LAO

60 YEARS OF SERVICE

2003-04 Analysis

MAJOR ISSUES

Health and Social Services

☑ **Realignment Proposal Has Merit, but Significant Issues Need to Be Resolved**

- The centerpiece of the administration's spending plan is a "realignment" of 12 percent of state General Fund program obligations, including a number of health and social services programs. Given the size and diversity of California, we think that realignment of some state programs could improve program outcomes. While the proposal has merit, there are a number of issues which the Legislature should consider in its review of the proposal (see page C-19 of this *Analysis* and "Part V" of the *2003-04 Budget: Perspectives and Issues).*

☑ **State Should Restructure Developmental Center (DC) System**

- As the number of residents of developmental centers continues to decline, the cost of care on a per resident basis is continuing to grow significantly. The Governor's budget proposes the closure of Agnews DC. We recommend that the state initiate the closure of two of the state's five DCs and address key issues pertaining to the future of the DC system (see page C-99).

☑ **Disease Management Could Reduce Medi-Cal Costs**

- Poor management of treatment for persons with chronic diseases, such as asthma, diabetes, and heart disease, is driving up the state's costs for Medi-Cal. Our analysis indicates that the implementation of a disease management program could eventually reduce state expenditures by as much as hundreds of millions of dollars annually (see page C-66).

Determining Who Is Eligible for Medi-Cal: Options for Savings

- The administration of eligibility rules is one of the most critical functions for the operation of Medi-Cal. Over the years, the state has had significant concerns about the increasing cost of these activities and the performance of counties in determining Medi-Cal eligibility. We offer alternative approaches to reforming the eligibility system (see page C-56).

State Should Assess Shift to Veterans Administration Benefits

- Federal survey data suggest that there could be tens of thousands of military veterans who could be receiving comprehensive medical services from the VA health care system but who are enrolled instead in Medi-Cal. If this data proved accurate, it is possible that the state could eventually save as much as $250 million annually by shifting eligible Medi-Cal beneficiaries to the VA system for their medical services (see page C-63).

Grant Reductions and COLA Suspensions Save $1.6 Billion

- Reducing CalWORKs and SSI/SSP maximum monthly grants by an average of 6.2 percent results in General Fund savings of $900 million compared to grant levels in 2002-03. Deleting the statutory cost-of-living adjustments in these programs results in further savings of $660 million compared to current law (see page C-153 and C-169).

CalWORKs Grants Overbudgeted By $350 Million

- The Governor's budget projects that the CalWORKs caseload will increase by 2 percent in 2002-03 and by 0.5 percent in 2003-04. However, the most recent data indicate that the CalWORKs caseload continues to decline. Based on our caseload projection, we estimate that the Governor's budget overstates CalWORKs costs by $350 million in federal TANF funds. We present options for the Legislature to convert these TANF savings into General Fund savings (see page C-152 and C-156).

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Health and Social Services

OVERVIEW

Health and Social Services

General Fund expenditures for health and social services programs are proposed to decrease by 34 percent in the budget year due primarily to the Governor's realignment plan. However, total state spending (General Fund plus special funds) for the budget year remains at about the current-year level as the cost to fund the realigned health and social services programs is shifted to special funds.

Beyond the realignment proposal, a variety of caseload and cost increases are largely offset by suspension of cost-of-living adjustments (COLAs) and grant reductions in social services programs and various specific health program reductions.

EXPENDITURE PROPOSAL AND TRENDS

Budget Year. The budget proposes General Fund expenditures of $15.1 billion for health and social services programs in 2003-04, which is 24 percent of total proposed General Fund expenditures. Figure 1 (see next page) shows health and social services spending from 1996-97 through 2003-04. The health and social services share of the budget as proposed would decline dramatically in the budget year. The budget proposal represents a General Fund decrease of $7.9 billion, or 34 percent, below the revised estimated expenditures in the current year. As we discuss below, this is due primarily to realignment of program funding responsibility from the state to the counties rather than to proposed changes in the level of program activity. Absent realignment, General Fund expenditures for these programs would have increased 1.1 percent.

The Governor's spending plan assumes a net increase in special funds expenditures of $7.5 billion in the budget year. This consists of an increase of $8 billion to fund realignment, partly offset by a decline in tobacco-related litigation settlement funds that had been set aside for the support of health programs. Because the *2002-03 Budget Act* relied upon

the sale of this stream of state revenue for a one-time gain in state revenues of $4.5 billion, the amount of tobacco settlement funds available for the support of health programs would decrease. The Governor's 2003-04 budget plan assumes the amount of revenues available (previously about $546 million) will decline to $220 million in the budget year and thereafter be unavailable for the support of health programs.

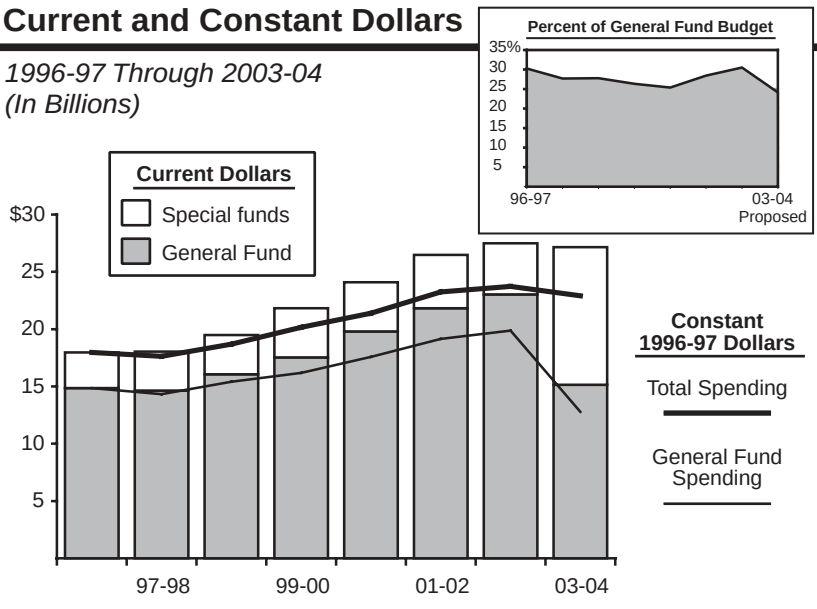
Historical Trends. General Fund support for health and social services programs has been growing steadily since 1996-97. This growth trend would largely be negated by the major reduction in General Fund spending for these programs proposed for 2003-04. Consequently, General Fund expenditures (current dollars) for health and social services programs in 2003-04 would be at about the same level as in 1996-97, as Figure 1 shows.

On a constant dollar basis, General Fund expenditures are estimated to decline by 14 percent during this period, an average annual decrease of 2.1 percent, again due almost entirely to the realignment proposal.

Figure 1

Health and Social Services Expenditures
Current and Constant Dollars

1996-97 Through 2003-04
(In Billions)



Although General Fund spending would decline sharply in 2003-04, total state spending actually increases in the budget year as the cost to fund the realigned health and social services programs is shifted to spe-

cial funds. Total state spending is projected to increase by about $9.2 billion, or about 51 percent, from 1996-97 through 2003-04. This represents an average annual increase of 6.1 percent. When combined state spending is adjusted for inflation, support for health and social services programs in constant dollars grows by almost 28 percent between 1996-97 and 2003-04. That represents an average annual growth rate of 3.5 percent.

