

The 2018-19 Budget:

Analysis of the Health and Human Services Budget

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Table of Contents

EXE	ecutive Summary	1
Ove	erview	3
	Health	3
	Human Services	4
Ме	di-Caldi	6
	Background	6
	Overview of the Medi-Cal Budget	7
	Caseload Projections	9
	Proposition 55	11
	Federal Reauthorization of CHIP Funding	
	Proposition 56	
Dei	partment of State Hospitals	20
	Overview	
	DSH-Coalinga Expansion	20
	Proposals to Expand IST Capacity	22
	Governor's IST Diversion Proposal	
O-1	WORKs	
Gai	Background.	
	CalWORKs Caseload Now at Historic Low	
	Budget Overview	
	Analysis of Governor's Proposed Single Allocation	
	Analysis of Governor's Proposed Use of Freed-Up TANF Funds	
	Legislature Has Opportunity to Build Its Own TANF Plan	37
ln-l	Home Supportive Services	39
	Background	39
	Budget Overview and LAO Assessment	40
SSI	/SSP	45
Day	velopmental Services	47
Dev	Background	
	Overview of the Governor's Budget Proposal	
	·	
	Issues for Legislative Consideration	49
Co	ntinuum of Care Reform	54
	Overview of the Child Welfare System	54
	Major Changes Under CCR	57
	Status Update on CCR Implementation	61
	Overview of the Governor's Budget for CCR	63
	LAO Assessment	65

Executive Summary

Overview of the Health and Human Services Budget. The Governor's budget proposes \$23.8 billion from the General Fund for health programs—a 7.1 percent net increase above the revised estimated 2017-18 spending total—and \$13.5 billion from the General Fund for human services programs—a net increase of 2.9 percent above the revised estimated 2017-18 spending total. For the most part, the year-over-year budget changes reflect caseload changes, technical budget adjustments, and the implementation of previously enacted policy changes, as opposed to new policy proposals. Significantly, the budget reflects a net increase of \$1.5 billion from the General Fund for Medi-Cal local assistance, in part reflecting (1) a lower proportion of Proposition 56 (2016) tobacco tax revenues offsetting General Fund cost growth and (2) a higher state cost share for the Patient Protection and Affordable Care Act optional expansion population.

Medi-Cal: Caseload Essentially Flat, No Proposition 55 Funding Assumed. The Governor's budget projects an average monthly Medi-Cal caseload of 13.5 million in 2018-19—virtually flat from estimated 2017-18 caseload. We find these caseload estimates to be reasonable. For the first time, the Director of Finance has made a calculation under a budget formula in Proposition 55 (2016) that determines whether a share of Proposition 55 tax revenues is to be directed to increase funding in Medi-Cal in a given fiscal year. The Governor's budget provides no additional funding for Medi-Cal pursuant to this formula. We are currently reviewing the administration's approach to this formula and will provide our comments to the Legislature at a later time.

Recent Federal Reauthorization of Children's Health Insurance Program (CHIP) Funding Will Result in General Fund Savings Not Assumed in the January Budget. CHIP is a joint federal-state program that provides health insurance coverage to about 1.3 million children in low-income families, but with incomes too high to qualify for Medicaid. Due to congressional appropriations made after the administration finalized its proposed 2018-19 budget, the proposed state budget makes federal funding assumptions that differ from the recent federal action. As the recent federal action continues federal funding for CHIP at a higher federal cost share than assumed in the budget, the Governor's May Revision budget proposal will reflect a downward adjustment of General Fund costs for CHIP totaling \$900 million over 2017-18 and 2018-19.

Governor's Proposition 56 Budget Proposal for Medi-Cal Essentially Aligns With the 2017-18 Budget Agreement; Legislature Afforded Opportunity to Target Funding Available for Additional Provider Payment Increases. Proposition 56 raised state taxes on tobacco products and dedicates the majority of associated revenues to Medi-Cal on an ongoing basis. We find that the Governor's budget proposal essentially aligns with a two-year 2017-18 budget agreement between the Legislature and the administration on the use of Proposition 56 revenues in Medi-Cal. Of the total amount of 2017-18 and 2018-19 Proposition 56 revenues, the Governor allocates a total of about \$1.4 billion to provider payment increases, with the remaining balance of \$880 million to be used to offset General Fund spending on Medi-Cal cost growth. Under the Governor's proposal, we estimate that \$523 million in total Proposition 56 funding is available for additional provider payment increases beyond those structured in the 2017-18 agreement. The Legislature will be able to determine how these new payments are structured.

Governor's Incompetent-to-Stand Trial (IST) Proposals Raise Several Issues for Legislative Consideration. The Governor's budget includes various proposals to increase IST capacity as a way to reduce the number of individuals waiting to be transferred to a treatment program. We recommend the Legislature define what it considers an appropriate IST waitlist, which would allow it to then determine how many additional beds are needed to reduce this waitlist. The budget also includes \$100 million (one time) for the Department of State Hospitals to contract with counties to establish IST diversion programs that are intended to primarily treat offenders before they are declared IST. While the concept of IST diversion programs has merit, we find that the Governor's proposal is not well structured to achieve its intended benefits. As such, we recommend the Legislature instead direct the department work with individual counties to develop proposals for specific county IST diversion programs that would include such information as the specific services that would be provided.

CalWORKs Caseload at Historical Low, Freeing Up Federal Funds for Other Uses. The Governor's budget estimates the California Work Opportunity and Responsibility to Kids (CalWORKs) caseload will be 400,000 in 2018-19—the fewest participants in the program's 20-year history. As a result of the caseload decline, federal funds that were previously used to fund the CalWORKs program are freed up for other purposes. The Governor proposes to spend the freed-up funds to (1) offset General Fund costs outside of CalWORKs, (2) fund a new home visiting program in CalWORKs, and (3) fund a one-time early education grant program in the California Department of Education. We evaluate the Governor's proposal for CalWORKs, highlight issues and questions for legislative consideration, and note that the freed-up funds provide the Legislature with an opportunity to create its own plan for spending the funds.

Governor's Proposals for IHSS and SSI/SSP Program Appear Reasonable. We have reviewed the administration's 2018-19 budget proposals for the In-Home Supportive Services (IHSS) and the Supplemental Security Income/State Supplementary Payment (SSI/SSP). While we raise a few issues for legislative consideration—mainly related to the new methodology for calculating administrative costs in IHSS—overall we find the administration's proposals to be reasonable at this time. We will continue to monitor IHSS and SSI/SSP programs and update the Legislature if we think any updates to the caseload and budgeted funding levels should be made.

Department of Developmental Services (DDS) Budget Reflects Continued Activity Leading to Closure of Developmental Centers (DCs). In 2015, the administration announced its plan to close the state's remaining DCs by the end of 2021. The transition of the remaining DC residents to the community appears on track for 2018-19. Noting that the Legislature has been considering a proposal to earmark any possible savings from the closures of DCs for the DDS community services program, we discuss the benefit of the Legislature directing DDS to conduct a comprehensive assessment of service gaps and related unmet funding requirements in the community services system overall.

Governor Continues to Implement Continuum of Care Reform (CCR), Some Challenges Emerge. The Governor's budget proposes funding in 2018-19 to continue to implement CCR in the state's foster care system. At a high level, CCR aims to reduce reliance on long-term group home placements and increase the utilization and capacity of home-based family placements for children in the foster care system. While the Governor's proposal reflects more realistic estimates of the costs and savings associated with CCR than assumed in recent Governor's budgets, it does not propose any major changes in CCR policy. We provide background on CCR, highlight a few implementation challenges that have emerged, describe the Governor's funding proposal, and raise issues and questions for legislative consideration with the goal of addressing these implementation challenges.

OVERVIEW

HEALTH

Background on Major Health Programs

California's major health programs provide a variety of health benefits to its residents. These benefits include purchasing health care services (such as primary care) for qualified low-income individuals, families, and seniors and persons with disabilities (SPDs). The state also administers programs to prevent the spread of communicable diseases, prepare for and respond to public health emergencies, regulate health facilities, and achieve other health-related goals.

The health services programs are administered at the state level by the Department of Health Care Services (DHCS), Department of Public Health, Department of State Hospitals (DSH), the California Health Benefits Exchange (known as Covered California or the Exchange), and other California Health and Human Services Agency (CHHSA) departments. The actual delivery of many of the health care services provided through state programs often takes place at the local level and is carried out by local government entities, such as commercial managed care plans. (Funding for these types of services delivered at the local level is known as

"local assistance," whereas funding for state employees to administer health programs at the state level and/or provide services is known as "state operations.")

Expenditure Proposal by Major Programs

Overview of General Fund Health Budget Proposal. The Governor's budget proposes \$23.8 billion from the General Fund for health programs. This is an increase of \$1.6 billion—or 7.1 percent—above the revised estimated 2017-18 spending level, as shown in Figure 1.

Summary of Major General Fund Budget
Assumptions and Changes. The year-over-year increase of \$1.6 billion General Fund over the revised estimated 2017-18 spending level is largely comprised of a net increase in expenditures in Medi-Cal local assistance. (We note that the roughly 15 percent increase in General Fund expenditures in DSH reflects in part the proposed implementation of various strategies intended to reduce the number of incompetent-to-stand-trial patients awaiting placement.) The net increase in Medi-Cal local assistance of \$1.5 billion General Fund is due to several factors, including:

Figure 1

Major Health Programs and Departments—Budget Summary

General Fund (Dollars in Millions)^a

	2017-18	2018-19	Char	nge
	Estimated	Proposed	Amount	Percent
Medi-Cal—Local Assistance	\$20,058	\$21,589	\$1,531	7.6%
Department of State Hospitals	1,544	1,773	229	14.8
Department of Public Health	148	143	-5	-3.4
Other Department of Health Care Services programs ^b	235	54	-181	-76.9
Office of Statewide Health Planning and Development	33	33	_	_
Emergency Medical Services Authority	9	9	_	_
All other health programs (including state support) ^c	226	224	-2	-0.8
Totals	\$22,254	\$23,826	\$1,572	7.1%

^a Excludes general obligation bond costs.

b Local assistance only. Reduction in 2018-19 reflects a \$222 million reimbursement from Proposition 98 funds related to certain Medi-Cal administrative activities performed by schools.

^C Includes Health and Human Services Agency.

- Higher projected General Fund spending due to a higher proportion of Proposition 56 tobacco tax revenues in 2018-19 being budgeted to pay for supplemental provider payments as opposed to offsetting General Fund cost growth.
- Increased costs related to the state's responsibility for a higher share of costs for the Patient Protection and Affordable Care Act (ACA) optional expansion population.
- Higher projected spending related to general growth in health care costs.

We note that the January Governor's budget, which was finalized before subsequent congressional action to reauthorize funding for the Children's Health Insurance Program (CHIP) administered through Medi-Cal, included \$300 million of higher year-over-year General Fund costs in 2018-19 for CHIP. These higher costs reflected a full-year cost to backfill an assumed reduction in federal funds, continuing from 2017-18, for CHIP. Recent federal action to reauthorize federal funding for CHIP initially at an enhanced rate will instead reduce General Fund costs by a total of \$900 million over 2017-18 and 2018-19 relative to what the January budget assumed. With the adjustment to the Medi-Cal General Fund budget, the year-over-year net increase in Medi-Cal local assistance would be roughly \$1.2 billion, or 6.2 percent.

Finally, we note that the Governor's budget does not provide any additional funding for Medi-Cal in 2018-19 pursuant to a budget formula in Proposition 55 (2016) that extended tax rate increases on high-income Californians.

Proposition 56 Medi-Cal Proposal. Proposition 56 (2016) raised state taxes on tobacco products and dedicates the majority of associated revenues to Medi-Cal on an ongoing basis. The 2017-18 budget included a two-year budget agreement between the Legislature and the administration on the use of Proposition 56 revenues in Medi-Cal. We find that the Governor's updated Proposition 56 Medi-Cal proposal—discussed in detail in the "Medi-Cal" section of this report—essentially aligns with the 2017-18 budget agreement. Specifically, of the total amount of 2017-18 and 2018-19 Proposition 56 revenues, the Governor allocates a total of about \$1.4 billion to provider payment increases, with the remaining balance of \$880 million to be used to

offset General Fund spending on Medi-Cal cost growth. We also note that the Governor's budget proposal reflects a downward adjustment in the estimated costs to implement the provider payment increases as specifically structured in the 2017-18 agreement. This in effect frees up Proposition 56 resources that the Legislature can target for use in Medi-Cal in 2018-19.

HUMAN SERVICES

Background on Major Human Services Programs

California's major human services programs provide a variety of benefits to its residents. These include income maintenance for the aged, blind, or disabled; cash assistance and employment services for low-income families with children; protecting children from abuse and neglect; providing home care workers who assist the aged and disabled in remaining in their own homes; providing services to the developmentally disabled; collection of child support from noncustodial parents; and subsidized child care for low-income families.

Human services programs are administered at the state level by the Department of Social Services, Department of Developmental Services (DDS), Department of Child Support Services, and other CHHSA departments. The actual delivery of many services takes place at the local level and is typically carried out by 58 separate county welfare departments. A major exception is the Supplemental Security Income/State Supplementary Payment program, which is administered mainly by the U.S. Social Security Administration. In the case of DDS, community-based services (the type of services received by the vast majority of DDS consumers) are coordinated through 21 nonprofit organizations known as Regional Centers.

Expenditure Proposal by Major Programs

Overview of the General Fund Human Services Budget Proposal. The Governor's budget proposes expenditures of \$13.5 billion from the General Fund for human services programs in 2018-19. As shown in Figure 2, this reflects a net increase of \$375 million—or 2.9 percent—above estimated General Fund

Figure 2

Major Human Services Programs and Departments—Budget Summary

General Fund (Dollars in Millions)

	2017-18	2018-19 _	Change	
Program	Estimated	Proposed	Amount	Percent
SSI/SSP	\$2,861.9	\$2,827.0	-\$34.9	-1.2%
Department of Developmental Services	4,205.2	4,440.9	235.7	5.6
CalWORKs	454.7	551.9	97.2	21.4
In-Home Supportive Services	3,388.0	3,641.7	253.6	7.5
County Administration and Automation	772.0	766.1	-5.9	-0.8
Child Welfare Services ^a	517.4	433.1	-84.2	-16.3
Department of Child Support Services	315.6	315.6	0.1	_
Department of Rehabilitation	64.6	64.6	_	0.1
Department of Aging	34.0	34.0	_	_
All other human services (including state support)	466.2	379.9	-86.4	-18.5
Totals	\$13,079.6	\$13,454.8	\$375.2	2.9%

a This includes, among other programs, child protective services, foster care services, and kin guardian and adoption assistance. It generally reflects child welfare services spending that is not realigned to counties.

expenditures in 2017-18. The budget reflects modest year-over-year changes in the General Fund budget for some departments and programs, while reflecting more significant changes for others, including California Work Opportunity and Responsibility to Kids (CalWORKs), In-Home Supportive Services (IHSS), and Child Welfare Services programs. In general, the more significant year-over-year changes in General Fund support for these programs are in part due to various funding shifts that have occurred over the last several years. These funding shifts result in General Fund increases and decreases that are not necessarily representative of

broader trends in caseload and service costs in these programs.

A Closer Look at Total Human Services Funding.

For those programs that are demonstrating more significant General Fund increases or decreases, taking a closer look at the total funding proposed for their support provides a clearer picture of their overall growth or decline. As shown in Figure 3, after accounting for total funding from all sources, growth or decline in most of these programs is generally relatively modest. We note that growth in IHSS remains relatively high even when looking at total funds—we describe the main

Figure 3

Major Human Services Programs and Departments—Budget Summary

Total Funds (Dollars in Millions)

	2017-18	2018-19 _	Change	
Program	Estimated	Proposed	Amount	Percent
SSI/SSP	\$9,935.7	\$10,096.7	\$161.0	1.6%
Department of Developmental Services	6,953.8	7,305.0	351.2	5.1
CalWORKs	5,001.9	4,818.5	-183.4	-3.7
In-Home Supportive Services	10,294.8	11,241.9	947.1	9.2
County Administration and Automation	2,314.9	2,285.3	-29.6	-1.3
Child Welfare Services ^a	6,287.4	6,246.7	-40.7	-0.6
Department of Child Support Services	1,010.7	1,011.5	0.8	0.1
Department of Rehabilitation	458.5	460.1	1.6	0.3
Department of Aging	210.2	201.5	-8.8	-4.2

a This includes, among other programs, child protective services, foster care services, and kin guardian and adoption assistance. It generally reflects child welfare services spending that is not realigned to counties.

factors contributing to this growth in the analysis that follows.

Governor's Budget Largely Reflective of Current Law and Policy. Our analysis of the Governor's human services budget proposal indicates that it is largely in line with the implementation of current law and policy. For example, the proposal adjusts for increases and decreases related to changes in program caseloads and the continued implementation of existing policy changes—such as the implementation of minimum wage increases in certain programs.

Although the Governor's 2018-19 budget is largely related to the implementation of current law, there are a few exceptions. One example is a proposal to create a new home visiting program in CalWORKs. In the analysis that follows, we provide an overview of the Governor's proposals for the major human services programs, provide insight into the underlying program trends that lead to the proposed budget levels, and raise issues for legislative consideration.

MEDI-CAL

BACKGROUND

In California, the federal-state Medicaid program is administered by DHCS as the California Medical Assistance Program (Medi-Cal). Medi-Cal is by far the largest state-administered health services program in terms of annual caseload and expenditures. As a joint federal-state program, federal funds are available to the state for the provision of health care services for most low-income persons. Before 2014, Medi-Cal eligibility was mainly restricted to low-income families with children, SPDs, and pregnant women. As part of the ACA, beginning January 1, 2014, the state expanded Medi-Cal eligibility to include additional low-income populations—primarily childless adults who did not previously qualify for the program. This eligibility expansion is sometimes referred to as the "optional expansion."

Financing. The costs of the Medicaid program are generally shared between states and the federal government based on a set formula. The federal government's contribution toward reimbursement for Medicaid expenditures is known as federal financial participation. The percentage of Medicaid costs paid by the federal government is known as the federal medical assistance percentage (FMAP).

For most families and children, SPDs, and pregnant women, California generally receives a 50 percent FMAP—meaning the federal government pays one-half of Medi-Cal costs for these populations. However, a subset of children in families with higher incomes qualifies for Medi-Cal as part of CHIP. Currently, the

federal government pays 88 percent of the costs for children enrolled in CHIP and the state pays 12 percent. (We describe recent federal actions that affect CHIP funding later in this write-up.) Finally, under the ACA, the federal government paid 100 percent of the costs of providing health care services to the optional expansion population from 2014 through 2016. Beginning in 2017, the federal cost share decreased to 95 percent, phasing down to 94 percent in 2018 and down further to 90 percent by 2020 and thereafter.

Delivery Systems. There are two main Medi-Cal systems for the delivery of medical services: fee-for-service (FFS) and managed care. In the FFS system, a health care provider receives an individual payment from DHCS for each medical service delivered to a beneficiary. Beneficiaries in Medi-Cal FFS may generally obtain services from any provider who has agreed to accept Medi-Cal FFS payments. In managed care, DHCS contracts with managed care plans, also known as health maintenance organizations, to provide health care coverage for Medi-Cal beneficiaries. Managed care enrollees may obtain services from providers who accept payments from the managed care plan, also known as a plan's "provider network." The plans are reimbursed on a "capitated" basis with a predetermined amount per person per month, regardless of the number of services an individual receives. Medi-Cal managed care plans provide enrollees with most Medi-Cal covered health care services—including hospital, physician, and pharmacy services—and are responsible for ensuring enrollees are able to access covered health services in a timely

manner. (In some counties, Medi-Cal managed care plans also provide long-term services and supports, including institutional care in skilled nursing facilities and certain home- and community-based services.) Managed care enrollment is mandatory for most Medi-Cal beneficiaries, meaning these beneficiaries must access most of their Medi-Cal benefits through the managed care delivery system. In 2018-19, more than 80 percent of Medi-Cal beneficiaries are projected to be enrolled in managed care.

Managed Care Models. The number and types of managed care plans available vary by county, depending on the model of managed care implemented in each county. Counties can generally be grouped into four main models of managed care:

- County Organized Health System (COHS). In the 22 COHS counties, there is one county-run managed care plan available to beneficiaries.
- **Two-Plan.** In the 14 Two-Plan counties, there are two managed care plans available to beneficiaries. One plan is run by the county and the second plan is run by a commercial health plan.
- Geographic Managed Care (GMC). In GMC counties, there are several commercial health plans available to beneficiaries. There are two GMC counties—San Diego and Sacramento.
- Regional. Finally, in the Regional model, there are two commercial health plans available to beneficiaries across 18 counties.

Imperial and San Benito Counties have managed care plans that are not run by the county and do not fit into one of these four models. In Imperial County, there are two commercial health plans available to beneficiaries, and in San Benito, there is one commercial health plan available to beneficiaries.

OVERVIEW OF THE MEDI-CAL BUDGET

The Governor's budget revises estimates of General Fund spending in 2017-18 upward by \$544 million (2.8 percent) relative to what was assumed in the 2017-18 Budget Act. The Governor's budget further proposes \$21.6 billion for Medi-Cal from the General Fund in 2018-19, an increase of \$1.5 billion (7.6 percent) over revised 2017-18 estimates. In

terms of federal funds, the Governor's budget revises estimates of federal spending in Medi-Cal in 2017-18 downward from previous estimates by \$5.2 billion (7.6 percent). The Governor's budget further estimates \$63.7 billion in federal funding for Medi-Cal in 2018-19, an increase of \$3.5 billion (5.4 percent) over revised 2017-18 estimates. Below, we summarize the main factors that contribute to changes in the Medi-Cal budget in both the current and the upcoming fiscal years.

Estimated and Proposed General Fund Spending

Current-Year Adjustments. Increased estimated General Fund spending in Medi-Cal in 2017-18 reflects the net effect of multiple adjustments, the most significant of which include:

- One-time costs of about \$300 million for retrospective payments to the federal government related to prescription drug rebates. Most of the increased costs from these payments is the result of a shift in timing, where some payments that were planned to be made in 2016-17 have been delayed until 2017-18.
- Offsetting savings of about \$270 million from a higher estimate of prescription drug rebates in managed care. Higher estimates for 2017-18 are based on actual rebate amounts coming in higher than previously budgeted.
- Costs of about \$200 million to correct a budgeting methodology used to construct estimates of managed care costs that previously underestimated costs for SPDs.
- Higher projected General Fund spending of about \$170 million related to a reduction in hospital quality assurance fee (HQAF) revenues available to offset General Fund costs in Medi-Cal. The amount of HQAF revenues available to offset General Fund costs is tied to the total amount of supplemental Medi-Cal payments made to private hospitals, the nonfederal share of which are financed with HQAF revenues. A technical change to how much federal funding is available for these supplemental payments resulted in lower total payments in some years and, therefore, decreased estimated HQAF revenues available to offset General Fund Medi-Cal costs in 2017-18.

Budget-Year Changes. Year-over-year growth in General Fund Medi-Cal spending in 2018-19 largely reflects the net effect of the following major factors:

- Higher projected spending of \$540 million to backfill Proposition 56 tobacco excise tax revenues that, while offsetting General Fund Medi-Cal costs in 2017-18, are proposed under the Governor's budget to instead pay for supplemental payments to certain providers in 2018-19. We describe the Governor's proposed allocation of Proposition 56 revenues in a later section.
- Higher projected spending of \$300 million to reflect a full year of an assumed reduction in federal funds, continuing from 2017-18, for CHIP. The lost federal funds are assumed to be backfilled with an equivalent amount of General Fund. We discuss this assumption and recent federal actions related to CHIP funding in a later section.
- Increased costs of roughly \$200 million related to the state's responsibility for a higher share of costs for the ACA optional expansion. The state's share of cost for newly eligible beneficiaries increases from an effective 5.5 percent in 2017-18 to an effective 6.5 percent in 2018-19.
- Increased costs of about \$130 million related to the planned expansion into additional counties of the Drug Medi-Cal Organized Delivery System waiver, a joint federal-state-county demonstration project aimed at providing a full continuum of substance use disorder services to Medi-Cal enrollees.
- Higher projected spending in the hundreds of millions of dollars related to general growth in health care costs.

Federal Funding Changes

Changes in federal funding in Medi-Cal assumed in the Governor's budget—a decrease in 2017-18 relative to prior estimates and an increase in 2018-19 relative to revised 2017-18 estimates—are also the result of a variety of factors. We briefly summarize the impact of two of the major factors below.

ACA Optional Expansion Retroactive Managed Care Rate Recoupment. When the state expanded

Medi-Cal eligibility under the ACA in January 2014, it was necessary to develop capitated rates that would be paid to managed care plans to provide health care services to the newly eligible population. In the absence of experience on the cost of providing health care to this new population, there was significant uncertainty about the appropriate level of the capitated rates. In recognition of this uncertainty, capitated rates for the expansion population were initially set relatively high, with the understanding that any excess funding provided to managed care plans would be recouped retroactively if actual experience turned out to be less costly than initial assumptions.

Since January 2014, the costs of providing health care services to the optional expansion population have come in below expectations, creating the need to recoup significant funds from the managed care plans. Specifically, DHCS has identified \$5.3 billion in recoupments for the period from July 2015 through December 2016 that will be collected from managed care plans during 2017-18. Since the federal government paid 100 percent of capitated rates for the optional expansion population during this period, these recouped funds will be returned to the federal government. These retroactive recoupments mean that net federal funding in Medi-Cal in 2017-18 is \$5.3 billion less than it otherwise would be, and the absence of recoupments related to the ACA optional expansion in 2018-19 is the largest factor contributing to the vear-over-vear increase in federal funding budgeted for Medi-Cal in 2018-19. Capitated rates have since been reduced to reflect actual experience, such that the need for additional recoupments in the future should be relatively limited.

Changes to Hospital Supplemental Payment Programs. The state operates various supplemental payment programs that provide increased reimbursements to various Medi-Cal provider types, including public and private hospitals. In 2016, the federal government finalized a sweeping set of regulations related to managed care payments in Medicaid that had significant implications for many of the state's supplemental payment programs. In order to comply with the final regulations, the state has restructured some aspects of key hospital supplemental payment programs. In some cases, this restructuring is resulting in shifts in the timing of supplemental payments, totaling in the billions of dollars. These timing

shifts account for a significant portion of the reduced federal funding in Medi-Cal in 2017-18. (The timing shifts also affect spending from related state special funds.) In addition to changes to hospital supplemental payment programs resulting from the federal managed care regulations, changes to the calculation of maximum payments allowed in these programs, such as under the HQAF program described above, also contribute to lower federal funds in 2017-18.

In the sections that follow, we (1) review the administration's caseload estimates for the Medi-Cal program, (2) describe the administration's calculation of Medi-Cal funding available under Proposition 55, (3) discuss recent federal actions related to CHIP, and (4) assess the administration's proposed plan for allocating Proposition 56 tobacco tax revenues.

