional annual costs above current expenditures in the range of \$375 million to \$450 million. Most of the impact is from employment service and child care costs that the state would likely incur in order to bridge the projected participation gap of about 36 percent. This estimate assumes that California follows current state law and makes only the minimum changes required by the federal measure. It does not reflect the Governor's proposed welfare reforms. The reduction in our most recent cost estimate from our 2002 estimate is largely due to an increase in the amount of funding that each county receives from the state for employment and related services, and a decrease in child care utilization.

Fiscal Impact of the Senate Version. The Senate Finance Committee bill passed in September 2003 is significantly different than the version passed by the same committee in 2002. Hence, our 2002 estimate of the Senate legislation is not a relevant reference point for estimating the impact the current bill. Nevertheless, given that the participation gap under the Senate measure is significantly less than under H.R. 4 (36 percent House gap, 16 percent Senate gap), we would expect that annual cost increases compared to current law expenditures under the most recent Senate version would probably be less than half of the costs that we estimated for the H.R. 4.

Conclusion

Outcome Uncertain. It is not clear when Congress will take final action on federal welfare reform and what specific provisions will be included. We will continue to monitor the federal welfare reform debate and keep the Legislature informed of the major changes to the TANF program and their effects on the CalWORKs program.

CALWORKS AUTOMATION

Withhold Recommendation on Proposed Increased to Consortium System

The budget proposes to increase funding by \$35.6 million (\$12.8 million General Fund) for the continued implementation of the Statewide Automated Welfare System C-IV Project. We withhold recommendation on the proposed increase pending additional information on the specific activities being proposed on the project.

The budget proposes to increase funding by \$35.6 million (\$12.8 million General Fund) for the continued implementation of the Statewide Automated Welfare System (SAWS) C-IV Project. The purpose of SAWS is to provide improved and uniform information technology capability to county welfare operations. The system is being delivered through a state partnership with the counties, which have chosen to be in one of four consortia. The SAWS C-IV consortium consists of Merced, Riverside, San Bernardino, and Stanislaus Counties. The SAWS C-IV project has a total project cost of \$589 million and it is currently being piloted in Stanislaus.

Withhold Recommendation Pending Additional Information. It is our understanding that the increased funding is to continue the implementation of SAWS C-IV. The administration, however, has not identified the specific activities that the additional funding will provide for the project. For this reason, we withhold recommendation on the proposed increase pending additional information from the administration.

ADOPTIONS PROGRAM

The department administers a statewide program of services to parents who wish to place children for adoption and to persons who wish to adopt children. Adoptions services are provided through state district offices, 28 county adoptions agencies, and a variety of private agencies. Counties may choose to operate the Adoptions Program or turn the program over to the state for administration.

There are two components of the Adoptions Program: (1) the Relinquishment (or Agency) Adoptions Program, which provides services to facilitate the adoption of children in foster care and (2) the Independent Adoptions Program, which provides adoption services to birth parents and adoptive parents when both agree on placement.

In addition to the Adoptions Program, the Adoptions Assistance Program (AAP) provides grants to parents who adopt “difficult to place” children. State law defines these children, as those who, without assistance, would likely be unadoptable because of their age, racial or ethnic background, handicap, because they are a member of a sibling group that should remain intact, or because they come from an “adverse parental background.”

The Governor’s budget proposes expenditures of \$104 million (\$59 million General Fund) for the Adoptions Program in 2004-05. This represents a 12 percent increase in General Fund expenditures from the current year. This increase is primarily attributable to offsetting the reduction of federal incentive funding for adoptions. Overall, program funding for adoptions remains virtually the same.

The Governor’s budget proposes expenditures of \$577 million (\$248 million General Fund) for the AAP in 2004-05. This represents an 11 percent increase in General Fund expenditures from the current year. This increase is primarily attributable to an increase in caseload and an increasing average monthly grant amount.

REFORMING THE ADOPTIONS ASSISTANCE PROGRAM

The current Adoptions Assistance Program (AAP) provides the maximum foster care grant for virtually every child who is adopted from the foster care program, regardless of whether or not that child would be “hard to place” in an adoptive home. This policy has turned AAP into one of the fastest growing social services programs in terms of caseload and cost.

In order to improve the program’s cost effectiveness, we recommend enactment of legislation that (1) sets grant levels at an amount that recognizes the adoptive parents’ financial responsibility for their adoptive children, (2) better ties benefit levels to the needs of adoptive children, and (3) narrows the definition of “special needs” so as to focus the program’s financial assistance on those children who are likely to benefit the most from such aid. These changes will save approximately \$2 million General Fund in 2004-05, growing to approximately \$12 million in 2005-06. (Reduce Item 5180-101-0001 by \$2 million.)

Background

The AAP was established in 1982 to provide monthly cash grants to parents who adopt difficult to place children. State law (Welfare and Institutions Code Section 16120) defines difficult to place children as those who, without financial assistance to defray costs associated with the children’s special needs, would likely be unadoptable because they are:

- Three years of age or older.
- Members of a racial or ethnic minority.
- Members of a sibling group that should remain intact.
- Physically, mentally, emotionally, or medically handicapped.
- From an adverse parental background.

Adoptive parents receive these grants until their child is 18 years of age or until age 21 if the child has a chronic condition or disability that requires extended assistance. The adopted children remain eligible for Medi-Cal benefits as long as their adoptive parents are receiving an Adoption Assistance grant on their behalf. Another option is for parents to defer their child’s enrollment in AAP. This option allows parents to avail themselves of the program at a later date, should their child need the assistance payments for unforeseen expenses.

Adoption Assistance grants are limited to the amount of the foster family home rate that the child would have received if she or he had remained in foster care. The foster family home rate ranges from \$425 to

\$597 per month depending on the age of the child. Also, if the child has specialized care needs that would have been covered had the child remained in foster care, the adoptions worker can set the grant as high as the foster family home rate plus a specialized care increment. This increment can range up to \$2,097 per month. As with foster care grants, the AAP grants are not subject to state or federal income tax.

For federally eligible children, the federal government pays 50 percent of the grant, the state pays 37.5 percent, and the counties pay 12.5 percent. Approximately 87 percent of AAP children are federally eligible. Nonfederally eligible children (referred to as state-only) receive the same benefits in AAP as federally eligible children. The state-only program is funded 75 percent from the state General Fund and 25 percent from county funds.

To be federally eligible, a child must come from a family that would have met all of the eligibility requirements for the Aid to Families with Dependent Children (AFDC) program as it was defined as of July 16, 1996. Typically, a child could not come from a two-parent family or a family whose income exceeded specified levels. Other than these two federal requirements, the children in the state-only program are virtually identical to the federally eligible children.

Growth of AAP

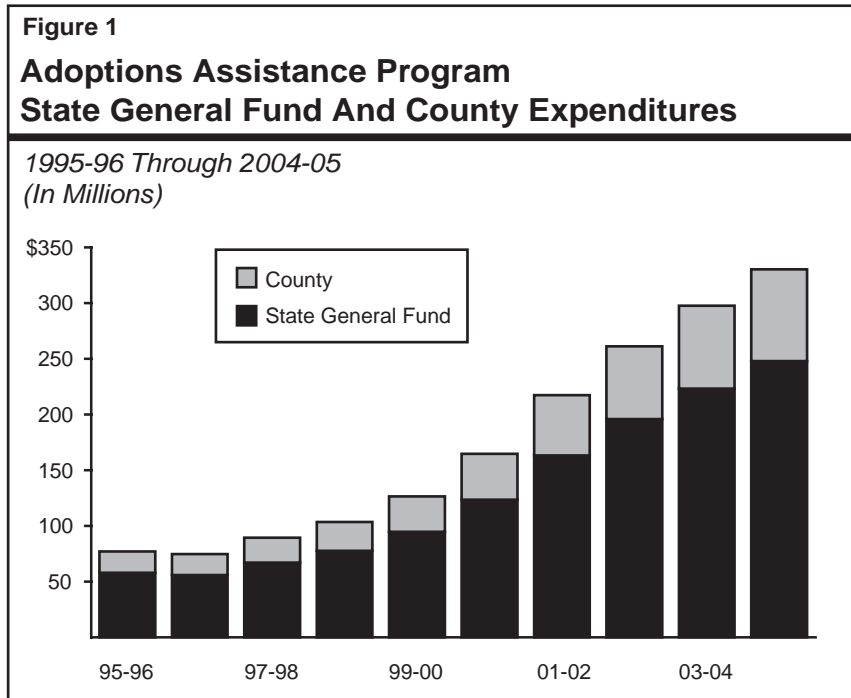
Historical Caseload Growth Rates. The AAP caseload has been growing steadily and rapidly since 1995-96. Until recently, the caseload was growing at an increasingly larger percentage rate each year, peaking in 2000-01 at a 21 percent growth rate. For 2001-02, the rate of increase slowed slightly to 16 percent. Finally, for 2002-03 the growth had slowed to 13 percent. Despite the slowing caseload growth, AAP continues to be one of the fastest growing programs in the Department of Social Services (DSS). The department's most recent forecast projects that the caseload will grow by 13 percent in 2003-04 and 10 percent for 2004-05.

Growth in Average Monthly Grants. During the same period, from 1995-96 through 2003-04, the average grant for AAP grew from \$447 for federally eligible children and \$459 for state-only children, to an estimated \$704 and \$756, respectively. This represents increases of 58 percent and 65 percent, or approximately 30 percent more than the rate of inflation.

A significant portion of that increase is probably due to the *Mark A. et al v. Davis* court settlement. This settlement limited the ability of counties to negotiate with adoptive parents for grant amounts that would be lower than the maximum amount that the child would have received in Foster

Care. While the *Mark A.* settlement limits the flexibility of the administration and counties, it is not binding for the Legislature. The Legislature could choose to make changes to the program, which are contrary to the *Mark A.* settlement, as long as those statutory changes are consistent with federal law. However, none of the recommendations presented later in this analysis are in conflict with the *Mark A.* settlement.

Increasing General Fund Commitment. While caseload and grant costs have grown rapidly, the General Fund commitment to the program has grown at an even faster rate. In 1995-96, the state spent \$57.6 million from the General Fund for AAP grants. On average, the General Fund investment has grown by approximately 20 percent each year. By 2002-03, the General Fund amount had grown to \$196 million. That amount is estimated to grow by an additional \$27 million in 2003-04 and by \$25 million in 2004-05 (as shown in Figure 1).



Examining AAP Eligibility and Payment Levels

Universal Eligibility for Foster Care Children. Under the current AAP program, virtually all children being adopted out of the foster care program are eligible for and receive AAP benefits at least until the age of 18.

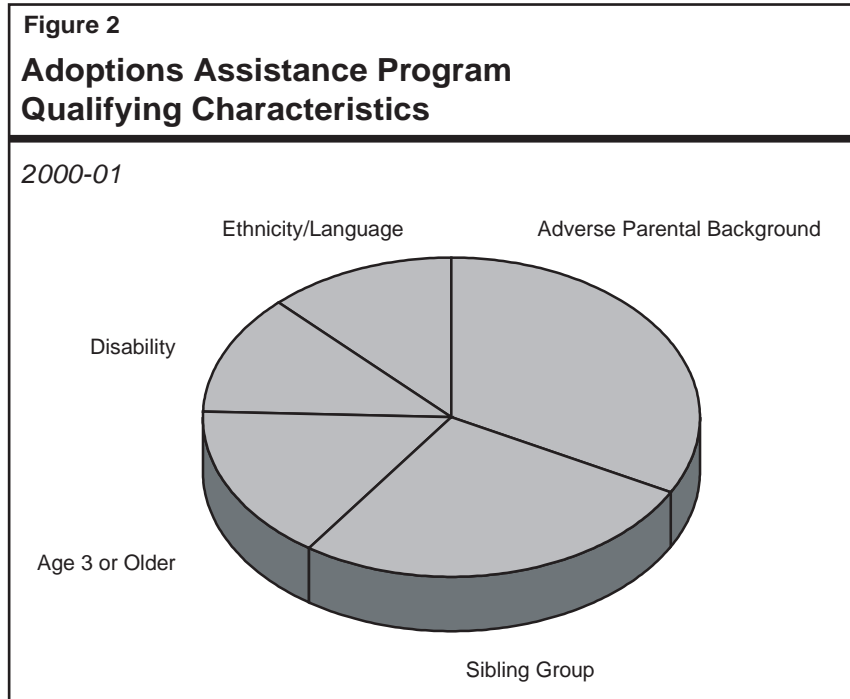
In 2000-01 (the latest year for which data are available), 93 percent of the children adopted from foster care received AAP benefits, another 3 percent of families opted to defer their AAP benefits, leaving only 4 percent of the children who did not receive AAP benefits. This 4 percent may have been eligible and their parents may have chosen not to apply for benefits or the parents may have been unaware of AAP benefits.

No Income Determination Is Used for Eligibility or Grant Levels. Adoptions Assistance is not a means-tested program. This means that eligibility for the program is not based on the adoptive parents' income nor is the income of the adoptive family considered in determining the monthly payment amount. Eligibility is solely determined by whether or not the child meets California's definition of special needs. Under current California law, a child meets the definition of special needs if he or she has one or more of the following characteristics:

- A member of a minority ethnic group, race, or color.
- Over 3 years of age.
- A member of a sibling group that should remain together.
- Diagnosed with a mental, physical, emotional, or medical disability.
- Non-English speaking.
- Comes from an adverse parental background.