CASELOAD TRENDS

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

Figure 2

Budget Forecasts Downturn in Medi-Cal Caseloads

1993-94 Through 2003-04
(In Millions)

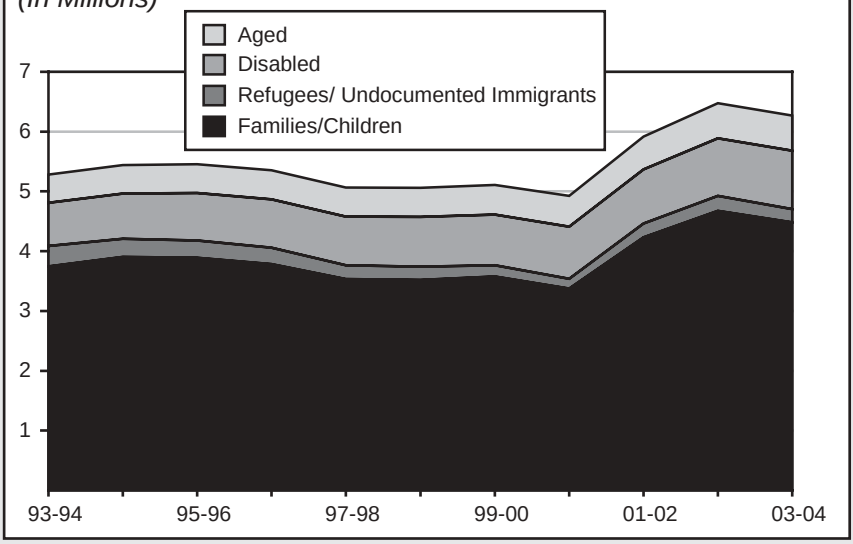
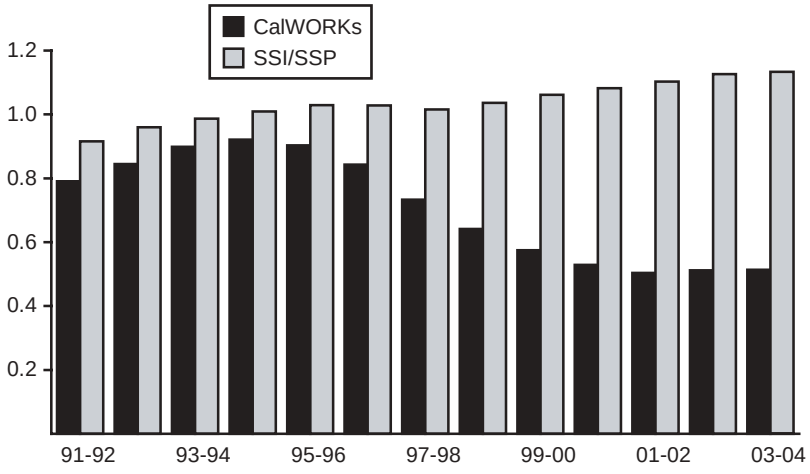


Figure 3

CalWORKs Caseload Decline Ending; SSI/SSP Caseloads Increasing Slightly

1991-92 Through 2003-04
(In Millions)



Medi-Cal Caseloads. As shown in Figure 2, the Governor's budget plan assumes that a significant decline in caseload will occur during the budget year in the Medi-Cal Program. Specifically, the overall caseload is anticipated to decrease by about 210,000 eligibles, or 3.3 percent, during 2003-04 compared to the estimated current-year caseload. This would reverse a trend of significant caseload growth in the program during the past couple of years.

The caseload projections for 2003-04 take into account the following Governor's proposals: (1) the proposed rescission of an expansion of health coverage for two-parent families earning up to 100 percent of the federal poverty level (FPL), (2) the proposed reinstatement of quarterly status reports for adults participating in the program, (3) the proposed rollback of an expansion of coverage for aged and disabled persons with income up to 133 percent of the FPL, (4) a step-up in efforts by county eligibility workers to remove ineligible persons on the Medi-Cal rolls, and (5) implementation of new procedures to help transfer children receiving immunization and screening services under the Child Health and Disability Prevention program into more comprehensive Medi-Cal coverage.

Healthy Families Caseload. The Governor's budget plan assumes that the caseload for the Healthy Families Program, which began enroll-

ing children in July 1998, will continue to grow at a significant rate. The budget provides for the enrollment of almost 100,000 additional children, a 15 percent increase in caseload, by the end of 2003-04. The Governor's January budget plan also indicates that a proposed major expansion of the program to parents in families earning up to 250 percent of the FPL would again be delayed, this time to July 2006, because of the state's fiscal problems.

The CalWORKs and SSI/SSP Caseloads. Figure 3 shows the caseload trend for CalWORKs and SSI/SSP. While the number of *cases* in SSI/SSP is greater than in the CalWORKs program, there are more *persons* in the CalWORKs program—about 1.4 million compared to about 1.1 million for SSI/SSP. (The SSI/SSP cases are reported as individual persons, while CalWORKs cases are primarily families.)

To the extent that caseloads increased in these two programs, it has been due, in part, to the growth of the eligible target populations. As Figure 3 shows, the CalWORKs caseloads increased through the early 1990s due to the recession, peaking in 1994-95. Then the caseloads declined steadily for several years, bottoming out in 2001-02, and the budget projects that they will increase slightly in 2002-03 and 2003-04. We note that the Governor's budget does not reflect the most recent actual figures (from the summer of 2002) which suggest that the caseload has started to decline again, though at a significantly lower pace than in the late 1990s. (Please see the "CalWORKs" section of this *Analysis* for a discussion of the caseload.)

As discussed in our annual *California's Fiscal Outlook* report, the CalWORKs caseload decline was due to various factors, including the improving economy, lower birth rates for young women, a decline in legal immigration to California, changes in grant levels, behavioral changes in anticipation of federal and state welfare reform, and, since 1999-00, the impact of the CalWORKs program interventions (including additional employment services). The administration believes that the pause in the caseload decline in 2001-02 can be attributed to (1) the downturn in the economy, (2) growth in the child-only component of the caseload, and (3) the likelihood that the remaining caseload with adults probably faces substantial barriers to employment.

The SSI/SSP caseload can be divided into two major components—the aged and the disabled. The aged caseload generally increases in proportion to increases in the eligible population—age 65 or older. This component accounts for about one-third of the total caseload. The larger component—the disabled caseload—grew significantly faster than the rate of increase in the eligible population group (primarily ages 18 to 64) in the early 1990s. This was due to several factors, including (1) the increas-

ing incidence of AIDS-related disabilities, (2) changes in federal policy that broadened the criteria for establishing a disability, (3) a decline in the rate at which recipients leave the program (perhaps due to increases in life expectancy), and (4) expanded state and federal outreach efforts in the program. In recent years, however, the growth of the disabled caseload has slowed.

In the mid-to-late 1990s, the total SSI/SSP caseload leveled off and actually declined in 1997-98, in part because of federal changes that restricted eligibility. Since March 1998, however, the caseload has been growing moderately, about 2 percent each year. The administration's proposed 6.2 percent grant reduction results in about 15,000 persons, who were receiving grants under $50 per month, being removed from the caseload. Thus, for 2003-04, caseload growth is projected to be 0.7 percent rather than the typical annual growth of 2 percent.

SPENDING BY MAJOR PROGRAM

Figure 4 shows expenditures for the major health and social services programs in 2001-02 and 2002-03, and as proposed for 2003-04. As shown in the figure, three major benefit payment programs—Medi-Cal, CalWORKs, and SSI/SSP—account for a large share of total spending in the health and social services area.

As discussed earlier, much of the reduction in General Fund spending shown in Figure 4, such as the 34 percent drop in expenditures for the Medi-Cal Program, results from the Governor's realignment proposal. General Fund spending for In-Home Supportive Services, Foster Care, and the Child Welfare Services programs would have increased but for the proposal to shift program responsibilities and funding to counties. General Fund support for the Department of Developmental Services (Regional Centers and community services), which is unaffected by realignment, would grow more than any other major health or social services program under the Governor's budget plan.