CASELOAD PROJECTIONS

According to the Medi-Cal Eligibility Data System, there were about 13.4 million people enrolled in Medi-Cal in August 2017. This count includes over 3.8 million enrollees—mostly childless adults—who became newly eligible for Medi-Cal under the ACA optional expansion. A substantial number of individuals who were previously eligible—sometimes referred to as the "ACA mandatory expansion"—are also assumed to have enrolled as a result of eligibility simplification, enhanced outreach, and other provisions and effects of the ACA. After several years of significant enrollment growth largely due to the ACA, the caseload appears to have stabilized. In the following sections, we describe recent historical trends in various components of the Medi-Cal caseload and projections in the Governor's budget for Medi-Cal enrollment in 2017-18 and 2018-19.

Historical Trends

Figure 4 (see next page) displays over a decade of observed and estimated caseload for the major categories of enrollment in Medi-Cal: (1) families and children, (2) SPDs, and (3) the ACA optional expansion.

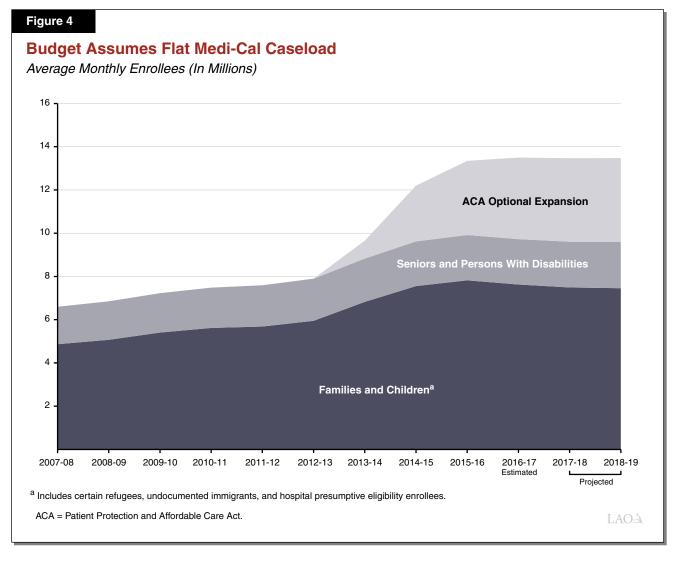
Families and Children Caseload Typically
Countercyclical to State Economy. Historically,
the families and children caseload has been
countercyclical to changes in the state's economy—
meaning enrollment has tended to increase during an
economic downturn and decrease during an economic

expansion. In the last recession, which formally lasted from December 2007 through June 2009, the families and children caseload did increase; however, enrollment did not decline in the years that followed as might have been expected, with growth continuing through 2015-16. This departure from the traditional countercyclical pattern for families and children in part reflects a shift of CHIP enrollees into the families and children caseload in Medi-Cal in 2013-14, as well as the effect of the mandatory expansion described above. These factors, which pushed families and children enrollment higher than it otherwise would be in an expanding economy, now appear to have taken their course and the families and children caseload has begun to decline. Specifically, the administration estimates that the families and children caseload declined 2 percent in 2016-17.

Growth in SPD Enrollment Slowed in Recent

Years. Both the seniors caseload and the persons with disabilities caseload have typically grown at a rate of roughly between 2 percent and 3 percent annually, and are typically less affected by changes in the state's economy. In a departure from the historical trend, annual growth in seniors enrollment spiked to above 5 percent from 2013-14 through 2015-16, but has returned to the historical trend since 2016-17. In contrast, growth in enrollment of persons with disabilities slowed beginning in 2013-14 and the caseload actually declined in 2015-16 and 2016-17. The overall net effect of these offsetting effects is growth in SPD enrollment of less than 2 percent since 2015-16—slower than would have been expected based on the historical trend.

The exact reasons for the departure from the historical trend for SPDs are not clear, but they likely relate to the implementation of the ACA. Unexpected faster growth in the seniors caseload from 2013-14 through 2015-16 could potentially have been due to the effect of the mandatory expansion. Alternatively, the growth in the seniors caseload might have been the result of delays in removing enrollees from the caseload that had changes in circumstances that made them no longer eligible. Some administrative processes in Medi-Cal experienced delays during this period because of increased workload from significant ACA-related enrollment. Unexpected declines in the enrollment of persons with disabilities may be related to some individuals enrolling in Medi-Cal as part of



the ACA optional expansion instead of as part of the persons with disabilities caseload. In any given year, individuals enter and exit the persons with disabilities caseload—the net growth or decline in the caseload in any given year is the difference between the entrances and the exits. It may be that, after Medi-Cal eligibility was expanded in 2014, some individuals that previously would have entered the persons with disabilities caseload instead entered the optional expansion caseload. This would result in declines in the persons with disabilities caseload being offset by a portion of the increase in the ACA optional expansion caseload.

ACA Optional Expansion Caseload Is Stabilizing.

The optional expansion population grew rapidly beginning in January 2014, but growth has since slowed significantly and appears to be stabilizing. In

2016-17, the administration estimates that the optional expansion population grew by only 0.1 percent.

Governor's Budget Caseload Projections

Governor's Budget Projects Flat Overall
Caseload in 2017-18 and 2018-19. The Governor's budget projects an average monthly Medi-Cal caseload of 13.5 million in 2017-18, a slight decrease of 0.5 percent relative to estimated total caseload in 2016-17. The budget further projects the Medi-Cal caseload to remain virtually flat in 2018-19. Within the total caseload projection, the budget assumes that (1) the families and children caseload will continue to slowly decline; (2) the seniors caseload will continue to grow consistent with historical trends and the persons with disabilities caseload will be flat, resulting on net in modest growth in the SPD caseload; and (3) the

ACA optional expansion caseload will experience slow growth.

Administration's Caseload Projections Appear **Reasonable.** We have reviewed the administration's caseload estimates and find them to be reasonable. As we have noted in recent years, substantial ACA-related changes have made it challenging to project caseload. For example, the unanticipated decline in the persons with disabilities caseload makes it challenging to anticipate how this component of the caseload will change in the future. However, we expect that the factors leading to this decline are likely not ongoing and think the administration's assumption that this caseload will remain flat in 2018-19 (ending the recent downward trend) is appropriate. We also expect that the families and children caseload will continue to decline gradually as the state's economy continues to expand, consistent with the administration's projections. Ultimately, we expect the optional expansion caseload to also follow a countercyclical pattern. Given remaining uncertainty about this newly eligible population, however, we think it is prudent to assume the optional expansion caseload may continue to slowly grow. We will provide the Legislature an updated assessment of DHCS' caseload projections at the May Revision when additional caseload trend data are available.

PROPOSITION 55

In 2016, voters passed Proposition 55, which extended tax rate increases on high-income Californians. Proposition 55 includes a budget formula that goes into effect in 2018-19. This formula requires the Director of Finance to annually calculate the amount by which General Fund revenues exceed constitutionally required spending on schools and the "workload budget" costs of other government programs that were in place as of January 2016. One-half of General Fund revenues that exceed constitutionally required spending on schools and workload budget costs, up to \$2 billion, are directed to increase funding for existing health care services and programs in Medi-Cal. The Director of Finance is given significant discretion in making calculations under this formula. Under calculations made for the 2018-19 budget, the Director of Finance finds that General Fund revenues do not exceed constitutionally required spending on schools and workload budget costs. As a result, the

Governor's budget provides no additional funding for Medi-Cal pursuant to the Proposition 55 formula. Our office is reviewing the administration's approach to the Proposition 55 formula and will provide our comments to the Legislature at a later time.

FEDERAL REAUTHORIZATION OF CHIP FUNDING

Background

CHIP Provides Health Insurance to Low-Income Children. CHIP is a joint federal-state program that provides health insurance coverage to children in low-income families, but with incomes too high to qualify for Medicaid. States have the option to use federal CHIP funds to create a stand-alone CHIP or to expand their Medicaid programs to include children in families with higher incomes (commonly referred to as Medicaid-expansion CHIP). California transitioned from providing CHIP coverage through its stand-alone Healthy Families Program to providing CHIP coverage through Medi-Cal. With this transition, completed in the fall of 2013, Medi-Cal (through CHIP) generally provides coverage to children in families with incomes up to 266 percent of the federal poverty level (FPL). Some infants and pregnant women in families with incomes up to 322 percent of the FPL may also be eligible through CHIP for Medi-Cal. The administration estimates that there will be around 1.3 million beneficiaries enrolled in CHIP coverage in 2018-19.

Federal Cost Share for CHIP Is Traditionally Higher Than for Medicaid. Traditionally, the federal government provides a higher FMAP for CHIP coverage in California relative to Medicaid. The historical FMAP for the CHIP population has been 65 percent (compared to the 50 percent FMAP traditionally for Medi-Cal), although this has been further enhanced to 88 percent by the ACA, as discussed below.

CHIP Funding Is Capped. Unlike Medi-Cal, CHIP is not an entitlement program. States receive annual allotments of CHIP funding based on their CHIP FMAP and historical CHIP spending. Generally, states receive allotments that are sufficient to cover the federal share of CHIP expenditures for the full federal fiscal year (FFY). (A FFY runs from October 1 through September 30.) If a state does not spend its full annual allotment in a given

year, the state may continue to draw down unspent funds in the next year.

The ACA and CHIP

ACA Authorized an Enhanced FMAP for CHIP, but Congress Had Only Appropriated Funding Through September 2017. Beginning in FFY 2015-16, the ACA authorized an enhanced FMAP for CHIP through FFY 2018-19. Under the ACA, California's CHIP FMAP increased from 65 percent to 88 percent. However, at the time of congressional reauthorization for an enhanced FMAP for CHIP, Congress had appropriated funding for CHIP only through FFY 2016-17 (ending September 30, 2017).

ACA Maintenance-of-Effort (MOE) Requirements for CHIP and Medicaid. Under an ACA MOE provision, states that operate CHIP through their Medicaid programs are required to maintain their March 23, 2010 Medicaid and CHIP eligibility levels for children through the end of FFY 2018-19. The implications of these MOE requirements are uncertain for California because the state transitioned from a stand-alone CHIP to a Medicaid-expansion CHIP after March 2010. The federal Centers for Medicare and Medicaid Services (CMS) will need to clarify the implications of the ACA MOE requirement for California.

Recent Federal Action

Congressional appropriation of federal funding for CHIP lapsed on September 30, 2017. However, California continued to operate CHIP at the higher 88 percent FMAP using a combination of rollover funding from the state's FFY 2016-17 allotment and funding redistributed from other states to California by CMS. On January 22, 2018, Congress passed (and the President later signed) a reauthorization of federal funding for CHIP, including the following major components:

- Appropriates Funding for CHIP Through FFY 2022-23. States will continue to receive annual allotments to cover the federal share of CHIP expenditures until September 2023. Annual allotments will continue to be calculated based on a state's CHIP FMAP and historical CHIP spending.
- Maintains Enhanced CHIP FMAP Under ACA Through FFY 2018-19. States will continue to

- receive the enhanced FMAP for CHIP authorized by the ACA until September 2019. As previously mentioned, under the ACA, California's current CHIP FMAP is 88 percent. As we will discuss later, federal funding at this higher FMAP will reduce the state's General Fund costs for CHIP in 2017-18, 2018-19, and the first quarter of 2019-20.
- Begins Ratcheting Down the Enhanced CHIP FMAP in FFY 2019-20 and Returns to Traditional CHIP FMAP in FFY 2020-21. For FFY 2019-20 (starting October 1, 2019), states will receive half of their FMAP enhancement for CHIP authorized by the ACA which, in California, results in a 76.5 percent FMAP instead of an 88 percent FMAP until September 2020. For FFY 2020-21 (beginning October 1, 2020), states will return to their traditional CHIP FMAPs which, in California, is a 65 percent FMAP.
- Maintains MOE Requirement for CHIP Under ACA Through FFY 2022-23. As previously mentioned, the ACA required states to maintain their March 23, 2010 Medicaid and CHIP eligibility levels for children through the end of FFY 2018-19. Federal reauthorization of CHIP funding generally extends the ACA's MOE requirement for CHIP until September 2023.
- Permits States to Limit Income Eligibility to 300 Percent of the FPL Starting in FFY 2019-20. One exception to the extension of the ACA's MOE requirement for CHIP through September 2023 is for children in families with household incomes above 300 percent of the FPL. Starting October 1, 2019, states can choose to limit income eligibility for CHIP to at or below 300 percent of the FPL. (Children in families with household incomes at or below 138 percent of the FPL would continue to be covered by Medicaid.) Only a small number of children in families with household incomes above 300 percent of the FPL are currently eligible for CHIP in California.

We note that as of the time of our finalizing this budget analysis, Congress passed (and the President later signed) legislation authorizing CHIP funding (at the traditional CHIP FMAP) and the ACA's MOE

requirement for CHIP for an additional four years—through FFY 2026-27.

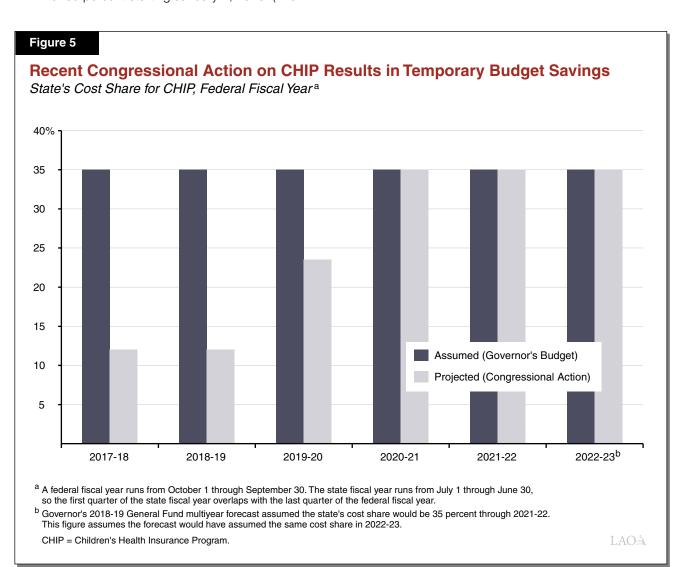
State Budget Implications

Due to congressional appropriations made after the administration finalized its proposed 2018-19 budget, the proposed state budget makes assumptions about the reauthorization of federal funding for CHIP that differ from the recent federal action outlined above.

2018-19 Proposed Budget Assumed Funding for CHIP Appropriated at Traditional CHIP FMAP, Beginning on January 1, 2018. The proposed 2018-19 state budget assumed federal funding for CHIP would be reauthorized, but not at California's ACA-enhanced CHIP FMAP of 88 percent. Instead, it assumed the state would receive its traditional CHIP FMAP of 65 percent starting January 1, 2018. (The

2017-18 budget enacted last June had assumed a return to the traditional CHIP FMAP of 65 percent beginning on October 1, 2017.)

Federal Action Reduces Estimated General Fund Medi-Cal Costs by About \$300 Million in 2017-18 and About \$600 Million in 2018-19. Assuming current caseload and program spending trends continue, reauthorization of federal CHIP funding at the enhanced FMAP of 88 percent will reduce estimated General Fund Medi-Cal costs by about \$300 million in 2017-18 and about \$600 million in 2018-19—relative to the Governor's proposed 2018-19 budget assumptions. The Governor's May Revision budget proposal will reflect this downward adjustment of General Fund costs totaling \$900 million over 2017-18 and 2018-19. Figure 5 reflects the reduction in the state's cost share in 2017-18 and 2018-19.



Reductions in CHIP FMAP in 2019-20 to Increase General Fund Costs Relative to 2018-19.

However, starting in 2019-20, the scheduled reduction of California's CHIP FMAP from 88 percent to 76.5 percent will increase General Fund costs by about \$225 million relative to 2018-19 (based on current caseload and program spending). A return to California's traditional CHIP FMAP of 65 percent in 2020-21 will further increase those costs by \$525 million relative to 2018-19. Figure 5 also reflects these increases in the state's cost share after 2018-19. (We note, however, that General Fund costs in CHIP are now projected to be lower in 2019-20, and the same in 2020-21, than as assumed in the Governor's January budget.) As previously mentioned, federal reauthorization of CHIP funding generally extended the ACA's MOE requirement for CHIP until September 2027. If CMS determines that California is subject to the ACA MOE requirements (as the administration currently assumes), reductions in available CHIP funding could necessitate changes in state spending to maintain current CHIP eligibility levels. If California is not subject to the ACA MOE requirements, the state would have more flexibility to change eligibility levels as a means to reduce costs in the future.

PROPOSITION 56

Proposition 56 raised state taxes on tobacco products and dedicates the majority of associated revenues to Medi-Cal on an ongoing basis. With Proposition 56 revenues that are dedicated to Medi-Cal, the Legislature can use this funding for two main purposes: (1) augmenting the program, such as, for example, by increasing Medi-Cal provider

payments and (2) offsetting General Fund spending on cost *growth* in Medi-Cal. In this piece, we describe: (1) the 2017-18 budget agreement on how funds were to be allocated to these two purposes in both 2017-18 and 2018-19, (2) the Governor's updated plan for expenditures over the two-year period, (3) the specific provider payment increases included in the 2017-18 budget agreement, and (4) the Governor's proposal to add a new service category—home health services—for provider payment increases.

The 2017-18 Budget Agreement

The 2017-18 budget package included a two-year budget agreement on Proposition 56 revenues in Medi-Cal. Broadly speaking, the agreement dedicates Proposition 56 Medi-Cal between the two main uses of Proposition 56 funding described above: (1) increasing payments for certain Medi-Cal providers and (2) paying for anticipated growth in state Medi-Cal costs over and above 2016-17 Budget Act levels, which offsets what otherwise would be General Fund costs. Figure 6 summarizes the use of Proposition 56 funding in Medi-Cal under the 2017-18 budget agreement between the Legislature and the administration. Specifically, it authorized up to \$546 million in 2017-18 and up to \$800 million in 2018-19 in provider payment increases, with any remaining Proposition 56 Medi-Cal funding from 2017-18 (\$711 million) and 2018-19 (\$125 million) to be used to offset General Fund spending on cost growth in the program.

For 2017-18, the 2017-18 budget agreement came with a structure of fixed dollar amount or fixed percentage increases in provider reimbursement levels that applied to an identified set of Medi-Cal services ranging from physician and dental visits to certain

Figure 6

The 2017-18 Budget Agreement on the Use of Proposition 56 Funding in Medi-Cal

(In Millions)

	2017-18	2018-19	Total
Provider payment increases ^a	\$546	\$800	\$1,346
Offsets to General Fund spending on Medi-Cal cost growthb	711	125	836
Total Proposition 56 Spending in Medi-Cal	\$1,257 ^c	\$925 ^c	\$2,182

a The 2017-18 budget agreement authorized supplemental provider payment funding amounts up to the amounts listed in this figure.

b Any Proposition 56 Medi-Cal funding not allocated to augment the program, such as to increase provider payments, is available to offset General Fund spending.

c Amounts reflect the administration's projection of total Proposition 56 revenue allocated to Medi-Cal as of the 2017-18 Budget Act. The Governor's 2018-19 budget revises upward estimated Proposition 56 revenue allocated to Medi-Cal in both 2017-18 and 2018-19.

women's health visits. Moreover, it is our understanding that the budget agreement provides that for any provider payment increases in 2018-19 above the total 2017-18 amount, 70 percent is to be dedicated to physician services payment increases and 30 percent is to be dedicated to dental services payment increases. As the 2017-18 budget agreement only goes through 2018-19, future use of Proposition 56 funding for Medi-Cal will be determined through the annual budget process.

Overview of the Governor's 2018-19 Budget Proposal

Governor's 2018-19 Budget Proposal Essentially Consistent With the 2017-18 Budget Agreement.

The Governor proposes spending the maximum amount authorized in the 2017-18 budget agreement (\$1.346 billion) on provider payment increases within the provider and service categories designated in the 2017-18 agreement. As such, we find that the Governor's budget proposal essentially adheres to the agreement. Specifically, the Governor's budget proposal would extend the provider payment increases structured in the 2017-18 agreement into 2018-19 and allocate the remaining Proposition 56 funding dedicated to provider payment increases to pay for *new* provider payment increases above 2017-18 levels.

Figure 7 summarizes the Governor's updated 2018-19 budget proposal on the use of Proposition 56 funding in Medi-Cal. The figure

shows that the Governor proposes spending slightly more Proposition 56 resources from 2017-18 and 2018-19 on provider payment increases—\$1.378 billion—than the maximum amount authorized under the two-year 2017-18 budget agreement. The increase is attributable to the Governor's proposed payment rate increase for Medi-Cal home health services, which we discuss later on in this analysis.

Governor Does Not Provide a Detailed Spending Plan for \$523 Million in Proposition 56 Funding That Is Available for Provider Payment Increases in 2018-19... Under the Governor's overall Proposition 56 budget proposal, we estimate that \$523 million in total Proposition 56 funding is available for additional provider payment increases beyond those structured in the 2017-18 budget agreement. (We note that this amount represents a preliminary estimate that is subject to change at the May Revision.) However, the Governor's budget proposal does not include a detailed plan for how to structure these additional provider payment increases.

... Intentionally Leaving Details of the Allocation to Be Worked Out With the Legislature. The Governor's proposal to allocate this funding broadly for additional provider payment increases without a detailed plan affords the Legislature an opportunity to provide input into how these new payments are structured. For example, the Legislature could identify new categories of providers or services to which

Figure 7

The Governor's 2018-19 Budget Proposal on Proposition 56 Funding in Medi-Cal

(In Millions)

	2017-18	2018-19	Total
Provider Payment Increases:			
Provider categories in 2017-18 agreement ^a	\$412	\$412	\$823
Additional funding to be committed ^b	_	523	523
Home health services (new)	_	32	32
Subtotals	(\$412)	(\$966)	(\$1,378)
Offsets to General Fund Spending on Medi-Cal Cost Growth ^c	\$711	\$169	\$880

- ^a Amounts listed represent annual cost estimates of supplemental payments structured in the 2017-18 budget agreement by the fiscal year that the affected services are rendered. As a result, the amounts do not account for supplemental payments that are delayed into subsequent fiscal years and are not directly reflected in the Governor's 2018-19 budget display totals.
- b Allocated by the Governor's 2018-19 budget to broad provider categories included in the 2017-18 budget agreement without a planned payment structure.
- ^C Any Proposition 56 Medi-Cal funding not allocated to augment the program, such as to increase provider payments, is available to offset General Fund spending.

to commit this available funding. Alternatively, the Legislature could identify different uses for this funding. For example, the Legislature could commit some or all of this amount to offset General Fund spending on Medi-Cal cost growth or further augment the Medi-Cal program in ways other than increasing provider payments.

In the sections that follow, we provide more detailed information on the Governor's budget proposal for (1) the continuation into 2018-19 of provider payment increases included in the 2017-18 budget agreement and (2) a new provider payment increase for home health services.

Governor's Budget Proposal: Provider Payment Increases Included in the 2017-18 Budget Agreement

Increases Structured as Supplemental Payments.

The provider payment increases discussed in this section take the form of fixed supplemental payments paid on top of standard reimbursement rates for the affected services. Since the federal government will share in the cost of these supplemental payments (at standard FMAP levels), federal approval of the payments is necessary. Certain 2017-18 supplemental payments began to be made in late 2017, while others are expected to be implemented in early 2018. Retroactive supplemental payments for services rendered dating back to July 1, 2017 are generally expected to be made in April and May of 2018.

Governor's 2018-19 Budget Proposes to Spend Maximum Amount Authorized for Provider Payment Increases in 2017-18 Budget Agreement . . . As discussed above, the Governor proposes spending the maximum amount authorized in the 2017-18 budget agreement (\$1.346 billion) on provider payment increases within the provider and service categories designated in the 2017-18 budget agreement. The agreement designated supplemental payment levels for a selected set of services at an estimated annual cost to the state of \$546 million. Figure 8 summarizes the maximum funding amounts by which the provider and service categories could be increased under the 2017-18 budget agreement.

... And Reflects Freed-Up Funding Due to Revised Cost Estimates. Under the Governor's 2018-19 budget, the estimated annual cost to the state of these designated supplemental payments has been revised downward to \$412 million in 2017-18 and 2018-19. It is our understanding that this downward revision is largely the result of revised assumptions related to the federal share of cost for the majority of these payments being higher than previously projected. The Governor's 2018-19 budget proposes to spend the funding freed up as a result of the lower updated cost estimates on additional provider payment increases beginning in 2018-19. Figure 9 summarizes the Governor's 2018-19 Proposition 56 budget proposal as it relates to the provider payment increases included in the 2017-18 budget agreement. This figure shows (1) the amount of annual Proposition 56 funding needed

Figure 8

2017-18 Budget Agreement on Proposition 56 Provider Payment Increases^a

(In Millions)

	2017-18	2018-19	Two-Year Total
Authorized maximum increases to supplemental payments:			
Physician services ^b	\$325	\$503	\$828
Dental services ^b	140	216	356
Women's health ^c	50	50	100
Intermediate Care Facilities for the Developmentally Disabled ^c	27	27	54
AIDS Medi-Cal Waiver Program ^c	4	4	8
Totals	\$546	\$800	\$1,346

a The 2017-18 budget agreement authorized supplemental provider payment funding amounts up to the amounts listed in this figure.

b The 2017-18 Proposition 56 budget agreement authorized physician and dental services provider payment increases to be increased by up to \$254 million between 2017-18 and 2018-19 (bringing total Proposition 56 funding for increased provider payments to \$800 million). After 2018-19, continuation of physician and dental services provider payment increases is expected to be reevaluated.

^C Payment increases are intended to be ongoing, though they might be funded with an alternative fund source following 2018-19.

to fully fund the provider payment increases specifically structured in the 2017-18 budget agreement and (2) the additional funding available (\$523 million) to be committed under the Governor's proposal to *new* provider payment increases beyond those structured in the agreement.

Below, we discuss in greater detail the Governor's 2018-19 budget proposal as it relates to the supplemental payment provider categories included in the 2017-18 budget agreement.

Supplemental Payments for Physician Services.

The 2017-18 budget agreement designated physician services, such as doctors' visits, to receive the majority of supplemental payments using Proposition 56 funding in both 2017-18 and 2018-19. This funding will increase physician payments for the targeted types of physician services by between 20 percent and 45 percent compared to their standard FFS reimbursement levels. These supplemental payments will occur in both the FFS and managed care delivery systems. The federal government has approved the physician services supplemental payments within the FFS delivery system. Federal approval remains pending for these payments within the managed care delivery system but is expected to be received in early 2018,

when supplemental payments across the two delivery systems are expected to begin. They are expected to expire after 2018-19, pending a new agreement being reached in the budget development process on whether and how to fund physician services payment increases in subsequent years.