The inclusion of adverse parental background in the definition of special needs allows virtually all children adopted out of the foster care system to qualify for AAP, regardless of whether or not they would otherwise be a hard to place child. This is because any child removed from his or her parents and placed in foster care, by definition, must have had an adverse parental background. Thus under the current program, a healthy infant would be considered as hard to place as would three teenage, physically, or developmentally disabled siblings. Both types of children would be eligible for monthly AAP payments until they reach the age of 18.

The most recent statistical information available shows that the largest qualifying characteristic of children in AAP is adverse parental background, as shown in Figure 2. The next largest qualifying characteristic is being a member of a sibling group.



Profile of a Typical Child and Adoptive Family. According to 2000-01 data, the typical child adopted through the Department of Social Services Agency Adoption program is white, experienced an adverse parental background, and did not have a sibling placed with them. They began living with their adoptive family at about 2 years old and were adopted when they were 5 years old. The adoptive family is a white, married couple, with some college education. They were not related to the child and had other children in their home. The median age for the adoptive mother and father was 44 years old. Their median gross annual income was \$41,000 and they received adoptions assistance benefits for the child.

Federal AAP Requirements Provide Latitude in Two Key Areas. The federal government gives states significant latitude in two areas of the AAP program: (1) to define special needs broadly or narrowly and (2) to decide the amount of benefits provided to adoptive parents. Because of this latitude, states vary widely in their definitions of special needs and in the ways that they determine grant amounts.

As regards the definition of special needs, a publication of the United States House of Representatives Committee on Ways and Means indicates that, generally, hard to place children would include older children, sibling groups, children with physical or mental disabilities, or member-

ship in a minority group. However, under federal law, states are free to define special needs more expansively or restrictively. California has chosen to expand eligibility by adding adverse parental background to the definition.

As regards the grant amounts, federal law gives states flexibility in the amount of benefits paid to families, although it does restrict the maximum allowable amount to no more than what the child would have received in a foster family home. States may choose to pay less than that amount.

In determining the amount of the AAP grant for an individual family, federal law requires that the family's circumstances must be taken into consideration. The law further defines family circumstances to mean "the family's ability to incorporate the child into the household in relation to the lifestyle, standard of living, and future plans and to the overall capacity to meet the immediate and future plans and needs, including education, of the child." Based on our review, we conclude that this definition allows the income of the family to be used in determining the grant amount as long as it is done in conjunction with the needs of the child. As a publication of the United States House of Representatives Committee on Ways and Means states, "No means test can be used to determine eligibility of parents for the program; however, States do consider the adoptive parents' income in determining the payment." In fact, our review of other states' programs shows that in 2000-01, 20 states used income in some capacity to determine the grant amount paid to the adoptive family. The State of Ohio, for example, considers the circumstances of the children, the income of the adoptive parents, and the current expenses of the adoptive parents during their grant negotiations.

Substantial Variation in Eligibility Among the States. Because of the flexibility allowed by the federal government, there is substantial variation in AAP programs throughout the country. For example, some states choose to limit their caseload by more narrowly defining special needs while others, like California, define special needs in such a way to include every child in the foster care system. Colorado, for example, limits special needs to children who are over age 7, a member of a sibling group that should remain intact, have a physical, emotional, or mental disability or have documented hereditary risk factors. On the other hand, Illinois broadly defines special needs. Its definition includes children over age 1; or are members of a sibling group; or have an irreversible physical, mental, or emotional disability or one that is correctable through surgery; or have a judicial determination that the child is abused, neglected, or dependent; or where efforts have been made to place the child without providing a subsidy. Both states' definitions are allowable under federal law.

Variation in AAP Benefits Among the States. States also vary significantly in the amount that they are willing to pay for AAP grants. Many states, including California, have chosen to pay the same amount to AAP families as the child would have received in Foster Care. However, other states have chosen to cap the amount they will pay for AAP. Ohio, for example, has chosen to cap the federal/state funding at \$250 per child. If a county is willing to supplement the nonfederal share with county funds, they may draw down additional federal funds. Another state that has chosen to limit AAP grants is Minnesota. In Minnesota, the maximum basic AAP grant is capped below the foster care basic rate. For example, according to the most recent data available, children younger than age 5 can receive \$473 per month in a basic foster care grant. However, in AAP, children in the same age group cannot receive more than \$247 per month.

Another significant variation among states is in the amount of specialized care funding that the program pays. A specialized care increment is funding provided above and beyond the base foster care amount for children with extraordinary needs. In California and several other states, specialized care increments are established by individual counties and vary significantly across the state. In the case of California, the specialized care increment ranges up to \$2,097 per month, depending on the county. However, in Texas, for example, no specialized rates are paid in the adoption assistance program. On the other hand, Michigan has established a statewide “difficulty of care” supplement amount, which ranges from \$5 to \$18 per day depending on the age of the child, medical fragility, and three established levels of medical or behavioral needs. Finally, North Carolina offers a specialized adoptions assistance payment for HIV-positive children only.

Other Differences. Other variations among states include whether or not they offer funds to offset adoption expenses, the provision of respite care for adoptive parents, and whether or not benefits are provided for children over 18 years of age. In California, parents are allowed a maximum of \$400 for nonrecurring adoption expenses, benefits for children between the ages of 18 and 21 are provided if there are extraordinary needs, and the state does not provide respite care.

Summary. The AAP is one of the fastest growing social services programs. It is projected to cost over \$500 million in 2004-05, over half of that cost is from the state General Fund. While the federal government provides states significant latitude in terms of defining the eligible population and in setting grant amounts, California has chosen to develop one of the most generous programs in the country. The current definition of special needs allows virtually every child that is adopted out of the foster care system to qualify for the program. Further, the settlement of the *Mark A.* court case has probably contributed to our rising grants be-

cause counties can no longer use a family's resources or income as a tool for determining grant levels. Other states, even when they have generous eligibility requirements, tend to set the grant amount so that it is below the maximum foster family home rate.

Overarching Considerations

In thinking about how best to restructure the AAP program, we recommend that the Legislature weigh the following considerations.

Adoption Means the State Is No Longer the Parent. As children leave the foster care system through adoption, the parenting responsibility shifts from the state to the adoptive parents. Under the foster care system, the state has taken on the financial role of the parent and, as such, the state pays for the basic needs of the child. However, once the child is adopted, the state is no longer functioning as the parent. The responsibility moves to the adoptive parents. Further, legally, adoptive parents take on the same responsibilities as parents who give birth to their own children. Part of that responsibility includes financially providing for their children. Adoptions literature distributed by DSS echoes this expectation. Specifically, DSS states that the ideal adoptive parents have a regular income and the ability to meet the needs of the adoptive child.

Parents Adopt Children Out of a Love for the Child and Desire to Be a Parent; Not Because of a Cash Incentive. Parents that adopt children, whether out of the foster care system or not, do so out of a desire to become parents and love for the child, not because they will receive ongoing, tax-free money from the state. This expectation is supported by CDSS adoptions literature, which notes that the ideal adoptive parent is expected to be loving and willing to deal with changes in their lifestyles as a result of adopting a child. Finally, many people become foster parents as a route to adoption. Therefore, the "incentive" provided by AAP may be unnecessary for many families, especially those adopting children with no identifiable emotional, mental, or physical problems.

Some Children and Families Do Require Ongoing Financial Support From the State. While many children coming out of the foster care system do not have any special needs which require exceptional levels of care, there are those children that do have special needs and do require additional, ongoing care. For example, a family may not be able to afford to adopt a sibling group. However, with ongoing financial assistance the family may be able to care for siblings and therefore keep the family intact. Likewise, there are children that will have ongoing health or emotional needs which do require intensive treatment that may be difficult for a family to afford. With adoption assistance payments, those children may be able to find a loving, stable, and permanent home.

Benefits Should Be Tied to Need. The AAP benefits should be limited to those children who would truly be hard to place without ongoing financial assistance, and the level of AAP benefits should be tied to the needs of the child.

Children in the State-Only Program Are No Different From Federally Eligible Children. The determination of whether or not a child is eligible for the federal AAP program is based upon the circumstances of their birth parents. The parents must meet the old AFDC eligibility criteria in order for the children to receive a federal grant. Those criteria are based upon the income of the parents and evidence of deprivation. Under these rules, deprivation means that one parent is absent or incapable of caring for the children. Essentially, the result is that the state-only children are no different from the federally eligible children. They do not come from more privileged backgrounds, nor do they have fewer special needs. The populations are virtually identical and, in our view, state policy should treat them in an identical manner.

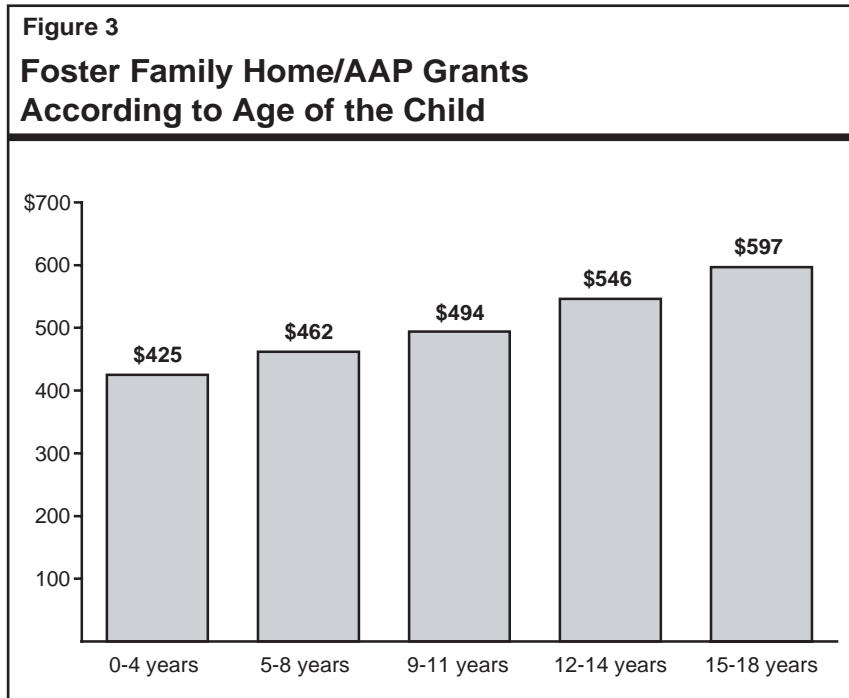
Analyst's Recommendation

Based on our review of the program, we conclude that there are several significant ways in which the Legislature could control the costs of the AAP program. Consistent with the above considerations, we recommend enactment of legislation making a series of reforms to AAP, which would improve the cost effectiveness of the program. The specific reforms are presented below.

Set Grant Levels to Recognize Adoptive Parents' Financial Responsibility. While states may not pay more than the maximum amount that the child would have received in Foster Care, there is nothing that precludes California from capping the amount of the AAP grant at a level below the maximum foster care rate. This cap would be consistent with an expectation that adoptive parents take over the role of parenting from the state, including some measure of fiscal responsibility. If the state capped the basic rate at 75 percent of the foster care rate, prospectively, the state would save \$600,000 in 2004-05 on new children entering the system and \$5.5 million in 2005-06 compared to the current program. This savings would increase annually as the pre-AAP reform children age-out of the program and new children are enrolled at the 75 percent level.

Better Tie Benefit Levels to Need. Currently, parents have the option of renegotiating the AAP grant they receive for their child at least once every two years. Essentially, these AAP negotiated increases mirror in-

creases in the Foster Care grants that occur as children age. Under the current program, children receive an average of \$45 per month more as they age in the program, starting at \$425 for 4 year olds and under, and ending at \$597 for children over 14 years old (see Figure 3). The state is not required by the federal government to increase the AAP grant amount based upon the age of the child.



Because these age-driven grant increases are virtually automatic and not based on a demonstration of need, we recommend such increases be eliminated. Instead, the reasons for grant increases should be more narrowly defined. That more narrow definition could include increased costs due to physical, mental, emotional, or medical problems that the child may have, which are directly tied to their birth parents or preadoptive circumstances. This reform would save the state approximately \$900,000 in 2004-05 and \$2 million in 2005-06.

Narrow Definition of Special Needs to Children Likely to Benefit the Most. As we noted earlier, inclusion of adverse parental background

as part of the definition of special needs means that virtually all children adopted from the foster care system are eligible for AAP assistance, regardless of whether they would otherwise be hard to place. In fact, one-third meet the definition through the catchall adverse parental background category. Assuming that a small percentage of those children would also qualify under another category, the incoming AAP caseload could be reduced by about 25 percent by eliminating the adverse parental background category. Specifically, under this approach, *healthy* children under the age of 3 that are not members of a minority group would no longer be eligible for immediate financial support. However, parents would remain eligible for deferred benefits. Specifically, if a child subsequently develops a physical, mental, emotional, or medical problem that can be traced directly to his or her birth parents or preadoptive circumstances, then those adoptive parents would be eligible to receive AAP benefits for their child. This is the approach that the State of Ohio has taken in limiting special needs, while still allowing those who may need it later to have access to the program.