Figure 4

Major Health and Social Services Programs Budget Summary[a]

(Dollars in Millions)

	Actual 2001-02	Estimated 2002-03	Proposed 2003-04	Change from 2002-03	
				Amount	Percent
Medi-Cal					
General Fund	$9,740.9	$10,597.1	$7,005.5	-$3,591.6	-33.9%
All Funds	26,556.9	28,811.0	24,139.7	-4,671.3	-16.2
CalWORKs					
General Fund	$2,016.4	$2,082.1	$1,603.8	-$478.3	-23.0%
All Funds	5,459.8	5,998.6	5,172.2	-826.4	-13.8
AFDC-Foster Care					
General Fund	$432.3	$446.9	—	-$446.9	-100.0%
All Funds	1,566.3	1,636.1	$1,688.6	52.5	3.2
SSI/SSP					
General Fund	$2,793.2	$3,013.2	$2,316.9	-$696.3	-23.1%
All Funds	7,153.8	7,540.5	7,124.8	-415.7	-5.5
In-Home Supportive Services					
General Fund	$854.9	$1,057.5	$15.8	-$1,041.7	-98.5%
All Funds	2,291.5	2,838.4	3,152.8	314.4	11.1
Regional Centers/Community Services					
General Fund	$1,342.1	$1,448.0	$1,573.7	$125.7	8.7%
All Funds	2,106.8	2,259.7	2,536.7	277.0	12.3
Developmental Centers					
General Fund	$344.9	$359.1	$361.0	$1.9	0.5%
All Funds	624.7	655.6	655.1	-0.5	-0.1
Healthy Families					
General Fund	$141.3	$29.2	$83.6	$54.4	186.3%
All Funds	547.8	701.4	809.7	108.3	15.4
Child Welfare Services					
General Fund	$600.2	$624.6	$68.9	-$555.7	-89.0%
All Funds	1,853.1	1,963.9	2,078.2	114.3	5.8
Children and Families First Commission					
General Fund	—	—	—	—	—
All Funds	$788.7	$740.5	$572.0	-$168.5	-22.8%
Child Support Services					
General Fund	$442.7	$465.0	$470.2	$5.2	1.1%
All Funds	1,125.4	1,182.2	1,164.4	-17.8	-1.5

[a] Excludes departmental support.

MAJOR BUDGET CHANGES

Figures 5 and 6 (see page C-16) illustrate the major budget changes proposed for health and social services programs in 2003-04. (We include the federal funds for CalWORKs because, as a block grant, they are essentially interchangeable with state funds within the program.) Most of the major changes can be grouped into five categories: (1) funding caseload changes, (2) suspending COLAs, (3) grant and rate reductions, (4) the Governor's realignment proposal, and (5) adoption of other policy and structural changes in programs.

Caseload Changes. The budget funds caseload growth in SSI/SSP, the Healthy Families Program, and CalWORKs. The budget reflects projected caseload increases of 0.7 percent in SSI/SSP, 0.5 percent in the CalWORKs program, and 15 percent in the Healthy Families Program. The budget also reflects a 3.2 percent reduction in the caseload of the Medi-Cal Program.

Cost-of-Living Adjustment Suspensions and Grant Reductions. The budget proposes to suspend statutory COLAs for CalWORKs, SSI/SSP, and does not provide the discretionary COLA for Foster Care and related programs. Similarly, the budget proposes no inflation adjustment for county administration of CalWORKs, Foster Care, Food Stamps, and Child Welfare Services. In addition to the COLA suspensions, the budget achieves significant savings from 6.2 percent grant reductions in SSI/SSP and CalWORKs.

The Governor's Realignment Proposal

The Governor's budget proposes a realignment plan to shift a total of $8.2 billion in program costs, including a substantial portion of current health and social services, to the counties along with the revenues to support them.

Specifically, in social services, the Governor proposes to shift $3.5 billion in program costs to the counties. With the exception of the CalWORKs program discussed below, the Governor proposes to realign 100 percent of most current state social services program costs to the counties. The current county shares for these programs range from 0 percent to 60 percent. With respect to CalWORKs, counties now have a fixed responsibility (about 21 percent) of CalWORKs administration and no share of cost for Employment Services. Under the realignment proposal, counties would have a 50 percent share for these two CalWORKs program components.

Figure 5

Health Services Programs
Proposed Major Changes for 2003-04
General Fund

Medi-Cal	**Requested:**	**$7.0 billion**	
	Decrease:	**$3.6 billion**	**(-34%)**

+ $395 million for increases in base program enrollment, plus $118 million for implementing various recent changes in eligibility procedures

+ $235 million to offset the loss of tobacco settlement funds

+ $113 million for increased support for county eligibility activities, with $194 million in offsetting savings from disenrolling ineligible persons

+ $54 million for increased premium costs for Medicare and Medicare HMOs, and $32 million for expansion of Adult Day Health Care

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– $3 billion from the realignment of: long-term care ($1.6 billion), and 15 percent share of benefit costs ($1.4 billion)

– $630 million from reducing rates for physicians, nursing homes, and certain other providers by 15 percent

– $299 million by eliminating specified optional services for adults

– $166 million in additional savings from antifraud activities

– $112 million from tightening eligibility rules for working poor families and $64 million by doing so for aged and disabled persons

– $80 million by restoring quarterly status reports for adults

Department of Developmental Services	**Requested:**	**$2 billion**	
	Increase:	**$131 million**	**(+7.2%)**

+ $205 million for Regional Center increases in caseload, cost, and utilization

– $100 million from establishing statewide standards for the purchases of services in Regional Centers

Figure 6

Social Services Programs
Proposed Major Changes for 2003-04
General Fund

CalWORKs	**Requested:**	**$1.6 billion**
	Decrease:	**-$478 million (-23%)**

+ $66 million to fulfill the remaining Welfare-to-Work match obligation
+ $114 million for welfare-to-work services

– $547 million from realigning 50 percent of administration and services costs to counties
– $238 million from a 6.2 percent grant reduction
– $252 million cost avoidance by deleting the June and October 2003 statutory COLAs

SSI/SSP	**Requested:**	**$2.3 billion**
	Decrease:	**-$696 million (-23%)**

+ $55 million for caseload increase

– $662 million from a 6.2 percent grant reduction
– $95 million from realigning the state-only program for immigrants to the counties
– $372 million cost avoidance by not providing the June 2003 and January 2004 statutory state COLAs

In-Home Supportive Services	**Requested:**	**$16 million**
	Decrease:	**-$1 billion (-99%)**

+ $71 million for caseload increase
+ $38 million for higher wages for certain providers

– $1.2 billion from realigning virtually all nonfederal program costs to the counties

The Governor's realignment plan would also achieve $3.4 billion in General Fund savings by shifting health programs to counties. Counties, which now generally do not share in the cost of Medi-Cal health programs, would have a 15 percent share of the cost of benefits. In addition, the entire nonfederal share of the cost of providing nursing home care under Medi-Cal would be shifted to counties as part of a larger realignment of long-term care programs. The administration proposal would also move to the counties a number of "safety net" public health programs to support clinics and indigent care, certain categorical mental health programs, as well as Drug Medi-Cal and other substance abuse treatment programs supported from the General Fund.

For a complete discussion of the Governor's Realignment proposal, please see "Part V" of *The 2003-04 Budget: Perspectives and Issues.*

Other Policy and Structural Changes in Programs

Medi-Cal. The spending plan proposes a significant increase in resources—about $36 million in state funds in the current fiscal year, and an additional $113 million increase in 2003-04—for county eligibility activities. The administration indicates that part of these funds will be used to disenroll a total of 560,000 ineligible Medi-Cal recipients at a savings to the state in 2003-04 of $194 million.

The spending plan also includes a number of significant program cuts. These include a 15 percent reduction in provider rates primarily affecting physicians and nursing homes; the elimination of certain optional services for adults, such as dental care and optometry; rollbacks of expansions of coverage to the working poor and aged and disabled; and tightening of program eligibility rules through the reinstatement of quarterly status reports for adult beneficiaries. The Governor's budget also would establish a new tax on intermediate care facilities as a mechanism to draw down additional federal support. Further savings from antifraud activities are also assumed in the spending plan.

Department of Developmental Services. The budget plan proposes to achieve $100 million in General Fund savings by establishing statewide standards for the purchase of services for the developmentally disabled. Additional General Fund reductions would be achieved by shifting more support for Regional Centers to federal funds and establishing fees for some parents of children receiving services.