Under the Governor's 2018-19 budget, the estimated state cost of the physician services supplemental payments structured in the budget agreement has been revised downward from \$325 million annually to \$252 million annually in 2017-18 and 2018-19. The Governor proposes to use the funding freed up as a result of these lower updated cost estimates to fund additional physician services supplemental payments beginning in 2018-19. Overall, the Governor proposes to spend \$828 million from 2017-18 and 2018-19 Proposition 56 revenues on physician services supplemental payments. This amount is the same as the maximum amount authorized to be allocated to physician services supplemental payments in the 2017-18 budget agreement. Of the \$828 million of total proposed spending on physician services provider payment increases, \$324 million has been only broadly allocated to this purpose without a detailed spending plan. For

Figure 9

The Governor's 2018-19 Proposal for Supplemental Payments Included in the 2017-18 Agreement

(Proposition 56 Revenues, in Millions)

	2017-18 ^a	2018-19 ^a	Additional Funding to Be Committed ^b	Total
Physician services ^c	\$252	\$252	\$324	\$828
Dental services ^c	95	95	166	356
Women's health ^d	50	50	_	100
Intermediate Care Facilities for the Developmentally Disabled ^d	12	12	_	23
AIDS Medi-Cal Waiver Program ^d	3	3	_	7
Funding expected to be reallocated among provider categories ^e		_	32	32
Totals	\$412	\$412	\$523	\$1,346

^a Amounts listed represent annual cost estimates of supplemental payments structured in the 2017-18 budget agreement by the fiscal year that the affected services are rendered. Therefore, while corresponding to the display of amounts in the 2017-18 budget agreement table, the amounts will differ from other Governor's budget documents displaying expenditures on a cash basis.

b Allocated by the Governor's 2018-19 budget to broad provider categories included in the 2017-18 budget agreement without a planned payment structure.

^C After 2018-19, continuation of the physician and dental services provider payment increases is expected to be reevaluated.

d Payment increases are intended to be ongoing, though they might be funded with an alternative fund source following 2018-19.

e Reflects available supplemental payment funding originally allocated to provider categories that we do not expect to be adjusted above the cost of the supplemental payments as structured in the 2017-18 budget agreement.

example, the Governor's budget does not target this funding toward additional physician services or specify higher reimbursement amounts for physician services that currently receive supplemental payments. (We would note that a portion of this \$324 million comprises funding that currently is not reflected in the Governor's budget's spending totals in 2018-19, but is reserved for commitments in the budget year.)

Supplemental Payments for Dental Services. The 2017-18 budget agreement dedicated Proposition 56 funding to pay for dental services supplemental payments in 2017-18 and 2018-19. These supplemental payments are expected to expire after 2018-19 pending a new agreement being reached on Proposition 56 funding for provider payment increases in subsequent years.

Under the Governor's 2018-19 budget, the estimated state cost of the dental services supplemental payments structured in the 2017-18 budget agreement has been revised downward from \$140 million annually to \$95 million annually in 2017-18 and 2018-19. The Governor proposes to use the funding freed up as a result of these lower updated cost estimates to fund additional dental services supplemental payments beginning in 2018-19. Overall, the Governor's 2018-19 budget proposes to spend \$356 million from 2017-18 and 2018-19 Proposition 56 revenues on dental services supplemental payments. This amount is the same as the maximum amount authorized to be spent on dental services supplemental payments under the 2017-18 budget agreement. Of the \$356 million of total proposed spending on dental services provider payment increases, \$166 million has been only broadly allocated to this purpose without a detailed spending plan. For example, the Governor's budget does not target this funding toward additional dental services or specify higher reimbursement amounts for dental services that currently receive supplemental payments. (We would note that a portion of this \$166 million comprises funding that currently is not reflected in the Governor's budget's spending totals in 2018-19.)

Supplemental Payments for Women's Health. The 2017-18 budget agreement allocated up to \$50 million annually in Proposition 56 funding in 2017-18 and 2018-19 for family planning services offered through the Family Planning, Access, Care, and Treatment Program. These supplemental payments are intended

to be ongoing, though they might be funded with an alternative source following 2018-19. The Governor's budget proposes to spend the maximum amount authorized under the 2017-18 budget agreement.

Supplemental Payments for Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs). ICF-DDs are health facilities that provide residential services to individuals with developmental disabilities. These supplemental payments are intended to be ongoing, though they might be funded with an alternative fund source following 2018-19. The 2017-18 budget agreement authorized up to \$27 million annually in 2017-18 and 2018-19 for supplemental payments for ICF-DDs. Under the Governor's budget, the estimated cost of these supplemental payments has been revised downward by over 50 percent due to federal limits on the amount by which ICF-DD reimbursement levels can be further augmented using federal funds. Accordingly, under the Governor's budget, the ICF-DD supplemental payments are estimated to cost around \$12 million annually in 2017-18 and 2018-19. The Governor proposes to use the \$31 million in funding freed up as a result of these lower updated cost estimates to fund additional supplemental payments beginning in 2018-19. (We would note that this funding is not currently reflected in the Governor's budget's spending totals in 2018-19.) It is uncertain to which provider or service categories this freed-up funding would be allocated since the state does not appear to be able to use additional Proposition 56 funding to fund ICF-DD supplemental payments above the amount budgeted in the Governor's 2018-19 budget proposal.

Supplemental Payments for AIDS Medi-Cal Waiver Program. The AIDS Medi-Cal Waiver Program. The AIDS Medi-Cal Waiver Program provides home- and community-based services (HCBS) to individuals with the human immunodeficiency virus (HIV) as an alternative to nursing facility care or hospitalization. Such HCBS services could include, for example, skilled nursing services. These supplemental payments are intended to be ongoing, though they might be funded with an alternative fund source following 2018-19. The 2017-18 budget agreement provided up to \$4 million annually in Proposition 56 funding in 2017-18 and 2018-19 for this program, nearly doubling reimbursement levels for many or most of the services provided through the program. The Governor's budget revised downward the annual

cost of these supplemental payments to \$3.4 million due to lower updated cost projections of how much Proposition 56 funding is needed to bring AIDS Medi-Cal Waiver Program reimbursement levels up to the levels determined in the 2017-18 budget agreement. The Governor proposes to spend the \$1 million in funding freed up as a result of these lower updated cost estimates on additional provider payment increases in 2018-19. (We would note that this funding is not currently reflected in the Governor's budget's spending totals in 2018-19.) However, it is uncertain whether the Governor intends this funding to be spent on higher supplemental payments in the AIDS Medi-Cal Waiver Program or whether the Governor intends to reallocate this funding to other provider or service categories.

Governor's Budget Proposal: New Proposed Provider Payment Increase for Home Health Services

The Governor's budget dedicates a portion of Proposition 56 Medi-Cal funding to pay for payment rate increases for a health care service type—home health services—that was not targeted to receive payment increases in the 2017-18 budget agreement. Relative to the agreement, this proposal increases the total amount of Proposition 56 revenue proposed to be used to increase Medi-Cal provider payments and decreases the amount of Proposition 56 Medi-Cal funding available to offset General Fund spending on cost growth in the program.

Home Health Services. Home health services are services provided to patients in their residence instead of an inpatient setting such as a hospital. Home health service providers such as home health agencies hire registered nurses, licensed vocational nurses, and certified home health aides to—for example administer patients' oral medications, insert feeding tubes, and treat wounds. All Medi-Cal beneficiaries are generally eligible for home health services as long as the services are medically necessary. Medi-Cal reimburses home health services at levels based on the type of health professional who provides the services and the length of time needed. These services are available through the two main Medi-Cal delivery systems, FFS and managed care, as well as through Medi-Cal's various HCBS waiver programs. (HCBS waiver programs allow states to deliver long-term

services and supports, such as home health services, to Medicaid beneficiaries in their residences.)

DHCS Identified Potential Problems With Access to Certain Home Health Services in Medi-Cal. The department monitors access to home health services in Medi-Cal FFS through federally mandated access monitoring and self-generated studies on access to particular services. For example, in a late 2016 self-generated study of access to home health services largely within the California Children's Services program, DHCS concluded there was a gap between the number of hours authorized for eligible beneficiaries and the number of hours rendered by providers. While the study could not explain the disparity, it cited for additional study specific barriers to access, including provider rates, staffing shortages, and geographic disparities. The administration cites this study in support of its proposal to increase certain home health service provider rates in 2018-19.

Proposed 2018-19 Budget Would Increase Home Health Services Provider Rates by 50 Percent.

Starting July 1, 2018, the administration proposes to increase provider rates for home health services participating in Medi-Cal FFS and four HCBS waiver programs—the Home and Community-Based Alternatives Waiver, the In-Home Operations Waiver, the Pediatric Palliative Care Waiver, and the AIDS Medi-Cal Waiver Program—by 50 percent. The administration estimates the total cost of the provider rate increase in 2018-19 would be \$65 million - \$41 million for the rate increase, and \$24 million for an anticipated increase in utilization of home health services by 15 percentage points. The Governor's budget proposes to fund the nonfederal share in 2018-19-\$32 million-using Proposition 56 revenues. While the administration proposes that these rate increases be ongoing, it does not identify funding for the nonfederal share after 2018-19.

Issues for Consideration. As discussed above, the Governor's budget proposes to use \$32 million in Proposition 56 revenue that would otherwise be available to offset General Fund spending on cost growth in Medi-Cal to increase payment rates for home health services. In support of its proposal, the administration has provided some evidence that access to home health services could be a challenge for certain Medi-Cal beneficiaries. In deciding whether to approve

the Governor's proposal, however, we recommend that the Legislature consider the following:

- Whether the rate increases should be ongoing or limited term, given the uncertain cause of the gap between the number of authorized hours and rendered hours for home health services.
- Whether the rate increases should assume increased utilization of roughly 15 percentage points in 2018-19 and, if not, whether the amount of Proposition 56 revenues allocated for these rate increases should be higher or lower to reflect a different assumption about changes in utilization.

Should the Legislature consider these issues and wish to increase payment levels for home health services in the amount proposed by the Governor's budget, we would recommend the Legislature direct DHCS to conduct an additional study to determine the primary cause of the gap between the number of authorized hours and rendered hours for home health services in Medi-Cal. We would also recommend the Legislature direct DHCS to report back to the Legislature on changes in utilization of home health services (and associated costs) in Medi-Cal after the rate increases went into effect.

DEPARTMENT OF STATE HOSPITALS

OVERVIEW

Department Provides Inpatient and Outpatient Mental Health Services. The Department of State Hospitals (DSH) provides inpatient mental health services at five state hospitals (Atascadero, Coalinga, Metropolitan, Napa, and Patton). In addition, DSH provides outpatient treatment services to patients in the community. Overall, the department is currently budgeted to treat about 6,500 patients in its facilities and another 700 in the community. Patients at the state hospitals fall into one of two categories: civil commitments or forensic commitments. Civil commitments are generally referred to the state hospitals for treatment by counties. Forensic commitments are typically committed by the criminal justice system and include individuals classified as Incompetent to Stand Trial (IST), Not Guilty by Reason of Insanity, Mentally Disordered Offenders (MDOs), or Sexually Violent Predators. Currently, about 90 percent of the patient population is forensic in nature. As of January 15, 2018, the department had about 1,100 patients awaiting placement, including about 900 IST patients.

Spending Proposed to Increase by \$226 Million in 2018-19. The Governor's budget proposes total expenditures of \$1.9 billion (\$1.8 billion from the General Fund) for DSH operations in 2018-19, which is an increase of \$226 million (13 percent) from the

revised 2017-18 level. This increase is primarily due to the implementation of various strategies intended to reduce the number of IST patients awaiting transfer, which we discuss in more detail below.

DSH-COALINGA EXPANSION

Background

DSH Has Minimum Staffing Standards. In order to meet the minimum standards for patient treatment, DSH is required to provide a minimum number of staff depending on the level of care the patient has been assigned to (commonly referred to as "level of care staff"). These staff provide treatment services to DSH patients, and include nursing staff and behavioral health treatment team staff. Based on patients' diagnoses and treatment plans, the department assigns patients to one of three levels of care (commonly referred to as acuity levels):

- Intermediate Care Facility (ICF). ICFs provide inpatient skilled nursing services to patients who do not require continuous nursing care.
- Acute. Acute units provide 24-hour inpatient care services, including medical, behavioral health, and pharmaceutical services.
- Skilled Nursing Facility (SNF). SNFs provide long-term skilled nursing care, including 24-hour

inpatient treatment and a variety of physical and behavioral health services.

The minimum number of staff needed for each acuity level are based on the following staffing standards:

• Title 22 Requirements. Title 22 of the California Code of Regulations sets the standards for operating an acute psychiatric hospital. Specifically, Title 22 requires hospitals to be licensed by the California Department of Public Health and sets minimum requirements for staffing and facilities. In particular, it requires a certain minimum number of nursing staff based on patient acuity and associated treatment needs for different nursing shifts (meaning morning,

afternoon, or overnight), as shown in Figure 10. Title 22 nursing staff have many responsibilities, including patient observation, medication distribution, and patient escorting.

• Treatment Teams. In addition to the nursing staff required by Title 22, DSH also uses a behavioral health treatment team model. Under this model,

clinicians work together to provide individual and group treatment to a set number of patients. Each treatment team includes five providers—a psychiatrist, psychologist, social worker, rehabilitation therapist, and registered nurse. Treatment team nursing staff are distinct from Title 22 nursing staff in that they are responsible for developing treatment plans and participating in treatment team meetings. They have an assigned group of patients, rather than being assigned to morning, afternoon, or overnight nursing shifts. The number of patients assigned to each treatment team is determined by patient acuity, as detailed in Figure 11.

In addition to these staff, DSH also provides a variety of other staff to ensure its effective operation. These staff include additional level of care staff, other treatment staff (such as dieticians and medical doctors), and nontreatment staff (such as administrative staff, janitors, firefighters, and hospital police). Currently, DSH

determines the number of non-level of care staff at a facility based on internal assessments of its operations and needs.

DSH Staffing Study. In 2016-17, DSH initiated a staffing study to determine whether the staffing at its hospitals resulted in adequate levels of care. The study will review staffing across all state hospitals and patient types in two phases. The first phase of the study covers level of care staff, other treatment staff, and hospital police, and was originally planned to be released by fall 2017. The second phase is planned to cover the remaining staff, including nontreatment staff (such as custodians and food service workers), hospital operations, and hospital administration staff. At the time of this analysis, neither phase of the staffing study has

Figure 10 Title 22 Staffing Requirements^a

		Patient Acuity	
Nursing Shift	Intermediate Care Facility	Acute	Skilled Nursing Facility
Morning	1:8	1:6	1:6
Afternoon	1:8	1:6	1:6
Overnight	1:16	1:12	1:12
a Requirements reflect	the minimum ratio of nurse	es to patients.	

been released and the department has not provided a timeline for when the two phases will be completed. This study is intended to help the administration and the Legislature determine the extent to which staffing beyond the minimum staffing standards is necessary.

MDOs. MDOs are parolees, who after their release from state prison, are transferred to a state hospital for treatment as a condition of their parole because a court has determined that the individual represents a substantial danger of physical harm to others as a result of their mental illness. Around 1,300 (or 18 percent) of

Figure 11

Treatment Team Staffing Ratios

	9
Acuity Level	Staffing Ratio
Intermediate Care Facility	1:35
Acute	1:15
Skilled Nursing Facility	1:15
a Ratios reflect the average ratio of trea	atment team to patients.

patients in state hospitals are MDOs. An MDO patient spends an average of two years in a state hospital.

Governor's Proposal

The Governor's budget proposes an \$11.5 million General Fund augmentation and 81 additional positions in 2018-19 to staff 80 additional MDO beds at 8 different units at DSH-Coalinga. Under the proposal, these resources would increase to \$13.7 million and 97 positions annually beginning in 2019-20. The department plans to initially activate 40 beds beginning July 1, 2018, then gradually activate additional beds until all 80 beds are activated by July 1, 2019. The 81 positions requested in 2018-19 include (1) 49 level of care staff to meet minimum staffing standards and (2) 32 positions above these standards. The 32 positions include additional level of care staff, other treatment staff, and nontreatment staff. The total requested positions are consistent with how the department is currently funded to staff other similar state hospital units.

According to the administration, the 80 additional beds are needed to house MDOs who are being displaced from DSH-Atascadero and DSH-Patton because the units that currently house them will be converted into Enhanced Treatment Program (ETP) units, which are specialized units for violent and/or aggressive patients. The 2014-15 Budget Act included \$13.6 million for DSH to construct four ETP units at these facilities. Two of the units are expected to be completed by December 2018, with the remaining two units being completed by April 2019.

LAO Assessment

Staffing Request Based on Current Practices.

As discussed above, the activation of the 80 additional beds at 8 different units at DSH-Coalinga is necessary to accommodate the MDOs who will be displaced by the activation of the ETP units at DSH-Atascadero and DSH-Patton. Based on the department's existing staffing standards, it will need at a minimum 49 positions in 2018-19—increasing to 59 positions in 2019-20—to activate these beds. The positions requested above these staffing standards would be consistent with how DSH staffs other similar units. However, as is the case at all DSH facilities, the number of additional staff beyond these standards that are

needed remains unclear. Presumably, the staffing study will shed light on this matter.

LAO Recommendations

Provide Funding to Allow DSH to Staff Proposed Beds Similar to Other Units. We recommend that the Legislature approve the resources requested for DSH to operate the 80 additional beds at DSH-Coalinga. This would allow these beds to be staffed at the same level as other similar units.

Require Completion of Staffing Study. In order to ensure that the department completes its staffing study as planned, we also recommend that the Legislature approve provisional language requiring that both phases of the staffing study be complete by January 10, 2019. This would provide the department one more year to complete the study. At that time, the Legislature would also be able to assess the staffing needs across the entire department and make necessary budget adjustments.

PROPOSALS TO EXPAND IST CAPACITY

Background

IST Referral and Placement Process. Individuals who are IST and face a felony charge are typically referred by a state trial court to DSH to receive restoration services. Once DSH receives the referral, the patient is put on a pending transfer list (commonly referred to by the department as the "IST waitlist") and DSH decides whether to treat the patient in a state hospital or a county-operated program under contract with the department—such as a Jail Based Competency Treatment (JBCT) program. (Under the JBCT program, counties provide restoration treatment in county jails to patients who do not require the intensive level of inpatient treatment provided in state hospitals.) Patients are removed from the waitlist when they are physically transferred to a treatment program. State law does not require an IST patient to be transferred to a program within a specified number of days. However, statute does require the department to report to the court on whether the patient is progressing towards being restored to competency no more than 90 days after he or she was referred to DSH by the court. State law allows felony IST patients to be treated

for the lesser of three years or the maximum length of time they would have served if convicted.

IST Waitlist Continues to Grow Despite Additional Capacity. Over the past several years, total IST felony referrals have increased. Since DSH began reporting referral data weekly in 2013, average monthly felony IST referrals have increased from 232 to 425-an increase of 83 percent. Additional funding has been provided to DSH in recent years to increase its IST capacity. For example, 55 IST beds were activated at DSH-Atascadero in 2015-16. These efforts, combined with existing IST treatment capacity, allow DSH to operate around 1,800 beds, which can serve around 3,600 patients per year. Despite these efforts, however, the department continues to not have enough IST beds—whether it be in a DSH hospital or program under contract—to treat all patients who are referred by the courts. In fact, the number of patients on the IST waitlist continues to grow. As shown in Figure 12, as of February 5, 2018, there were 933 patients on the waitlist. This is about 270 patients (or 41 percent) higher than the waitlist on August 22, 2017, when the department began providing this information for both DSH hospitals and programs under contract. We note that this includes some patients who have only been waiting for a relatively short period of time, as

DSH determines where the patient should receive treatment and they are transferred to the appropriate program.

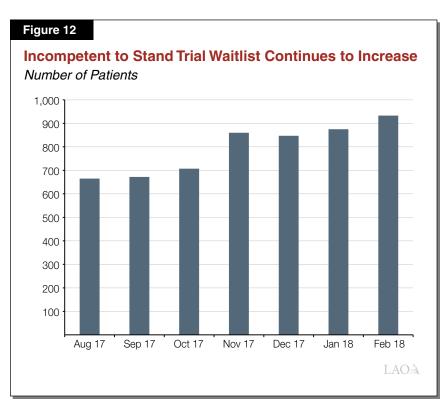
Patients on the waitlist are typically housed in county jails while they wait to be transferred to a DSH program, which is problematic for two reasons. First, due to limited access to mental health treatment in some jails, these patients' condition can worsen ("decompensate") while they are in jail, potentially making eventual restoration of competency more difficult. Second, long waitlists can result in increased court costs and a higher risk of DSH being found in contempt of court orders to admit patients. This is because courts in some counties have required DSH to admit patients within certain time frames and

DSH can be ordered to appear in court or be held in contempt when it fails to do so.

Construction Project at DSH-Metropolitan to Increase IST Beds. In 2015-16, as part of its efforts to expand IST capacity, the Legislature approved funding to increase secure treatment area capacity at DSH-Metropolitan in Norwalk. These modifications are necessary to house forensic patients—including ISTs—because these patients generally are required to be housed in a secure treatment area due to security concerns. Once this project is completed, the department plans to activate 236 new beds, which would be prioritized for IST patients. When this project was approved by the Legislature, the staffing costs for the 236 new beds were estimated to be \$48 million annually, or \$207,000 per bed.

Governor's Proposal

The Governor's budget for 2018-19 includes an \$87.4 million General Fund augmentation for various proposals to expand IST capacity and reduce the waitlist. (As we discuss later in this write-up, the Governor also proposes \$100 million on a one-time basis for DSH to contract with counties to create diversion programs intended to primarily treat offenders



before they are declared IST.) Specifically, the Governor proposes to:

- Staff DSH-Metropolitan Beds. The budget proposes \$56.8 million and 346 positions in 2018-19 (increasing to \$72.6 million annually and 473 positions beginning in 2019-20) to staff the 236 beds that are part of the DSH-Metropolitan expansion. These beds are expected to serve around an additional 470 IST patients annually at an average cost of around \$308,000 per bed. The 346 positions requested in 2018-19 include (1) 182 level of care staff to meet minimum staffing standards and (2) 164 positions above these standards. The 164 positions include additional level of care staff (such as registered nurses), other treatment staff (such as dieticians), and nontreatment staff (such as janitors). The total requested positions are consistent with how the department is currently funded to staff other similar state hospital units.
- Expand JBCT Programs. The budget proposes \$15.9 million in 2018-19 to add up to an additional 160 JBCT beds. This would allow the department to serve around an additional 270 IST patients annually at a cost of around \$150,000 per bed.
- Establish Los Angeles County IST Treatment Program. The Governor's budget proposes \$14.8 million to establish a community-based IST treatment program in Los Angeles County. This program is expected to add an additional 150 IST beds. This includes (1) 5 beds in locked units of psychiatric hospitals (\$183,000 per bed), (2) 45 beds in locked mental health facilities that provide a somewhat lower level of care

(\$120,000 per bed), and (3) 100 beds in unlocked mental health facilities (\$60,000 per bed). In total, these beds are expected to serve 150 to 200 IST patients annually.

As shown in **Figure 13**, these proposals would allow DSH to treat 940 additional patients annually upon full implementation.

LAO Assessment

Number of Pending Transfers Does Not Accurately Reflect Waitlist. Typically, waitlists are used to track the number of individuals who temporarily cannot be served by a program due to a lack of available capacity. While the IST waitlist—as currently defined by DSH-includes patients who cannot be served due to a lack of capacity, it also includes patients who are being processed by the department to determine where to treat them as well as those who are waiting a short period of time to be physically transferred to an available bed. The department reports that it should generally take three to six weeks to process IST referrals to determine placement. Accordingly, a more reasonable waitlist for IST treatment might only include individuals who have been on the waitlist for more than six weeks (or 42 days). This would reflect the number of referrals that DSH should have had sufficient time to process and transport to an IST treatment program. If the waitlist were defined on this basis, the actual waitlist would be around 650—or about one-third lower than the current waitlist. If the referral rate did not increase further, the department could service this waitlist with around 325 additional IST beds. However, the waitlist could be reasonably defined in other ways which would result in a higher or lower waitlist.

Figure 13

Number of Beds and Patients Served by Governor's Proposals

	2018-19		201	9-20
	Number of Beds	Number of Patients	Number of Beds	Number of Patients
Staff DSH-Metropolitan beds	158	317	236	472
Expand JBCT programs	106	252	159	268
Establish Los Angeles County IST program	150	200	150	200
Totals	414	769	545	940
DSH = Department of State Hospitals; JBCT = Jail-Base	d Competency Treatn	nent; and IST = Incompe	tent to Stand Trial.	

All of Governor's Proposed Beds May Not Be

Necessary. As noted above, alternative methods of defining the IST waitlist would significantly impact the number of additional IST beds needed to ensure that patients are transferred to a treatment program within a reasonable time frame. For example, if the waitlist were established based on the 42-day time frame and the referral rate did not increase, only 325 additional IST beds would be required rather than the 545 beds proposed by the Governor.

Activating Beds at DSH-Metropolitan Is Costly Way to Address IST Needs. The annual cost of activating the beds at DSH-Metropolitan (\$308,000 per bed) is significantly higher than the JBCT beds (\$150,000 per bed) or the Los Angeles County program beds (\$83,000 per bed on average) proposed by the Governor. This is partly due to the intensive treatment provided in state hospitals. We also note that proposed staffing costs for the DSH-Metropolitan beds are much higher than initially estimated when the Legislature approved the expansion of secure treatment capacity at the hospital. According to the department, the initial estimate inadvertently did not include certain staffing costs. While these beds are expensive, some of them may be necessary depending on the size of the waitlist and the extent to which there are patients that require relatively intensive treatment.

Proposed County-Operated Beds Have Various Advantages, but Additional Information Needed. As discussed above, both the proposed JBCT expansion and Los Angeles County IST program cost significantly less than activating state hospital beds on a per-bed basis. While this is because the county-operated beds would provide less intensive treatment, they have other advantages. For example, these beds allow patients to remain relatively close to their families and the Los Angeles County program would help address the significant need for IST beds in that county. However, the Governor's proposal does not identify the specific counties that would receive JBCT funding or whether contract terms have been agreed to. We note that DSH has had difficulty in recent years finding counties willing to operate JBCT programs. In addition, while the Los Angeles County program represents a new approach that could reduce the IST waitlist, it is uncertain whether it is a cost-effective strategy. Without the above information, it is difficult to for the Legislature to assess whether or not to approve these two proposals.

LAO Recommendations

Define IST Waitlist. We recommend that the Legislature define what it considers to be an appropriate IST waitlist, which would allow it to then determine how many additional beds are needed to reduce or eliminate this waitlist. We suggest defining the waitlist as consisting of those patients who have not been placed within six weeks of being found IST—the amount of time DSH reports it takes to process IST referrals. This would represent how many patients are waiting in county jail for treatment. In addition, we recommend that the Legislature approve budget trailer legislation requiring DSH to report weekly on the size of the waitlist according to the Legislature's waitlist definition.

Approve Additional Capacity Based on Waitlist Definition. After the Legislature defines the IST waitlist, it will be in a much better position to determine the extent to which the additional IST beds proposed by the Governor are necessary. If it is shown that additional beds are needed, we recommend the Legislature first consider the Governor's proposals to expand JBCT programs and establish the Los Angeles County community-based restoration program before activating any of the DSH-Metropolitan beds. As noted above, these county-operated beds are less costly and may allow patients who do not require the more intensive level of treatment provided in state hospitals to be treated closer to their families and faster than if they waited for a state hospital bed to become available.