This narrowing of the definition of special needs would save the state approximately \$500,000 in 2004-05, growing to \$4 million in 2005-06.

Implementation. The changes outlined above would require new regulations and county guidance. Assuming mid-year implementation, adopting these recommendations would result in General Fund savings of \$2 million in 2004-05 and \$12 million in 2005-06.



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 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 just over \$1 billion from the General Fund for support of the IHSS program in 2004-05, a decrease of \$136 million (13 percent) compared to estimated expenditures in the current year. Most of the decrease is attributable to (1) the full-year impact of the Governor’s mid-year proposal to eliminate the residual program, and (2) proposed reductions in state participation in provider wages.

GOVERNOR PROPOSES TO RESTRICT ELIGIBILITY AND REDUCE PROVIDER WAGES

The Governor's budget reflects his mid-year proposal to eliminate the residual (state-only) program and presents new proposals to limit state support for provider wages to the minimum wage, and reduce services for recipients living with able-bodied relatives. Together these proposals result in net General Fund savings of \$492 million in 2004-05. This is roughly 35 percent of total program costs based on the requirements of current law.

The Governor proposes sweeping reductions to the IHSS program in the form of eligibility restrictions, provider wage reductions, and limitations on services. The details of each aspect of the proposal are discussed below. In a subsequent discussion, we comment on the Governor's proposal and present alternatives for legislative consideration.

Eligibility Restriction

The proposed elimination of the residual (state-only funded) program represents a significant eligibility restriction. Eliminating the residual program is estimated to remove 57,000 aged, blind, or disabled individuals from the caseload and results in estimated net General Fund savings of \$366 million in 2004-05.

Currently, the residual program provides services to 75,000 recipients who are not eligible for federal reimbursement through Medicaid, which provides 50 percent federal funding for the PCSP. Figure 1 (see next page) shows the reasons the major components of the residual caseload are not eligible for the federally funded PCSP. The three largest components of the residual caseload are (1) those individuals receiving no personal care services (in other words, they only receive domestic services such as cleaning and meal preparation), (2) those persons who have chosen a responsible relative as their provider (generally the parent of a minor child or a spouse), and (3) those individuals receiving protective supervision services. The Governor's budget assumes that the approximately 18,000 recipients who have chosen a responsible relative as their provider will switch to a nonrelative provider and will therefore retain eligibility for IHSS by switching to the federally funded PCSP. The budget assumes that the remaining 57,000 cases will become ineligible for IHSS services.

Figure 1
IHSS Residual Program Caseload
Reason for Federal Ineligibility

Type of Case	Estimated Caseload ^a 2004-05	Percent of Total	
		Cases ^b	Expenditures
Receives advance pay	837	1.1%	3.8%
No personal care services (domestic services only)	29,175	38.9	20.4
Responsible relative provider (spouse or parent)	18,042	24.1	25.5
Protective supervision	14,516	19.4	23.4
Unknown	12,424	16.6	27.0
Totals	74,995	100.0%	100.0%

^a Based on percentages from September 2001 Department of Social Services (DSS) data applied to the caseload for 2004-05.
^b Based on DSS September 2001 special data report.

In addition to the above proposal to eliminate the state-only residual program, the Governor has two proposals that would impact the PCSP which is in part federally funded through Medicaid. These proposals are reducing provider wages and reducing services for recipients living with able-bodied relatives.

Reducing State Participation in Provider Wages

Minimum Wage. The Governor's budget proposes to limit state participation in provider wages to the California minimum wage (\$6.75 per hour). Currently, the state participates in provider wages of \$9.50 per hour plus 60 cents per hour worked for health benefits. Some counties pay more than this amount while others pay less. The proposed reduction in state participation in wage payments results in General Fund savings of \$98 million in 2004-05. Under the proposed policy, counties would be free to pay wages above the minimum wage, and the federal government would share in about 50 percent of the cost for wages above the minimum.

Implementation of the reduction would begin no sooner than October 2004 and would be delayed in any county until such time as their current collective bargaining agreements expire. According to the De-

partment of Social Services (DSS), the reduction would phase in between October 2004 and March 2005.

Elimination of Related Employer Mandates. Currently, counties are required to designate an entity as the “employer of record” for IHSS providers for purposes of collective bargaining. Many counties formed “public authorities” for this purpose. Current law also requires that counties form advisory committees to assist in this process. The Governor’s budget proposes to eliminate the requirement that counties designate an employer of record. This effectively removes the requirement that counties operate public authorities and have advisory committees. Accordingly, the budget eliminates funding for advisory committees and the portion of public authority costs attributable to collective bargaining negotiations. The state would continue to pay 70 percent of the nonfederal cost of the remaining public authority costs related to program administration—the county share is the remaining 30 percent. The net General Fund savings from eliminating these requirements are estimated to be \$2.2 million in 2004-05.

Reducing Services for Recipients Living With Relatives

The budget proposes to eliminate domestic services pertaining to common areas of residences that are shared with relatives. The reduction in services would be phased in during annual eligibility redeterminations beginning in October 2004 and is estimated to result in General Fund savings of \$26.3 million.

Background. Under current law, domestic services (cleaning, cooking, laundry, etc.) are provided to the recipient for his or her own room, and for common areas (such as the kitchen, living room, dining room) on a pro-rated basis depending on the number of individuals living in the household. For example, if one recipient occupying one bedroom with its own private bath lived in a household with 3 common rooms and 3 other individuals, current law would assign necessary domestic services for 100 percent of the recipient’s living quarters and a 25 percent share of the necessary upkeep for the three common rooms. The Governor’s budget proposes to eliminate services for common areas when the recipient lives with able-bodied relatives.

Future Proposal for Reducing Service Hours

The Governor’s budget notes that state level reviews of county determinations of service hours indicate that up to 25 percent of authorized service hours “may be unnecessary or not actually provided” to the recipient. The administration has indicated its intent to submit a quality

assurance proposal in the spring to improve the IHSS needs assessment designed to reduce the over-authorization of service hours.

We would note that the county reviews did not include Los Angeles County, which tends to assign less hours than the state average. Further, counties indicate that the review methodology did not employ a completely random sample. The 25 percent finding, was based on a subset of cases for which a desk audit first indicated a significant potential for error. For these reasons, the 25 percent figure should probably be viewed as an upper end estimate. Nevertheless, a well-designed quality assurance program could result in significant savings.

COMMENTS ON THE GOVERNOR'S IHSS PROPOSAL

The Governor's proposal to eliminate the residual program, limit state participation in provider wages, and reduce services to recipients with relatives results in substantial state budgetary savings and a potential hardship for low-income Californians who receive IHSS. We recommend that the Legislature consider each aspect of the proposal on a case-by-case basis, assessing both its impact on recipients and the estimated savings. We believe the proposal to limit services for recipients living with family members merits approval because it is a reduction in services that can probably be absorbed by family members. With respect to the other proposals, we make no recommendation. Finally, we recommend that the administration report at budget hearings on the costs and benefits of a quality assurance program.

Below we comment on each aspect of the Governor's IHSS proposal. To assist the Legislature in evaluating the proposal, we developed a series of considerations which we apply to the relevant elements of the Governor's proposal. Specifically, the Legislature should consider:

- ***Impact on Recipients.*** What is the impact on recipients? Does the proposal achieve savings through benefit termination, by shifting recipients to the federally funded PCSP, or by reducing services or reducing choices available to the recipients?
- ***Increasing Federal Funds.*** Are there ways to facilitate more recipients becoming federally eligible? Shifting recipients from the state-only funded residual program to the federally supported PCSP benefits both the state and recipients. The state benefits from the federal financial participation which effectively reduces state and county costs by 50 percent. Recipients benefit by retaining their services.

- **Administration Issues.** Does the proposal raise implementation concerns?
- **Realistic Savings.** Are the savings estimates reasonable and what is the potential for cost shifts to other state programs?

Eliminating the Residual Program

As discussed earlier, the residual program provides services to those who are not eligible for the federal PCSP. (Please refer to Figure 1 for a breakdown of the reasons recipients in the residual IHSS program are ineligible for federal benefits.)

Impact on Recipients. Eliminating the residual program means that some recipients will lose benefits while others may be able to transfer to the federally funded PCSP. The budget assumes that 18,042 recipients with responsible relative providers will switch to nonrelative providers, thereby obtaining eligibility for the federally funded PCSP. (Responsible relative providers are typically a parent providing services to a dependent child, or a spouse providing services to a husband or wife.) In addition, 837 recipients who receive their IHSS funds at the beginning of the month and then disburse wages to their provider over the course of the month, will have the option of shifting to PCSP if they are willing to give up their “advance payment.” Also, some portion of the 29,175 cases which receive only domestic services, and do not receive personal care services (bathing, toileting, etc.), could potentially become federally eligible if a social worker determines that some personal care services may be needed. (The federal government will pay for domestic services, so long as some personal care services are provided as well.) The remaining 27,000 residual cases will probably lose eligibility for the program.

Potential Income Loss for Certain Households. As discussed above, recipients with responsible relative providers may obtain eligibility for the federally funded PCSP by choosing a nonrelative to provide their IHSS services. That means the responsible relative would no longer be paid IHSS wages. In order to maintain the household income, the responsible relative would need to replace the lost IHSS wages with other earnings. However, under current federal regulations, such earnings in certain circumstances would be counted as family income available to the IHSS recipient and could reduce or completely eliminate the IHSS recipient’s SSI/SSP payment. (Most IHSS recipients receive an SSI/SSP grant.) The DSS was unable to provide sufficient data to determine how many households might face this potential reduction in SSI/SSP benefits.

Facilitating the Shift to the Federal Program. Although the budget assumes that 18,000 recipients with responsible relative providers will

switch to PCSP by changing to a nonrelative provider, such a massive change in providers may be difficult to achieve in a three-month transition period. If the Legislature were to adopt the Governor's proposal, it may wish to consider phasing in over a longer period the program change for recipients with responsible relative providers in order to facilitate the transition. Also, some recipients may be uncomfortable with a nonrelative as their IHSS service provider. Accordingly, the Legislature could consider a system whereby current responsible relative providers switch and become the provider for other families with IHSS recipients. For example, a mother currently caring for her daughter might be more comfortable with a nonrelative provider if she understood that the provider herself had a daughter receiving IHSS. To this end, the Legislature could provide technical assistance to public authorities to maintain registries of providers who have relatives receiving IHSS.

Estimated Savings Appear Reasonable. The administration estimates that net General Fund savings from eliminating the residual program will be \$366 million in 2004-05 (\$422 million in residual savings offset by cost of \$56 million for former responsible relative provider cases shifting to PCSP). It is difficult to anticipate exactly how recipients and social workers would react under this proposal. On the one hand, not all recipients with responsible relative providers may be willing to switch to nonrelative providers. This would tend to increase the savings. Conversely, some of the advance pay cases are likely to switch to PCSP where the state has a share of costs, which would decrease state savings. Similarly, some of the domestic service only cases may switch to PCSP after reapplying for benefits, again potentially reducing the savings. Finally, the earnings of responsible relatives who no longer serve as IHSS workers could reduce SSI/SSP payments to recipients, which would result in state savings on SSI/SSP grant expenditures. Since the above factors could offset each other, the overall estimated savings appear to be reasonable.

Potential for Cost Shifts to Other State Programs. It is difficult to predict what may happen to recipients losing their in-home services. Some recipients may rely on extended family resources and move in with relatives or enter private assisted living centers. Others may need state-funded skilled nursing home care. Exit data compiled by DSS indicates that 9 percent of IHSS recipients exit to skilled nursing facilities and that 6 percent exit to some other type of out of home care. For illustration purposes, if 9 percent of the 57,000 cases facing service termination ultimately moved into a state-funded skilled nursing facility, the state costs would be about \$125 million per year.

Reducing Provider Wages

Impact on Recipients. The proposal to reduce state participation in provider wages to the minimum wage has no *direct* impact on services for recipients. Instead, it reduces the income of providers. Reducing provider wages could have *indirect* impacts on recipients, however, by changing the labor pool available for IHSS. With lower wages, it is possible that some recipients may be unable to find providers and/or that their providers will be less skilled.

Savings Estimates. The administration estimates that limiting state support for provider wages to the minimum wage will result in savings of \$98 million in 2004-05 based on part-year implementation. The full-year savings in 2005-06 would be \$148 million. Based on our analysis, these savings estimates appear reasonable.

Reducing Services for Recipients Living with Relatives

Impact on Recipients. The proposal to eliminate domestic services related to the maintenance of common areas of living quarters shared with relatives has no impact on program eligibility. Rather, it results in a reduction in service hours. The impact would largely fall on the able-bodied family members who would need to assume responsibility for common area upkeep.

Savings Estimates. The estimated General Fund savings from this proposal are \$26 million in 2004-05 based on part-year implementation. Full-year savings in 2005-06 would be \$84 million. The amount of savings depends on how many IHSS recipients live with relatives. The DSS assumed that 65 percent of IHSS cases with “in common” domestic services lived with relatives, but has no data to support this assumption.