Other Health Programs. Significant reductions are proposed in a variety of public health programs, including establishment of copayments for individuals participating in the AIDS Drug Assistance Program, reforms in the operation of the Genetically Handicapped Persons Program, and reductions in support for certain health research activities. A major increase in General Fund support would be provided for mental health services for Medi-Cal children. Also, the Governor would raise $4.5 million a year by imposing a surcharge on various medical licenses to pay for various medical training programs.

Restructuring Proposals. The Governor has several proposals to restructure health and social services programs. The budget proposes to shift the habilitation services program from the Department of Rehabilitation to the Department of Developmental Services. The Department of Community Services and Development would be eliminated and the operation of its federal programs transferred to the Department of Social Services. Similarly, the Emergency Medical Services Authority would become part of the Department of Health Services (DHS). Domestic violence programs administered by the Office of Criminal Justice Planning would also be consolidated into DHS. The Governor would also initiate steps to close the Agnews Developmental Center.

CROSSCUTTING ISSUES

Health and Social Services

REALIGNMENT

REALIGNMENT PROPOSAL AFFECTS HEALTH AND SOCIAL SERVICES PROGRAMS

The centerpiece of the administration's spending plan is a "realignment" of 12 percent of state General Fund program obligations, including a number of health and social services programs. Given the size and diversity of California, we think that realignment of some state programs could improve program outcomes. For this reason, we think that realignment merits consideration by the Legislature. To assist the Legislature in its review, we identify factors for the Legislature to weigh in considering which programs would benefit from realignment. Using these factors, we identify other programs meriting consideration.

The Governor's realignment proposal, and our discussion of alternative programs for realignment, pertains to the following departments within the Health and Human Services Agency:

- Aging
- Alcohol and Drug Programs
- Health Services
- Mental Health
- Social Services

Our analysis of the Governor's proposal can be found in "Part V" of *The 2003-04 Budget: Perspectives and Issues.*

CALIFORNIA CHILDREN'S SERVICES

MISSED OPPORTUNITIES FOR GENERAL FUND SAVINGS IN THE CCS PROGRAM

The California Children's Services (CCS) program provides medical treatment and therapy services to eligible children and young adults under 21 years of age with certain debilitating medical conditions or major traumatic injuries. Our analysis indicates that the CCS program is missing opportunities to control increasing costs and preserve General Fund resources that could help address the state's fiscal problems. Specifically, we found that CCS is not taking full advantage of available federal funds, that some CCS costs could appropriately be funded under Proposition 98, that some state reimbursement practices have created incentives for expensive inpatient care, and that the state lacks data that could be used to help prevent program overspending.

Background

Services Provided

Two Major Components. The California Children's Services (CCS) program provides diagnostic and treatment services, medical case management, and medical and occupational therapy services to eligible children and young adults under 21 years of age. The CCS program, which is administered by the state Department of Health Services (DHS), has two major components. The first provides medical case management and payment of treatment and diagnostic services (which we refer to later as the CCS treatment program), while the second provides school-based physical and occupational therapy services through what is called the Medical Therapy Program (MTP).

Eligibility Rules

The administration estimates that by June 2004 the total CCS caseload will be about 178,380 children. To be eligible for CCS, a child must meet both income and medical eligibility requirements and also be a permanent resident of the county in which an application for the child is filed.

Income Eligibility. The initial diagnostic and evaluation services to determine the presence of a CCS-eligible condition are available to families free of charge regardless of family income, as are MTP services. However, to be eligible for CCS medical treatment services, the child's family generally must have an adjusted gross income of no more than $40,000. Children in families with a higher income may also be eligible if expenses for treating the CCS-related medical condition exceed 20 percent of family income.

Children enrolled in the Medi-Cal and Healthy Families Programs are deemed to automatically meet income eligibility requirements for CCS. About 75 percent of the children receiving treatment services, or about 134,080 CCS clients, are estimated to be enrolled in both CCS and Medi-Cal and an estimated 13 percent are enrolled in both CCS and the Healthy Families Program.

Medical Eligibility. In order to receive CCS services, a child must also have a qualifying medical condition. These conditions include serious birth defects, disabling injuries, certain nervous system diseases, blood diseases, some types of cancer, certain types of heart conditions, and HIV infection. Medical eligibility for CCS treatment services and the MTP differ. A child receiving CCS treatment services may not necessarily be eligible for the MTP. The MTP only serves children with conditions that could benefit from therapy services.

Benefits

The CCS program is not a comprehensive health insurance program, but instead is intended to provide medical, therapy, and case management services related to a child's specific qualifying condition. In addition, the CCS program will only pay for medical services provided by a CCS-approved provider. Program benefits include diagnostic and treatment services, case management, and school based therapy.

Program Funding Structure

The CCS program is funded with state General Fund, federal funds, county funds, and a small amount of enrollment and assessment fees.

Medi-Cal Enrollees (CCS/Medi-Cal). For these enrollees, the federal government pays about 50 percent of the cost of medical treatment services, with the state General Fund paying the remaining 50 percent. As regards MTP services, federal funds finance half the costs with the state and counties each paying about half of the remaining costs.

Healthy Families Enrollees. For these enrollees, the federal government pays about 65 percent of the costs of treatment services, with the remaining 35 percent split equally between the state and counties. The MTP component of the CCS program does not bill for services provided to children enrolled in the Healthy Families Program.

State-Only Program. The state and counties each pay about 50 percent of the cost of treatment and MTP services for children who are enrolled in the CCS program and who are not identified as being enrolled in Medi-Cal or the Healthy Families Program. This is often referred to as the "state-only" CCS program because no matching federal funds are used to provide services for these children.

The Budget Proposal

State-Only Program Budget. As Figure 1 shows, the Governor's budget proposes to spend about $69 million from the General Fund ($141 million all funds) on the state-only component of CCS in 2003-04, a small decrease from estimated current-year expenditures.

Within the state-only program, medical treatment costs are estimated to decrease 6 percent while MTP costs are estimated to grow by 3 percent. County administrative costs within the state-only component of CCS are anticipated to account for $19.5 million in expenditures, about 14 percent of program costs, about the same amount as in the previous year.

CCS/Medi-Cal Budget. At the time this analysis was prepared, the DHS indicated it was not able to estimate the amount that would be spent from within the Medi-Cal budget for CCS program services in 2003-04. However, based upon historical data, we estimate that Medi-Cal expenditures for CCS services would be about $614 million from the General Fund ($1.2 billion all funds) in the budget year. Of this sum, we estimate that less than 1 percent of total expenditures (about $3.5 million from the General Fund) would be for MTP services.

CCS/Healthy Families Program Budget. The Governor's budget proposes to spend about $9 million from the General Fund ($47 million all funds) for CCS medical treatment services for children enrolled in the Healthy Families Program. This is about a 4 percent increase in estimated spending from the previous year.

Figure 1

Projected CCS Expenditures

(In Thousands)

	2002-03	2003-04
CCS-State Only		
Treatment services	$62,298	$58,704
Medical therapy program	61,228	63,187
County administration	19,336	19,534
Totals	**$142,862**	**$141,425**
General Fund	$71,474	$69,491
County funds	$66,184	$61,530
Federal funds	$4,704	$4,704
Enrollment fees[a]	$500	$5,700
CCS/Healthy Families		
Treatment services	$45,404	$47,056
Totals	**$45,404**	**$47,056**
Federal funds	$29,626	$30,586
General Fund	$8,678	$9,059
County funds	$7,100	$7,411
CCS/Medi-Cal[b]		
Treatment services	$1,066,911	$1,220,466
Medical therapy program	6,455	7,120
Totals	**$1,073,366**	**$1,227,586**
Federal funds	$536,683	$613,793
General Fund	$535,069	$612,013
County funds	$1,614	$1,780

a Includes reimbursements and enrollment fees.

b LAO estimate based on historical data.