If the Legislature defined the waitlist as not being placed within six weeks of being found IST (as we suggest), we estimate that around 325 additional IST beds would be needed. A large portion of this need could be met by approving the Governor's proposed JBCT expansion and Los Angeles County program, which would collectively add an additional 256 IST beds. To address any potential bed need for IST patients who require the more intensive treatment provided in state hospitals, the remaining 69 beds could be provided by activating two 48-bed units at DSH-Metropolitan. This would also give the department some additional beds in case the waitlist increases further than expected. (We note that the remaining two units at DSH-Metropolitan would also be available to address any future increases in the IST waitlist.)

In order to assist the Legislature in determining the extent to which it wants to approve the Governor's JBCT and Los Angeles County program proposals, we recommend requiring the department to report at spring budget hearings on (1) which counties will operate the proposed JBCT programs and the status of the negotiations with these counties and (2) a plan to evaluate the cost-effectiveness of the Los Angeles County program. If the Legislature decides to approve funding for the Los Angeles County program, we recommend that it do so on a limited-term basis until the program is evaluated.

GOVERNOR'S IST DIVERSION PROPOSAL

Background

IST Referrals Continue to Increase. As previously mentioned, the number of IST referrals has increased steadily since DSH began tracking referrals in 2013-14. Specifically, as shown in Figure 14, average monthly felony IST referrals have increased by 17 percent annually. While funding has been provided to increase capacity to treat IST referrals, this increased capacity

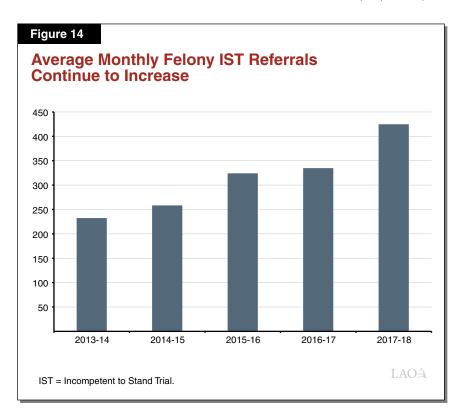
does not address the rate at which patients are being referred by the courts to DSH.

Governor's Proposal

The administration has set a goal of reducing annual IST referrals by 20 percent to 30 percent by July 1, 2021. In order to help achieve this goal, the Governor's budget includes a one-time \$99.5 million General Fund augmentation for DSH to contract with counties to establish IST diversion programs that are intended primarily to treat offenders before they are declared IST. The budget also includes \$500,000 to support one psychologist and one health program specialist at DSH to review county plans and manage the contracts, as well as support various research-related activities. Under the Governor's proposed budget trailer legislation, the diversion programs would target individuals who have (1) been arrested for a felony offense, (2) a mental health condition that could render them IST, and (3) a low public safety risk. Courts would have the authority to refer individuals who meet these criteria to the county IST diversion programs. If such individuals successfully complete these programs, judges could drop or reduce their charges.

The administration indicates that \$91 million (91 percent) of the proposed funding would be

allocated to the 15 counties with the highest number of felony IST referrals to DSH, with the remaining funding available to other counties. Participating counties would be required to match 20 percent of the state funding received for the program. Under the Governor's proposal, counties would be required to use the one-time funds to provide mental health treatment as well as services necessary to meet participants' non-mental health needs, such as housing and transportation services. In addition, counties would be required to report various information to DSH on a quarterly basis, including the number of people who successfully completed the diversion program and whether charges were dismissed or reduced.



LAO Assessment

Concept of IST Diversion Programs Has

Merit . . . If successful, diverting offenders who might otherwise eventually be declared IST and referred by the courts to DSH would help reduce the number of future IST referrals. As a result, such a program could reduce the number of IST patients waiting in county jails for a treatment space at DSH to become available, potentially resulting in some savings for local governments in the near term. In addition, treating individuals in community-based mental health programs at the county-level is generally less costly than providing competency restoration treatment through DSH-\$50,000 annually per patient versus between \$140,000 and \$310,000 annually per patient. We note that if referrals decrease to the point that there is no IST waitlist, it is possible that the state could consider reducing the number of IST treatment beds it operates, which would result in state savings.

- ... But Governor's Proposal Not Well Structured. While the concept of diversion programs has merit, we find that the Governor's proposal is not well structured to achieve its intended benefits. This is due to the following reasons:
 - Key Program Details Unclear. The Governor's proposal does not include several key program details. For example, it is unclear (1) how the proposed funding will be allocated to specific counties, (2) the level of funding that will provided, (3) what specific programs and services will be provided, and (4) roughly how many individuals will be served with the proposed funding. The absence of such information makes it difficult for the Legislature to assess whether the amount of funding proposed by the Governor is appropriate and what impact it could have on IST referrals if approved.
 - County Incentives to Participate Are Unclear.

 Since DSH is responsible for treating felony IST patients, the primary reason counties would want to reduce referrals is to reduce the number of individuals waiting in county jail to be treated by DSH. However, it is unclear whether this benefit is sufficient for counties to justify providing the matching funds required by the program. In addition, since the funding proposed by the Governor is one-time in nature, counties would

- have to identify the necessary resources to backfill the expiration in state funds if they wanted to continue the programs on an ongoing basis. As a result, it is unclear how many counties would be interested in contracting with DSH to establish a diversion program on a one-time basis, as well as continue the program with their own resources.
- Impact of Proposal Would Likely Be Minimal. Given that it would take some time for county diversion programs to have a meaningful impact—particularly for those offenders who may need treatment for an extended period—and that the Governor is proposing only to provide funding on a one-time basis, we find that the impact of the proposal on IST referrals would likely be minimal. Moreover, while the Governor's proposal does require counties to report specific information to DSH, the proposal does not require DSH to conduct a meaningful evaluation of the programs, such as which specific strategies had the greatest impact on reducing IST referrals. Such an evaluation would be important to determine whether certain diversion programs were effective at reducing IST referrals and merit continuation.

LAO Recommendation

In view of the above concerns, we recommend that the Legislature reject the Governor's proposal and, instead, direct the department to work with counties to develop specific IST diversion programs that the Legislature could consider funding in 2018-19 or beyond. In order to ensure that the Legislature has sufficient information to assess each specific program, the department should identify in its proposal the specific services each county would provide, the number of patients the county would serve, and a plan to evaluate the program's effectiveness. If the Legislature chooses to approve such proposals, we would recommend providing funding on a limited-term basis over a few years and not require a local funding match (as proposed by the Governor). To the extent that a particular county diversion program is shown to be effective at reducing the number of IST referrals from that county, we would recommend the Legislature consider providing ongoing funding for the program.

CALWORKS

BACKGROUND

The California Work Opportunity and Responsibility to Kids (CalWORKs) program was created in 1997 in response to the 1996 federal welfare reform legislation that created the federal Temporary Assistance for Needy Families (TANF) program. CalWORKs provides cash grants and employment services to low-income families. The CalWORKs program is administered locally by counties and overseen by the state Department of Social Services (DSS).

Cash Assistance. Grant amounts vary across the state and are adjusted for family size, income, and other factors. For example, a family of three in a high-cost county that has no other income currently receives the maximum cash grant for that family size—\$714 per month. On average, families enrolled in CalWORKs are estimated to receive an average grant of \$567 per month in 2017-18. Families enrolled in CalWORKs are generally also eligible for food assistance through the CalFresh program and health coverage through Medi-Cal.

Work Requirement. As a condition of receiving aid, adults are generally subject to a work requirement, meaning that they must be employed or participate in job search and readiness training intended to lead to employment. People who are enrolled in work-related activities may also receive services to help them meet this requirement, including subsidized child care and reimbursement for transportation and certain other expenses.

Funding. CalWORKs is funded through a combination of California's federal TANF block grant allocation (\$3.7 billion annually), the state General Fund, realignment funds, and other county funds. In order to receive its annual TANF allocation, the state must spend a maintenance-of-effort (MOE) amount from state and local funds (including realignment and other county funds) to provide services for families eligible for CalWORKs. The MOE amount is \$2.9 billion. In addition to funding for cash grants, counties receive various funding allocations from the state to administer CalWORKs. As will be discussed in greater detail below, the largest of these—known as the "single allocation"—

funds employment services, eligibility determination and other administrative costs, and child care subsidies.

Outline of the CalWORKs Analysis. In the analysis that follows, we (1) describe the program's ongoing caseload decline, which reduces program costs and consequently provides an opportunity for the Legislature to allocate new resources in CalWORKs or to other areas of the budget; (2) provide an overview of the Governor's proposed 2018-19 CalWORKs budget; (3) assess the Governor's proposals to spend freed-up TANF funds available in the budget year; and (4) lay out options the Legislature may wish to consider as it crafts its own priorities for these freed-up funds.

CALWORKS CASELOAD NOW AT HISTORIC LOW

Fewest Participants in Program's 20-Year

History. The number of families in California receiving cash assistance declined rapidly following federal welfare reform in 1996, largely as a result of new time limits on receiving aid and the requirements that most adults receiving aid participate in work-related activities. Following this transition, as shown in Figure 15, the CalWORKs caseload settled at approximately 480,000 families during the early 2000s. Caseload then increased during the Great Recession, peaking at 585,000 families during 2010-11. The caseload has declined each year since 2010-11. Over that time, the number of CalWORKs families has fallen by nearly 30 percent (about 160,000 families) to 425,000 families in 2017-18.

Low Caseload Due Primarily to Strong Economy.

The CalWORKs caseload increases or decreases over time depending on how many new families enter the program each month and how many leave each month. When more families enroll each month than leave, the overall caseload increases (the opposite causes the caseload to decrease). During a typical month when the caseload is steady, about 40,000 eligible families enroll in CalWORKs and about 40,000 families leave the program. When economic conditions and the labor market are strong, employment opportunities are more accessible, hourly wages may rise, and a greater

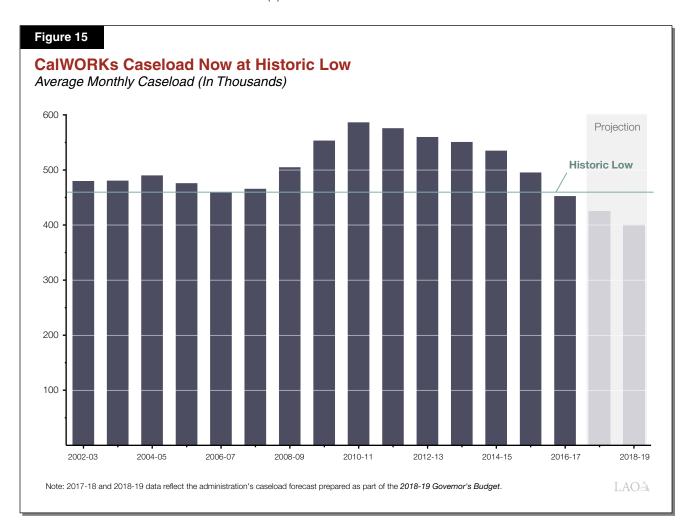
share of families are able to meet their basic economic needs. During these times, somewhat fewer families enroll each month than depart, and the overall caseload declines from month to month. In recent years, as the state economy has recovered from the recession and the labor market has expanded, about 3,000 fewer families have enrolled in CalWORKs each month than have left the program.

Caseload Decline Expected to Continue in Short Term, but Long-Term Floor Unknown. Both our office and the administration assume that the caseload decline will continue for at least 2018-19 and perhaps longer. In regard to longer-term trends, however, we are less certain about this trajectory. This is because we anticipate that some number of families will continue to be eligible for and benefit from the CalWORKs program even as the economic expansion continues. These cases likely would consist of (1) families experiencing a temporary financial crises that enroll in CalWORKs for a short time and (2) families

whose adult members struggle with substantial barriers to long-term employment—such as mental health challenges, substance use, domestic violence, or other issues causing family instability. Although we believe a caseload floor exists, it is difficult to estimate its general level as measured in the overall caseload number. Should this number be relatively high (closer to the current caseload level), the ongoing caseload decline would likely begin to slow relatively soon. If, on the other hand, this floor is lower, the ongoing caseload decline could continue for several years.

BUDGET OVERVIEW

Total Funding Trends. As shown in **Figure 16** (see next page), the Governor's budget proposes \$4.8 billion in total funding for the CalWORKs program in 2018-19, a net decrease of \$183 million (4 percent) relative to the most recent estimate of current-year spending. The net effect is the result of lower spending on cash assistance



payments due to a declining caseload (\$174 million less than 2017-18) and a net reduction to the single allocation (\$32 million), offset somewhat by new proposed spending on the governor's home visiting initiative (\$27 million). The \$32 million year-over-year reduction in the single allocation represents a \$55 million reduction offset by \$23 million in funding to implement new activities.

Administration's Updated Caseload Forecast Appears Reasonable. The Governor's budget updates previous caseload projections and assumes that an average of 425,855 families will receive CalWORKs assistance each month during 2017-18. This updated projection reflects a nearly 6 percent decline relative to 2016-17 and is 5.6 percent lower than the level assumed in the 2017-18 Budget Act. The Governor's budget further projects that an average of 400,777 families will receive CalWORKs assistance each month during 2018-19, a year-over-year decline of about 6 percent. Although the continued rate of caseload decline appears reasonable, more data will be available for us to fully assess the estimate for the May Revision.

Recent Shifts in Funding Sources. As shown in Figure 17, the CalWORKs program is funded by a mix of revenue sources—the federal TANF block grant, state General Fund, and various sources of county realignment funds. Within the total funding amount for CalWORKs, the budget proposes \$552 million from the General Fund, almost \$100 million higher than the 2017-18 level. This increase is primarily the result of fewer available county funds overall, requiring that additional state funds be spent in order for the state to meet its MOE requirement.

State Has Broad Flexibility in the Allocation of TANF Block Grant Funds. As illustrated in Figure 18, the 2018-19 Governor's Budget proposes to dedicate about half of the state's TANF block grant to support the CalWORKs program. The remainder is used to support other state programs, including student financial aid, Child Welfare Services, and community-based services for individuals with developmental disabilities. Federal law provides states significant flexibility in how TANF block grant funds may be spent. First, TANF block grant funds may be used

Figure 16

CalWORKs Budget Summary

All Funds (Dollars in Millions)

	2017-18	2017-18 2018-19 _	Change Fr	om 2017-18
	Revised	Proposed	Amount	Percent
Cash Grants	\$2,898	\$2,724	-\$174	-6%
Single Allocation				
Employment services	\$828	\$813	-\$14	-2%
Cal-Learn case management	20	19	-1	-4
Eligibility determination and administration	380	351	-29	-8
Stage 1 child care	318	324	6	2
Single Allocation augmentation	180	187	7	4
Subtotals	(\$1,726)	(\$1,694)	(-\$32)	(-2%)
Other County Allocations				
Mental health/substance abuse services	\$129	\$129	_	_
Expanded subsidized employment	134	134	_	_
Housing Support Program	47	47	_	_
Family Stabilization Program	47	47	_	_
Subtotals	(\$356)	(\$356)	(—)	(—)
Home Visiting Initiative	_	\$27	\$27	_
Other ^a	\$21	\$17	-\$4	-19%
Totals	\$5,002	\$4,819	-\$183	-4%
^a Primarily includes various state-level contracts.				

Figure 17

CalWORKs Funding Sources

(Dollars in Millions)

,				
	2017-18 Revised	2018-19 . Proposed	Change From 2017-18	
			Amount	Percent
Federal TANF block grant funds	\$2,127	\$1,938	-\$189	-9%
State General Fund	455	552	97	21
Realignment and other county funds ^a	2,420	2,328	-92	-4
Totals	\$5,002	\$4,819	-\$183	-4%

^a Primarily various realignment funds, but also includes county share of grant payments, about \$60 million. TANF = Temporary Assistance for Needy Families.

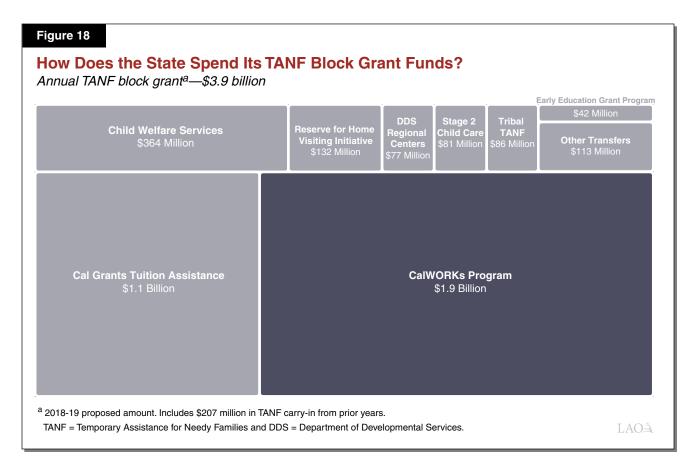
to meet any of the four purposes of the TANF program, displayed in Figure 19 (see next page). Second, TANF funds may be used to support activities that were allowable under TANF's predecessor program. And, finally, the state may transfer a portion of the TANF block grant to certain other federal block grants to be used according to the rules of the block grant receiving the transfer.

State May Use TANF Funds Flexibly to Offset Existing General Fund Spending. Because the

state has significant flexibility in the use of TANF funds, these funds may be used to support programs (other than CalWORKs) that would otherwise be supported by the General Fund, thereby freeing up General Fund resources for other state priorities. For example, prior to 2012-13, student financial aid in the Cal Grants program was supported almost entirely by the General Fund. In 2012-13, TANF funds were used to replace \$800 million in General Fund spending in Cal Grants on the basis

that student financial aid furthers purposes two and three of TANF. That year, consequently, the Legislature was able to redirect a portion of these funds to other legislative priorities. This budgetary practice has continued each year thereafter.

Caseload Decline Frees Up TANF Funds. When the CalWORKs caseload declines year to year, a reduced amount of funding is needed to pay for the program's ongoing cash assistance, employment



training, administrative, and child care costs. Generally, the decline in these costs from one year to the next results in a similar amount of freed-up TANF funds in later years that can be spent in CalWORKs or on programs that further the TANF purposes. (We use the phrase freed-up TANF funds to refer to funds that were used for CalWORKs program costs in the prior year but are no longer needed to maintain cash assistance and services

at their prior year levels and are therefore available now to be spent elsewhere.)

In Recent Years, Freed-Up TANF Funds Used to Offset General Fund Spending. As a result of the steady caseload decline in the CalWORKs program since the end of the recession and the flexibility in the use of TANF funds to replace existing General Fund spending, freed-up TANF funds have been used each year to increasingly offset General Fund spending elsewhere in the state budget. In particular, TANF funds spent outside CalWORKs have grown from roughly \$1 billion in 2014-15 to \$1.8 billion proposed in 2018-19. Additional funds have been directed to program areas that offset existing General Fund spending. We note that TANF funds could be redirected back to the CalWORKs program to pay for augmentations, but that this would require backfilling lost TANF funding in other areas of the budget with state General Fund dollars.

2018-19 CalWORKs Proposals Stem From Caseload Decline. The Governor's two major CalWORKs proposals, which we examine in the following sections, reflect responses to the rapid decline in the CalWORKs caseload over the past several years. First, the Governor proposes a one-year compromise funding amount for the county single allocation. The level is higher than what counties would receive under the historical budgeting methodology due to concerns that counties may have difficulty adjusting to lower funding while continuing to provide services to CalWORKs families. Second, the administration includes two new proposals to be funded with freed-up TANF funds—a home visiting initiative for young CalWORKs families and an early education grant program to be run by the California Department of Education.

Figure 19

The Four Purposes of TANF

- (1) Provide assistance to needy families so that children can be cared for in their own homes.
- (2) Reduce the dependence of needy parents by promoting job preparation, work, and marriage.
- (3) Prevent and reduce the incidence of out-of-wedlock pregnancies.
- (4) Encourage the formation and maintenance of two-parent families.

 TANF = Temporary Assistance for Needy Families.

ANALYSIS OF GOVERNOR'S PROPOSED SINGLE ALLOCATION

Background on Single Allocation

Single Allocation Provides Bulk of County
Funding to Administer CalWORKs. As shown in
Figure 16 earlier, the Governor's budget provides nearly
\$1.7 billion in funding for the county single allocation
in 2018-19. The single allocation encompasses
three main categories of funding that are used to run
the CalWORKs program: (1) employment training
and other services intended to help participants
obtain employment, (2) eligibility determination and
administration of the program, and (3) Stage 1
subsidized child care available to parents who are
working or participating in employment training.

Single Allocation Categories Budgeted

Separately... As part of the annual budget process, the administration proposes statewide funding amounts for each category in the single allocation separately, based on established methodologies that adjust funding from prior years based on caseload projections, assumed costs per case, and adjustments for policy changes. After the statewide amounts are determined through the budget process, funds for each category are allocated to individual counties. Single allocation funds generally must be spent by counties within the fiscal year and unspent funds are carried forward to the following year as part of that year's overall TANF block grant funds.

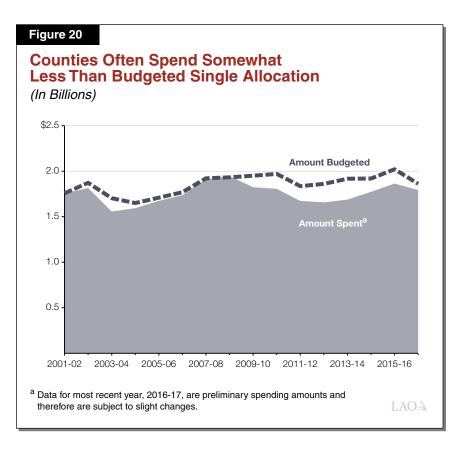
... But Single Allocation May Be Spent Flexibly Across Categories. Although single allocation categories are budgeted and allocated to counties separately, counties can, and do, spend their total single allocation funds flexibly across the categories.

As a result, actual spending on the individual single allocation categories often differs from the amounts allocated to counties in the state budget. This flexibility allows counties to adapt to local factors that may not be well reflected in the process used to determine and allocate the statewide single allocation amount.

Budgeted Amounts Do Not Correspond Well With County Spending. On the one hand, as shown in Figure 20, counties tend to spend less than their budgeted allocation to operate CalWORKs. On average, since 2001-02, counties have spent about \$100 million (roughly 5 percent) less each year than was allocated. In some years, this amount has been higher—above \$200 million—as it was in 2012-13 and 2013-14, or lower, as it was in the years before the recent recession and as it was in

2016-17, the most recent year of data. Lower spending than was allocated may result from challenges counties face in administering the program, such as difficulty ramping up staffing, services, and facilities at the pace that additional funding is provided. Counties also may budget the CalWORKs program with some caution because county general fund money must be used in the event that counties spend more than their allocation.

At the same time that counties spend less than their overall budgeted allocation, counties spend beyond the amount budgeted for the eligibility administration component of the single allocation while spending less than the amount budgeted for employment services. These budget trends indicate that the single allocation may not correspond well with actual county spending on CalWORKs. As we discuss below, recognition of these issues led the Legislature to request, as part of the 2017-18 Budget Act, that the administration and county officials update the budgeting methodology for the single allocation.



Single Allocation Reduced in Recent Years

Single Allocation Reduced in 2016-17. After increasing from 2013-14 through 2015-16, the 2016-17 Budget Act decreased funding for the single allocation by \$160 million that year to reflect a projected caseload decline. At the time, we noted that the lower amount would align the single allocation more closely with what counties were spending at the time to run CalWORKs.

Single Allocation Reduced Again in 2017-18.

The 2017-18 Governor's Budget reduced the single allocation by an additional \$200 million (10 percent) below its 2016-17 level as a result of the continued decline in the CalWORKs caseload. Our office and others noted that the additional reduction might lead counties to eliminate staff positions, reassign staff to other health and human services programs, reduce services, or a combination of all three. In light of these concerns, the 2017-18 Budget Act restored more than one-half of the originally proposed reduction.

Legislature Requests Review of Single Allocation Methodology. In recognition that counties may face challenges operating the CalWORKs program with the level of resources provided according to the existing

single allocation methodology, the 2017-18 budget package directed the administration and county officials to provide "recommendations for revising the methodology used for development of the CalWORKs single allocation annual budget" to the Legislature in January 2018.

Governor's Single Allocation Proposal

Administration Outlines Plan to Revise Budget **Methodology.** In response to requirements in the 2017-18 Budget Act, the administration has made available its plan to recalculate and update the eligibility administration and employment services components of the single allocation. (Stage 1 child care and the Cal-Learn components of the single allocation are budgeted based on recent actual expenditures and therefore the administration does not plan to revisit them.) In consultation with stakeholders, the administration is currently reviewing county time study data and work processes to identify county costs for the administration component of the single allocation, namely direct costs associated with processing initial applications and confirming eligibility status and indirect costs related to these operations. (The employment services component of the single allocation will be reviewed in the coming year.) The new methodology for administrative costs will be used to update the single allocation for the May Revision.

In the Meantime, Administration Proposes
Lower Single Allocation for 2018-19. The 2018-19
Governor's Budget proposes to allocate \$1.694 billion to counties to operate the CalWORKs program, a decline of \$32 million (about 2 percent) from the 2017-18 Budget Act amount allocated to counties. The interim proposal, though somewhat below the prior year's budgeted amount, remains \$187 million above the amount estimated using the administration's long-standing caseload driven methodology.

LAO Assessment

Plan to Update Budget Methodology Likely to Improve CalWORKs Budget Process... In our view, the administration's plan to update the single allocation methodology would revisit important cost components of operating the CalWORKs program and therefore is likely to be a more accurate representation of current county costs than the existing budget methodology. Insofar as the update results in better information

about county costs, it should help improve the annual CalWORKs budget process by more closely aligning budgeted amounts for administration and employment services with what counties spend to provide these services each year.

... But True Costs to Meet the Goals of CalWORKs Remain Unknown. Assessing how much counties spend in CalWORKs is helpful in understanding how counties operate the program but provides policymakers little information as to whether the program is meeting its objectives and what amount of funding might be needed to do so. It could be the case that current county spending is at the "correct" level, providing sufficient resources for counties to operate the program in a way that achieves the purposes of the program as the Legislature intended. Alternatively, it could be that county spending is higher than the correct amount and that similar outcomes could be achieved with fewer resources: or, that county spending is too low and therefore does not provide administrators the necessary resources to achieve these objectives for CalWORKs families.

Proposed Interim Single Allocation Higher on a Cost Per Family Basis. The Governor's 2018-19 proposed allocation represents an average statewide cost per family of \$4,226, 4 percent above the amount assumed in the 2017-18 Budget Act (\$4,053 per family), 7 percent above counties' actual spending in 2016-17 (\$3,960 per family), and 12 percent higher than the amount that would be allocated according to longstanding budgetary practice (\$3,762 per family). According to the administration, the proposed single allocation maintains stability for counties while the revised methodology is being developed. It does this, specifically, by budgeting the eligibility administration component of the single allocation at its 2017-18 level, despite the year-over-year caseload decline, while continuing to budget the other components using the longstanding methodology. Although our office has not evaluated how much average costs per case typically increase as the caseload declines, we would anticipate some increase in average costs because some county costs, such as those for facilities, operations, and administrative personnel, may be difficult to reduce as quickly as the budget declines. Thus, we acknowledge that counties may face some challenges if required to

reduce spending, on a percentage basis, by the same amount that the caseload has declined.