Implementation Concerns. In reviewing this proposal, the Legislature needs to carefully consider the definition of “common” services. For example, if the relatives work during the day, then lunch-time meal preparation and clean-up should probably not be considered a common service. Finally, under this proposal, recipients living with relatives will face a service reduction while recipients living with a nonrelative will not. This proposed difference in treatment in the PCSP may not be allowable under Medicaid rules pertaining to “state wideness” and “comparability.” Under the state wideness rule, all recipients must have access to similar types and levels of care. Under comparability, Medicaid services must be equal in amount, duration and scope for those who are categorically eligible. To implement this proposal, the state may need a waiver of these federal rules.

Establishing a Quality Assurance Program

As mentioned earlier, the Governor's budget indicates that as much as 25 percent of service hours may be unnecessary or not actually provided to the recipient. The budget further indicates that a quality assurance proposal designed to address the over-authorization issue will be submitted during the spring of 2004.

State staff indicate that county workers in assessing the level of functional impairment of IHSS clients often fail to ask follow up questions to better determine the precise need for service hours. As a result, some cases are assigned more hours than necessary to compensate for the functional impairment of the IHSS client.

Investing in Quality Assurance. Given the potential for county over-authorization of hours, an investment in a quality assurance program could yield significant savings. Quality assurance could take many forms. For example, the Legislature could provide funding for technical assistance to better train county social workers who make IHSS assessments and ensure more consistency. In addition, the Legislature could provide increased funding for county social worker positions, so that IHSS intake caseloads could be reduced so as to allow social workers the time needed to be more thorough and assign service hours in a manner more consistent with state guidelines.

Potential Funding Source for Quality Assurance Activities. One potential source of funds to support a quality assurance program would be a fee on providers. Under this approach, providers would be "held harmless" because the proposed fee would be offset by a corresponding wage increase. Although all IHSS providers (both residual and federally funded PCSP providers) would pay the fee and receive the wage increase, the wage increase paid to PCSP providers would draw down federal funds through Medicaid. These federal funds would free up some of the fee revenues that otherwise would be needed to fund the wage increase for PCSP providers. The freed-up fee revenues could then be used to fund a quality assurance program. For a complete discussion of quality assurance fees (including other caveats and considerations), please see the "Crosscutting Issues" section of this chapter.

Analyst's Recommendation

The Governor's proposal to eliminate the residual program, limit state participation in provider wages, and reduce services to recipients living with relatives results in substantial state budgetary savings, but a potential hardship on low-income Californians who rely on their IHSS providers. We recommend that the Legislature consider each aspect of the pro-

posal on a case-by-case basis, assessing both its impact on recipients and the estimated savings. Whether to adopt any of these proposals is a policy decision for the Legislature.

We believe the proposal to limit services for recipients living with family members merits approval because it is a reduction in services that can probably be absorbed by family members. With respect to the other IHSS proposals, we make no recommendation. Finally, we recommend that the administration report at budget hearings on the costs and benefits of a quality assurance program.

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 \$3.3 billion from the General Fund for the state's share of SSI/SSP in 2004-05. This is an increase of \$202 million, or 6.4 percent, above estimated current-year expenditures. This increase is primarily due to costs associated with replacing one-time federal fiscal relief funds with General Fund monies and a caseload increase, partially offset by savings due to not "passing through" the January 2005 federal cost-of-living adjustment (COLA), and eliminating the California veterans cash benefit.

In December 2003, there were 345,116 aged, 21,753 blind, and 788,331 disabled SSI/SSP recipients. In addition to these federally eligible recipients, the state-only Cash Assistance Program for Immigrants (CAPI) was estimated to provide benefits to about 8,600 legal immigrants in December 2003.

Budget Proposes COLA Suspensions

By suspending the January 2005 state cost-of-living adjustment (COLA) and not passing through the January 2005 federal COLA, the budget achieves combined savings of \$147 million in 2004-05 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 COLAs are funded by both the federal and state governments. The state COLA is based on the California Necessities Index 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) is applied annually to the SSI portion of the grant. The remaining amount needed to cover the state COLA on the entire grant is funded with state monies.

Governor's Proposals Achieve \$147 Million in Savings. The Governor proposes to suspend the January 2005 state COLA (2.77 percent) which

results in a cost avoidance of \$84.6 million in 2004-05. In addition, the Governor proposes no pass through of the January federal SSI which results in savings of \$62.5 million. Under this proposal the state funded SSP portion of the grant is reduced by the precise amount of the federal increase which becomes effective January 2005.

Impact on Recipients. Figure 1 shows the SSI/SSP grants for January 2005 for individuals and couples under both current law and the Governor's proposal. Although the total grant remains the same in January 2005, the SSP portion is \$22 (9.2 percent) less than the grant under current law. For couples, the SSP grant is \$39 (6.8 percent) less than current law. Figure 1 also compares the grants under current law and the Governor's proposal to the 2003 federal poverty guideline. Specifically, the maximum monthly grant for individuals would be 109 percent of poverty under current law, but would fall to 106 percent under the Governor's proposal. Grants for couples would be 142 percent of poverty under current law, but would fall to 139 percent under the Governor's proposal. (We note that poverty guidelines are adjusted annually for inflation.)

Figure 1

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

January 2004 Through January 2005

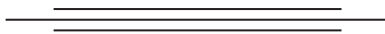
Recipient Category	January 2004	January 2005		Change From Current Law	
		Current Law	Governor's Budget	Amount	Percent
Individuals					
SSI	\$564	\$574	\$574	—	—
SSP	226	238	216	-\$22	-9.2%
Totals	\$790	\$812	\$790	-\$22	-2.7
Percent of Poverty^a	106%	109%	106%		
Couples					
SSI	\$846	\$861	\$861	—	—
SSP	553	577	538	-\$39	-6.8%
Totals	\$1,399	\$1,438	\$1,399	-\$39	-2.7%
Percent of Poverty^a	139%	142%	139%		

^a 2003 U.S. Department of Health and Human Services Poverty Guidelines. We note that the guidelines are adjusted each year for inflation.

About 560 Recipients Would Become Ineligible. Recipients who receive social security payments in excess of the federal SSI grant do not receive SSI but may receive SSP payments, and are known as “SSP-only” cases. The Governor’s proposal to not pass through the federal COLA has the effect of reducing the maximum monthly SSP grant by \$10 for an individual and \$15 per couple compared to the current SSP grant. Under this proposal, individuals receiving \$10 or less in SSP benefits in December 2004 would have their benefits drop to zero and become ineligible for SSI/SSP in January 2005. (The corresponding figure for couples is \$15 per month.) In total, about 560 individuals and couple members would lose eligibility under this proposal. Becoming ineligible for SSI/SSP may result in a Medi-Cal share of cost for affected individuals.

Enrollment Cap and County Block Grant For Program Serving Immigrants

The CAPI provides state-only SSI/SSP for legal noncitizens who are ineligible for federal benefits. The Governor proposes to cap enrollment in this program at 8,645 recipients effective April 1, 2004. As of October 2004, the Governor proposes to shift funding for this program (and other programs that serve immigrants) to counties in the form of a block grant. The budget assumes that counties will achieve service delivery efficiencies and therefore reduces funding for this program (and the other block grant programs) by 5 percent. For our comments on this proposal, please see the “Crosscutting Issues” section of this chapter of this *Analysis*.



FOOD STAMPS PROGRAM

The federal food stamps program is estimated to provide about \$2 billion in food coupons to approximately 1.8 million low-income families in California in 2004-05. With the exception of the state-only food assistance program (discussed below) the cost of the federal food coupons is borne entirely by the federal government. The associated administrative costs are shared between the federal government (50 percent), the state (35 percent), and the counties (15 percent).

Generally, individuals and families eligible for food stamps must have a net income (after income deductions are applied) of less than 100 percent of the FPL (about \$15,260 a year for a family of three). In addition, certain resource restrictions apply, such as a limit on the value of a vehicle. Other nonfinancial restrictions also apply.

California Food Assistance Program (CFAP)

The 1996 federal welfare reform legislation significantly restricted food stamp eligibility for noncitizens. In response, the state created the CFAP in 1997 to provide state-only funded food stamp benefits to qualified legal immigrants who are ineligible for federal food stamps. Since 1997, the federal government has incrementally reinstated benefits for some legal noncitizens. Under current federal law, generally all legal noncitizens are eligible for federal benefits except for those who have been residing in the United States less than five years, and are between 18 and 65 years old.

The budget estimates that in 2004-05 the average monthly CFAP caseload is expected to decrease to about 10,230 at a total state cost of \$10 million for food coupons and \$2 million for administrative costs. The budget proposes to cap the CFAP caseload at the April 1, 2004, level for savings of \$146,000. In addition, effective October 2004 program funding would be reduced by 5 percent and the funds for CFAP would be given to counties in a block grant. (For more information about the proposed

enrollment cap and the block grant proposal, please see our discussions in the “Crosscutting Issues” section of this chapter.)

Revenue Loss Exceeds Administrative Savings From Governor’s Food Stamp Proposals

The Governor’s budget proposes to repeal recent legislation which expanded eligibility for the food stamps program. Eliminating these eligibility expansions would result in (1) combined General Fund administrative and CFAP savings of about \$3.5 million in the budget year, and (2) foregoing \$203 million in federal food coupons for low-income Californians. In addition, the loss of General Fund revenue associated with these proposals would be about \$4.5 million. Accordingly, we recommend (1) rejecting the Governor’s proposal to delete the expansions and (2) recognizing the General Fund revenue associated with the expansions. (Increase Item 5180-001-0001 by \$3.5 million in 2004-05 and increase General Fund revenue by \$4.5 million.)

Recent Food Stamps Program Changes. Chapter 225, Statutes of 2003 (AB 1752, Oropeza), created the Transitional Food Stamps Program (TFS), which provides five months of additional food stamps to families leaving welfare without requiring the family to reapply for benefits. In addition, Chapter 743, Statutes of 2003 (AB 231, Steinberg), made TFS rules less restrictive, allowed for the exclusion of the value of a motor vehicle in determining eligibility in the food stamps program, and allowed for the elimination of a face-to-face interview as a requirement of the food stamps application process.

These changes to the food stamps program are estimated to increase the federal food stamp and CFAP caseloads by 81,000, increase the amount of federal food coupons the state receives by \$203 million, increase administrative costs by about \$1.9 million, and increase CFAP costs by \$1.6 million in the budget year.

Budget Proposal. The Governor’s budget proposes to eliminate the TFS and repeal the recently enacted program changes include Chapter 743. These changes would result in combined General Fund administrative and CFAP savings of about \$3.5 million in the budget year. However, after accounting for one-time administrative costs, the ongoing savings would be \$2.2 million. The Governor’s proposals to eliminate these eligibility expansions would also result in foregoing about \$203 million in federal food coupons.

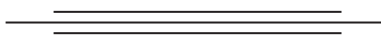
The Budget Proposal Ignores General Fund Revenue Effect. Research shows that low-income individuals generally are not able to save money because their resources are spent on meeting their daily needs, such as

shelter, food, and transportation. Therefore, for every dollar in food coupons that a low-income family receives, an additional dollar is available for the consumption of food or other items. Research done at the University of California and elsewhere indicates that individuals with income low enough to be eligible for food stamps would, on average, spend about 45 percent of their income on goods for which they would pay sales tax. The state General Fund receives about 5 cents for every dollar that is spent on a taxable good. Local governments and special funds receive the remainder of the sales tax revenue (generally about 2.25 percent). Because additional food coupons would result in low-income families spending more of their other resources on taxable goods, the receipt of federal food coupons helps to generate revenue for the state and for local governments.

The administration anticipates that eliminating TFS and the Chapter 743 expansions would result in foregone federal food coupons of about \$203 million. However, that is not the only loss the state would experience. The state would also lose General Fund sales tax revenue. This is because, based on the research described above, we estimate that the foregone food coupons would have freed up an equal amount of income that families could spend on other items, including taxable goods. Assuming that 45 percent of the family's purchases are on taxable goods, about \$91 million would be spent on taxable goods. Because the state General Fund receives 5 cents for every dollar that is spent on a taxable good, these purchases would generate about \$4.5 million in General Fund revenue annually.

The revenue loss of \$4.5 million annually (\$3.7 million associated with TFS and \$835,000 associated with Chapter 743) is greater than the estimated General Fund administrative savings of about \$3.5 million in the budget year. Accordingly, the total impact of the Governor's proposals is a net loss of about \$1 million in the budget year (\$4.5 million revenue less \$3.5 million costs). The ongoing loss would be about \$2.3 million annually (\$4.5 million in revenue less \$2.2 million in ongoing costs).

Analyst's Recommendation. As described above, the General Fund revenues associated with retaining TFS and Chapter 743 eligibility expansions outweigh the administrative costs. Accordingly, we recommend rejecting the proposed elimination, restoring the necessary administrative and CFAP expenditures to the budget, and recognizing General Fund revenue of \$4.5 million.



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 *2004-05 Governor's Budget* proposes \$2.1 billion from all funds and \$610 million from the General Fund for CWS. This represents a decrease of 3 percent from the General Fund over current-year expenditures. This decrease is primarily due to a reduction in automation costs and declining emergency shelter and direct services costs.