State Has Missed Opportunities to Save General Fund

Caseload and Costs Continue to Rise

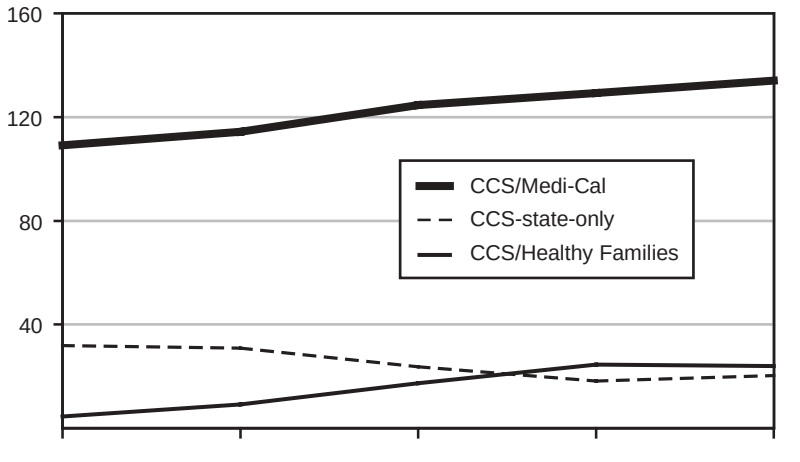
Significant growth in overall cost and caseload have occurred in both the Medi-Cal and state-only components of CCS.

Caseload Trends. Figure 2 shows the CCS caseload trends since 1999-00. During this period of time, the CCS / Medi-Cal caseload has grown at an average annual rate of about 14 percent, while the CCS state-only caseload has decreased at an average annual rate of about 8 percent. This decrease in the state-only program is primarily due to a corresponding increase in the CCS caseload enrolled in Healthy Families.

Figure 2

CCS Caseload Continues to Grow

1999-00 Through 2003-04
(In Thousands)



At the time this analysis was prepared, data on the number of Healthy Families enrollees being served by the CCS program were available for the years 1999-00 through 2001-02, but not for subsequent years. Based upon this information, we estimated the caseload for the current and budget years. The upward trend in the CCS / Healthy Families caseload appears to be consistent with the rapid growth in the Healthy Families Program, which began operation in 1998-99.

Adding the CCS-state only and the Healthy Families caseloads together, the non-Medi-Cal caseload has grown by an average of 6 percent annually in this time period.

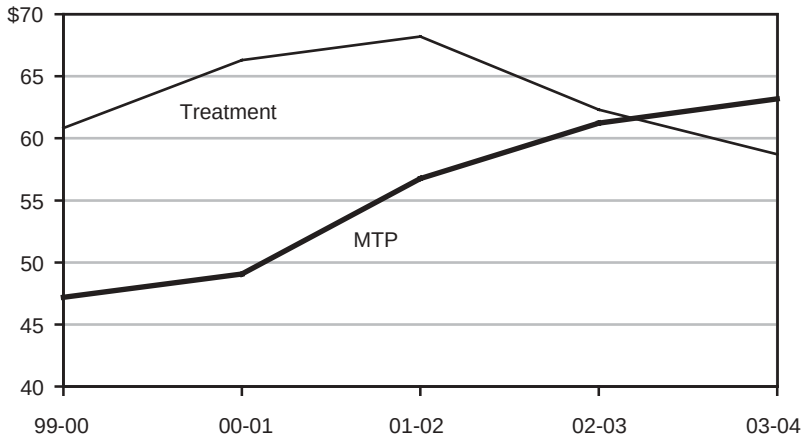
Expenditure Trends. Because we do not have updated expenditure estimates for CCS / Medi-Cal from DHS, Figure 3 focuses on expenditure trends for the CCS-state only caseload since 1999-00. Notably, during this

five-year period, the growth in expenditures for MTP services has continued to outpace growth in treatment services for CCS-state only enrollees. During this time period, expenditures for MTP services have grown at an average annual rate of 9 percent, while spending for treatment services has grown at an average annual rate of about 2 percent.

Figure 3

MTP Costs Rise as Treatment Costs Decrease In CCS-State Only Program

1999-00 Through 2003-04
(In Millions)



Ramifications of These Trends. The growth in CCS caseloads and costs appears to be due to several factors. One key factor is the expansion of the number of children enrolled in recent years in the Healthy Families and Medi-Cal Programs, which has resulted in increased identification of children eligible for CCS services. Expansion of medical therapy services to children in special education programs and medical inflation have also increased costs. Increases in the rates paid to CCS providers which took effect in 1999 and 2000 also played a role by encouraging them to identify additional CCS children who could receive CCS treatment services and to bill CCS for these services.

The growth in CCS caseloads and costs emphasizes the need for the state to evaluate cost control measures, or to at least slow the further increase in these costs in ways that will not undercut the provision of health care for some of the state's most medically fragile children.

CCS Not Taking Advantage of Available Federal Funds

Our analysis indicates that, in a number of different ways, the state is failing to take advantage of available federal funds, resulting in additional state General Fund costs of more than $6 million. We discuss these findings in more detail below.

Healthy Families Children Not Being Identified. Our analysis indicates that there may be as many as 5,000 additional children in the CCS medical treatment program who are enrolled or eligible for Healthy Families. The state may be spending about $3 million more annually from the General Fund for CCS treatment services than necessary for these children.

In addition, we estimate that the state could save as much as $2 million annually beginning in 2003-04 if it began to identify children in MTP who could be in the Healthy Families Program. Currently, MTP does not identify such children. If the state did so, it could reduce its share of cost of the services provided to these children from the current 50 percent to 17.5 percent.

We would also note that the failure to enroll CCS children in Healthy Families also means that the state is missing another opportunity—the chance to provide them with more comprehensive medical care. The Healthy Families Program provides a comprehensive package of health care services, including dental and vision care, while the CCS program only covers those specific services that address a child's CCS-eligible condition.

Duplicative Services at Regional Centers. Our analysis indicates that some of the community services provided through the Regional Centers (RCs) under the direction of the Department of Developmental Services could be provided through the CCS program. Providing services through CCS could reduce state cost because RC services are funded entirely with General Fund while CCS receives federal and county funds.

Developmentally disabled individuals receive case management from the 21 RCs located throughout the state. The RCs are statutorily required to exhaust all available public resources, such as the CCS program, before purchasing services through its own contractors using state General Fund resources. However, after a child has been determined to be eligible for services, RCs have only 60 days under state law to establish a start date for services. If CCS is unable to complete intake for a child within that 60-day period, an RC may then opt to pay its own vendor for services rather than wait for CCS to complete its intake process. This situation results in RCs paying for services using General Fund resources

that could instead be provided through CCS with a county and federal share of cost.

The available data suggest the General Fund impact could be significant. During 2001-02 (the last fiscal year for which data were available), RCs spent $10.7 million for physical and occupational therapy services similar to the services offered by MTPs. As many as 15 percent of the children receiving these services through the RCs may be eligible for services provided through the MTP. The caseload data suggest that providing the services through CCS instead of RCs could save the state about $1.2 million in General Fund annually.

Some MTUs Not Certified as Medi-Cal Providers. The state may be missing an additional opportunity to offset state General Fund support provided to children for medical therapy services. Medical therapy services are provided in school-based medical therapy units (MTUs).

In order to receive federal Title XIX funds under the Medi-Cal Program, an MTU must be certified as an outpatient rehabilitation center. Currently, 18 of the 107 MTUs statewide are not certified, and therefore are unable to bill Medi-Cal for the services they provide to CCS children. As a result, each visit to one of these 18 MTUs is paid for entirely by the counties and the state.

The DHS was unable to provide information regarding how many MTU therapy visits are conducted annually by those MTUs that are not certified as rehabilitation centers. Nor was DHS able to document the cost of a typical MTU visit. As a result, we were not able to estimate the loss of federal funds and the resulting additional cost to the state for medical therapy services provided through uncertified MTUs. Given the caseload and cost of such services, however, we believe the fiscal impact on the counties and the state could be significant.

Missed Opportunities in Use of General Fund Resources

In addition to the lost opportunities to recoup federal funds, our analysis indicates that there may be other alternatives in the way the CCS program is being funded and operated.

CCS Providing Education Services. Our analysis indicates that some medical therapy services provided under the CCS program could appropriately be considered to be educational in nature and thus could be provided within the Proposition 98 funding guarantee.