Recommend Waiting for Budget Update in Coming Months. It is our understanding that the administration intends to release an updated single allocation budget based on new caseload information and a new budgeting methodology as part of the May Revision. The amount of the single allocation could differ substantially from the amount included in the Governor's proposed budget. We therefore recommend the Legislature wait until May to make a decision about what amount to budget for the single allocation.

ANALYSIS OF GOVERNOR'S PROPOSED USE OF FREED-UP TANF FUNDS

The 2018-19 Governor's Budget identifies about \$226 million in freed-up TANF block grant funds that are available to be spent on program augmentations in CalWORKs or to offset General Fund spending in other areas of the state budget. These funds are available due to the shrinking CalWORKs caseload. The administration proposes to spend a small portion of freed-up TANF funds (\$26 million) to offset additional General Fund spending. In a departure from the recent practice of dedicating most, if not all, freed-up TANF to existing programs so as to offset General Fund spending, the remaining \$200 million is proposed for new initiatives that would not offset General Fund spending.

Below, we describe and assess the Governor's two proposed initiatives for the use of freed-up TANF funds.

Proposed Home Visiting Initiative

Three-Year Home Visiting Program for CalWORKs Families. The 2018-19 Governor's Budget proposes to spend \$26.7 million in freed-up TANF block grant funds in 2018-19 to begin a three-year voluntary home visiting program for first-time mothers in CalWORKs. Families would receive regular visits—typically weekly or bi-weekly—from a nurse, parent educator, or early childhood specialist who works with the family to improve maternal health, parenting skills, and child cognitive development; and to connect families, as needed, with other available resources.

Budgeting Approach. The proposed \$26.7 million reflects the half-year cost to run the program—full-year costs are estimated to be \$52 million—because the initiative would begin in January 2019. In addition, the Governor's 2018-19 budget proposes to set aside additional funds (\$132 million) in 2018-19 in order to fund the initiative through 2020-21. Federal law allows states to set aside a portion of their TANF block grant in the reserve fund to be used in future years.

Program Details. The home visiting program would be available, on a voluntary basis, to first-time mothers and pregnant women under 25 years old who are enrolled in the CalWORKs program and whose child is younger than two years old. Families would receive home visits for up to two years. According to the administration's statewide estimates, there are currently about 6,500 women in the CalWORKs program who meet these eligibility criteria. For budgeting purposes, it is assumed that 90 percent of women who are eligible for home visiting will enroll in the program.

Counties to Submit Proposals. Counties would participate on a voluntary basis, with those participating required to submit proposals for how they intend to use home visiting funds for approval by DSS. Counties would not be allowed to supplant existing home visiting funding with these new funds.

LAO Assessment of Home Visiting

Other Home Visiting Programs in California. Local governments and community-based organizations operate home visiting programs in many parts of the state. Funding for these programs is made available from various sources. The largest of these sources are (1) locally controlled Proposition 10 (1998) tobacco tax revenues that fund county First 5 Commissions; (2) federal grants to local providers as part of the Early Head Start program; (3) federal grant funds available through the state-administered Maternal, Infant, Early Childhood Home Visiting (MIECHV) Program; and (4) various county-led initiatives. Although comprehensive data are unavailable, it appears that at least \$120 million, and possibly more, is spent annually on home visiting in California. Experts on home visiting estimate that existing home visiting programs serve 10 percent to 20 percent of at-risk families who would likely benefit from home visiting.

Many Home Visiting Models Exist. Although all home visiting program models pair a trained

professional with new mothers or pregnant women for regularly scheduled visits, existing evidence-based programs differ in important respects that dictate the model's cost and expected outcomes. These include (1) how often visits are made; (2) at what age visits begin and whether visits begin during pregnancy; (3) which elements of childhood and maternal well-being are addressed; and (4) whether a registered nurse, early childhood development specialist, or social worker makes the visits.

Effectiveness of Home Visiting Has Been Well Studied. Economists and social scientists have completed many high-quality studies of home visiting programs. In these studies, known as randomized controlled trials, researchers collect data on child and family well-being for families who received home visiting and for otherwise similar families who did not. Afterward, researchers compare the two groups and identify differences that can be attributed to the home visiting program. In some studies, these differences, or outcomes, have been used to compare the long-term fiscal benefits of the program to its short-term costs.

Home Visiting Is an Effective Tool to Improve Childhood Outcomes. Strong empirical evidence exists that home visiting improves child development, school performance, and maternal well-being and that home visiting programs decrease the prevalence of substantiated child maltreatment and teenage involvement with the criminal justice system.

Some Home Visiting Models May Also Help Promote Family Self-Sufficiency. In addition to improving child and maternal well-being, some studies show that home visits help parents obtain employment, enroll in high school coursework, and stabilize family relationships.

Long-Term Fiscal Benefits Typically Outweigh Costs, Especially for Low-Income Mothers.

One method researchers use to evaluate policies is to compare the policy's benefits for participants, government, and society with the policy's costs. Most studies of home visiting programs have found that, over the long term, the monetary benefits to participants and governments exceed the programs' costs. In thinking about home visiting within the CalWORKs program, in particular, we note that benefits tend to most outweigh costs—by as much as \$5 in benefits to \$1 in program costs—when staff are paired with low-income women

with risk factors that are associated with poor childhood health and well-being.

LAO Comments on Home Visiting Initiative

Overall, Home Visiting Proposal Merits
Consideration. The Governor's home visiting proposal is rooted in sound, evidence-based policy, and is closely aligned with the state's main goal for CalWORKs—reducing child poverty—and therefore merits serious consideration. Though less certain and dependent on how well home visits are integrated with existing services, the proposal also has the potential to improve economic self-sufficiency for participating families.

Cost and Participation Estimates, Though Uncertain in Nature, Appear Reasonable.

Budgeting for a new initiative is subject to considerable uncertainty, in this case regarding how many counties will volunteer to participate; which home visiting models are used and therefore how costly they might be; how many of the eligible families will choose to participate; and of those who participate, how many will seek additional employment services. In general, we believe the administration has estimated these elements reasonably, but nevertheless note that the number of families who receive home visiting could vary significantly from the estimated amount (6,522) due to these uncertainties.

Key Implementation Questions. Below, we outline some additional questions for the Legislature to consider as it evaluates the Governor's initiative.

• What Role Should Various State Departments Play? As mentioned earlier, the federal government provides MIECHV grants to the states to fund home visiting programs. In California, the state Department of Public Health (DPH) manages these grant funds. In this role, DPH funds two evidence-based home visiting models (Healthy Families America and the Nurse-Family Partnership), provides technical assistance to service providers, collects industry-standard data, and evaluates program performance. (We note that DPH collects several indicators of family economic self-sufficiency.) In order to minimize new requirements for service providers and to take advantage of DPH's existing

administrative infrastructure and experience managing home visiting grants, the Legislature may wish to consider a system where DSS leads programmatic management via their longstanding partnership with county human services agencies while DPH remains the primary state contact for service providers, managing data collection and program evaluation as it does now for the federal MIECHV program. This data could be shared with DSS for county oversight purposes.

 How Will Initiative Work Alongside Existing Local Programs? County human services agencies that participate in the home visiting initiative would submit plans for approval by DSS. The Legislature may wish to consider whether there are certain elements it expects to be included in these plans. For example, the Legislature may wish to require county plans to document how the county intends to: (1) combine its home visiting funds with other available funds so that providers have diversified funding sources. (2) collaborate with county public health and early education departments to coordinate referrals, and (3) track home visiting programs to confirm that new funds do not supplant existing county funding.

Proposed Grant Program for Early Education

Provides One-Time Funding for Early Education Expansion. The Governor's budget transfers

\$42 million in new freed-up TANF funds to the California Department of Education (as well as \$125 million in Proposition 98 funding) for a competitive grant program to increase the availability of early education for children under age five who have special needs. Freed-up TANF funds would be used to provide one-time grants to child care providers (the Proposition 98 funds would be directed to school districts and county offices of education) and are proposed to be used for a variety of purposes, including facility renovations, training, and equipment.

LAO Assessment. Federal regulations generally prohibit the use of TANF funds for infrastructure. Therefore, it appears unlikely that federal TANF funds could be used for facility renovations as proposed by the Governor. Due to this restriction and additional concerns about the proposal that we raise in our analysis of K-12 education proposals, we recommend that the Legislature reject this proposal.

LEGISLATURE HAS OPPORTUNITY TO BUILD ITS OWN TANF PLAN

Legislature Has Opportunity Now to Choose Best Use of Excess TANF Funds. The existence of freed-up TANF in 2018-19 provides the Legislature with an opportunity to build its own TANF plan in a way that balances its priorities for the CalWORKs program with priorities in other areas of the state budget. Below, we discuss the options that are available to the Legislature.

Governor's TANF Budget Plan Is One Approach.

Figure 21 details the Governor's proposed use of freed-up TANF funds that are available primarily due to declining caseload within the CalWORKs program. A small portion of freed-up TANF block grant funds are proposed to be used to further offset General Fund spending, whereas the majority are directed toward new, short-term initiatives. Consequently, the Governor's proposal places less emphasis on using TANF funds to offset existing General Fund costs, as has been the consistent practice in recent years.

Legislature Should Develop Its Own TANF
Budget Plan. The Legislature may wish to consider

Figure 21

Governor's Plan to Spend Freed-Up TANF Funds

TANF Funds Available Relative to Enacted 2017-18 Budget (In Millions)

New Augmentations	
Transfer to CDE for early education grants	\$42
Home visiting initiative	27
Home visiting initiative reserve	132
Total	\$201
Additional TANF Used to Offset General Funda	\$26
Total Freed-Up TANF Funds	\$226

a Includes the net effect of the TANF transfer to California Student Aid Comission for tuition assistance, and other transfers.

Total does not add due to rounding.

TANF = Temporary Assistance for Needy Families; CDE = California Department of Education; and MOE = maintenance-of-effort.

uses for freed-up TANF funds other than those the Governor has proposed. It could use these funds to (1) augment the CalWORKs program, (2) augment non-CalWORKs programs that further the TANF objectives (but would not offset current General Fund spending), or (3) backfill existing non-CalWORKs programs that further the TANF objectives to achieve General Fund savings. Below, we describe each of these potential uses:

- New CalWORKs Spending. In thinking about its TANF budget plan, the Legislature could make changes to the Governor's proposals for CalWORKs spending or fund different priorities within CalWORKs. For instance, the Legislature may wish to consider whether to fund the home visiting initiative on an annual basis, rather than funding the full three-year costs in 2018-19, to make additional TANF funds available to be spent in 2018-19. (In this case, additional TANF funding would need to be identified in 2019-20 and 2020-21 to fund the home visiting initiative.) Alternatively, on an ongoing basis, the Legislature could also consider increasing CalWORKs grant amounts.
- New Spending Outside CalWORKs. The
 Legislature could allocate freed-up TANF funds to
 new initiatives outside CalWORKs that further the
 TANF objectives. This spending would not offset
 General Fund spending. The Governor's early
 education grant proposal falls in this category.
- General Fund Savings Outside CalWORKs.

 If the Legislature is interested in continuing past practice for the use of freed-up TANF funds, it may wish to consider whether to use these funds to backfill existing General Fund spending, thereby freeing up additional General Fund dollars for other priorities. To do so, programs that are currently supported by the General Fund but meet the purposes of the TANF program would have to be identified. Although there do not appear to be many additional options, we believe one option could be the expansion of the annual TANF transfer to the California Student Aid Commission for Cal Grant financial aid.

Consider Ongoing Commitments With Some Caution. In crafting its priorities for the use of freed-up TANF funds, we recommend the Legislature budget

ongoing TANF commitments cautiously because General Fund resources would be needed in future years to maintain those spending levels should the CalWORKs caseload increase. In general, one-time or temporary commitments carry fewer budgetary risks than using freed-up TANF funds for ongoing programmatic commitments. Potential one-time uses might include a one-year augmentation to existing CalWORKs programs, such as the family stabilization or housing support programs, in order to provide temporary services to a greater number of CalWORKs families.

Multiyear Approach to Program Goals That Also Addresses Long-Term Budget Pressure. Both our office and the administration anticipate that the CalWORKs caseload will continue to decline for the next year and potentially longer. As a result, we expect that freed-up TANF funds will become available above the amount identified this year—in coming budget cycles. As with all forecasts, however, these expectations are subject to considerable uncertainty and could change if the condition of the state's economy were to deteriorate. As a point of reference. each 5 percent decline in the annual CalWORKs caseload frees up about \$200 million in TANF funds to be spent in CalWORKs or elsewhere in the state budget. The opposite is also true. A 5 percent increase in the caseload would cost the state \$200 million in General Fund dollars (either directly through increased spending in CalWORKs or indirectly because fewer TANF funds would be free to offset General Fund spending elsewhere) or require the Legislature to reduce CalWORKs grants or services.

In light of these dynamics, the Legislature may wish to plan its major CalWORKs policy goals using a framework that balances (1) how it expects the caseload to change in the short term with (2) what amount of spending it is willing to commit to CalWORKs on an ongoing basis, acknowledging that the caseload might rise again over the long term. The Legislature could, for instance, balance any ongoing spending it makes in the CalWORKs program by setting aside (in the TANF reserve) a portion of the freed-up TANF funds each year. These reserves would be available in later years, should the caseload rise, to help pay for increased costs related to those ongoing commitments, thereby reducing budgetary pressure on the General Fund in those years.

Budget Picture Likely to Change in the Coming Months. While we strongly encourage the Legislature to begin crafting its own proposals for the CalWORKs program and for the use of freed-up TANF funds, the current estimates will change when the administration releases its updated May Revision caseload forecast.

Mindful of these forthcoming changes, we encourage the Legislature to consider its goals and priorities for the program broadly and to not focus too closely on specific budgeted amounts because these are likely to fluctuate between now and when the Legislature enacts its 2018-19 budget package.

IN-HOME SUPPORTIVE SERVICES

BACKGROUND

Overview of the In-Home Supportive Services (IHSS) Program. The IHSS program provides personal care and domestic services to low-income individuals to help them remain safely in their own homes and communities. In order to qualify for IHSS, a recipient must be aged, blind, or disabled and in most cases have income below the level necessary to qualify for the Supplemental Security Income/State Supplementary Payment cash assistance program. IHSS recipients are eligible to receive up to 283 hours per month of assistance with tasks such as bathing, dressing, housework, and meal preparation. Social workers employed by county welfare departments conduct an in-home IHSS assessment of an individual's needs in order to determine the amount and type of service hours to be provided. In most cases, the recipient is responsible for hiring and supervising a paid IHSS provider—oftentimes a family member or relative. The average number of service hours that will be provided to IHSS recipients is projected to be about 108 hours per month in 2018-19.

IHSS Receives Federal Funds as a Medi-Cal Benefit. The IHSS program is predominately delivered as a benefit of the state-federal Medicaid health services program (known as Medi-Cal in California) for low-income populations. The IHSS program is subject to federal Medicaid rules, including the federal reimbursement rate of 50 percent of costs for most Medi-Cal recipients. Additionally, about 40 percent of IHSS recipients, based on their assessed level of need, qualify for an enhanced federal reimbursement rate of 56 percent, referred to as Community First Choice Option. As a result, the effective federal reimbursement rate for IHSS is about 54 percent. The

remaining costs of the IHSS program are paid for by counties and the state.

Counties' Share of IHSS Costs Is Set in **Statute.** Historically, counties paid 35 percent of the nonfederal-state and county-share of IHSS service costs and 30 percent of the nonfederal share of IHSS administrative costs. Between 2012-13 and 2016-17, the historical county contribution rates were replaced with an IHSS county MOE. Budget-related legislation adopted in 2017-18 eliminated and replaced the initial IHSS county MOE with a new county MOE financing structure. Under the new MOE, the counties' share of IHSS costs was reset to roughly reflect the counties' share of estimated 2017-18 IHSS costs based on historical county cost-sharing levels (35 percent of the nonfederal share of IHSS service costs and 30 percent of the nonfederal share of IHSS administrative costs). The new MOE will increase annually by (1) the counties' share of costs from locally negotiated wage increases, and (2) an annual adjustment factor. (We provide updates on the implementation of the new IHSS county MOE later in this chapter.)

Treatment of IHSS Services Versus

Administrative Costs Under New MOE. The state
General Fund is expected to pay all nonfederal IHSS
service costs above the counties' MOE expenditure
level. However, as part of the 2017-18 budget package,
the amount of General Fund that can be used for
county IHSS administrative costs is capped. This
means that counties will pay the full nonfederal IHSS
administrative costs above the General Fund cap. (We
discuss in detail the state and county cost-sharing
arrangement under the IHSS county MOE later in this
chapter.)

BUDGET OVERVIEW AND LAO ASSESSMENT

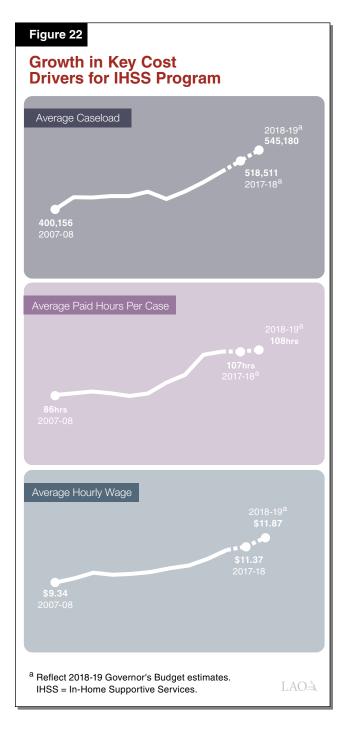
The Governor's budget proposes a total of \$11.2 billion (all funds) for IHSS in 2018-19, which is about \$950 million (9 percent) above estimated expenditures in 2017-18. The budget includes about \$3.6 billion from the General Fund for support of the IHSS program in 2018-19. This is a net increase of \$254 million (7.5 percent) above estimated General Fund costs in 2017-18. The year-over-year net increase in IHSS General Fund expenditures is primarily due to caseload growth and increased state minimum wage costs, which are partially offset by the decrease in General Fund assistance given to counties to assist with the transition to the new MOE. Below, we discuss some of the main components of the Governor's budget for IHSS and note any issues with them.

Primary Divers of Increased Costs in IHSS

Caseload growth, rise in paid hours per case, and wage increases for IHSS providers are key drivers of increasing IHSS costs. **Figure 22** shows how these factors have increased over the past ten years. Below, we describe these trends and how these cost drivers affect the Governor's 2018-19 budget proposal for IHSS.

Increasing Caseload. Average monthly caseload for IHSS has increased by 30 percent over the past ten years, from 400,000 in 2007-08 to an estimated 520,000 in 2017-18. IHSS caseload has historically fluctuated, increasing at most by 8 percent in 2007-08 and decreasing by 4 percent in 2013-14. More recently, year-to-year IHSS caseload growth has remained at about 5 percent and is expected to continue growing at this rate in 2018-19. The reasons for the steady caseload growth in recent years are not completely understood, but could be related to the growth in California's senior population (adults aged 65 and older). The 2018-19 budget projects that the average IHSS caseload will increase to 545,000 in 2018-19about 5 percent above 2017-18 estimates. We have reviewed the caseload projections in light of actual caseload data available to date and do not recommend any adjustments at this time.

Increasing Paid Hours Per Case. Over the past ten years, the average amount of paid monthly hours per case for IHSS has increased by 25 percent, from about 86 in 2007-08 to an estimated 107 in 2017-18. Between 2007-08 and 2012-13, average paid hours per case remained relatively flat—at around 86 hours. However, between 2013-14 and 2016-17, average paid hours per case has increased annually by an average of 6 percent.



The growth in average paid hours per case reflects, in part, a series of policy changes. For example, one reason for the recent increase in paid hours per case includes the implementation of the federal requirement that IHSS providers be compensated for previously unpaid work tasks, such as time spent waiting during their recipient's medical appointments. Additionally, similar to the increase in the caseload, as the IHSS population ages there may be an increasing number of more complex IHSS cases that typically require more service hours—for example, recipients who are severely impaired. We note that the administration is requesting additional positions to, in part, assess recent growth trends in paid hours per case. Although we are still analyzing the details of the proposal, given the recent increase in paid hours per case, we believe that it merits consideration.

The Governor's budget estimates that average hours per case will be the same in 2017-18 as they were in 2016-17 and will then increase slightly to about 108 hours in 2018-19. We have reviewed the average hours per case estimates in light of actual hours per case data available to date and do not raise any major concerns at this time.

State and Local Wage Increases. In addition to increasing caseload and paid hours per case, provider wage increases at the county and state level have contributed to increasing IHSS costs. Since 2007-08, the average hourly wage for IHSS providers increased by 27 percent, from \$9.34 to an estimated \$11.87 in 2017-18. (We note that this average IHSS wage reflects the base hourly wages for IHSS providers averaged across all counties.) IHSS provider wages generally increase in two ways—(1) increases that are collectively bargained at the local level and (2) increases that are in response to IHSS-related state minimum wage increases. The Governor's budget includes \$170 million General Fund (\$372 million total funds) for the combined impact of the recent state minimum wage increase from \$10.50 to \$11.00 per hour on January 1, 2018 and the scheduled increase from \$11.00 to \$12.00 per hour on January 1, 2019. The General Fund costs associated with state minimum wage in 2018-19 are roughly three times more than 2017-18 costs. This is primarily due to the fact that a greater number of counties are expected to be impacted by the state minimum wage increase to \$12.00 in 2019 (46 counties) than the increase to \$11.00 in 2018

(37 counties) or the increase to \$10.50 in 2017 (35 counties). (A county is impacted by the state minimum wage increase when the current local wage is below the new state minimum wage level.) We note that in future years, as the state minimum wage continues to increase, more counties will be impacted, resulting in higher IHSS costs.

Update on Federal Labor Regulation Compliance Costs

In accordance with federal labor regulations that became effective in 2015-16 and affect home care workers, the state is required to (1) pay overtime compensation—at one-and-a-half times the regular rate of pay—to IHSS providers for all hours worked that exceed 40 in a week, and (2) compensate IHSS providers for authorized time spent waiting during their recipient's medical appointments and traveling between the homes of IHSS recipients. The average number of IHSS providers is projected to be about 513,000 in 2018-19.

In preparation for IHSS compliance with the overtime rule, the Legislature adopted statutory workweek caps generally limiting the number of hours an IHSS provider can work to 66 hours per week—up to 26 hours of overtime per week. When multiplied by roughly four weeks per month, this weekly limit is almost equal to the maximum number of service hours that may be allotted to IHSS recipients per month (283). In addition, providers serving multiple IHSS recipients can be paid up to 7 hours per week for time spent traveling between the homes of the IHSS recipients. Allowable travel time hours do not count towards the statutory workweek caps or a recipient's authorized monthly hours.

Additionally, in 2016 DSS administratively established two types of exemptions in response to federal guidance asking states implementing workweek caps for IHSS to consider provider exemptions in situations where the caps could lead to increased risk of institutionalization for the consumer. Budget-related legislation in 2017-18 largely codified these two exemptions. Below, we provide an update to the costs associated with overtime pay, newly compensable work, and provider exemptions, and discuss differences in the 2018-19 Governor's Budget relative to prior budget assumptions.

Lower-Than-Expected 2017-18 Overtime and Travel Time Costs. As illustrated in Figure 23, the revised 2017-18 General Fund cost estimate to comply with federal labor regulations (\$274 million) is about \$70 million less than the 2017-18 budget appropriation (\$346 million). This is primarily due to fewer providers working overtime hours than assumed in initial budget estimates. In addition, of those IHSS providers expected to work overtime, it is now estimated that they will claim fewer overtime hours. Figure 23 also provides rough cost estimates for revised 2017-18 and 2018-19 medical wait time in order to capture the full state cost to comply with federal labor regulations.

Estimated Increase in IHSS Overtime Costs
Between 2017-18 and 2018-19. The 2018-19 budget includes \$297 million in General Fund for compliance and administration of the federal labor regulations, an increase of \$23 million (8 percent) over revised estimates for 2017-18. This is primarily due to an increase in the number of providers expected to work overtime hours as a result of the estimated increase in the IHSS caseload.

Estimated Increase in Issued Exemptions to Overtime Limits for Certain Providers. As previously mentioned, in 2016 DSS issued guidance to counties establishing two exemptions to the 66-hour workweek cap for certain providers with multiple recipients, which were largely codified in 2017-18. For both exemptions, the weekly maximum allowable hours are extended

from 66 hours per workweek to 90 hours per workweek (not to exceed 360 hours per month).

The first exemption, referred to as the family exemption, applies to IHSS providers who are related to, live with, and work for two or more IHSS recipients on or before January 31, 2016. Eligible recipients were notified of the exemption and mailed application forms by DSS. The second exemption, referred to as the extraordinary circumstances exemption, applies to IHSS providers who work for two or more IHSS recipients whose extraordinary circumstances place them in imminent risk of out-of-home institutionalized care. Qualifying extraordinary circumstances include (1) complex medical or behavioral needs that require a live-in provider, (2) residence in a rural and remote area where available providers are limited and as a result the recipient is unable to hire another provider, or (3) an inability to hire a provider who speaks his/her same language in order to direct his/her own care. It is our understanding that IHSS providers and recipients potentially eligible for an extraordinary circumstances exemption will be notified and mailed application forms by DSS in Spring 2018.

Budget-related legislation in 2017-18 requires that, as a part of initial IHSS assessment and subsequent reassessments, county social workers evaluate IHSS recipients to determine if their provider is eligible for either exemption. In addition, recipients or providers may contact their IHSS county social worker to

determine whether they meet the eligibility criteria for an exemption. To be considered for the extraordinary circumstances exemption, it first must be determined that the recipient, with county assistance, has explored and exhausted all other options to meet their additional service needs, such as hiring another provider. If denied, the IHSS provider or recipient may request a second review by DSS.

Between January 2017 and January 2018, the number of providers issued a family exemption remained roughly the same, about 1,500, while the number of providers issued an extraordinary circumstances exemption increased, on average, by 11 percent per

Figure 23

Updated IHSS General Fund Costs to Comply With Federal Labor Regulations^a

(In Millions)

	2017-	2018-19	
	Appropriation	Revised	Governor's Budget
Overtime pay	\$283	\$220	\$240
Travel time pay	18	14	15
Medical wait time payb	35	30	30
Provider exemptions	7	7	8
Administration	4	4	4
Totals	\$346	\$274	\$297

^a Under the IHSS county maintenance-of-effort, the nonfederal costs are assumed to be 100 percent General Fund.

b Reflects our rough estimates of costs associated with compensating IHSS providers for time spent waiting during their recipient's medical appointments.
IHSS = In-Home Supportive Services.

month, from about 50 providers to 120 providers. The Governor's budget estimates that the average number of family exemptions will remain relatively flat in 2018-19. However, the budget projects that the average number of issued extraordinary circumstances exemptions will increase at a faster rate in 2018-19 than 2017-18—to about 700 in 2018-19. Based on past growth trends, it is likely that the number of issued extraordinary circumstances exemptions and associated General Fund costs may be less than estimated in the 2018-19 budget. For example, if the number of issued extraordinary circumstances exemptions continued to increase at its recent rate (11 percent per month), the estimated number of providers with this exemption in 2018-19 would be 240. rather than 700, resulting in about a \$4 million decrease in General Fund costs.