BUDGET FOR IMPROVING CHILDREN'S PROGRAMS SHOULD REFLECT LEGISLATIVE PRIORITIES

The Governor's Budget proposes spending a total of \$39 million (\$4.6 million General Fund) on a variety of child welfare services and foster care program improvements. The majority of that funding is for continuing the Child Welfare Services (CWS) Redesign planning process including provision of technical assistance to counties as they complete the planning stages of the redesign and for upfront training for county personnel. The funds will not be used to provide additional or new services for children and families. We believe the funding request is premature and that the administration needs to provide more details to the Legislature about the specific goals of the CWS Redesign and the steps and funding needed to reach those goals. Accordingly, we recommend eliminating the proposed funding. (Reduce Item 5180-151-0001 by \$558,000. Reduce Item 5180-151-0803 by \$3,850,000. Reduce Item 5180-151-0890 by \$14,343,000.)

Governor’s Budget Provides \$39 Million for Improving Children’s Programs

Background. Over the last few years, California has undertaken three major efforts designed to improve the outcomes for children and families in the CWS program. The first effort was driven by the federal government when it established a performance-based review of the states to determine the success of their children’s programs. States that failed the reviews were required to develop a Performance Improvement Plan (PIP). The second effort originated with the prior administration, which in the 2000-01 Budget Act obtained authority to establish the CWS Stakeholders group to review the current CWS system in California and make recommendations for restructuring the program (referred to as the CWS Redesign). The final effort is embodied in the Child Welfare System Improvement and Accountability Act (Chapter 678, Statutes of 2001 [AB 636, Steinberg]). This act called for the development of a county review process to identify strengths and weaknesses in local child welfare services programs and assist in sharing and implementing best practices. The Governor’s Budget provides a total of \$39 million in federal funds, state General Fund, county funds, and special funds to implement a variety of changes tied to these three efforts to improve child welfare services. Figure 1 provides details of the funding for the three separate projects.

Figure 1				
Child Welfare Services Improvements				
Governor’s Funding Priorities				
<i>(In Millions)</i>				
	Total Funds	General Fund	TANF^a	All Other^b
Redesign	\$19.1	\$0.6	\$7.0	\$11.5
Federal PIP	10.6	0.7	9.0	0.9
Chapter 678	9.5	3.2	2.0	4.3
Totals	\$39.2	\$4.5	\$18.0	\$16.7

^a These Temporary Assistance for Needy Families (TANF) funds are transferred to the Title XX social services block grant and then are expended for specified purposes.

^b This includes other federal funds (\$10.9 million), state special funds (\$3.9 million), county funds (\$1.6 million), and foundation grants (\$375,00).

Funding for the Child Welfare System Improvement and Accountability Act of 2001. With the enactment of Chapter 678 the Legislature declared that the State of California had failed in its obligation to protect and care for children removed from their homes and placed in the foster care system. As a way of addressing that failure, the Legislature required the development and implementation of an outcome-based system designed to evaluate county operations of child welfare services. The system includes Web-based reporting of county specific program outcomes, and requires counties to conduct self-assessments and to develop system improvement plans.

The Governor's budget proposes spending \$9.5 million for improving data gathering for county self assessments, funding six reviewers for the required peer quality case reviews, and hiring 58 county coordinators for the county self assessments and system improvement plans. However, there is no funding dedicated to helping the counties implement any corrective actions that may be necessary as a result of the reviews.

Funding for Program Improvement Plan Requirements. Federal performance reviews of state child welfare services and foster care programs were conducted in California for the first time in the fall of 2002. California failed to meet any of the seven safety, permanency, and well-being outcomes measured by the federal government. The state also failed five of the seven "systemic factors" that measure the quality of services provided to children and families. As a result, the state was required to submit a PIP, with specific, measurable improvements that will be made under specific time frames. (For more detail on this issue see our discussion of California's performance in the *2003-04 Analysis of the Budget Bill*.) Failure to achieve these improvements could result in federal penalties and reduced Title IV-E funding.

Specifically, the budget provides a total of \$10.6 million for the federal PIP requirements. This includes \$3 million to recruit minority foster parents, \$6 million to backfill for social workers as they attend training, \$1 million for improving data quality in CWS/Case Management System (CMS), and \$500,000 for additional positions at the state level to handle the increased data activities.

Funding for CWS Redesign. The *2000-01 Budget Act* appropriated \$800,000 for the development of the Child Welfare Stakeholders' Group. These stakeholders were charged with reviewing the existing CWS program and providing recommendations for improvements. This process has come to be known as the CWS Redesign.

The prior administration spent three years on the redesign process intended to improve outcomes for children and families involved in the child welfare services program. The first year (2000-01) was set aside for

studying the problems with the current program. The second year (2001-02) was designed to search for solutions and improvements. Finally, the third year (2002-03) was to be focused on developing a detailed implementation plan for the new, redesigned CWS program. Unfortunately, only the first two phases were completed during the three-year project. The final CWS Redesign report was released in September 2003. The report offers high-level concepts for improving the child welfare services program. It also notes that there currently are funding constraints which do not allow many of the concepts to be implemented and that state and federal law changes are necessary to implement many of the Redesign objectives.

The Governor's budget proposes allocating \$19 million to counties to continue the planning process begun during the Child Welfare Stakeholders' Group and to provide upfront training.

Redesign Funding Should Be Eliminated

Redesign Proposal Lack Necessary Details. The Legislature appropriated \$800,000 in the *2000-01 Budget Act* to study the current child welfare services system with the expectation that detailed recommendations for improvements would be presented at the end of the study. It was anticipated that the final report would provide a detailed framework for improving the program. With this framework, the administration and the Legislature could then establish priorities and begin making improvements to child welfare services. However, as noted above, the final report provides only high level concepts for reforming CWS. In addition, the administration has failed to produce a detailed implementation plan that outlines the specific programmatic changes that will take place and their associated costs and outcomes. The administration proposes \$19 million for planning, technical assistance, and training without sufficient detail as to what outcomes can be expected from this investment.

Analyst's Recommendation. In view of the above, we believe that the budget's funding request is premature, and we recommend that the \$19 million budgeted for the CWS Redesign be eliminated. We also recommend that any future funding for the Redesign be contingent upon the administration presenting an implementation plan that identifies specific activities that will be implemented, their associated costs and the outcomes expected from those activities, and necessary legislation. This type of detailed plan would allow the Legislature to review an array of options designed to improve services. Such information would permit the Legislature to prioritize the program changes and select which improvements should be put into place and along what timeframe. Absent that type of detailed implementation plan,

the Legislature does not have sufficient information to assess the value of the proposed restructuring of CWS.

We note that the majority of the funding for the Redesign is federal funding or from special state funds, therefore the General Fund savings resulting from this recommendation are relatively small (\$558,000) in the overall context of the total expenditure for the Redesign. However, most of this funding could be redirected within the CWS program to fund other legislative priorities. Further, \$7 million of the proposed amount is Temporary Assistance for Needy Families funding that has been redirected into Title XX. That funding can be redirected to the California Work Opportunity and Responsibility for Kids program and could possibly be used to offset some state General Fund expenditures.

CHILD WELFARE SERVICES/ CASE MANAGEMENT SYSTEM

Background

The CWS/CMS provides a statewide database, case management tools, and a reporting system for the state's CWS program. The system has been in operation for seven years and is maintained and operated by an independent contractor. The CWS/CMS system costs about \$100 million annually to operate (\$70 million for contractor costs and \$30 million in other costs).

Federal Government Provided Enhanced Funding. In 1993, the federal government offered enhanced funding to any state that agreed to develop a Statewide Automated Child Welfare Information System (SACWIS). A SACWIS system performs certain functions such as processing child abuse investigations and preparing foster care case plans. If a state chose to develop such a system, then the federal government provided "incentive funding" at 75 percent of total costs for the first three years of the project's development and then 50 percent for the subsequent years. If a state received incentive funding but is ultimately unable to meet the SACWIS requirements, the federal government requires that the state return the difference (25 percent) in funding. In 1994, the state received federal approval to develop CWS/CMS as California's SACWIS system.

CWS/CMS Does Not Meet SACWIS Requirements

In 1997, the state announced the completion of the CWS/CMS system when it became operational in all counties. The federal government, however, did not consider CWS/CMS complete because the system did

not meet all the SACWIS requirements. Since 1999, the federal government has repeatedly raised concerns about the inability of the CWS/CMS system to meet SACWIS requirements. We discuss these federal concerns in more detail below.

Failure to Address Federal Procurement Requirements. In 1997, the federal government and the Departments of Finance and General Services directed the Health and Human Services Agency Data Center (HHSDC) to conduct a competitive procurement for a new contract to pay for the ongoing maintenance and operation activities of CWS/CMS. In 2000, the state began the competitive procurement. It was subsequently cancelled in 2002 because HHSDC was unable to address federal procurement requirements.

Inability to Implement All SACWIS Functions. In 1999, the federal government conducted a review of CWS/CMS and determined that the system did not meet the following SACWIS requirements: (1) adequate adoption case management, (2) an automated interface between CWS/CMS and the state's welfare and child support automation systems, (3) authorizations for service provider payments, and (4) foster care eligibility determinations. Of these requirements, the state has only begun addressing the adoption component.

Lack of Full Project Review. In 2001, the federal government directed the state to conduct a thorough project review of CWS/CMS. The scope of the review was to include (1) an audit of past and current CWS/CMS costs and expenditures, (2) an analysis of the state's procurement strategy for the new maintenance and operation contract, and (3) a review of CWS/CMS project roles and responsibilities. To date, the state has only completed the analysis of the procurement strategy.

Failure to Require Full CWS/CMS Usage. In 2002, the federal government conducted a review of the state and counties use of CWS/CMS. The review found that the state did not require counties to use all of the functions in the system despite the federal requirement that a state use all of the SACWIS functions. Current state policy allows each county some discretion in determining how much of the CWS/CMS system to use. For example, some counties use the CWS/CMS health and education data collection system whereas other counties do not use these functions. To meet SACWIS requirements, the state must require use of all CWS/CMS functions by all counties.

Failure to Transfer CWS/CMS Hardware to HHSDC. The CWS/CMS system operates at the contractor's data center in Boulder, Colorado. In June 2003, the federal government directed the state to transfer the CWS/CMS hardware to a state facility. The state has not started this effort.

Federal Government Reduces Funding

As a result of long-standing concerns, the federal government reduced funding for the maintenance and operation of the Child Welfare Services/Case Management System. As the administration does not recognize this drop in federal funds, the budget understates General Fund costs by \$43 million for the current and budget years combined.

In June 2003, the federal government notified the state that it did not consider CWS/CMS a SACWIS compliant system for the reasons discussed above. As a result of this decision, the federal government, starting in July 2003, reduced its share of funding for CWS/CMS from roughly 50 percent to 30 percent. (The precise funding ratio is still being determined by the state and federal governments.) In addition, the federal government notified the state that it would not provide any federal funding for the current contract (which, again, is almost three-fourths of total system costs) after August 2005. We discuss the consequences of these funding reductions below.

Current-Year Deficiency About \$23 Million. As summarized in Figure 2, the 2003-04 Budget Act estimates \$56 million will be received in federal funding for CWS/CMS. This estimate is based roughly on (1) a 50 percent funding ratio and (2) an overall CWS/CMS cost of \$111 million. Since the lower federal funding ratio began at the start of 2003-04, we estimate that the state share of cost for CWS/CMS will be about \$78 million General Fund—\$23 million more than what is estimated in the 2003-04 budget. (If the state took actions to reduce current-year expenditures, the state’s share of costs would also decline. As of December

Figure 2

Child Welfare Services/Case Management System Estimated Costs for Current and Budget Years

(In Millions)

	2003-04		2004-05	
	Enacted Budget	LAO Estimate	Proposed Budget	LAO Estimate
Federal funds	\$56	\$33	\$49	\$29
General Fund	55	78	47	67
Totals	\$111	\$111	\$96	\$96

2003, the state had not reduced the CWS/CMS current-year activities.) The administration fails to account for this \$23 million increase in projected costs in its spending plan.

Additional \$20 Million Needed in Budget Year. The budget proposes \$96 million for CWS/CMS ongoing maintenance and operation in 2004-05. This includes a \$15 million reduction from estimated current-year expenditures due to the completion of one-time computer upgrades and contract reductions. The budget again assumes roughly a 50 percent federal funding ratio in 2004-05 (\$49 million). Given that the current federal funding ratio is about 30 percent, we estimate the state's General Fund share of costs in the budget year will be about \$67 million—\$20 million more than what is proposed in the budget.

One-Time Repayment of \$50 Million. Since the federal government has determined CWS/CMS to be a non-SACWIS system, the state will need to eventually repay the federal government for the incentive funding it received in the first three years of CWS/CMS development. According to the administration, this one-time repayment is about \$50 million. In its June 2003 letter, the federal government indicates that the amount and payment time period are open to negotiation. The Governor's budget does not contain any funding to begin this repayment.

Additional Costs Beyond 2004-05. Beginning in August 2005, the federal government will no longer provide any funding for the state's current CWS/CMS contract. (The federal government will continue to provide its share of funds for the noncontract costs.) Consequently, the state will be financially responsible for all costs from the current contract until a new contract can be procured. Once a new contract is procured, the federal government will share in the costs of the new contract. The federal share will depend on whether the state is SACWIS compliant. The administration estimates that it will complete the procurement for the new contract in 2008. Thus, we estimate the state will incur annual General Fund contract costs of about \$75 million from 2005-06 to at least 2007-08.