Under Proposition 98, a portion of state revenues must be dedicated each year for the support of educational programs. Our analysis indicates that it would be possible to shift part or all of the General Fund cost

of these CCS services to Proposition 98, thus permitting a net reduction in non-Proposition 98 General Fund expenditures. Because we forecast greater growth in the Proposition 98 minimum guarantee than the administration for 2003-04, the Legislature could use this option to meet the higher Proposition 98 minimum guarantee for education spending without increasing General Fund expenditures. These savings presume that the Legislature (1) does not over-appropriate the minimum guarantee, and (2) does not adjust the minimum guarantee to reflect the transferring of CCS into Proposition 98. The State Constitution is silent on adjusting the minimum guarantee to reflect new responsibilities shifted to school districts.

We have been advised that the school-based medical therapy services could be considered an education program supported by Proposition 98. While therapists and other MTU employees are employed by the county, school districts typically donate the building space and other "overhead" expenses. The budget proposes to spend $37 million in General Fund resources for MTP services in 2003-04. We believe that these services could be funded with Proposition 98 General Fund.

Billing Problems. Our analysis indicates that county billing practices for medical therapy services may be resulting in the state foregoing federal funds and spending additional General Fund resources for these services.

Data we have reviewed indicate that the amount of claims being billed to Medi-Cal for MTP services is significantly lower than expected, given the size of the CCS enrollment and other factors. This discrepancy could be the result of counties' submitting eligible claims to the state under the CCS-state only program rather than as required under CCS program rules to Medi-Cal. The low level of Medi-Cal billings could also partly be the result of counties' use of vendors to provide CCS services. The DHS indicates that services provided by vendors cannot be billed to Medi-Cal.

We were unable to obtain data from DHS that would allow us to determine exactly why the discrepancy in Medi-Cal billings exists or the potential loss to the state due to this situation. Given the size of the Medi-Cal / CCS caseload and costs of the program, we believe that cost to the state General Fund resulting from these problems could be significant.

Billing Process Creates Incentives for Expensive Inpatient Care. Our analysis indicates that the way the state reimburses CCS providers for medical treatment services creates an unintended incentive for them to provide care in expensive inpatient settings instead of less costly outpatient settings.

Advances in medical treatment have enabled physicians to deliver services in outpatient settings where they once could be provided only on an inpatient basis. However, CCS providers have reported that the opposite is sometimes occurring for CCS patients. For example, due to reimbursement policies and procedures, sometimes higher reimbursement rates are paid for treatment of similar conditions when provided in hospitals as compared to treatment provided in an outpatient setting. In addition, providers indicate that they are sometimes able to get more timely approval for inpatient services. Families also report experiencing longer waiting periods for outpatient care for CCS children than if they obtain the same services from hospitals.

As a result, the state is probably spending more than necessary for the provision of some CCS services. While these additional costs are unknown, they are probably significant.

Program Lacks Protections Against Overspending. Our analysis suggests that an inadequate system of data reporting and analysis is creating a risk of overspending within the CCS program.

As the program is currently operated, counties provide minimal information to DHS about CCS clients and the services they utilize. This lack of data makes it difficult for the state to monitor important program trends such as the utilization of CCS services, the cost of those services, enrollee characteristics, the availability of private insurance to offset the cost of CCS services, or provider enrollment patterns. Each of these measures is a standard data component commonly collected for other health programs to protect against program overspending.

There is also a lack of current data regarding CCS / Medi-Cal caseload and costs. While the delivery of CCS / Medi-Cal services to children is "carved-out" from the regular Medi-Cal program, the budget for these services is folded into the DHS Medi-Cal budget. However, DHS does not regularly track overall CCS costs as a distinct part of the Medi-Cal budget. The state therefore lacks basic information on projected costs, service utilization, and other factors necessary for effective program oversight, even though Medi-Cal-eligible children constitute 75 percent of the total CCS caseload.

The lack of information creates a significant fiscal risk to the state. For example, the DHS has advised us that a significant percent of CCS enrollees receive services through relatively expensive Special Care Centers. However, CCS was unable to provide even basic utilization or expenditure data about these centers. As a result, it is not possible now to track changes in the utilization of Special Care Center services to ensure that utilization is appropriate and costs are being controlled.

After encountering significant delays, the DHS is now planning the implementation of a new data system, known as CMS Net, that could eventually address some of these concerns. However, it is not clear that the data that would be collected in the new system will provide all of the tools needed to ensure the appropriate tracking of costs to protect the state against overspending.

Maximizing the State's Opportunity to Improve CCS

We recommend that the Legislature consider taking a number of steps to improve the operation of the California Children's Services program that could free-up as much as $43 million in General Fund resources in the budget year.

We recommend that the Legislature consider a series of actions that could reduce state costs for the CCS program and free-up General Fund resources. Figure 4 outlines the opportunities for cost savings which we have identified in this program. Our analysis suggests that these actions would not harm the state's program to assist some of its most medically fragile children, and could improve the care available to some CCS children. Each of these actions are discussed below.

Figure 4

Reforming CCS:
Potential 2003-04 General Fund Savings

(In Millions)

Summary of Recommendations	
Require counties to screen for Healthy Families eligibility	$5
Shift care from regional centers to CCS	1
Require all MTUs to be certified as outpatient rehabilitation centers	Unknown
Shift medical therapy costs to Proposition 98	37
Investigate county billing practices	Unknown, but significant
Create greater incentives for outpatient care	Unknown
Require additional data collection	Unknown
Total	**At least $43**

Require Counties to Screen for Healthy Families Eligibility. We recommend that the Legislature change state law to require counties to en-

roll those CCS children who are eligible into the Healthy Families Program. Counties could be required to screen for eligibility in much the same way they are already required to do so for children who are eligible for enrollment in Medi-Cal. Implementation of this change could result in net savings to the state General Fund (after the state cost of Healthy Families coverage has been taken into account) of as much as $5 million annually beginning in 2003-04.

Shift Care From RCs to CCS We recommend that DHS and DDS be directed to report to the Legislature by December 2004 regarding: (1) how RC and CCS intake procedures could be streamlined to facilitate the timely provision of CCS services to eligible children who are developmentally disabled, (2) the state fiscal effect of shifting services now paid for by RCs to CCS, (3) an estimate of the number of developmentally disabled children currently eligible for CCS services but who are receiving services through the RCs other providers, and (4) recommendations for improving intake into CCS for RC clients and to reduce state costs for these services. We therefore recommend adoption of the following supplemental report language:

> The Department of Health Services (DHS), in consultation with the Department of Developmental Services, shall report to the Chair of the Joint Legislative Budget Committee and the chairs of the fiscal committees of both houses of the Legislature, information regarding the effect of California Children Services (CCS) intake practices on Regional Center (RC) clients. The DHS report shall include, but not be limited to, (a) an evaluation of the time required for CCS to complete its intake assessment of RC referrals and to commence the provision of services once an RC client is deemed eligible; (b) the number of RC clients currently receiving services from other providers who could instead be receiving those same services through CCS; (c) the expenditures by RCs for the purchase of services that could instead be obtained through CCS; (d) its recommendations, if any, regarding how CCS and RC intake practices could be improved to ensure the timely provision of services to RC clients and to reduce state costs for the provision of these services. The department's findings shall be reported to the Joint Legislative Budget Committee and the fiscal and policy committees of both houses of the Legislature by December 1, 2004.

Require All MTUs to Be Certified as Outpatient Rehabilitation Centers. The Legislature may wish to consider changing state law to require that all existing and new MTUs to be certified as outpatient rehabilitation centers, thereby enabling them to bill Medi-Cal for therapy services. The DHS indicates that it does not collect data regarding the number of visits to uncertified MTUs and the cost per visit. As a result, the extent to which this option would result in cost savings is unknown.