IHSS Providers Continue to Receive Time Sheet Violations. Starting July 1, 2016, DSS began issuing time sheet violations to providers for exceeding their authorized monthly work caps or permitted travel time. Violations are administered based on a four-level violation system, with providers receiving a three-month suspension from the IHSS program after the third violation and a one-year suspension after the fourth violation. In 2017, the average number of providers that received a violation per month was about 3,000. The number of providers with third and fourth violations is slightly increasing, but remains a significantly small portion of the overall IHSS provider population.

Implementation of Paid Sick Leave

Pursuant to state legislation, beginning on July 1, 2018, IHSS providers will be eligible to receive 8 hours of paid sick leave, ramping up to 24 hours annually when the state minimum wage increases to \$15 per hour (scheduled for January 1, 2022). In general, providers must first work a certain amount of hours to receive and use their paid sick leave hours. The 2018-19 budget includes \$30 million General Fund to provide 8 hours of paid sick leave to IHSS providers. The estimated costs are primarily driven by the assumption that *all* IHSS providers will become eligible for and use the full 8 hours of paid sick leave in 2018-19. We note General Fund costs would be lower if fewer than estimated providers utilize paid sick leave in 2018-19.

Update on the IHSS County MOE

As previously mentioned, budget-related legislation enacted in 2017-18 established a new MOE for counties' share of IHSS costs. The new MOE increased county IHSS costs to reflect estimated 2017-18 IHSS costs. The county MOE is expected to increase annually by an adjustment factor and the counties' share of costs associated with locally negotiated wage increases. The annual adjustment factor varies based on the year-to-year growth in realignment sales tax revenue, which generally reflects overall economic conditions. Below, we provide an update on the implementation of the new IHSS county MOE.

Estimated IHSS County MOE Costs in 2017-18 and 2018-19. As illustrated in Figure 24, the revised 2017-18 IHSS county MOE cost estimate (\$1.74 billion) is about \$28 million less than the initial 2017-18 budget appropriation (\$1.77 billion). Budget-related legislation enacted in 2017-18 authorized the administration to adjust the 2017-18 IHSS MOE downward on a one-time basis if total IHSS costs were lower than initial estimates. The resulting decrease to the IHSS MOE is

Figure 24

Increase in IHSS County MOE Costs

(In Millions)

			2018-19	Change From	
			Governor's Budget	Revised 2017-18	
Total IHSS County MOE Costs ^a	\$1,768	\$1,740	\$1,835	\$95	
Share of IHSS service costs	1,672	1,630	1,720	90	
Share of IHSS administrative costs	96	110	115	5	

Total IHSS county MOE costs are partially offset by General Fund assistance provided to counties to assist them in meeting their increased IHSS MOE costs in 2017-18 (\$400 million) and 2018-19 (\$330 million).
 IHSS = In-Home Supportive Services and MOE = maintenance-of-effort.

partially offset by increasing county costs associated with locally negotiated wages that occurred after the budget was enacted. In addition, it is projected that the IHSS MOE costs will increase by \$95 million in 2018-19. This increase reflects the impact of the estimated annual adjustment factor (5 percent) to the IHSS MOE and the counties' share of costs associated with locally negotiated wage increases.

Revised Budget Assumptions to Calculate State and County IHSS Administrative Costs.

Historically, state and county IHSS administrative costs were budgeted using 2001 county worker costs and workload estimates. Budget-related legislation enacted in 2017-18 required the Department of Finance (DOF), in consultation with counties, to update the budgeting assumptions used to estimate IHSS administrative costs. The Governor's budget includes about \$640 million total funds for IHSS administrative costs in 2018-19, which includes IHSS automation costs, IHSS public authority costs (a local entity that, in part, provides training to recipients and providers), and direct service-related and fixed administrative costs. The revised administrative cost estimates are primarily based on updated assumptions about average county wages and the average number of county workers needed to fulfill statutorily required activities at current IHSS caseload levels. It is our understanding that in future years, total nonfederal IHSS administrative costs will be increased by the year-to-year rate of growth in the IHSS caseload.

State's Share of IHSS Administrative Costs Is **Capped.** Under the IHSS MOE financing structure, counties continue to receive federal funds for a portion of county administrative costs. However, the portion of the county MOE obligation that can be met by county administrative costs is limited. Additionally, the amount of General Fund that is available for county administrative costs in IHSS is capped. As shown in Figure 24, the Governor's budget estimates that only \$110 million of the total IHSS county MOE obligation in 2017-18 (\$1.7 billion) and \$115 million of the 2018-19 obligation (\$1.8 billion) can be met by county administrative costs. In addition to the county MOE obligation, it is assumed that the General Fund will provide up to \$220 million of county administrative costs in 2017-18 and \$208 million in 2018-19. To the extent that actual county administrative costs exceed the county MOE administrative cost limit and

the available state General Fund (about \$330 million in 2017-18 and \$323 million in 2018-19, combined), counties are responsible to pay the difference. (We note that the federal government will share these costs with the counties.) It is our understanding that in future years, the county MOE administrative cost limit will be adjusted by the annual MOE adjustment factor, while the General Fund cap will be adjusted by the year-to-year rate of growth in the IHSS caseload.

Determine What Data Are Needed in Preparation for the Proposed Reexamination of Budget

Assumptions. The Governor's budget includes a reexamination of the revised administrative cost budget assumptions as a part of the 2020-21 budget process. It is our understanding that the reexamination will focus on whether the revised budgeting assumptions reasonably reflect county administrative expenditures, as documented by county administrative claims data. In addition to the county claims data, the Legislature should consider if there are other cost measures or data that should be collected to better inform the reexamination and potential need to modify the revised budget assumptions in 2020-21. One example of this may be tracking changes to county salary and benefit costs to determine if an annual cost-of-doing-business inflator for IHSS administrative costs is necessary.

Decrease in General Fund Assistance Provided to Offset IHSS County Costs. Beginning in 2017-18, additional General Fund support was provided to counties to assist them in meeting their increased IHSS MOE costs. The General Fund support to counties is expected to decrease from \$400 million in 2017-18 to \$330 million in 2018-19, and eventually to \$150 million in 2020-21 and future years.

Update to County Loans and Appeals to Public Employment Relations Board (PERB). In addition to establishing a new IHSS county MOE, budget-related legislation enacted in 2017-18 authorized DOF to provide loans to counties experiencing significant financial hardship as a result of the new MOE. It is our understanding that currently no county has applied for a loan to assist in paying its IHSS costs. Additionally, counties and unions were provided with the ability to appeal to PERB if a bargaining agreement over IHSS provider wages and benefits had not been reached by January 1, 2018. It is our understanding that as of today, no appeal has been made to PERB concerning an IHSS bargaining agreement.

SSI/SSP

The Supplemental Security Income/State Supplementary Payment (SSI/SSP) program provides cash grants to low-income aged, blind, and disabled individuals. The state's General Fund provides the SSP portion of the grant while federal funds pay for the SSI portion of the grant. Total spending for SSI/SSP grants increased by about \$160 million—or 1.6 percent—from \$9.9 billion in 2017-18 to \$10.1 billion in 2018-19. This is primarily due to increased federal expenditures as a result of an increase to the federal SSI grant levels in 2018-19. Of this total, the Governor's budget proposes about \$2.8 billion from the General Fund, an amount relatively equal to revised estimates of 2017-18 expenditures.

Caseload Slightly Decreasing. The SSI/SSP caseload grew at a rate of less than 1 percent each year between 2011-12 and 2014-15. More recently, the caseload has slightly decreased—by 0.8 percent in 2015-16, 1.2 percent in 2016-17, and an estimated 0.5 percent in 2017-18. The budget projects that caseload will be about 1.3 million individual and couple SSI/SSP recipients in 2018-19, a decrease of 0.1 percent below estimated 2017-18 caseload levels.

Background on SSI/SSP Grants

Both the State and Federal Government Contribute to SSI/SSP Grants. Grant levels for SSI/SSP are determined by both the federal government and the state. The federal government, which funds the SSI portion of the grant, is statutorily required to provide an annual cost-of-living-adjustment (COLA) each January. This COLA increases the SSI portion of the grant by the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W). In years that the CPI-W is negative (as was the case in 2010, 2011, and 2016), the federal government does not decrease SSI grants, but instead holds them flat. The federal government gives the state full discretion over whether and how to provide increases to the SSP portion of the grant. Until 2011, the state had a statutory COLA. Although this statutory COLA existed, there were many years when, due to budget constraints, the COLA was not provided. As part of the 2016-17 budget package, the Legislature provided a COLA of 2.76 percent on the SSP portion of the grant,

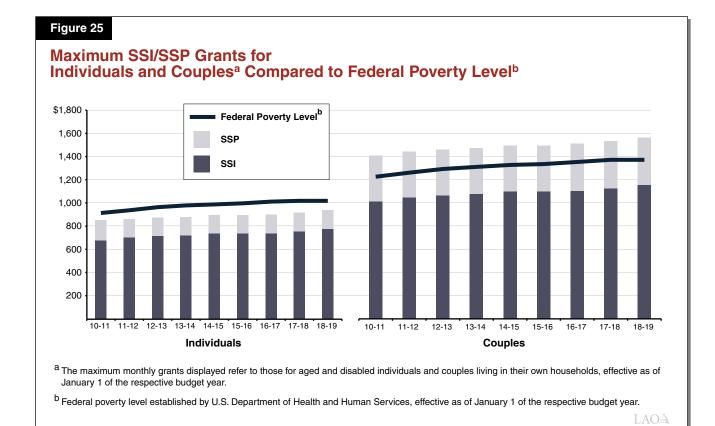
the first since 2005. The Governor's 2018-19 budget proposal does not include an increase to the SSP portion of the grant.

During Constrained Budget Environment, SSP Grants for Individuals and Couples Reduced to Federally Required Minimum. The state is required to maintain SSP monthly grant levels at or above the levels in place in March 1983 (\$156.40 for SSP individual grants and \$396.20 for SSP couple grants) in order to receive federal Medicaid funding. During the most recent recession, the state incrementally decreased SSP grants for individuals and couples until they reached these minimum levels in June 2011 and November 2009, respectively. Beginning January 1, 2017, SSP grants for individuals and couples slightly increased above the minimum level due to the COLA on the state's SSP portion.

Total Grants Have Been Gradually Increasing Largely Due to Federal COLAs, but Remain Below FPL for Individuals. As shown in Figure 25 (see next page), the maximum SSI/SSP monthly grant amount for individuals (the bulk of the SSI/SSP caseload) and couples have been increasing gradually since 2010-11 - predominantly due to the provision of federal COLAs. However, despite these increases, current maximum SSI/SSP grant levels for individuals remain below the federal poverty level (FPL), while grant levels for couples remain above the FPL. We note that during some difficult budget times prior to 2010-11, the state negated the impact of federal COLAs by reducing the SSP portion of the grant by the amount of the federal increase, thereby holding total SSI/SSP grant levels flat. After the state reduced SSP grants to the federally required minimum levels, the state could no longer do this.

Governor's Budget Estimates

Federal SSI Grant Increase May Be Slightly Less Than Governor's Budget Estimate. As shown in Figure 26 (see next page), the Governor's budget estimates that the CPI-W that the federal government will use to adjust the SSI portion of the grant in 2019 will be 2.6 percent, increasing the maximum monthly SSI/SSP grant by \$20 for individuals and \$30 for couples. However, our estimate of the CPI-W is lower,



at 1.8 percent. (The actual CPI-W will not be known until the fall.)
As a result, we estimate that total maximum monthly SSI/SSP grants would increase by \$13 for individuals and \$20 for couples in 2018-19.

Issue for Legislative Consideration

Potential Effects of Ending the SSI Cash-Out. Due to a long-standing state policy known as the SSI cash-out, SSI/SSP recipients receive an extra \$10 payment in lieu of their being eligible to receive federal food benefits (CalFresh benefits) in California. There has been legislative interest in the fiscal and policy implications of ending the SSI cash-out policy. The decision of whether to end the SSI cash-out involves trade-offs, which we discuss

Figure 26

SSI/SSP Monthly Maximum Grant Levels^a Governor's Proposal

	2017-18	2018-19 Governor's Estimates ^b	Change From 2017-18
	2017-10	Estillates	F10111 2017-10
Maximum Grant—Individuals			
SSI	\$750.00	\$770.00	\$20.00
SSP	160.72	160.72	_
Totals	\$910.72	\$930.72	\$20.00
Percent of federal poverty level ^c	90%	92%	
Maximum Grant—Couples			
SSI	\$1,125.00	\$1,155.00	\$30.00
SSP	407.14	407.14	_
Totals	\$1,532.14	\$1,562.14	\$30.00
Percent of federal poverty level ^c	112%	114%	

a The maximum monthly grants displayed refer to those for aged and disabled individuals and couples living in their own households, effective as of January 1 of the respective budget year.

b Reflects Governor's budget estimate of the January 2019 federal cost-of-living adjustment—2.6 percent—for the SSI portion of the grant.

^C Compares grant level to federal poverty guidelines from the U.S. Department of Health and Human Services for 2018.

in our legislatively requested report *The Potential Effects* of *Ending the SSI Cash-Out* (January 2018).

Estimates developed by Mathematica, a national research organization, and DSS indicate that the majority of households with SSI/SSP recipients would benefit from the elimination of the SSI cash-out. However, some households currently receiving CalFresh benefits would either experience a decrease in food benefits or become ineligible for CalFresh. While

negatively affected households generally have limited financial means, they tend to have more income than households that would benefit from ending the SSI cash-out. If the Legislature wishes to end the SSI cash-out, it could consider establishing a state food benefit program that would replace some or all of the lost food benefits. There are many ways a state food benefit program could be structured, each with its own trade-offs.

DEVELOPMENTAL SERVICES

BACKGROUND

Overview of the Department of Developmental Services (DDS). Under the Lanterman Developmental Disabilities Services Act of 1969 (known as the Lanterman Act), the state provides individuals who have developmental disabilities with services and supports to meet their needs, preferences, and goals in the least restrictive environment possible. These services and supports are overseen by DDS. The Lanterman Act defines a developmental disability as a "substantial disability" that starts before the age of 18 and is expected to continue indefinitely. This definition includes cerebral palsy, epilepsy, autism, intellectual disabilities, and other conditions closely related to intellectual disabilities that require similar treatment (such as traumatic brain injury). Unlike most other public human services or health services programs, individuals receiving services through DDS need not meet any income or qualification criteria other than a diagnosis of a developmental disability. The department administers both community-based services and state-run services. These are each described below.

Community Services Program. DDS currently serves an estimated 318,000 individuals with developmental disabilities ("consumers" in statutory language) in 2017-18 through its community services program. Twenty-one independent nonprofit Regional Center (RC) agencies coordinate services for consumers, which includes assessing eligibility and developing individual program plans. RCs coordinate residential, health, day program, employment, transportation, and respite services, among others, for consumers. As the mandated payer of last resort,

RCs only pay for services if they are not covered and paid for through another government program, such as Medi-Cal or public education, or through a third party, such as private health insurance. RCs contract with tens of thousands of vendors around the state to purchase services and supports for consumers. DDS provides RCs with a budget for both their administrative operations and the purchase of services (POS) from vendors.

State-Operated Residential and Community Facilities. At the start of 2017-18, DDS served about 800 individuals in three Developmental Centers (DCs), which are licensed and certified as general acute care hospitals, and one state-run community facility. It is also in the process of developing a state-run community-based "safety net," which includes smaller five-person homes and mobile crises teams. We describe each element of DDS' state-run services below.

- Closure DCs. In 2015, the administration announced its plan—which the Legislature approved—to close the state's remaining DCs (which we refer to as "closure DCs")—Sonoma DC in Sonoma County by the end of 2018, Fairview DC in Orange County by the end of 2021, and the general treatment area of Porterville DC in Tulare County by the end of 2021. At the start of 2017-18, 534 residents lived at closure DCs.
- Nonclosure Facilities. DDS will continue to operate a secure treatment program at Porterville DC, which, by statute, can serve up to 211 people, all of whom have been deemed a

safety risk and/or incompetent to stand trial. DDS also runs Canyon Springs Community Facility in Riverside County, which can house up to 63 people at a time.

• Safety Net Facilities and Crisis Services.

DDS currently operates two five-bed acute crisis units—one at Sonoma DC and one at Fairview DC—which serve anyone in the DDS system undergoing an acute crisis. Because these facilities will no longer be available once the DCs close, DDS is developing two five-bed homes in the Napa area and two five-bed homes on the Fairview DC property (a fifth home will open in 2019-20 in Northern California) to address crisis needs. The state will also operate two mobile crisis units to respond to consumers in crisis at their current residence.

OVERVIEW OF THE GOVERNOR'S BUDGET PROPOSAL

The Governor's budget proposes \$7.3 billion (all funds) for DDS in 2018-19, a 5.1 percent increase over estimated 2017-18 expenditures. General Fund expenditures comprise \$4.4 billion of this amount, a 5.6 percent increase over estimated 2017-18 General Fund spending. Given that the declining cost to run closure DCs has lowered the overall budget for state-run facilities and services, the year-over-year increases are nearly all due to increasing costs in the community services program. Growth in the number of people served in the community services program and growing costs associated with implementing state minimum wage increases are the primary drivers of these year-over-year increases. Federal funding makes up about 40 percent of the DDS budget.

Community Services Program Budget Summary

The community services program is estimated to grow 7.6 percent in 2018-19 to \$6.9 billion (all funds). The General Fund comprises \$4.1 billion of the total budget, up 8.4 percent from 2017-18, while federal reimbursements, primarily through Medicaid Waiver programs and Title XX social services funding will

provide an estimated \$2.7 billion. The Governor's budget reflects a \$25 million (\$21 million General Fund) downward adjustment in POS expenditures in 2017-18, in large part due to lower actual expenditures than previously estimated related to state minimum wage increases implemented in 2017. In 2018-19, the Governor's budget proposes an increase of \$451 million (\$285 million General Fund) in POS expenditures over revised 2017-18 estimates. Of this amount, \$179 million (\$98 million General Fund) is due to state minimum wage increases that took effect on January 1, 2018 and the subsequent increase that will take effect on January 1, 2019. In 2018-19, the DDS RC budget will lose about \$11 million in federal funding from the "Money Follows the Person" grant. This federal grant was a limited-term source of funding for services provided for consumers transitioning from institutional settings. The General Fund will backfill this loss.

The DDS system is preparing itself for some fundamental changes in the way services are delivered, which affects the DDS POS budget, New federal home- and community-based service (HCBS) regulations that take effect in March 2022 and affect the state's ability to receive federal Medicaid HCBS Waiver funding require programs that are more integrated, promote personal choice, and foster consumer independence. Some shifts may already be evident in the proposed POS budget. Work activity programs, also known as sheltered workshops, are non-integrated programs that include large groups of DDS consumers conducting work for subminimum wage. Between 2017-18 and 2018-19, the Governor's budget reflects a decline of nearly \$4 million General Fund for work activity programs and a nearly commensurate increase of about \$3 million General Fund in individual supported employment.

Finally, we note that under recently enacted law, behavioral health treatment for children that is considered medically necessary has been approved as a covered Medi-Cal benefit and the cost for this treatment is shifting from the DDS POS budget to the Medi-Cal budget. This transition, which began among children who have an autism diagnosis and now includes children without an autism diagnosis, is reflected as a further reduction of nearly \$49 million General Fund in DDS' 2018-19 budget.

State-Operated Residential and Community Facilities Program Budget Summary

While DDS previously referred to all its state-run programs as DCs, its new nomenclature—
State-Operated Residential and Community Facilities—
reflects the changing role of the state in developmental services—from delivering its state-staffed services primarily in institutional DC settings to delivering services in more varied ways. This still includes operating two state-run facilities (Canyon Springs Community Facility and the secure treatment program at Porterville DC), but also includes providing community-based, but state-operated, safety net and crisis services.

The budget for these state-run programs is expected to decline nearly 25 percent—from about \$500 million (all funds) in 2017-18 to about \$375 million in 2018-19. General Fund expenditures will decline approximately 20 percent—from about \$365 million to about \$290 million over this period. The year-over-year reductions are primarily due to DC closure activities. The budget reflects a substantial reduction in DC staff from 2017-18 to 2018-19—about 830 positions—as more and more DC residents transition to the community.

DDS Headquarters Budget Summary

The Governor's budget proposes \$68 million for DDS headquarters operations in 2018-19, an increase of \$4 million. The General Fund will provide \$40 million. up \$3 million from 2017-18. The Governor's budget proposes \$2 million (\$1.4 million General Fund) and nine positions for clinical oversight and monitoring of the new models of homes that were recently developed for consumers moving from DCs. These homes and associated services specialize in intensive medical care, behavioral treatment, and crisis intervention. The Governor's budget also proposes to create an internal audit unit, which includes two positions and \$295,000 (\$178,000 General Fund). Currently, headquarters staff that conduct and oversee audits of RCs and service providers step in when needed to conduct audits of internal DDS activities.

ISSUES FOR LEGISLATIVE CONSIDERATION

Caseload Projections

Caseload Growth Outpaces General Population Growth. Caseload in the DDS system continues to grow at a steady, but rapid, pace. While DDS serves nearly 318,000 consumers in 2017-18, it is estimated to serve about 333,000 in 2018-19, a 4.8 percent increase. Overall caseload growth has been increasing by about the same rate each year since 2014-15, when expanded eligibility for DDS' Early Start program for infants and toddlers was restored (eligibility was more limited during the recession from 2009 through 2014). By comparison, the state's total population has been growing at a rate of less than 1 percent in recent years.

to Outpace Growth in Lifelong DDS Consumer Caseload. The Early Start program serves infants and toddlers under age 3 who exhibit developmental delays in speech, cognitive, social or emotional, adaptive, or physical and motor development, or have a known risk factor for developmental delay. The number of Early Start infants and toddlers is projected to grow by almost 10 percent—from about 43,000 in 2017-18 to about 47,000 in 2018-19. By comparison, the caseload for those age 3 and older is growing at a slower rate of 4 percent. According to DDS, about 20 percent of Early Start participants go on to become lifelong DDS

consumers at age 3. The rate of growth among the

Early Start Program has been similar in recent years

(about 9 percent to 10 percent), as has the rate of

growth among those 3 and older (about 4 percent).

Growth in Early Start Caseload Continues

Caseload Projections Reflect Historical Trends.
Caseload growth assumptions in the Governor's budget are in line with recent caseload trends and our own projections, for caseload overall as well as for caseload in the Early Start program. We will continue to monitor caseload growth trends and recommend adjustments to the Governor's caseload assumptions, if necessary, following our review of the May Revision.

Reasons for Growth Not Well Understood.

Although the Governor's caseload projections are in line with recent trends, we note that it is not well understood why DDS caseload is growing at a rate that far outpaces overall state population growth. While the broader eligibility criteria in the Early Start program may

help explain why caseload in this program outpaces growth in caseload among those age 3 and older, it does not explain why caseload would increase so much on an annual basis, particularly since the number of infants and toddlers overall in California has held steady or even declined in recent years. It is not clear the extent to which the rapid growth reflects an increasing incidence of developmental delays and disabilities in the general population versus improved identification and/or diagnoses of these conditions.

DC Closures

Community Placements on Track, Despite Minor Setback in 2017-18. The transition of DC residents from closure DCs to the community appear on track for 2018-19. The Governor's budget has revised downward its estimate for the number of placements in 2017-18, primarily due to 20 fewer residents moving from Fairview DC than previously estimated. The consumers who currently live at closure DCs, especially Fairview DC, tend to be more medically fragile or have more intensive behavioral treatment needs, on average, than residents who moved in previous years. DC and RC staff work closely with the consumers, their families, and with community-based service providers to ensure successful community placements. Sometimes this means changing the planned date of transition. Despite this current-year setback, DDS remains on track with scheduled DC closure dates. At Sonoma DC, it plans to place 173 residents in 2017-18 (as of December 2017, it had placed more than 80 consumers) and the final 83 in the first half of 2018-19. Fairview DC and the general treatment area of Porterville DC are scheduled to close at the end of 2021, but the Governor's budget estimates the populations will be below 100 at each by the end of 2017-18 and down to 26 and 48, respectively, by the end of 2018-19.

Sonoma DC Set to Close in December, Requiring Final Decisions About Disposition of Property.

The last resident will move from Sonoma DC, which first opened in 1891, in December 2018. DDS will continue to incur what are called "warm shutdown" costs through at least the end of 2018-19. These costs include maintenance of the buildings and grounds, basic heating and electrical, record archival, disposal of assets, and site security. The Legislature will soon be faced with the decision of what to do with the state-owned property that houses Sonoma DC. (The

Governor's budget does not reflect any assumptions about this issue.) The Legislature's options include, for example, transferring the land to another state department; selling the land to a local government, affordable housing developers, or to a private entity; or retaining the property and leasing out various parcels. (Please see our recent report, Sequestering Savings From the Closure of Developmental Centers for a more in-depth discussion of these options and the associated trade-offs.)

Federal Funding Extended at Fairview DC and the General Treatment Area of Porterville DC. The state receives federal funding for DCs from Medicaid. Several years ago, the California Department of Public Health—the state department responsible for licensing and certification at DCs-found the intermediate care facilities for the developmentally disabled (ICF/DD) units at all three DCs to be out of compliance with federal certification requirements. While the ICF/DD units at Sonoma DC were decertified and lost federal funding in 2016, ICF/DD units at Fairview DC and the general treatment area at Porterville DC remain certified through a settlement agreement with the federal government. Per the terms of the agreement, the units must be recertified each year and certification can be revoked at any time. The units at both DCs were recently recertified for 2018 and will thus continue to receive federal funding through December 2018. (The Governor's budget assumes the ICF/DD units will be recertified in 2019 and federal funding will continue for the balance of 2018-19.) DDS intends to have moved most of the ICF/DD residents into the community by the end of 2019, the time at which federal funding for these units is scheduled to end.

DDS Is Reducing the Number of DC Staff.

As DDS continues to place DC residents in the community, it is also reducing the number of DC staff. This happens in several ways. First, the Legislature authorized a "community state staff program (CSSP)," which allows DDS to contract with a community-based service provider to hire a DC employee for work in the community. The employee remains a state employee and the service provider covers the full cost of state employee compensation and benefits. The benefit of CSSP is that experienced employees continue to work with DDS consumers, sometimes the individual consumers they served at the DCs. This helps smooth the transition to the community for the

former DC residents. The incentive for the employee is retaining state employee status and benefits. CSSP contracts currently last for one year (new contracts will last for two years beginning July 2018), but can be renewed. Currently, 49 former DC employees are employed under CSSP contracts. DDS is authorized to contract for another 220 positions through this program. Second, some DC employees transfer to another state department (for example, in the final three months of 2017, 130 employees transferred to other state departments, such as the Department of State Hospitals and the California Department of Corrections and Rehabilitation). Third, some DC employees retire. Fourth, others elect to resign from state service and pursue employment opportunities elsewhere, which could include working directly for a community service provider. For employees who retire or resign from state service, the Governor's budget requests \$4.7 million General Fund in 2017-18 and \$5.5 million General Fund in 2018-19 to compensate them for unused leave balances.