Administration Should Consider Two Alternatives

The state has to make a choice about what to do with CWS/CMS. We believe there are two basic alternatives. One alternative is to make CWS/CMS compliant with SACWIS. The other alternative is to acknowledge that the system will not meet SACWIS requirements. Under either alternative, the state will need to procure a new contract in order to receive any federal funding. As of December 2003, the state had not conducted an analysis of the two alternatives. The administration has so far simply

assumed that pursuing SACWIS compliance is advisable. Since the department has not prepared costs estimates for modifying CWS/CMS to meet SACWIS requirements, we are unable to recommend which of these two alternatives is the most cost-effective approach and would provide the most benefits to the state. We do, however, discuss below some of the general benefits and cost implications of each alternative.

Meeting Federal SACWIS Requirements. To meet SACWIS requirements, the state will need to implement a number of changes to the current CWS/CMS system. The federal government believes these SACWIS requirements offer significant program benefits to states' CWS programs. For example, if the state implemented the SACWIS foster care eligibility requirement, the state would be able to qualify children for foster care and Medi-Cal at the same time. The administration has not completed an analysis of the benefits from the SACWIS functions from the state's perspective. We do know, however, that the required changes to CWS/CMS would ultimately increase state costs by tens of millions of dollars. This alternative likely would also result in (1) restoration of increased federal funding and (2) avoidance of the one-time repayment of the incentive funding.

Non-SACWIS System. Alternatively, the state could declare CWS/CMS a non-SACWIS system. According to the federal government, the benefits of a non-SACWIS system are: (1) elimination of the need for SACWIS modifications, (2) more state control over changes and enhancements to the system, and (3) less federal review and oversight. A non-SACWIS system would allow the Legislature more discretion in setting the priorities for the CWS/CMS system. If the state chose to declare CWS/CMS a non-SACWIS system, the state would continue to receive a lower level of federal funding (30 percent). In addition, the state could face the one-time repayment costs for the incentive funding (about \$50 million).

Administration Should Report on Alternatives and Revise Proposal's Costs

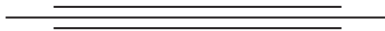
The Legislature must make a decision on how to proceed with the Child Welfare Services/Case Management System (CWS/CMS) system. For this reason, we recommend the administration report at budget hearings on (1) the actions it can take to reduce the ongoing costs of the CWS/CMS system and (2) its analysis of the costs and benefits of the alternatives. In addition, we recommend that the administration provide a revised budget proposal that reflects the current federal funding ratio.

It is important that the Legislature set direction for the future of the CWS/CMS system. From a program standpoint, it is important to ensure that the system meets the needs it was intended to serve. From a budget-

ary standpoint, it is important to know current and future costs. For these reasons, we make recommendations below on how to best move forward with the system.

Address Increased Costs. For the current and budget years combined, the Governor's budget fails to account for a \$43 million drop in federal funding (and corresponding increases in General Fund costs). The administration has existing authority in the current year to implement cost savings strategies to address \$23 million of this amount. During budget hearings, we recommend that the administration report on any actions it has taken or could take to reduce CWS/CMS costs.

Require Administration to Analyze and Report on Alternatives. At this stage, the Legislature does not have the necessary information to make an informed decision. Yet, a choice needs to be made. Consequently, we recommend that the administration report at budget hearings on its analysis of the two alternatives, including each alternative's benefits and costs. The Legislature could then make an informed decision on the preferred alternative. The administration could then provide a revised budget proposal in its May Revision. The revised budget proposal should be consistent with the current federal funding ratio and include any costs to implement the proposed alternative.



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 provides oversight for the county-administered foster care system. County welfare departments make decisions regarding the health and safety of children and have the discretion to place children in one of the following: (1) a foster family home, (2) a foster family agency home, or (3) a group home.

The Governor's budget proposes expenditures of \$1.7 billion (\$470 million General Fund) for the Foster Care Program in 2004-05. This represents an 11 percent decrease in General Fund expenditures from the current year. This decrease is primarily attributable to a foster care reform proposal and using Federal Title XX funds to offset General Fund costs, offset by an increase in both the foster care caseload and the average grant. The caseload in 2004-05 is estimated to be approximately 78,652, an increase of 1.2 percent compared to the current year.

PROPOSED FOSTER CARE REFORMS LACK NECESSARY DETAILS

The administration assumes savings of \$72 million (\$20 million General Fund) from unspecified foster care reforms, and indicates that a stakeholders group will be formed to develop the reform proposal. Given the magnitude of the reduction and complexity surrounding any reforms, we believe that savings in 2004-05 will be significantly less than has been budgeted. In order to assist the Legislature, we present a series of options regarding foster care reforms.

Governor's Proposal

The Governor's budget document indicates that it is the intent of the administration to propose reforms to the Foster Care Program. The ad-

ministration indicates that the reforms—although yet to be selected—will generate savings of \$72 million (\$20 million General Fund) in the budget year. According to the administration, a broad variety of options will be considered to reform the Foster Care Program. The reforms will not take the form of grant reductions, according to the administration. The focus will be on better promoting program goals and improving the efficiency of the program. The administration indicates that its goal is to increase permanence of placement for children and generally improve outcomes for both children and families. The Governor’s budget document identifies three potential proposals as examples of the types of proposals that will be considered.

- ***Performance-Based Contracts for Foster Family Agencies (FFA) and Group Homes (GH).*** This reform would implement performance-based contracting for the higher cost placements. These contracts would require that FFA and GH providers meet federal and state outcome measures as a condition of employment. While we agree that this may improve oversight over these types of providers and may improve the state’s performance overall, it is unclear whether this type of reform would produce any actual savings. At the time this analysis was prepared, the administration was unable to provide any details on their assumption that this would lead to a savings in foster care.
- ***Restructuring Foster Care Rates.*** The Governor’s budget document indicates that this proposal would restructure the rates paid by the state to “encourage counties to increase the use of less-restrictive, less-costly placements” and “to establish a standard statewide rate for other high-cost specialized foster care services and payments.” There were no details available about the type of restructuring envisioned under this proposal, nor about the amount of associated savings.
- ***Pursuing Federal Funding Waiver.*** The Governor proposes pursuing a Title IV-E federal waiver, which would allow the state to use a portion of its federal funding for “flexible child welfare purposes.” Currently, without a waiver, Title IV-E funding is restricted for use on eligible foster care children. This waiver, if granted, would allow these funds to be used on prevention and to provide intensive services designed to keep children out of the foster care system. While this type of prevention is valuable, we would note that it does not lead to immediate savings. In fact, these services generally require additional funding up front, with the anticipation of long-term savings as fewer children are removed from their homes and foster care caseloads decline.

At the time this analysis was prepared, the administration indicated that the details of the foster care reform proposals would not be available until the May Revision.

Evaluating the Reform Proposal

\$20 Million Savings Unlikely. The administration has stated that the foster care reforms will not take the form of grant reductions. Without rate reductions, the only way to achieve \$72 million in savings (all fund sources) is by moving children into less costly placement types or reducing the total number of children entering the foster care system. If children were moved to a less restrictive, less costly form of care rather than somehow removed from the caseload altogether, the necessary caseload shifts would be substantial. For example, at least 30 percent of the children currently residing in group homes would need to be shifted to less expensive foster family agencies in order to achieve the stated savings goal. Further, any placement shifts would require funding for additional social worker time because the social workers would need to find appropriate, less restrictive placements for the children. Therefore, any savings achieved by moving the children to less costly placements would be partially offset by the need for additional social worker funding in Child Welfare Services. Alternatively, in order to achieve savings through reducing the number of children entering the foster care system would necessitate caseload reductions in the range of 20 percent to 33 percent depending on the type of placement. Given the magnitude of the shifts necessary to achieve the savings, we conclude that the reform savings are significantly overstated.

Options for Reforming Foster Care

While the immediate savings associated with foster care reform are likely overstated, we do believe that there is room for reform in the foster care program. If designed properly, foster care reform could improve outcomes for children and families, create efficiencies, and generate savings. However, it is important to note that most significant reforms designed to decrease the number of children in foster care or shift them to less costly types of care, may require some up front funding to be successful.

The administration has stated that it will be consulting the Legislature and stakeholders when developing foster care reforms. To assist the Legislature and stakeholders, we offer the following potential areas of reform.

Foster Family Agencies. Previously, we have offered a foster family agency reform proposal which would reduce the length of time a child stays in FFA homes by increasing the incentives to move children toward permanency placement. Our proposed reforms could save the state \$5 million from the General Fund the first year, growing to about \$15 million by the second year. (See our *Analysis of the 2002-03 Budget Bill* for a detailed discussion of this proposal.)

Specialized Care Increments. We would also recommend that the Legislature consider reforms to the current specialized care increment rate structure. The specialized care increments range from zero in some counties to over \$2,000 per month in other counties, depending upon the special needs of the child. The amount of the specialized care increment should have some rational connection to the actual needs of the child and family. Variation in increments should reflect state policy, not historical rate structures which vary by county.

Increasing the Supply of Foster Family Homes. Finally, we would suggest the development of a detailed plan, which includes funding sources, to increase the number of available foster family homes. One consideration might be providing some form of subsidized childcare for working foster parents. While this would result in up front additional costs, we believe that it would remove a significant barrier for many potential foster parents, thus creating more affordable, less restrictive placements for children who might otherwise be placed in more expensive group homes. Without additional homes, any reforms designed to shift children to less costly and less restrictive types of care will not succeed.

GOVERNOR'S BUDGET UNDERSTATES SAVINGS ASSOCIATED WITH RECENT COURT DECISION

The March 2003 Rosales court decision makes many children in "state-only" foster care eligible for federal funding by invalidating the "home of removal" criteria when determining federal eligibility. The Governor's budget in part reflects the fiscal impact of this eligibility change. We estimate however, that a modest investment in foster care redetermination activities will allow California to claim additional federal funding, resulting in a net savings of \$5.3 million. (Reduce Item 5180-101-0001 by \$5,517,000, and increase Items 5180-141-0001 by \$100,000 and 5180-151-0001 by \$50,000.)

Background. On March 3, 2003, the Ninth Circuit Court of Appeals fundamentally altered the way in which federal Title IV-E eligibility is determined for foster care children in its ruling in *Enedina Rosales and the*

California Department of Social Services v. Tommy G. Thompson (321 F.3d 835) (*Rosales*).

Impact on Federal Eligibility. Under the *Rosales* decision, if a child lived, at any time during the six months prior to removal or at the time of removal with a relative, then that child would be federally eligible for foster care because only the child's income would be taken into account during an Aid to Families with Dependent Children (AFDC) means test. Prior to the court decision, relatives who were caring for children who were deemed ineligible for the federal foster care program were only provided with a California Work Opportunity and Responsibility to Kids (CalWORKs) child-only grant of about \$350 per month. Under the new eligibility rules, families will now receive a regular foster care grant (an average of \$678 per month).

Budget in Part Reflects Fiscal Impact of Rosales. The eligibility change described above reduces CalWORKs costs and increases foster care costs. Specifically, the Governor's budget reflects a savings of \$13 million in Temporary Assistance for Needy Families funding in CalWORKs and a General Fund cost of \$8 million in foster care. Further, it recognizes an additional cost of \$11 million in foster care costs for counties, reflecting their share of foster care grant payments.

Additional Children Affected by Rosales. Based on our review, we conclude that a portion of the current state-only foster care caseload will now be eligible for federal foster care. This is because many of these state-only foster care children lived with relatives prior to their removal to foster care and would now under the court ruling be considered federally eligible. Further, we believe that a portion of the Adoptions Assistance Program (AAP) state-only caseload will now be eligible for federal AAP for essentially the same reason. The administration, however, did not include in the budget the General Fund savings that would result from shifting these populations to the federally eligible programs. We estimate the savings associated with that shift below.

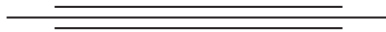
Investment Needed to Achieve Savings. The estimated costs and savings as a result of the *Rosales* decision presented in the Governor's budget are only related to those children who were considered CalWORKs child-only cases and could now be considered federally-eligible foster care cases. However, a study done by the MAXIMUS Corporation in San Bernardino County indicates that a portion of the current state-only foster care population would also now be eligible for Title IV-E federal funding as a result of the *Rosales* decision. (These results were verified by case file reviews conducted by San Bernardino social workers.) Based on this data, almost 5 percent of the state-only foster care population would meet the new federal eligibility criteria. Although San Bernardino County did

not examine their AAP caseload, we believe that the same criteria will apply to this caseload statewide. Children that were once deemed ineligible for federal AAP because of the AFDC means test, will now be eligible under the revised eligibility criteria.

Using the most conservative interpretation of the *Rosales* decision, our analysis suggests that shifting this portion of the foster care caseload from the state-only program to the federal foster care program would require a minimal investment of about \$100,000 to review the eligibility of the state-only cases that were placed in the foster care system after April 1, 2003. This review effort should result in making about 5 percent of the state-only caseload federally eligible. This would result in a General Fund savings of \$4.2 million and a county savings of \$6.3 million. The AAP savings are smaller. We believe that a review of the AAP program, costing the state approximately \$50,000 will lead to a General Fund savings of \$1.3 million. This same level of savings for AAP and foster care could be achieved in 2003-04 with a similar level of investment for administration.