Shift Medical Therapy Costs to Proposition 98. The Legislature may wish to consider changing state law to enable the shift of part or all of the state's General Fund cost of the MTP to Proposition 98, thus permitting a net reduction in non-Proposition 98 General Fund expenditures. Adoption of this option would shift funding for these services from the CCS program to the California Department of Education but would not result in any significant operational change in the program. Since we forecast a higher minimum guarantee than the Governor, shifting CCS to Proposition 98 would help the state meet the minimum guarantee without additional spending. Consequently, the state could save $37 million General Fund. These savings only occur if the Legislature (1) does not over-appropriate the minimum guarantee, and (2) does not adjust the minimum guarantee to reflect the program transfer.

Investigate County Billing Practices. The Legislature should request the Bureau of State Audits (BSA) to conduct an audit to examine whether counties are appropriately billing the state under Medi-Cal for medical therapy services provided to CCS children. The BSA should further be requested to specifically report on the fiscal impact of any such billing errors and possible steps to remedy and prevent any further billing errors, if they are occurring. Accordingly, we recommend the Legislature adopt the following supplemental report language:

> It is the intent of the Legislature that the Bureau of State Audits (BSA) review county billing practices for the California Children's Services (CCS) program to determine whether medical therapy services are being appropriately billed under the Medi-Cal Program. The BSA may review what it deems to be a representative sample of county billings for CCS medical therapy services in conducting its review. It is the further intent of the Legislature that BSA report to the Legislature by December 1, 2003 the results of its review, along with its recommendations, if any, for improvement of CCS program rules to ensure that county billing practices minimize state costs for the provision of these services. The report shall be provided to the Chair of the Joint Legislative Budget Committee and the chairs of the fiscal committees of both houses of the Legislature.

Create Greater Incentives for Outpatient Care. The Legislature may wish to consider directing DHS to review the way the CCS program reimburses certain medical treatment services that could be accomplished at less cost in an outpatient setting. Specifically, the DHS should be directed to monitor the outcome of a study now being conducted by the Los Angeles Children's Hospital that will compare the medical outcomes and costs of treating CCS children with certain medical conditions in either a hospital or an outpatient setting. If it were to be determined that some medical conditions could be treated as effectively in less costly out-

patient settings without harm to patients, the Legislature may wish to consider implementing a pilot project to change the CCS billing system in a way that encourages a less costly medical approach to treatment. The DHS has already initiated discussions with CCS providers regarding this issue.

Accordingly, the Legislature may wish to consider the adoption of the following supplemental report language:

> It is the intent of the Legislature that the Department of Health Services (DHS) shall examine whether California Children's Services (CCS) are unnecessarily being provided in expensive inpatient settings if these same medical conditions could be appropriately treated at less cost in outpatient settings. The DHS shall also recommend what steps, if any, are warranted to change state reimbursement to providers to address this problem. The DHS shall report its findings on this matter by December 1, 2004 to the Chair of the Joint Legislative Budget Committee and the chairs of the fiscal committees of both houses of the Legislature.

Require Additional Data Collection. The Legislature may wish to consider changing state law to require DHS, in consultation with county CCS programs and providers, to collect additional CCS program data that could protect the state from potential overspending. One option would be to require county MTPs to submit a quarterly report providing additional information regarding CCS clients and the services provided to them. The DHS could be further directed to use these additional data to better analyze CCS utilization and expenditure trends and provider participation patterns, to develop better cost containment policies, and to provide better service to CCS clients.

There would be some cost to the state from imposing additional reporting requirements on counties because existing reporting forms would have to be modified to collect this information. Given these potential additional costs, the Legislature may want to implement this change once the state's fiscal situation has improved.

DEPARTMENTAL ISSUES

Health and Social Services

DEPARTMENT OF AGING (4170)

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

The budget proposes total expenditures of $181.8 million, a reduction of $2.2 million (1.2 percent) compared to estimated expenditures in 2002-03. While total spending remains relatively flat, the Governor's budget proposes to reduce General Fund support by $6.4 million (17 percent), down to a total of $31.9 million. This 17 percent savings is primarily due to reductions in nutrition programs and special projects (Respite Registry, Brown Bag programs, Foster Grandparent, and Senior Companions).

Consolidate All Aging Programs In the Department of Social Services

The California Department of Aging (CDA) and the Department of Social Services (DSS) operate programs that support the state's senior population. In order to improve program operation, we recommend eliminating the CDA and shifting departmental functions to DSS. By eliminating 37 positions, this consolidation results in net savings of $3,419,000 ($908,000, General Fund). (Reduce Item 4170 by $31,910,000 for state operations and local assistance, and increase Item 5180 by $31,002,000 for state operations and local assistance.)

Two Departments With Overlapping Missions. As described above, the CDA provides many services to the state's senior citizens. These include nutrition programs, supportive services, employment services, and preventive health services. The CDA administers federal Older Americans Act programs for supportive services, in-home services, and nutrition. The CDA contracts with, and provides guidance to 33 Area Agencies on Aging (AAAs). The AAAs coordinate and deliver services to senior citizens at the community level.

The DSS also operates several programs that serve older Californians, including the Supplemental Security Income / State Supplementary Program (SSI / SSP), the In-Home Supportive Services program (IHSS), and the Adult Protective Services program. These programs are housed within DSS's Disability and Adult Programs Division. With the exception of SSI / SSP, these services are delivered by county welfare departments working under the guidance of DSS.

Consolidation Should Improve Service Delivery. We believe that combining programs that serve senior citizens into one division at DSS should result in program efficiencies, because one division would oversee the bulk of services for California senior citizens. For example, CDA operates the Linkages Program and MSSP. The purpose of these programs is to assist frail elderly clients in avoiding institutionalization. The IHSS program operated by DSS has the same mission—providing home-based services so that clients can live independently. Moreover, recipients of the DSS programs could be more easily linked to other services currently offered by the CDA, such as the nutrition programs, if most aging programs were under the control of one department. In order to improve service delivery to California' senior population, we recommend that the program functions of the CDA be shifted to the Disability and Adult Programs Division at DSS.

Economies of Scale. For 2002-03, DSS has 4,625 authorized positions. About 82 percent of these positions are in program divisions, which ei-

ther directly provide social services to clients or assist counties in providing services. About 18 percent of DSS positions are distributed among the executive office, legal division, research and development division, information systems division, and the administration division. By contrast, the CDA has 169 authorized positions for 2002-03. About 58 percent of these positions are in program divisions (delivering services), while 42 percent are in the executive office or the administration division. Because it is a larger department, DSS achieves economies of scale and needs proportionately fewer staff for executive and administrative activities than does CDA. Specifically, for every one program staff at DSS there are .22 administrative (nonprogram) staff. Conversely, at CDA, for every one program staff, there are .72 nonprogram staff. Combining these departments would build on the economies of scale at DSS.

Most States Locate Aging Programs Inside a Larger Agency. Currently 21 states (including California) operate their Older Americans Act programs under a stand-alone department. Twenty-nine states operate these programs with an office housed in a larger agency—specifically, 6 within health agencies, 16 with human services agencies, and 7 within combined health and human services agencies. Although both the Department of Health Services and DSS operate programs that serve California seniors, we believe DSS programs have more in common with the mission of CDA—fostering the independence and improving the quality of life of senior citizens.

Estimated Administrative Savings. For 2002-03, the CDA had 169 authorized positions distributed as follows: 23 in the directorate (14 percent), 48 in administration (28 percent), and 98 positions for program operations (58 percent). We recommend that all of the program positions be shifted to DSS, thus retaining all program capabilities of CDA. Within the directorate, we recommend eliminating 9 positions, and moving 14 positions to DSS (10 ombudsman positions, 1 deputy director, 1 legal counsel, and 2 support staff). Of CDA's administration division, we recommend eliminating 28 positions and shifting 20 positions to DSS (12 auditors, 2 humans resources staff, and 6 fiscal staff). In total, this results in a reduction of 37 positions and $1,860,000 in salary costs. When staff benefits and operating expenses and equipment are incorporated, total savings are approximately $3.4 million. Based on the current 27 percent General Fund share of state operations costs at CDA, General Fund savings from this consolidation are estimated to be $908,000.

Retain AAA Delivery Structure. Under our consolidation proposal, AAAs would continue to deliver aging services. The DSS would contract and guide the AAAs in the same manner as the CDA.