Development of Safety Net Facilities and Crisis Services. As noted in the background, DDS is developing community-based safety net and crisis services to replace and expand upon crisis services currently available at Sonoma DC and Fairview DC. One-time development costs totaled \$21.2 million in 2017-18 (most of this from the General Fund). The Governor's budget proposes \$13.2 million General Fund to operate four acute crisis homes and two mobile crises teams in 2018-19, an increase of \$5.5 million over revised 2017-18 spending, when only two crisis units operated out of Sonoma and Fairview DCs. In addition, the Governor's 2018-19 budget assumes about \$7 million General Fund in the RC POS budget to pay for services provided in six new vendor-operated safety net homes. Four of these homes will provide transitional services for DDS consumers with mental health diagnoses and two will provide transitional services for people leaving the secure treatment program at Porterville DC.

Chapter 18 of 2017 (AB 107, Committee on Budget) requires DDS to provide quarterly updates about the development of community-based safety net and crisis services. The Legislature may wish to request some specific additional information from DDS in these updates (beyond what DDS has thus far provided) to help it more fully understand whether the planned

safety net and crisis services are adequate for the needs of DDS consumers. For example, the Legislature could seek information on:

- How often DDS' mobile crisis units are engaged, the average length of time they are needed, and whether they are able to respond to all calls.
- How often the safety net homes reach capacity and remain at capacity.
- Whether each RC provides crisis intervention services and how these services are coordinated with DDS-operated services.
- The number of consumers who end up getting placed in a more restrictive setting, such as an Institution for Mental Disease (IMD), how long they remain in the more restrictive setting, and how many lose their community-based residential placement as a result of their placement in a more restrictive setting. (We note that recently collected DDS data indicate that more than 75 percent of the 59 consumers recently placed at IMDs have been there longer than the legal limit of 180 days.)

Minimum Wage Issues

State Minimum Wage Increases. The Legislature has increased the state minimum wage several times over the past decade. Currently, the state minimum wage is \$10.50 for businesses with 25 or fewer employees and \$11 for businesses with 26 or more employees. The state minimum wage is statutorily scheduled to increase each year until it reaches \$15—in 2022 for the larger businesses and in 2023 for the smaller businesses.

Statutory Policy Guides Rate Adjustments to DDS Service Providers When the Minimum Wage Increases. To a large extent, allowable rates paid to DDS service providers ("vendors") are subject to parameters set in statute. Currently, statute allows DDS to adjust the rates paid to vendors when the adjustment is needed to bring their lowest wage staff up to the state minimum wage. However, statute and administrative practice generally do not provide for vendor rate adjustments in response to local minimum wage increases. Currently, about 20 cities and counties have minimum wages that are higher than the state minimum wage. Two cities in the Silicon Valley already have a \$15 dollar minimum wage and San Francisco will reach this level in July. Only in rare cases when a

vendor demonstrates that the health and safety of an individual consumer is at risk and both the RC and DDS agree with the vendor's assessment, will DDS make an exception (as it is authorized to do) and adjust rates for the vendor as a result of local minimum wage cost pressures.

The Way DDS Has Interpreted Statute Has Perhaps Led to Unintended Consequences. Vendors in areas with a local minimum wage that is higher than the state minimum wage appear to be more adversely affected by the statutory policy on rate adjustments for state minimum wage increases than likely was intended. This is because these vendors, in addition to generally being ineligible for rate adjustments due to local minimum wage increases, are also considered ineligible for any of the rate adjustments due to state minimum wage increases. They are considered ineligible for the state increases because they already pay their minimum wage workers a wage that is higher than the state minimum wage. In contrast, vendors providing the same service in another part of the state. but who are not subject to a local minimum wage requirement, can seek an adjustment per state policy for their minimum wage workers. To see how this plays out, consider a vendor in San Francisco (which has had a local minimum wage above the state minimum wage since 2014). This vendor cannot request an adjustment when the state minimum wage goes up because it already has to pay its lowest wage staff more than the state minimum wage. This means it may still operate with the rate it had before 2014, whereas a vendor in Modesto (which does not have a local minimum wage) would have been able to request an adjustment each of the four times the state minimum wage has increased since 2014. Not only does the vendor in San Francisco have to pay higher wages to its minimum wage staff (currently \$14 per hour), but it cannot benefit from any of the adjustments, due to changes in state policy, that are afforded vendors in other areas of the state without local minimum wages.

Analyst's Recommendation. Given the information presented above, the Legislature may wish to clarify what it intended when it authorized DDS vendors to seek rate adjustments. For example, when the state minimum wage increases from \$11 per hour to \$12 per hour, does the Legislature want to allow a vendor in San Francisco paying the local minimum wage of \$14 per hour to seek a rate adjustment to account for

the \$1 increase in the state minimum wage to partially offset its costs, as it allows a vendor in Modesto (paying the state minimum wage) to do? If so, we recommend statutory clean up to clarify that vendors in areas with a local minimum wage that is higher than the state minimum wage can seek an adjustment related specifically to the increase in the *state* minimum wage. In addition, we recommend the Legislature direct DDS to report at budget hearings about the estimated General Fund cost of this statutory clean up.

Uniform Holiday Schedule Proposal

Traditional Treatment of Holiday Schedule for Service Providers. Traditionally, each RC has required service providers in its catchment area to observe a certain number of holidays each year, meaning service providers cannot bill for services on those days (in practice, most do not provide services on those days, and if they do, they go uncompensated). The holiday policy typically would apply to providers of services such as day program, transportation, work activity programs, and early intervention services for infants and toddlers, rather than services such as residential care. Traditionally, RCs have required service providers to observe an average of ten holidays per year.

State Policy Dictating a Uniform Holiday
Schedule Initiated as a Budget Solution. As part
of a package of budget solutions passed in 2009 in
response to the significant state budget deficit, the
state enacted a policy prohibiting RCs from paying
service providers on 14 holidays per year (rather than
the typical ten) and requiring that all service providers
statewide uniformly observe the same 14 holidays. This
was called the "uniform holiday schedule." Prohibiting
billing on four additional days per year was estimated
to save \$22 million in POS expenditures (\$16.3 million
General Fund) at the time of enactment of this policy.

The Policy Was in Effect for More Than Five Years While Litigated. While legal action was brought against the state by service provider associations in 2011 in an effort to have the state policy repealed, the policy remained in effect for more than five years. Despite an initial ruling in favor of service providers in 2015, a subsequent court ruling in 2016 upheld the state's policy. Since the initial ruling in 2015, the state has not enforced the policy. RCs went back to the traditional practice of setting their own holiday schedules for vendors, which included on average

about ten days per year. Service providers were able to bill again for the four extra days, meaning that although the DDS budget was not directly adjusted to reverse the savings assumed in 2009, the funding required for the four additional days was occurring through POS billing on the natural. In other words, the 2017-18 POS budget likely reflects the cost for services provided on the four additional days.

Governor's Budget Proposes Reinstating Enforcement of the Policy. Because the 14-day uniform schedule remains in statute and the court upheld it, the Governor's budget proposes enforcing it again starting in 2018-19, with an estimated incremental savings of \$10.2 million (\$3.2 million General Fund) on top of the previously estimated savings.

Options for Legislative Consideration. The Legislature has several options in response to the Governor's plan. First, it could approve the Governor's plan - enforcement of the 14-day uniform holiday schedule in current law. The Governor's budget assumes General Fund savings of about \$3 million. (However, since the policy has not been enforced since 2015 and vendors began billing for services on four additional days, there would likely be even more savings than what the Governor's budget assumes.) Second, the Legislature could reject the proposal outright and repeal the state policy. This would reinstate the traditional (and current) practice of allowing RCs to set their own holiday schedules and would not-in effect—cost the state any more in POS than what is in the 2017-18 budget. However, compared to what the Governor's budget proposes for 2018-19, it would increase costs. Finally, the Legislature could approve a compromise solution, requiring a uniform holiday schedule, but one that includes ten days rather than 14. This would reinstate the benefit of a coordinated schedule among service providers across RCs (this is mostly a benefit when RCs are in close geographic proximity and consumers receive services from service providers in more than one RC catchment area). It would allow consumers to continue receiving services on the four days eliminated from the holiday schedule. Although rejecting the Governor's proposal or approving the offered compromise solution would increase costs compared to what the Governor's budget proposes for 2018-19, it would likely not increase costs compared to

2017-18, since RCs currently typically observe and pay their vendors according to a ten-day holiday schedule.

Assessing Gaps in Community Services Program

Community Service Gaps Need to Be Better Understood. Although the DDS system is structured through the individual program plan (IPP) process ideally to account for and fund each individual's needs, it is a commonly held view that RCs struggle to help consumers find certain services, such as affordable, accessible, and safe housing; regular dental care; employment opportunities; and transportation. It is currently difficult to quantify the full extent of any service gaps since DDS lacks a standardized method for understanding these gaps on a systemwide basis. At best, DDS may know anecdotally that certain services are hard to find or that certain providers are going out of business.

DDS Granted New Authority for Use of Community Placement Plan (CPP) Funds.

Chapter 18 authorized DDS to expand the use of CPP funding to the entire community services program. Previously, CPP funding was designed specifically to address the community service needs of people moving out of DCs. It has funded the development of new homes and programs and paid for the transition costs to place these formerly institutionalized consumers in the community. Now DDS has the authority to use this funding to address unfunded needs of other community-based consumers in the DDS system.

Legislature Is Considering a Proposal to Shift Savings From DC Closures to Community Services.

The Legislature has been discussing a proposal to earmark any possible savings from the closures of DCs for the DDS community services program. (For more information on this proposal, please see our recent report, Sequestering Savings From the Closure of Developmental Centers.)

Analyst's Recommendation. We continue to suggest, as we did in our 2017-18 budget analysis and our recent report, that the Legislature may benefit from directing DDS to conduct periodic comprehensive assessments of service gaps and related unmet funding requirements in the community services system. Such assessments would help guide the use of additional resources provided for this system. The current lack of such assessments constrains the Legislature's

and DDS' ability to prioritize and effectively target the use of CPP or other additional resources provided to the community services system. As one example, the Legislature could consider requiring DDS to revamp its IPP process to allow for standardization of information collected. This would allow information to be aggregated at a systemwide level. Although some collection of information must be done in a highly

individualized way as part of the person-centered planning process, other information could be easily standardized, such as whether a consumer needs a particular service and how many providers are currently available to provide this service. Standardizing such information would also allow DDS to see which geographic areas or demographic groups lack choice or service coverage.

CONTINUUM OF CARE REFORM

California's child welfare system serves to protect the state's children from abuse and neglect, often by providing temporary out-of-home placements for children who cannot safely remain in their home, and services to safely reunify children with their families. Beginning in 2012, the Legislature passed a series of legislation implementing the Continuum of Care Reform (CCR). This Legislative package—which includes Chapter 35 of 2012 (SB 1013, Committee on Budget and Fiscal Review), Chapter 773 of 2015 (AB 403, Stone), Chapter 612 of 2016 (AB 1997, Stone), and Chapter 732 of 2017 (AB 404, Stone) makes fundamental changes to the way the state cares for children in the foster care system. CCR aims to increase the foster care system's reliance on family-like settings rather than institutional settings such as group homes. Additionally, CCR makes changes to ensure that the state's foster children receive mental health and other supportive services regardless of their placement setting.

To facilitate these reforms, the Legislature has provided annual General Fund support for CCR since 2015-16. In 2017-18, the Governor's budget estimates spending on CCR at \$198 million General Fund. In 2018-19, the Governor's budget proposes \$139 million in General Fund to support continued CCR implementation efforts. Estimated CCR spending in 2017-18 and proposed CCR spending in 2018-19 represent significant increases over previous administration projections for these same fiscal years. (For this section of the report, we restrict our CCR funding estimates and projections to what is provided for county child welfare and probation services, where most CCR spending is occurring. We therefore exclude from these estimates CCR spending on county mental health services and state operations.)

This analysis provides a brief overview of the existing foster care system, summarizes the major policy changes under CCR, provides a status update on CCR implementation to date, and assesses the Governor's CCR budget proposal for 2018-19 in light of the reform effort's current successes and challenges.

OVERVIEW OF THE CHILD WELFARE SYSTEM

California's child welfare system provides an array of services for children who have experienced, or are at risk of experiencing, abuse or neglect. These child welfare services (CWS) include responding to and investigating allegations of abuse and neglect, providing family preservation services to help families remain intact, removing children who cannot safely remain in their home, and providing temporary out-of-home placements until (1) the family can be successfully reunified or (2) an alternative permanent placement can be found. After family reunification, adoption and guardianship are the two most common permanent placement options.

Child Welfare Programs Are State Supervised, County-Administered. DSS oversees CWS, while county welfare departments carry out day-to-day operations and services. DSS is responsible for statewide policy development and enforcing state and federal regulations. Counties have flexibility around the design of their operations and to some extent the range of services they provide. All counties investigate allegations of abuse, engage with families to help them remain intact, and provide foster care payments to foster caregivers and providers. Services that may vary at the discretion of counties include, for example, child care made available to certain children in care.

Assisting the counties are several hundred private Foster Family Agencies (FFAs) and congregate care providers that provide services ranging from basic care and supervision to foster parent recruitment to mental health treatment. (We provide a basic overview of FFAs and congregate care—the latter of which is comprised of both group homes and CCR's recently created "Short-Term Residential Therapeutic Programs (STRTPs)"—in the sections that follow.)

The Role of County Probation Departments in the Child Welfare System. County probation departments carry out many of the same services provided by county welfare departments but for children who have been declared wards of the court through a delinquency hearing. Unlike the majority of children who enter the child welfare system, children in out-of-home care due to probation decisions have not necessarily been subject to abuse or neglect. Instead, probation departments often utilize foster care placements with the aim of rehabilitating the child following a criminal offense.

Foster Care Payments. A significant component of CWS is the making of per child per month payments to foster caregivers and providers to cover costs associated with the care, supervision, and service needs of a foster child. We refer to these as foster care payments. The state sets base-level foster care payments that can vary from under \$1,000 to over \$12,000 depending on the type of placement setting a foster child is in as well as by other factors. (Below, we discuss the various foster care placement settings.) In addition to state-mandated, base-level foster care payments, most counties—at their own discretion and with flexible county funding-pay foster caregivers caring for children with high needs supplemental payments known as "specialized care increments (SCIs)." SCI levels vary from county to county, generally ranging from under \$100 per child per month with slightly elevated needs to over \$1,000 per child per month for foster children with the highest needs. Counties design their own assessments to determine whether a foster child qualifies for an SCI and what the SCI level should be. As a result, there is great variance in the level of SCIs throughout the state.

CWS Funding

Total funding for CWS is projected to be \$6.3 billion for 2018-19. Below, we describe the major sources of this funding.

2011 Realignment Revenues Are a Major Source of CWS Funding. Until 2011-12 the state General Fund and counties shared significant portions of the nonfederal costs of administering CWS. In 2011, the state enacted legislation known as 2011 realignment, which dedicated a portion of the state's sales tax to counties to administer CWS. The 2018-19 budget projects that nearly \$2.5 billion will be available from realignment revenues to fund CWS programs in 2018-19.

As a result of Proposition 30 (2012), under 2011 realignment, counties are either not responsible or only partially responsible for CWS programmatic cost increases resulting from federal, state, and judicial policy changes. Counties are responsible for all other increases in CWS costs—for example, those associated with rising caseloads. (Conversely, if overall CWS costs fall, counties get to retain those savings.) Proposition 30 protects the state from having to reimburse counties for increasing costs of child welfare policies that were in place prior to 2011 realignment. Conversely, Proposition 30 protects counties by establishing that counties only need to implement *new* state policies that increase overall program costs to the extent that the state provides the funding.

Federal Funding for CWS. Federal funding for CWS stems from several sources and is projected to be around \$2.9 billion in 2018-19.

State General Fund Supports Non-Realigned Components of Child Welfare and State Oversight Functions. The 2018-19 budget proposes around \$433 million General Fund for county welfare and probation departments to implement components of the child welfare program that were not part of 2011 realignment. CCR implementation spending constitutes a significant portion of total General Fund spending on CWS. In addition to this \$433 million, the General Fund supports the state's CWS oversight function at DSS.

Out-of-Home Placement Options

Counties have historically relied on four primary placement options for foster children—kinship care,

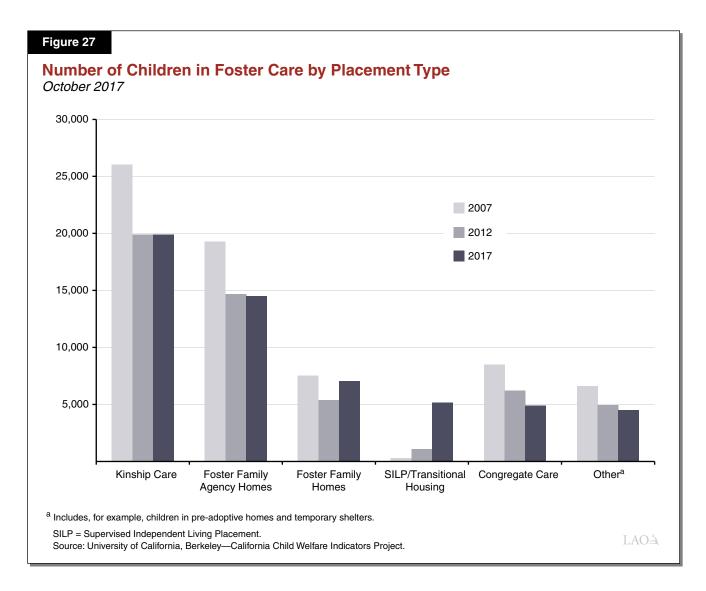
foster family homes (FFHs), FFAs, and congregate care. (For this report we refer to kinship care, FFHs, and FFAs as home-based family care [HBFC].) In recent years, Supervised Independent Living Placements (SILPs) and transitional housing placements have become increasingly utilized as placement options for older foster youth.

As of October 2017, there were around 60,000 children in foster care in California. Federal and state law mandate that children be placed in the least restrictive placement setting, which state law describes as a setting that promotes normal childhood experiences and the day-to-day needs of the child.

Figure 27 shows the number of foster children in each of the above mentioned placement settings over time. The selected placement types vary in their level of restrictiveness, serve children with different though

overlapping needs, provide different kinds of specialized services, and receive varying foster care payment rates from the state.

Kinship Care. Established child welfare policy and practice in the state prioritizes placement with a noncustodial parent or relative. Kinship care comprises care from relatives and nonrelative extended family members and is the state's most utilized placement option at 36 percent of foster placements as of October 2017. Kinship care is a unique foster care placement type in multiple respects. For example, unlike other placement types, kin caregivers can take in foster children on an emergency basis before having been fully approved by counties as foster caregivers. Instead, kin caregivers only must meet basic health and safety standards before an emergency placement is made. As a result of not meeting full foster caregiver approval



standards prior to taking in a foster child, kin caregivers are generally not eligible to receive full monthly foster care payments until they have received full foster caregiver approval. Instead, they typically receive the CalWORKs child-only grant of almost \$400 per month. Once fully approved, in 2017-18, kin caregivers receive a minimum foster care payment of at least \$923 per month for the care and supervision of each foster child in their home.

FFHs. County-licensed foster homes, known as FFHs, are often the preferred placement option when a suitable kin caregiver cannot be found and the child does not have needs requiring a higher level of services. Counties recruit FFH caregivers and provide basic social work services to the approximately 13 percent of foster children statewide residing in an FFH as of October 2017. In 2017-18, FFH caregivers receive the same minimum foster care payment as kin caregivers of at least \$923 per month for the care and supervision of each foster child in their home.

FFA Homes. FFAs do not directly house the children under their care. Instead, FFAs are private nonprofit agencies that recruit and approve foster caregivers. place children into FFA-supervised foster homes, and provide supportive services to the children in their care. typically children with elevated needs compared to those placed in FFHs. Because they offer a relatively high level of services and often serve children with elevated needs, counties reimburse FFAs at a higher rate than either kin caregivers or FFHs. In 2017-18, FFAs receive a minimum payment of \$2,139 per month for each foster child under their supervision. Of this amount, \$923 is passed directly onto the foster child's caregiver, while the remaining amount funds the FFA's administrative and supportive services activities. FFA-supervised foster caregivers have not historically been eligible to receive county-funded SCIs. Instead, FFA-supervised foster caregivers historically received a fixed supplemental per child per month payment on top of the standard foster care payment mandated by the state for all HBFC placements. As of October 2017, 26 percent of the state's foster children were placed through an FFA.

Congregate Care. Congregate care includes group homes and STRTPs, the latter of which are expected to replace group homes under CCR as the permissible congregate care placement setting for CWS-supervised foster children unable to be placed in an HBFC home.

We discuss the differences between group homes and STRTPs in the "Major Changes Under CCR" section of this analysis.) Operated as private, nonprofit agencies, group homes and STRTPs provide 24-hour care. supervision, and services to foster children with the highest levels of need, often children whose significant emotional or behavioral challenges can make it difficult for them to successfully remain in home-based family foster care settings. Professional staff, as opposed to a parent-like foster caregiver, provide care and supervision to children in group homes and STRTPs. Group homes and STRTPs are considered the most restrictive, least family-like foster care setting, and are generally the least preferred placement option. Group homes and STRTPs are compensated at significantly higher rates than the other placement types—in 2017-18, ranging from just under \$3,000 to over \$12,000 per child per month. As of October 2017, approximately 9 percent of California's foster children were living in group homes or STRTPs.

SILPs and Transitional Housing. In recent years. counties have increasingly relied upon SILPs and transitional housing placements instead of home-based family placements and congregate care settings for older, relatively more self-sufficient youth. SILPs are independent settings, such as apartments or shared residences, where nonminors who remain in the foster care system past their 18th birthday may live independently and continue to receive monthly foster care payments. Nonminor foster youth residing in SILPs receive a monthly foster care payment of \$923. Transitional housing placements provide foster youth ages 16 to 21 supervised housing as well as supportive services, such as counseling and employment services, that are designed to help foster youth achieve independence. The monthly foster care payment rate for foster youth in transitional housing placements ranges between \$2,000 and \$3,000. As of October 2017, 9 percent of all foster youth were residing in either SILPs or transitional housing. This is slightly greater than the number living in group homes or STRTPs.

MAJOR CHANGES UNDER CCR

CCR aims to achieve a number of complementary goals including: (1) ending long-term congregate care home placements; (2) increasing reliance on

home-based family placements; (3) improving access to supportive services regardless of the kind of foster care placement a child is in; and (4) utilizing universal child and family assessments to improve placement, service, and payment rate decisions. In this section, we first highlight some of the key problems CCR is intended to address and then discuss some of the major changes underway as a result of CCR. (We note that the changes we highlight are not a comprehensive accounting of all CCR changes, but are those most relevant in understanding the Governor's 2018-19 budget proposal for CCR.)

Congregate Care Placements Are Costly and Associated With Poor Outcomes for Children.

Congregate care placements can cost over \$12,000 per child per month depending on the level of care provided. In contrast, foster care payments for home-based family settings generally range from around \$1,000 per child per month for relative and FFH placements to somewhat more than \$2,000 per child per month for FFA placements. Moreover, long-term stays in congregate care are associated with elevated rates of reentry into foster care, lower educational achievement, and higher rates of involvement in the juvenile justice system. (We note that given the potentially higher needs of children placed in congregate care, it is difficult to determine whether congregate care placements themselves directly lead to these poor outcomes.) Recognizing the above shortcomings associated with congregate care, CCR aims to end long-term congregate care placements.

Concerns About the Availability and Capacity of Home-Based Family Placements. Reducing reliance on congregate care placements has been a priority for the state for some time. A major challenge to achieving this goal has been an inadequate supply of home-based family placements which are capable of caring for children with elevated needs. Additionally, the mental health and other supportive services to help home-based family caregivers care for children with elevated needs have not historically been readily accessible at all home-based family placement types. Improving the capacity and availability of home-based family placements is a principal goal under CCR.

CCR Creates a New Placement Type

STRTPs Replace Group Homes for CWS-Supervised Foster Children. CCR ends group

homes as a placement option for CWS-supervised foster children by January 2019. (Probation departments may continue to utilize group home placements indefinitely. Nevertheless, CCR aims to encourage probation departments to make similar changes regarding their use of congregate care as child welfare departments.) STRTPs are expected to replace group homes as the permissible placement setting for children who cannot safely and stably be placed in home-based family settings, providing a similar level of supervision as group homes, but with expanded services and supports. In contrast to group homes sometimes serving as long-term placements for children for whom home-based family placements cannot be found, STRTPs are intended to exclusively provide short-term, intensive treatment and other services to allow children to transition to a family setting as quickly and successfully as possible. CCR restricts STRTP placements to children who have been assessed as requiring the high level of behavioral and therapeutic services that STRTPs will be required to provide. Children whose level of need may qualify them for STRTP placement include, among others, those assessed as having a serious mental illness and victims of commercial sexual exploitation. To ensure the ongoing appropriateness of all STRTP placements, resident children's case plans are subject to review every six months by the director or deputy director of the supervising county child welfare or probation department. The case plans specify the reasons for the child's placement, the expected duration of stay, and the transition plan for moving the child to a less restrictive environment. As a result of the shorter expected durations of stay in STRTPs, as well as the restrictions around which foster children may be placed in STRTPs compared to group homes, it is anticipated that statewide STRTP capacity (number of beds) will be considerably lower than existing statewide group home placement capacity.

New CCR Foster Care Payment Rate Structure

CCR Foster Care Payment Rates to Generally Vary Based on Children's Needs. Until January 2017, the state's foster care payment rates primarily varied by age for children in HBFC. For example, a foster caregiver caring for a child below age 5 would receive a monthly foster care payment of around \$700 while

a foster caregiver caring for a child over age 14 would receive a monthly payment of around \$900. Under the foster care payment rate structure being implemented under CCR, foster care payment rates vary by children's level of need as determined by a statewide "level of care" (LOC) assessment tool, which we describe below. There are five payment rates under CCR's "HBFC payment rate" structure, each with a corresponding LOC. LOC 1 represents the lowest level of care and corresponds with the lowest payment rate. LOC 5 also referred to as the Intensive Services Foster Care level of care—represents the highest level of care and comes with the highest payment rate. In addition to changing the basic structure of foster care payment rates, the new HBFC base foster care payment rates are generally higher than they were prior to CCR. Some form of county-optional SCIs is expected to continue under the new HBFC foster care payment rate structure. However, counties may make adjustments to their SCI rate structures in order to harmonize their SCI rate structures with the HBFC rate structure. Figure 28 summarizes the HBFC payment rates under CCR.