The savings noted above only take into account the home the child was living in at the time of their placement in foster care. Looking at the six months prior to placement in foster care for all new cases would probably produce significantly higher savings. We note that the President's budget includes legislation to return foster care eligibility determination to the pre-*Rosales* rules.

Analysts Recommendation. We recommend increasing the administrative funding for the Foster Care Program and AAP by \$150,000 to fund required county evaluations of the state-only children under the new Title IV-E eligibility standards. This county redetermination process should save the state \$5.5 million General Fund as more children are shifted to the federal program. This shift will be invisible to the children and will have no impact on their funding level or current placements. Adopting this recommendation results in a net state savings of \$5.3 million.



COMMUNITY CARE LICENSING

The Community Care Licensing Division (CCL) 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 \$124.9 million (\$42.2 million General Fund) for the CCL in 2004-05. This represents a less than one-half of 1 percent increase in General Fund expenditures from the current year. Additionally, the Governor's budget proposes an increase in CCL fees, which will result in increased General Fund revenues of \$5.9 million for 2004-05.

Increase Oversight by Establishing a Special Fund

The Governor's budget proposes an increase in Community Care Licensing (CCL) fees over the next three years, which would result in General Fund expenditures in the program being completely offset by fee revenue. We recommend the enactment of legislation to establish a fund for the CCL fees and make the funds available upon appropriation by the Legislature. This will increase legislative oversight by allowing the Legislature to assess the adequateness of the fees and to ensure that the funds generated by these fees are directed into the program. (Reduce item 5180-001-0001 by \$21,875,776 and increase new special fund item under 5180 by like amount.)

Background. The CCL division of the Department of Social Services oversees the licensing of child care centers, adult residential facilities, group homes, adoption agencies, and foster family homes. The division is also responsible for investigating any complaints lodged against these facilities and for conducting inspections of the facilities. The state monitors approximately 92,000 homes and facilities, which provide services for almost 1.4 million individuals.

In order to receive and maintain a license to operate a facility, applicants and providers are charged an initial licensing fee and an annual renewal fee. These fees are generally based upon the size of the facility and the number of individuals served. Until 2003-04, CCL fees had not been increased since 1992. However, in 2003-04 the fees were increased anywhere from 25 percent to 100 percent, depending on the type of facility. Prior to that increase, the fee revenues covered approximately 8 percent of the total CCL budget. As a result of that increase, fees now cover approximately 40 percent of the General Fund portion of the CCL budget.

Governor's Proposal. The Governor's budget proposes an increase in most CCL fees. Further, the budget proposes to continue to increase the fees by equal increments each year for the next two years (through 2006-07). Figure 1 shows examples of a few of the various types of facilities licensed by CCL and illustrates how the fees have grown and are projected to grow if the Governor's proposal is adopted. By 2006-07, the fees generated should be enough to fully offset the General Fund costs associated with administering the program. Currently, CCL fees are considered General Fund revenue and offset 40 percent of the General cost of the program.

Figure 1

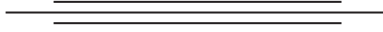
CCL Licensing Fees

2002-03 Through 2006-07

Examples of Facilities	2002-03	2003-04	2004-05	2005-06	2006-07
Family child care home (1-8 children)	\$25	\$50	\$67	\$83	\$100
Child care centers (31 to 60 children)	200	400	533	667	800
Adult day care centers (16 to 30 adults)	100	125	167	208	250
All residential care facilities (7 to 15 people)	450	563	793	1,023	1,253

Recommend Creation of Special Fund. Currently, the CCL fee revenues are considered General Fund revenue and as such are deposited into the General Fund along with all other General Fund revenues. This makes it difficult for the Legislature to determine whether or not the fees are adequate or excessive when it comes to funding the General Fund portion of the CCL budget. We believe that greater oversight of these revenues is necessary given the significant fee increases being proposed by the administration. Toward that end, we recommend enactment of legislation to create a special fund into which the fee revenues would be deposited, with expenditures subject to appropriation by the Legislature.

This would increase the Legislature's oversight of the use of these fees. Further, it would help the Legislature determine the appropriateness of the fee level and whether or not it was keeping pace with or outpacing the cost of administering the program.



FINDINGS AND RECOMMENDATIONS

Health and Social Services

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Crosscutting Issues

Child Care

- C-19 ■ **Budget Proposes New Child Care Reforms.** The Governor's budget proposes a number of significant reforms to California's subsidized child care system. Given the state's difficult fiscal situation, these proposals effectively prioritize limited child care resources. However, the Governor's proposals lack important policy, implementation, and administrative details that would help the Legislature weigh state savings against reducing child care services for a significant number of lower-income families. We evaluate the proposals' effect on children, families, and the state budget, and present some alternative approaches.
- C-35 ■ **Proposition 49 Not Likely to Trigger for Several Years.** Based on the Governor's proposed budget and our fiscal forecast, Proposition 49 would not trigger an increase in funding for the After School Education and Safety Program until 2007-08. This assessment, however, depends on (1) how the state solves the structural imbalance between General Fund expenditures and revenues and (2) future growth in General Fund revenues.

Health and Social Services Enrollment Caps

- C-37 ■ **Most Enrollment Cap Proposals Flawed.** Recommend that the Legislature consider the Governor's enrollment cap proposal on a case-by-case basis, weighing the potential fiscal benefits against the complexities and issues relating to the creation of caseload caps. Based upon such an analysis, we recommend that most of the limits be rejected because of these concerns.

County Block Grant for Immigrants

- C-47 ■ **Programs Proposed for Block Grant Would Be a Poor Fit for Counties.** Recommend rejection of the Governor's proposal to

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consolidate funding for certain state programs which serve immigrants into a single block grant for counties because the programs selected are not well-suited for local control.

Quality Improvement Fees

- C-52 ■ **Additional Federal Funds Possible Through Fee Mechanism.** Recommend approval of the Governor's proposal to impose quality improvement fees on Medi-Cal managed care health plans. Further recommend that the Legislature explore the options of imposing a quality improvement fee on mental health managed care plans.

Senate Bill 2

- C-60 ■ **Budget Lacks Funding for Health Insurance Measure.** We recommend that the administration provide the Legislature with information at budget hearings regarding the funding and personnel that might be needed in 2004-05 to implement the new law for a "pay or play" system to expand health coverage for employees and, in some cases, their dependents.

Department of Aging

- C-64 ■ **Consolidating Local Assistance Into Single Block Grant.** The budget proposes to (1) eliminate the requirements for local Area Agencies on Aging (AAAs) to provide Community Based Services Programs (CBSP), (2) consolidate funding for CBSP and the Older Americans Act programs into a single block grant for the AAAs, and (3) reduce the proposed block grant by 5 percent. Recommend approval of the consolidation proposal and make no recommendation on the proposed 5 percent reduction.

Department of Alcohol and Drug Programs

- C-67 ■ **Federal Funding Requirement May Not Be Met.** Expenditures under the Governor's budget proposal for community treatment services now appear likely to fall short of the level that would be required in the current fiscal year to satisfy a maintenance-of-effort requirement imposed on the state as a condition of receiving certain federal grant funds. As a result, the state is at risk of being penalized with the loss of as much as \$3.2 million in federal grant funds in the future.

California Medical Assistance Program

- C-85 ■ **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

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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-88 ■ **Savings From Provider Rate Reductions in Doubt.** There is a significant risk whether the state would achieve the level of savings anticipated from a provider rate reduction enacted last year and from a proposed further rate reduction because of ongoing litigation over rate issues. As it considers the Governor's proposal for deeper rate cuts, we recommend that the Legislature examine alternative approaches that would strike a balance between concerns over how such reductions would affect access to care and quality of care for Medi-Cal beneficiaries and the need to address the state's serious fiscal problems.
- C-92 ■ **Reject Staff to Process Authorizations Requests. Reduce Item 4260-001-0001 by \$1 Million.** Recommend that the Legislature reject the Governor's request for 36 additional positions to process treatment authorization requests (TARs). We propose instead to give the Department of Health Services (DHS) the authority it needs to better manage its workload by adopting the proposed statutory language and to improve the TAR process to better ensure that it controls costs and that decisions on TARs are made more consistently. The DHS should also be directed to implement the Service Utilization Review Guidance and Evaluation system for pharmacy claims by the end of 2004-05.
- C-94 ■ **Proposals to Reform Medi-Cal Should Be Pursued. Reduce Item 4260-001-0001 by \$100,000.** Recommend the Legislature direct DHS to present more detailed information about the reform plan at budget hearings so that it will be in a better position to assess the policy implications and savings that would actually be achieved by the administration's plan. We also propose to modify the request for staffing and funding to develop the proposal and recommend changes in managed care enrollment procedures that would help further reduce Medi-Cal Program costs.
- C-100 ■ **Additional Opportunities for Reform Worth Considering.** In addition to the concepts proposed by the Governor for reforming the Medi-Cal Program, the Legislature should consider other opportunities to improve the program and achieve savings. These include providing coordinated care to the aged and disabled, combining Medi-Cal and Healthy Families coverage, improving the eligibility determination process, studying the impact of Medicare legislation, and advocating for federal changes in the Medicaid Program.

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- C-103 ■ **Failure of County Organized Health Systems (COHS) Would Increase State Costs.** Because COHS plans are a critical component of the success of the Medi-Cal program, we recommend that the Legislature initially reject the administration's proposal to budget for the phase-out of the Health Plan of San Mateo (HPSM) and direct the DHS to explore alternatives that would permit it to remain in operation. We also recommend that the Legislature also consider a series of options for state actions to help mitigate the financial problems affecting HPSM and other COHS plans.
- C-111 ■ **Overall Effectiveness of Antifraud Efforts Could Improve. Reduce Item 4260-001-0001 by \$2,354,000.** Recommend that the Legislature take a systematic and coordinated long-term approach to addressing the fraud problem. Based on these principles we recommend: (1) denial of the Governor's proposal to increase staffing for audits of hospitals; (2) that DHS report at budget hearings regarding how encounter data could be used to prevent managed care fraud; and (3) increased legislative oversight of DHS antifraud efforts through additional reporting requirements.
- C-125 ■ **Additional Oversight Needed for Data Systems Contract.** Recommend the adoption of supplemental report language directing DHS to develop and submit a corrective action plan to the Department of Finance's, Office of State Audits and Evaluations (OSAE) and the Legislature, and submit reports to OSAE and the Legislature every six months, beginning July 1, 2004, regarding its progress towards implementation of the audit recommendations. In addition, we recommend that the Legislature request the Bureau of State Audits to conduct a follow-up audit by July 2005 to assess DHS' progress towards improving the management of its contract with Electronic Data Systems.
- C-128 ■ **Los Angeles County Monitoring Contract Terminated.** Recommend that the Legislature direct DHS to report at budget hearings on the findings of the final monitoring reports of the Los Angeles County Medicaid Demonstration Project prepared by the contractor. The Legislature should also direct DHS to provide more detailed information on the specific monitoring activities it will carry out during the remainder of the project to help ensure that the goals of the restructuring effort are met.

Department of Health Services

- C-135 ■ **Transfer of Eligibility Work to Counties Would Be More Expensive.** Recommend that the Legislature not adopt the Governor's proposal to shift eligibility determinations for the Breast

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and Cervical Cancer Treatment Program to the counties because it would be more costly than adding Department of Health Services staff for the same purpose.

- C-140 ■ **Major Uncertainties in Child Health and Disability Prevention (CHDP) Gateway Budget Proposal.** Withhold recommendation on the CHDP budget proposal, and the related budget adjustments to the Medi-Cal and Healthy Families programs, until more information is available about the impact on caseload and costs of the CHDP gateway at the time of the May Revision.
- C-142 ■ **Reports on Information System Project Not Submitted. Delete Item 4260-011-0001.** Recommend denial of proposed \$5 million General Fund loan for the Genetic Disease Branch Screening Information System unless required reports are submitted and the Department of Health Services is able to demonstrate its ability to manage the project.

Managed Risk Medical Insurance Board (MRMIB)

- C-147 ■ **Enrollment Cap Proposal Raises Policy Concerns.** The Governor's budget proposal to cap Healthy Families Program enrollment, while feasible and effective in addressing the state's fiscal problems, raises a number of policy concerns. Recommend against this approach because other alternatives are available to the Legislature to hold down the cost of the Healthy Families Program.
- C-152 ■ **Choice of Two-Tier Benefit System Worth Considering.** A two-tier benefit system represents a reasonable alternative for reducing Healthy Families Program costs to help address the state's fiscal problems. Withhold recommendation on this funding request for resources until the administration has fully developed the proposal and provided updated cost and savings estimates to the Legislature.
- C-153 ■ **Alternatives for Reducing Healthy Families Program Costs.** The budget plan proposes several measures to contain the costs of the Healthy Families Program. Recommend that the Legislature also consider alternative approaches including program consolidation with the AIM, changes in premium levels, trimming benefits, or shifting coverage of children in families with higher incomes to county coverage.
- C-158 ■ **Federal Approval of County Health Initiative Matching (CHIM) Fund Still Pending.** The implementation of the CHIM Fund is contingent upon federal approval. Withhold recommendation at this time on the Governor's budget proposal to continue the fund at its

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current funding level because a decision by federal authorities on the state's request may be known by this May.