LOC Assessment Tool. The DSS developed an LOC assessment tool to determine the foster care payment rate that caregivers will receive. The assessment is designed to identify the care needs of a foster child and to translate those care needs into an appropriate foster care payment rate.

Single STRTP Payment Rate. Unlike the rate structure that governed group home payment rates—which differentiated group home payment rates by the level of care and supervision different group homes provided—under CCR, there is a single monthly payment rate paid for all STRTP-placed children. In

2017-18, STRTPs are paid a per child per month foster care payment rate of \$12,498.

CCR Aims to Expand Access to Mental Health and Other Supportive Services

Improving foster children's access to mental health services has been a longstanding goal of the state. CCR builds on these efforts by requiring STRTPs—and therefore all CWS congregate care providers beginning in January 2019—to directly provide specialty mental health services to resident foster children. In addition, FFAs are required to ensure access to mental health services for the foster children they supervise by either providing the services themselves or contracting with mental health service providers to do so on their behalf. On top of aiming to improve access to mental health services, CCR mandates that certain other "core services" be made available to foster children. These core services include permanency services to help foster children reunify with their parents or, alternatively, secure permanency through guardianship or adoption.

CCR Changes to the Caregiver Approval and Placement Processes

Resource Family Approval (RFA) Replaced the Previous Multiple Approval, Licensing, and Certification Processes for Home-Based Family Caregivers. Before foster caregivers may receive full foster care payments, they must be approved to provide care. Prior to CCR, the approval process differed by placement type—for example, non-relative caregivers were licensed according to one set of criteria while relative caregivers were approved under a different set of criteria. CCR replaced the multiple

Figure 28

2017-18 Home-Based Family Care Foster Care Payment Rates Under CCR

Per Child Per Month Payment Rates

Level of Care (LOC)	1	2	3	4	5
County-supervised foster caregivers FFA payments:	\$923	\$1,027	\$1,131	\$1,235	\$2,410
Foster caregivers	\$923	\$1,027	\$1,131	\$1,235	\$2,410
Services and administration	1,216	1,260	1,304	1,383	3,682
Totals	\$2,139	\$2,287	\$2,435	\$2,618	\$6,092

a In addition to this amount, counties receive \$3,682 per child per month for service costs for the LOC 5 foster children that they directly supervise. CCR = Continuum of Care Reform and FFA = Foster Family Agency.

approval standards with a single, more comprehensive approval process that incorporates features included in assessments for prospective adoptive parents (such as a psychosocial assessment). Because it is a more comprehensive approval process, completing the RFA process is intended generally to automatically qualify a foster caregiver for guardianship and adoption. CCR legislation requires all new prospective foster caregivers to complete the RFA process beginning in January 2017. Obtaining RFA is required of all existing foster caregivers by January 2019 in order for them to continue to serve as foster caregivers.

More Collaborative Placement and Service Decisions Through the Use of Child and Family Teaming. To increase child and family involvement in decisions relating to foster children's care, CCR mandates the use of child and family "teaming" through every stage of the case planning and service delivery process. The child and family team (CFT) may include, as deemed appropriate, the affected child, her or his custodial and noncustodial parents, extended family members, the county caseworker, representatives from the child's out-of-home placement, the child's mental health clinician, and other persons with a connection to the child. The CFT will meet as needed to discuss and agree on the child's placement and service plan whenever an important foster care decision is made.

Functional Assessment Tool to Inform Placement and Services Decisions. CCR calls for children to receive a comprehensive strengths and needs assessment upon entering the child welfare system in order to improve placement decisions and ensure access to necessary supportive services. In late 2017, the Child and Adolescent Needs and Strengths (CANS) tool was chosen by DSS as the state's functional assessment tool. The CANS assessment tool will be used to inform the decisions of the CFT and will be administered separately from the LOC assessment tool discussed above.

CCR Funding

The budget contains funding for most of the major programmatic components identified above, including, for example, CCR's new foster care payment rates and the new costs associated with the RFA and CFT processes. This section briefly summarizes how the Governor's CCR budget is structured.

CCR Creates Some Immediate New Costs for

Counties. CCR increases certain costs for counties. For example, county administrative costs are higher as a result of the new RFA and CFT processes, which result in greater time commitments on county social workers. CCR's relatively higher foster care payment rates also increase county costs.

CCR Expected to Result in Savings Due to CCR-Related Caseload Movement. In addition to generating higher county costs, CCR is expected to result in offsetting savings for counties. As previously discussed, CCR aims to shorten foster children's lengths of stay in congregate care, reduce the number of children ever placed in congregate care, and provide greater resources to home-based family placements in order to improve their stability. To the extent that CCR succeeds in reducing the number of foster children in more costly placements, such as congregate care, in favor of less costly placement settings, such as HBFC settings, counties are expected to experience savings.

State Provides Funding for CCR's Net Costs.

As previously discussed, counties are responsible for the costs of administering CWS that were included in 2011 realignment. Counties are only required to implement new state CWS policies to the extent that the state provides funding to cover the new policies' costs. CCR creates new costs on counties, for example, in the form of higher administrative costs, while also potentially generating savings for counties as the proportion of foster children in costly placements such as congregate care placements decreases. The state has agreed with counties to fund CCR's net costs on a county-by-county basis. That is, the state will fund the difference between (1) the new costs that CCR creates on a county and (2) any savings that CCR generates for that same county. The state will continue to fund counties' CCR activities until each county's CCR-related savings equal or exceed its CCR costs. The state will not recoup from counties any CCR-related savings that exceed counties' CCR-related costs. It is our understanding that the state and counties have agreed on a methodology to track CCR's ongoing net costs for counties in order to identify the amount of state funding needed, if any, to pay for CCR on an ongoing basis.

CCR Previously Anticipated to Be Largely Cost Neutral to the State Beginning in 2019-20. In developing previous years' budgets for CCR, DSS created a multiyear projection of CCR's state costs. The previous multiyear CCR projection released in May 2017 projected county CCR-related savings to exceed county CCR costs beginning in 2019-20, resulting in the end of state CCR funding for counties beginning in that fiscal year.

STATUS UPDATE ON CCR IMPLEMENTATION

State and county implementation of CCR's various components has been spread out over several years, with most of CCR's major components implemented beginning in January 2017. Some elements of CCR implementation have gone relatively smoothly. Other components of CCR implementation have been met with delays and challenges. Our analysis that follows focuses on some of the major challenges of CCR implementation.

RFA

RFA Taking Significantly More Time Than Envisioned in Law. CCR legislation generally directs RFA to be completed within 90 days of application. In practice, RFA is taking between 90 days (3 months) and 270 days (9 months) before completion for a typical case. It is our understanding that there is variation among counties in how long the RFA process is taking—with early RFA implementer counties, for example, completing the process relatively faster. It has also been reported that FFAs, which complete RFA for foster caregivers of children who are placed through FFAs, have to a greater extent been able to meet the 90 days for approval standard compared to counties. While the reasons behind the prolonged RFA process are not entirely known, the relatively intensive set of social worker activities related to the psychosocial assessment—which was not a part of the foster caregiver approval process prior to RFA—appears to be a significant factor behind the slower than previously anticipated RFA process.

DSS Issuing New County Guidance to Streamline RFA Process. In early 2018, DSS is expected to release revised guidance to counties on ways to streamline the RFA process. This guidance is expected to, for example, encourage counties to initiate all steps of the RFA process, such as the background checks and the psychosocial assessment, concurrently

rather than along a linear timeline. Moreover, we understand that DSS is working with the counties to reduce the overall administrative burden that the more comprehensive RFA process places on counties by clarifying what is and is not required under RFA. For example, updated DSS guidance is expected to clarify what steps in the RFA process must be completed before RFA is granted and what steps may be completed after RFA is granted.

Prolonged RFA Delaying the Payment of Standard Foster Care Assistance Payments for Affected Kin Caregivers. As previously discussed, children are allowed to be placed with kin caregivers on emergency placements before the kin caregivers are fully approved as foster caregivers. However, under CCR, kin caregivers are generally not eligible to receive full foster care payments of \$923 per month until RFA is complete. Instead, they often receive the CalWORKs child-only grant of almost \$400 per month during the time between the emergency placement and the completion of RFA—up to nine months in some cases. Due to the prolonged RFA process, therefore, kin caregivers may be caring for foster children for months at a time without receiving a full foster care payment. It is our understanding that under the kin caregiver approval process that preceded RFA, it typically took one month to two months to receive kin caregiver approval and initiate full foster care payments. Certain counties have elected to use flexible county CWS funding to increase certain kin caregivers' payments beyond the CalWORKs child-only grant and closer to or at the full foster care payment rate while the RFA application is pending. We note that certain kin caregivers—specifically non-relative extended family members—are ineligible for the CalWORKs child-only grant and, as a result, may in certain cases receive no payment while the RFA application is pending.

HBFC Rate Structure

LOC Assessment Tool Not Currently Being Used.

The LOC assessment tool developed by DSS is not currently being used to determine foster care payment rates. This is largely due to systems delays related to the programming of the HBFC payment rate structure. The tool has undergone testing by DSS over the last year or more.

LOC-Based Rates Set to Implement in Stages
Beginning in March 2018. Although no foster children

are being assessed using the LOC assessment tool, the state has begun to implement the new HBFC payment rate structure. Rather than implementing the new LOC-based HBFC payment rate structure at a single time, the state has elected to implement the new CCR rate structure in phases. During Phase 1, which began in January 2017, the state implemented the new HBFC LOC 1 rate (the foster care payment rate for children with the lowest level of need) and the STRTP payment rate. (A relatively small number of foster children with highly elevated needs in HBFC placements began to receive LOC 5 foster care payment rates based on existing case information that does not involve the LOC assessment tool.) This means that most foster caregivers of newly placed foster children began receiving the LOC 1 payment rate without regard to the actual LOC of the foster children. Because even the LOC 1 rate is generally higher than the prior age-based rates, foster caregivers of newly placed foster children are receiving higher foster care payments with the implementation of Phase 1 of the HBFC payment rate structure than they would have under the pre-CCR payment rate structure. In Phase 2, the state will start using the LOC assessment tool to implement the full LOC-based HBFC foster care payment rate structure for all foster children. This will make the full range of LOCs available for foster children.

Phase 2 itself will be split into two stages. The first stage of Phase 2 will be implemented in March 2018 for FFA-supervised foster children only (both new and existing FFA-supervised youth). The second stage of Phase 2 is then scheduled to be implemented in May 2018 for the rest of the HBFC placement types (kin caregivers and FFHs). The reason behind the two-stage implementation of Phase 2 relates at least in part to stakeholder concerns about the LOC assessment tool developed by DSS, which we discuss immediately below.

Stakeholder Concerns About LOC Assessment

Tool. Stakeholders have reported concerns around whether the LOC assessment tool developed by DSS to determine the foster care payment rates that foster caregivers are paid is reliable. These concerns arose after initial testing of the LOC assessment tool was done on a sample of foster children in selected counties throughout the state. Stakeholders' concerns are at least threefold:

- Potential Bias Toward Lower LOC Levels. Stakeholders contend that the LOC assessment tool assigns foster children with elevated needs into inappropriately low LOC levels, resulting in lower foster care payment rates for their foster caregivers. During testing of the LOC assessment tool, the highest proportion of foster children received an LOC 1 determination, with decreasing proportions receiving higher LOC determinations until LOC 5, where there was an increase in the number of foster children receiving the highest LOC determination.
- Potential Lack of "Inter-Rater Reliability."
 Stakeholders are concerned about the objectivity of the LOC assessment tool insofar as different social workers using the tool may make different LOC determinations for the same foster child (a challenge referred to as inter-rater reliability).
- Uncertain Compatibility With Existing County SCI Determination Processes. As discussed earlier, certain counties provide SCIs for foster caregivers of children with elevated needs and have their own need-based SCI assessment processes that do not necessarily correspond to the state's new LOC assessment tool. Stakeholders are concerned that certain caregivers could see reductions in their overall foster care payment rates due to inconsistencies between the LOC and SCI assessment processes. Reductions in certain foster caregivers SCIs could potentially come about if counties begin using the LOC assessment tool to determine SCI levels and the LOC assessment tool results in a lower SCI determination than the previous, county-operated assessment process.

DSS Will Test LOC Assessment Tool During
First Stage of Phase 2 HBFC Payment Rate
Implementation. It is the intent of DSS to test the
reliability of the LOC assessment tool as it is being
implemented for FFA-supervised children during
stage one of the LOC-based HBFC payment rate
implementation beginning in March and ending in May.
Lessons learned from this testing will inform whether
changes need to be made to the LOC assessment tool
and potentially, if so, whether wider implementation of
the LOC assessment tool should be delayed.

Group Homes and STRTPs

Phase Down of Group Homes and Replacement by STRTPs Are in Their Early Stages. Group homes must end operations as congregate care providers or convert into STRTPs by January 1, 2019. (To maintain operations past January 1, 2017, group homes have had to apply to DSS for temporary license extensions, which the department has so far generally granted.) As of November 2017, there were 62 STRTPs that had received licensure from DSS (a requirement to begin STRTP operations and receive STRTP payments). All of these 62 operating STRTPs converted from group homes. These 62 operational STRTPs have a total license capacity of nearly 1,000 beds.

Minimal Caseload Movement as of January 2018

Movement From Higher-Level Placements
Into Lower-Level Placements Has Been Slower
Than Previously Anticipated. As of October 2017,
around 5,000 foster children in both the CWS and
probation systems remained in congregate care. The
number of children residing in congregate care has
been declining without interruption since 2003—long
before the implementation of CCR. It is uncertain
what portion of the decline in congregate care
placements, if any, is attributable to CCR efforts. Rates
of caseload movement out of congregate care settings

do not appear to be appreciably faster since CCR implementation largely began in 2017 than they were in 2016.

OVERVIEW OF THE GOVERNOR'S BUDGET FOR CCR

The Governor's 2018-19 budget increases estimated General Fund spending on CCR in 2017-18 and 2018-19 compared to previous projections. Higher estimated 2017-18 and 2018-19 CCR spending does not result from any major proposed changes in CCR policy. Rather, this higher CCR spending reflects updated cost projections of the various components of CCR implementation. We describe the changes in estimated spending below.

Upward Revision in Estimated 2017-18 CCR State Spending. Figure 29 breaks down the changes in estimated and projected CCR General Fund spending by CCR component for 2017-18 and 2018-19. The Governor's 2018-19 budget increases estimated General Fund spending on CCR in 2017-18 compared to the 2017-18 budget. The General Fund provided \$134 million in 2017-18 to counties through DSS to implement CCR. (We solely focus on state CCR funding for counties through DSS as this comprises the bulk of total CCR-related spending.) The Governor's 2018-19 budget revises

Figure 29

Differences in Projected CCR Spending Between the 2017 Budget Act and the Governor's 2018-19 Budget^a

General Fund (In Thousands)

	2017-18			2018-19		
	2017-18 Budget Act	Governor's 2018-19 Budget	Difference	2017-18 Budget Act	Governor's 2018-19 Budget	Difference
CCR foster care payments ^b	\$11,273	\$74,408	\$63,135	-\$88,081	\$34,084	\$122,165
Child and family teams	51,177	51,177	_	51,177	51,943	766
Foster parent recruitment, retention, and support	43,260	43,260	_	21,631	21,630	-1
Resource family approval	18,556	18,556	_	23,145	23,145	_
Other administrative and automation components	9,940	10,134	194	7,895	8,101	206
Totals	\$134,206	\$197,535	\$63,329	\$15,767	\$138,903	\$123,136

a Only includes local assistance funding through the Department of Social Services. It therefore excludes all state operations spending as well as CCR-related mental health expenditures.

CCR = Continuum of Care Reform.

b This line includes the net costs of the following (1) the costs associated with the new higher CCR payment rate structure and (2) the offsetting savings generated by children moving out of more costly foster care placements to less costly placements.

estimated 2017-18 General Fund spending on CCR upward by \$63 million to \$198 million.

Higher Than Previously Anticipated Proposed State Spending on CCR in 2018-19. Previous multiyear CCR spending projections anticipated \$16 million in General Fund spending on CCR in 2018-19. As Figure 29 shows, the Governor's 2018-19 budget now proposes \$139 million in General Fund spending on CCR in 2018-19, a \$123 million increase over previous projections.

Higher CCR Spending Largely the Result of Updated Caseload Movement Projections. The main driver of higher than previously anticipated and proposed state spending on CCR is the projected slower speed at which foster children are moving out of congregate care into HBFC settings. As previously discussed, projected spending on CCR from 2016-17 through 2021-22 depends significantly on the number of children transitioning out of costly placements such as congregate care placements and into lower cost placements such as HBFC settings, which generates savings for counties that the state uses to offset its CCR-related costs. Previous CCR spending projections included significant movement out of congregate care as a result of CCR efforts beginning as early as 2016-17.

The net costs associated with now slower projected caseload movement are reflected in the "CCR Foster Care Payments" line of Figures 29 (and Figure 31 below). This line combines (1) the costs associated with the new higher HBFC payment rate structure and (2) the offsetting savings generated by children moving out of more costly placements such as congregate care settings to less costly placements such as HBFC settings.

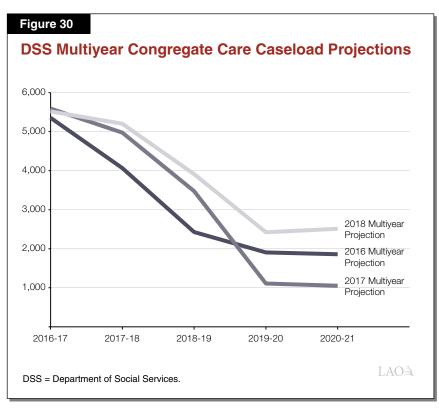
Because the expected speed at which children exit congregate care is a major a factor in understanding CCR's net costs,

Figure 30 compares the Governor's updated caseload movement projections with previous budgets' caseload movement projections.

In the figure, we show the number of foster children projected to reside in congregate care settings under the Governor's 2018-19 proposal (both traditional group homes and STRTPs) compared to prior CCR projections. The latest caseload movement projections assume approximately 2,500 foster children remain in congregate care through 2020-21, whereas the previous projection in January 2017 assumed around 1,000 foster children would remain in congregate care.

2018-19 Proposed Budget Reflects a Year-Over-Year Decline in Costs for CCR. While overall CCR costs in 2017-18 and 2018-19 are higher than under the administration's previous projections, the Governor's 2018-19 budget proposal reflects a net year-over-year reduction in state General Fund costs for CCR of almost \$60 million. Three factors largely explain the net decrease:

• Greater Projected Caseload Movement in 2018-19. The Governor's 2018-19 budget projects that CCR-related caseload movement out of congregate care and into HBFC settings will pick up speed and result in greater county savings in 2018-19 compared to 2017-18. These county savings are available to offset more state General Fund spending on CCR in 2018-19.



A Planned Reduction in Funding for Foster Caregiver Recruitment and Retention.

Consistent with previous multiyear CCR spending plans, the Governor's budget proposes a 50 percent reduction in General Fund for counties for their foster caregiver recruitment and retention efforts in 2018-19 compared to 2017-18. The Governor's budget proposes almost \$22 million in General Fund funding for this purpose in 2018-19.

• Increase in RFA Funding. The Governor proposes a nearly \$5 million increase in General Fund for counties to approve existing foster caregivers under the new RFA process. Previous funding primarily covered the costs of completing RFA for new foster caregivers. Current law requires all existing foster caregivers to complete full RFA by January 1, 2019.

Figure 31 summarizes the change in year-over-year General Fund spending on CCR between 2017-18 and 2018-19.

CCR Expected to Result in Net State Costs for Foreseeable Future. In the administration's prior multiyear CCR spending projection, released at the 2017-18 May Revision, the administration projected CCR to be cost neutral to the state by 2019-20. These projected savings were the result of projected CCR-related caseload movement savings exceeding the total projected costs of CCR's other components. The administration no longer expects caseload movement-related savings to exceed the costs of CCR's other components within the administration's

multiyear time horizon, which extends through 2021-22. Based on information from the administration, we project the net state costs directly attributable to CCR to be between around \$20 million and \$30 million annually from 2019-20 to 2021-22. (We note that these spending projections exclude \$30 million to \$40 million in projected spending on a program enacted around the same time as CCR to increase foster care payments for certain kin caregivers who previously were ineligible for full foster care payments.)

LAO ASSESSMENT

Below, we provide a brief assessment of the Governor's 2018-19 CCR budget and raise several issues for legislative consideration. This assessment is based on our initial review of the Governor's CCR budget. We will provide an update to the Legislature as needed as we continue to analyze the Governor's budget and how CCR implementation is going.

Governor's Upward Revision of Estimated and Projected CCR Spending Appropriate

The Governor's 2018-19 budget revises upward estimated General Fund spending on CCR in 2017-18 and General Fund costs for CCR in 2018-19. We find these upward adjustments in estimated and projected CCR spending to be reasonable.

Slower Projected Caseload Movement Reasonable in Light of Slower CCR Implementation.

The administration's previous projections of

Figure 31

Year-Over-Year CCR Spending Under the Governor's 2018-19 Budget^a

General Fund (In Thousands)

	2017-18	2018-19	Difference
CCR foster care payments ^b	\$74,408	\$34,084	-\$40,324
Child and family teams	51,177	51,943	766
Foster parent recruitment, retention, and support	43,260	21,630	-21,630
Resource Family Approval	18,556	23,145	4,589
Other administrative and automation components	10,134	8,101	-2,033
Totals	\$197,535	\$138,903	-\$58,632

^a Only includes local assistance funding through the Department of Social Services. It therefore excludes all state operations spending as well as CCR-related mental health expenditures.

b This line includes the net costs of the following (1) the costs associated with the new higher CCR payment rate structure and (2) the offsetting savings generated by children moving out of more costly foster care placements to less costly placements.

CCR = Continuum of Care Reform.

CCR-related caseload movement were relatively ambitious, assuming that the changes under CCR would guickly translate into movement of children away from more costly placement settings such as congregate care to less costly placements such as HBFC settings. Certain components of CCR implementation have taken longer to implement than originally intended. The principal example is the delayed rollout of the full LOC-based HBFC payment rate structure, originally intended to start in January 2017 and now not expected to be fully operational until May 2018. Given this and other CCR implementation delays, it is reasonable to expect that certain goals of CCR will take longer to be realized, including CCR-related caseload movement and the associated savings. From the initial data available, it doesn't appear that movement out of congregate care placements, for example, has increased appreciably between 2016 (pre-CCR implementation) and 2017 (post-initial CCR implementation). As such, we believe it is prudent to assume slower caseload movement as the administration has proposed in the 2018-19 budget.

Speeding Up RFA Process Critical to CCR's Success

CCR's success in part depends on the state and counties' ability to increase the number of HBFC caregivers.

Prolonged RFA Process Has Potential Negative Impact on the Supply of HBFC Settings. A critical first step in increasing the supply and capacity of HBFC caregivers is to complete the foster caregiver approval process, RFA, in a timely manner. The prolonged RFA approval process described earlier impedes the state's ability to increase the number of foster caregivers and, accordingly, prevents the state from moving foster children out of congregate care settings and into HBFC settings as fast as it otherwise could.

Prolonged RFA Process May Impair the Stability of Certain Kin Caregiver Placements. In addition, the prolonged RFA process may impair the stability of some emergency placements with kin caregivers. As previously discussed, the prolonged RFA process increases the amount of time in which kin caregivers providing emergency placements for kin foster children do not receive the full foster care payment and instead receive a payment potentially up to half of the full foster care payment. Caring for a kin foster child without

the full monthly foster care payment can represent a significant economic burden that has potential to impair these kin caregiver placements' stability.

Recommend the Legislature Closely Monitor How Long the RFA Process Is Taking and Consider Legislative and/or Budgetary Fixes if There Is Limited Improvement. DSS is in the process of releasing new county directives aimed at shortening the time it takes to complete the RFA process. At this time, the administration is not proposing that additional funding resources are needed to shorten the RFA process. We recommend that, between now and the May Revision, the Legislature closely monitor whether the RFA process does begin to speed up as a result of (1) increasing county experience implementing the new CCR-mandated caregiver approval process and (2) the new DSS directives aimed at streamlining the process. Should little improvement be shown in the speed of the RFA process between now and the May Revision, the Legislature should consider whether legislative policy changes around RFA and/or augmentations to state funding for counties to complete RFA are necessary.

Consider Funding for Kin Caregivers at the Time of Placement. The prolonged RFA process is resulting in delays in the payment of full foster care payments for certain kin caregivers. The Legislature might consider ways to provide full foster care payments to kin caregivers at or close to the time they take in kin foster children as emergency placements. It is our understanding that the administration is exploring ways to fund full foster care payments at or close to the time of the emergency placement. One potential funding source being considered, for example, is federal funding from Temporary Assistance for Needy Families. We recommend that the Legislature ask the administration during upcoming budget proceedings to (1) report on the potential for the state to utilize these or other funding sources to fund full foster care payments for kin caregivers at or close to the time of emergency placement, (2) the potential trade-offs associated with the various funding sources being considered, and (3) the estimated cost.

Implementation of LOC-Based HBFC Rates

Implementation of CCR's full HBFC payment rate structure requires the use of an assessment to determine foster children's general level of need and,

accordingly, determine an appropriate foster care payment rate. DSS developed the LOC assessment tool to perform this function.

Issues to Consider Related to the Planned Implementation of the Full LOC-Based HBFC Payment Rate Structure. As noted above, there are stakeholder concerns related to the LOC assessment tool's reliability. As such, the administration plans to implement the full LOC-based payment rate structure in stages beginning with FFA-placed foster children in March 2018 and then for all foster children in HBFC settings in May 2018. On the one hand, because FFA-supervised children are not eligible for the SCI. the concerns raised about the new rate structure's compatibility with the SCIs do not apply. In addition, implementation of the LOC-based HBFC payment rate structure for FFAs would give the state and counties experience administering the LOC assessment tool and present the state with an opportunity to refine its guidance and training on using the tool. On the other hand, we recognize stakeholders' concerns about the LOC assessment tool's reliability. As a result, we recommend that the Legislature ask the administration to report at budget hearings on how the earlier implementation of the LOC-based HBFC payment rate structure will be used to inform the implementation of the LOC rate structure for non-FFA supervised foster children. Specifically, the administration should report on how it will be assessing the tool's ability to accurately assess level of care and how the consistent application of the tool will be assessed and assured.

Additional State Funding Likely Needed to Fund Counties to Perform LOC Assessment. The Governor's 2018-19 budget for CCR generally appears reasonable. One component that appears missing from the Governor's CCR budget is funding for county social workers to carry out the LOC assessment with the LOC assessment tool. Since this is a new requirement placed on counties by a new state policy, Proposition 30 likely requires that the state provide funding. We recommend that the Legislature ask the administration for its rationale for not including funding for this component in its 2018-19 CCR budget proposal and to provide an estimate of this component's cost if it in fact warrants state funding.

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