- C-161 ■ **Shift New Access for Infants and Mothers (AIM) Mothers to Healthy Families Program.** Recommend that the Legislature take steps to shift all new AIM-eligible mothers to the Healthy Families Program possibly as soon as the budget year. The Legislature also has the option of shifting this group of enrollees to Medi-Cal coverage. Our analysis indicates that either approach would maximize the state's use of available federal funds and result in significant state savings.
- C-164 ■ **Eliminate Perinatal Insurance Fund Reserve. Reduce Item 4280-111-0232 by \$998,000.** Recommend repealing the statutory requirement that MRMIB maintain a reserve in the Perinatal Insurance Fund for the AIM program to achieve state savings of about \$1 million in Proposition 99 funds.

Department of Developmental Services

- C-176 ■ **Regional Center Caseload Estimate.** Withhold recommendation on the Governor's caseload estimate for regional centers (RCs) at this time. Because of the relatively high degree of uncertainty over the caseload projection, it is possible that the revised 2004-05 budget proposal may understate the amount of state funding required for the program.
- C-177 ■ **Title XX Funding Shift Appears Viable Now.** We concur in the proposal to shift federal Social Services Block Grant funding to achieve General Fund savings but note that the success of this action depends on a successful effort to collect client income data.
- C-177 ■ **Evaluating the Governor's 2004-05 Budget Proposals.** The Governor's proposals for RC cost containment appear to have merit, but a lack of detail about how the proposals would be implemented and what they would save means the Legislature is not in a position to fully assess their policy and operational implications. The Legislature should request that the administration present its completed proposals at budget hearings and not wait until the May Revision.
- C-183 ■ **An Agenda for Further Reform.** The Legislature could broaden the discussion of the Governor's proposals for reform of RC services to consider the improvement of audit functions, clarification of some provisions of the Lanterman Act, modification of the nursing home rate structure, and reductions in certain contracted activities.

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- C-188 ■ **Developmental Centers (DCs) May Require Additional Funding.** Three factors that we have identified make it possible that as much as about \$80 million in additional funding may be required to fund DC operations in the current year and in the budget year. These relate to (1) the Agnews DC closure plan, (2) the possible decertification of Lanterman DC, and (3) the possibility that savings from a proposal to contract out food preparation at the DCs may not be realized.

Department of Mental Health

- C-194 ■ **Activation of Coalinga Hospital Could Be Delayed. Reduce Item 4440-011-0001 by \$20,143,000.** The Governor's budget requests \$27.7 million to continue the activation of the Coalinga State Hospital. However, our analysis indicates that the state hospital system has sufficient capacity and could postpone the activation to reduce costs in the budget year. Recommend that the Legislature delay the activation until March 2006 in order to achieve one-time state savings of up to \$20.1 million.
- C-198 ■ **Capping Enrollment and Shifting Sexually Violent Predators (SVPs) Could Make Better Use of Beds.** Recommend that the Legislature approve the Governor's proposal to limit the population of certain forensic patients in state hospitals. Recommend that legislative policy committees consider statutory changes that would provide the Department of Mental Health (DMH) more authority to prioritize hospital beds for patients who are willing and ready to receive treatment. Concur with administration's proposal to shift some individuals who have been referred for commitment as SVPs out of the state hospitals to prioritize the use of beds for patients amenable to treatment.
- C-202 ■ **Additional Funding for SVP Evaluations Not Justified. Reduce Item 4440-001-0001 by \$1 Million.** An administration proposal to change state law to reduce the number of evaluations of SVPs in order to save \$2 million in the budget year is an important policy matter for the Legislature to decide. A request for a \$1.1 million augmentation based on a projected increase in evaluation caseloads should be rejected because it is not supported by recent caseload trends.
- C-205 ■ **Budget Includes Beds Missing From CDC Budget.** The Governor's budget plan includes a \$2 million increase in reimbursement authority for the Department of Mental Health for a California Department of Correction (CDC) proposal to purchase hospital beds. General Fund resources have not been included in CDC's 2004-05 budget request. Recommend deletion of increased reimbursement expenditure authority until resources are added to the spending plan for CDC.

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- C-206 ■ **EPSDT Costs Still Soaring, but Some Progress in Sight.** Our analysis indicates that, while the program is still growing significantly, recent efforts to slow down the growth in EPSDT expenditures appear to be succeeding. Recommend approval of further efforts to contain program costs by adjusting rate limits, auditing program expenditures, and developing a request for a federal waiver to tighten the definition of what services must be provided by the state.

Department of Child Support Services

- C-214 ■ **Governor's Budget Proposes Keeping County Share of Child Support Collections.** Governor's budget proposes keeping counties' 2.5 percent share of assistance collections, thus creating a further disincentive for counties to invest in collecting child support payments for families. Recommend allowing those counties that meet state and federal performance measures to keep their share of the assistance collections.
- C-215 ■ **Withhold Recommendation on Child Support Collections.** Withhold recommendation on estimated child support collections pending the release of the Governor's May Revision due to the fact that they may be overstated based upon the Department of Child Support Service's (DCSS's) new method of projecting collections.
- C-217 ■ **Option to Transfer Project.** Recommend administration report on potential problems and anticipated savings from transferring the California Child Support Automation System from the Franchise Tax Board to the DCSS.

CalWORKs Caseload and Grants

- C-221 ■ **Caseload Decline Ends.** The California Work Opportunity and Responsibility to Kids (CalWORKs) caseload has declined significantly since 1994-95. However, recent caseload trend data suggest that, absent any policy changes, caseload would increase about 1 percent in the budget year. The Governor's proposed policy changes would result in a caseload reduction of about 1.3 percent from what it otherwise would have been, which would more than offset this baseline 1 percent increase.
- C-222 ■ **Budget Suspends Statutory Cost-of-Living Adjustments (COLAs) and Reduces Grant Payments.** The Governor's budget proposes to (1) reduce grant payments by 5 percent and (2) suspend both the October 2003 and July 2004 COLAs. Compared to current law, these proposals result in estimated state savings of \$135 million in 2003-04 and \$408 million in 2004-05.

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**Expanding TANF Transfers Results
 In General Fund Savings**

- C-225 ■ **State Spending Budgeted at Temporary Assistance for Needy Families (TANF) Maintenance-of-Effort (MOE) Floor.** The Governor's budget proposes to spend the minimum amount of General Fund monies needed to meet the MOE spending requirement for the CalWORKs program in 2004-05 and maintains a \$160 million TANF reserve. Any net augmentation to the Governor's spending plan would result in General Fund costs, or would deplete the TANF reserve amount. Any net reduction would generally result in TANF savings, not General Fund savings.
- C-226 ■ **TANF Transfers.** The budget achieves General Fund savings by increasing TANF transfers to the Title XX Social Services Block Grant by \$41 million in the current year and \$120 million in the budget year, which would be used to offset General Fund costs in In-Home Supportive Services, Child Welfare Services, the Department of Developmental Services, and Foster Care.

Significant CalWORKs Reforms

- C-230 ■ **Framework for Evaluating the Governor's Proposals.** In order to assist the Legislature in evaluating the Governor's CalWORKs proposals, we summarize the Governor's approach to reform and offer a framework for assessing specific aspects of the proposal.
- C-234 ■ **Proposal Requires Job Search While CalWORKs Application Is Pending.** Recommend that the Legislature ensure county programmatic and fiscal flexibility by making the policy to require job search while the CalWORKs application is pending, a county option.
- C-235 ■ **Proposal Requires Aided Adults to Complete a Welfare-to-Work Plan Within 60 Days of Aid.** Recommend that the Legislature consider modifying the Governor's proposal to require aided adults who are not already meeting program requirements to complete and sign a welfare-to-work plan within 60 days of the receipt of aid, in order to give counties more flexibility in meeting this potentially beneficial requirement.
- C-236 ■ **Proposal Requires 20 Hours of Core Work Activities.** Recommend that the Legislature retain as much county flexibility as possible with respect to the Governor's proposal to require clients to participate in at least 20 hours of core work activities within 60 days of the receipt of aid.

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- C-240 ■ **Proposal Would Reduce Grant for Sanctioned Cases.** Recommend that the Legislature weigh the benefits of higher participation against any potential negative impact of a grant reduction on children as a result of the administration's proposed policy to reduce child-only grants by 25 percent after one month in sanction status.
- C-242 ■ **Proposal Would Reduce Grant for Safety Net Cases with a Nonworking Adult.** Recommend that the Legislature weigh the savings from the Governor's proposal to reduce grants by 25 percent for safety net cases in which the adult is not working, against the negative impact that the grant reduction may have on families and children.

Federal Welfare Reauthorization

- C-243 ■ **Update on Federal Welfare Reauthorization** As of February 2004, Congress has not completed action on federal welfare reauthorization. We describe the major features of the currently pending House and Senate versions of welfare reform and update our fiscal estimates of these measures.

CalWORKs Automation

- C-253 ■ **Statewide Automated Welfare System C-IV Project.** Withhold recommendation on proposed increase pending additional information from the administration.

Adoptions Programs

- C-255 ■ **Adoption Assistance Program (AAP) Reforms. Reduce Item 5180-101-0001 by \$2 Million.** Adopt a series of AAP reforms that would tie AAP benefits to the actual needs of the child and would result in General Fund savings of \$2 million in 2004-05 and \$12 million in 2005-06.

In-Home Supportive Services (IHSS)

- C-267 ■ **Governor Proposes to Restrict Eligibility and Reduce Provider Wages.** The Governor's budget reflects the mid-year proposal to eliminate the residual (state-only) program and presents new proposals to limit state support for provider wages to the minimum wage, and reduce services for recipients living with able-bodied relatives. Together these proposals result in net General Fund savings of \$492 million (35 percent) compared to the requirements of current law.

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- C-270 ■ **Comments on the Governor's IHSS Proposal.** The Governor's proposal to eliminate the residual program, limit state participation in provider wages, and reduce services to recipients with relatives results in substantial budgetary savings and a potential hardship for low-income Californians who receive IHSS. Recommend that the Legislature consider each aspect of the proposal on a case-by-case basis, assessing both its impact on recipients and the estimated savings.

Supplemental Security Income/State Supplementary Program

- C-276 ■ **Budget Proposes COLA Suspensions.** By suspending the January 2005 state cost-of-living adjustment (COLA) and not "passing through" the January 2005 federal COLA, the budget achieves combined savings of \$147 million compared to current law.

Food Stamps Program

- C-280 ■ **Revenue Loss Exceeds Administrative Savings From Governor's Food Stamp Proposals. Increase Item 5180-001-0001 by \$3.5 Million in 2004-05 and Increase General Fund Revenue by \$4.5 Million in 2004-05.** Recommend (1) rejecting the Governor's proposal to delete recent food stamps expansions and (2) recognizing the General Fund revenue associated with the expansions.

Child Welfare Services

- C-282 ■ **Budget for Improving Children's Programs Should Reflect Legislative Priorities. Reduce Item 5180-151-0001 by \$558,000. Reduce Item 5180-151-0803 by \$3,850,000. Reduce Item 5180-151-0890 by \$14,343,000.** Recommend eliminating the \$19 million for the continuation of the Child Welfare Services (CWS) Redesign planning process. The funds will not be used to provide additional or new services for children and families.
- C-288 ■ **Child Welfare Services/Case Management System (CWS/CMS) Funding.** The budget understates the General Fund costs for CWS/CMS by \$43 million for the current and budget years combined.
- C-290 ■ **CWS/CMS Revised Proposal.** Recommend the administration report (1) on actions it can take to reduce the ongoing costs of the CWS/CMS system and (2) on its analysis of the costs and benefits of the alternatives to support the system. Recommend the administra-

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tion provide a revised budget proposal that reflects the current federal funding ratio.

Foster Care

- C-292 ■ **Proposed Foster Care Reforms Lack Necessary Details.** The administration assumes savings in the amount of \$72 million (\$20 million General Fund) from unspecified foster care reforms. Given the magnitude of the reduction and complexity surrounding any reforms, we believe that savings in 2004-05 will be significantly less than has been budgeted. To assist the Legislature in developing foster care reforms, we present a series of options.
- C-295 ■ **Governor's Budget Understates Savings Associated With *Rosales v. Thompson* Court Decision. Reduce Item 5180-101-0001 by \$5,517,000, and Increase Items 5180-141-0001 by \$100,000 and 5180-151-0001 by \$50,000.** Recommend increasing the administrative funding for the Foster Care Program and the Adoptions Assistance Program (AAP) by \$150,000 to fund required county evaluations of the state-only children under the new Title IV-E eligibility standards. The Governor's budget overlooks the impact of *the Rosales* decision on the funding for foster care and AAP children who are currently funded by the state-only programs. By applying the new eligibility rules to this population, the state will save approximately \$5.3 million.

Community Care Licensing

- C-298 ■ **Legislature Should Increase Oversight of Community Care Licensing (CCL) through the Creation of a Special Fund. Reduce Item 5180-001-0001 by \$21,875,776 and Increase New Special Fund Item Under 5180 by Like Amount.** Recommend the enactment of legislation to establish a fund for the CCL fees and make the funds available upon appropriation by the Legislature.