CALIFORNIA MEDICAL ASSISTANCE PROGRAM (4260)

In California, the federal Medicaid Program is administered by the state as the California Medical Assistance Program (Medi-Cal). This program provides health care services to welfare recipients and other qualified low-income persons (primarily families with children and the aged, blind, or disabled). Expenditures for medical benefits are shared equally by the General Fund and by federal funds. The Medi-Cal budget also includes additional federal funds for (1) disproportionate share hospital (DSH) payments, which provide additional funds to hospitals that serve a disproportionate number of Medi-Cal or other low-income patients, and (2) matching funds for state and local funds in other related programs.

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

Proposed Spending. The budget for DHS proposes Medi-Cal expenditures totaling $28 billion from all funds for state operations and local assistance in 2003-04. The General Fund portion of this spending ($7 billion) decreases by $3.6 billion, or 34 percent, compared with estimated General Fund spending in the current year. The remaining expenditures for the program are mostly federal funds, which are budgeted at a level

($17 billion) that is about 4 percent less than estimated to be received in the current year.

Most of the reduction in General Fund spending is based upon an assumption in the Governor's spending plan that about $3 billion in Medi-Cal expenditures will be shifted to the counties—along with revenues—as part of a larger realignment of state and county funding and program responsibility. This includes shifting to the counties 15 percent of the nonfederal cost of Medi-Cal health care services ($1.6 billion) and all nonfederal costs for Medi-Cal long-term care ($1.4 billion). The realignment proposal is discussed in more detail in "Part V" of *The 2003-04 Budget: Perspectives and Issues.*

The spending total for the Medi-Cal budget includes an estimated $1.7 billion (federal funds and local matching funds) for payments to DSH hospitals, and about $4.5 billion budgeted elsewhere for programs operated by other departments, counties, and the University of California.

MEDI-CAL BENEFITS AND ELIGIBILITY

What Benefits Does Medi-Cal Provide?

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

How Medi-Cal Works

Based on recent caseload information, 43 percent of the Medi-Cal caseload consists of participants in the state's two major welfare programs, which include Medi-Cal coverage in their package of benefits. These programs are (1) the California Work Opportunity and Responsibility to Kids (CalWORKs) program, which provides assistance to families with children and replaces the former Aid to Families with Dependent Children program; and (2) the Supplemental Security Income / State Supplementary Program (SSI / SSP), which assists elderly, blind, or disabled persons. Counties administer the CalWORKs program through county welfare offices that determine eligibility for CalWORKs benefits and Medi-Cal coverage concurrently. Counties also determine Medi-Cal eligibility for

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

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

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

Managed Care. Prepaid health plans generally provide managed care. The plans receive monthly "capitation" payments from the Medi-Cal Program for each enrollee in return for providing all of the covered care needed by those enrollees. These plans are similar to health plans offered by many public and private employers. More than half (3.2 million of the total of 6.1 million Medi-Cal eligibles in July 2002) are enrolled in managed care plans. Beneficiaries in managed care choose a plan and then must use providers in that plan for most services. Since payments to the plan do not vary with the amount of service provided, there is much less need for utilization control by the state. Instead, plans are monitored to ensure that they provide adequate care to enrollees.

Who Is Eligible for Medi-Cal?

Almost all Medi-Cal eligibles fall into two broad groups of people. They either are aged, blind, or disabled or they are in families with children. More than half of Medi-Cal eligibles are welfare recipients. Figure 1 shows, for each of the major Medi-Cal eligibility categories, the maximum income limit for eligibility for health benefits and the estimated caseload and total benefit costs for 2002-03. The figure also indicates, for each category, whether an asset limit applies and whether eligible persons with incomes over the limit can participate on a "spend down" basis. If spend down is allowed, then Medi-Cal will pay the portion of any qualifying medical expenses that exceed the person's "share-of-cost," which is the amount by which that person's income exceeds the applicable Medi-Cal income limit.

Figure 1

Major Medi-Cal Eligibility Categories

2002-03

	Maximum Monthly Income Or Grant[a]	Asset Limit Imposed?	Spend Down[b] Allowed?	Enrollees (Thousands)	Annual Benefit Costs (Millions)[c]
Aged, Blind, or Disabled Persons					
Welfare (SSI/SSP)	$1,364	✓	—	1,225	$9,224
Medically needy	954	✓	✓	254	1,684
133 percent of poverty equivalent	1,325	✓	✓	—[d]	—[d]
Medically needy—long-term care	Special limits	✓	✓	69	2,820
Families					
Welfare (CalWORKs)	$1,112[e]	✓	—	1,574	$2,563
Section 1931(b)-only[f]	1,599	✓	—	2,485	3,557
Medically needy	1,190	✓	✓	—[g]	—[g]
Children and Pregnant Women					
200 percent of poverty—pregnancy service and infants	$3,107	—	—	188	$631
133 percent of poverty—ages 1 though 5	2,097	—	—	124	124
100 percent poverty—ages 6 though 18	1,599	—	—	133	107
Medically indigent—ages 6 though 18	1,190	✓	✓	163	269
Medically indigent adults—all services	1,190	✓	✓	6	70
Emergency Only					
Undocumented immigrants may qualify in any category and are limited to emergency services (including labor and delivery and long-term care)				760	$1,151

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

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

c Combined state and federal costs.

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

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

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

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

Aged, Blind, or Disabled Persons. About 1.6 million low-income persons who are (1) at least 65 years old or (2) blind or disabled persons of any age receive Medi-Cal coverage—about 24 percent of the estimated total Medi-Cal caseload for the current year. Overall, the disabled make up more than half (62 percent) of this portion of the Medi-Cal caseload. Most of the aged, blind, or disabled persons on Medi-Cal (79 percent) are recipients of SSI/SSP benefits and receive Medi-Cal coverage automatically.

The other aged, blind, or disabled eligibles are in the "medically needy" category. They have low incomes, but do not qualify for, or choose not to participate, in SSI/SSP. For example, aged low-income noncitizens generally may not apply for SSI/SSP (although they may continue on SSI/SSP if they already were in the program as of August 22, 1996). As another example, some of the medically needy persons have incomes above the Medi-Cal limit and participate on a share-of-cost basis. Included in the number of eligibles in the "medically needy" category are aged, blind, and disabled persons with incomes up to 133 percent of the poverty level. Beginning January 1, 2001, these persons could receive Medi-Cal coverage without a share-of-cost.

More than 870,000 or about 60 percent of the aged or disabled Medi-Cal eligibles are also beneficiaries of Medicare—the federal health insurance program for persons 65 and older and for younger persons with disabilities who cannot work. Medi-Cal generally pays the Medicare premiums and any copayments or deductibles for these "dual eligibles," and Medi-Cal pays for services not covered by Medicare, such as prescription drugs and long-term care. Medi-Cal also provides some limited assistance to a small number of dual eligibles with incomes somewhat higher than the medically needy standard.

The number of Medi-Cal eligibles in long-term care is small—only 68,900 people, or 1 percent of the total caseload. Because long-term care is very expensive, benefit costs for this group total $2.8 billion, or 13 percent of total Medi-Cal benefit costs.

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

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

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

About 24 percent of all Medi-Cal eligibles are CalWORKs welfare recipients. Although CalWORKs recipients constitute the largest single group of Medi-Cal eligibles by far, they account for only 12 percent of total Medi-Cal benefit costs. This is because almost all CalWORKs recipients are children or able-bodied working-age adults, who generally are relatively healthy. Similarly, 1931(b)-only and medically needy families who are Medi-Cal eligible account for 38 percent of all Medi-Cal eligibles and only 16.5 percent of total benefit costs.

Women and Children. Medi-Cal includes a number of additional eligibility categories for pregnant women and for children. Medi-Cal covers all health care services for poor pregnant women in the medically indigent category, which has the same income and asset limits and spend-down provisions as apply to medically needy families. However, pregnancy-related care is covered with no share-of-cost and no limit on assets for women with family incomes up to 200 percent of the FPL (an annual income of about $36,200 for a family of four).

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

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

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

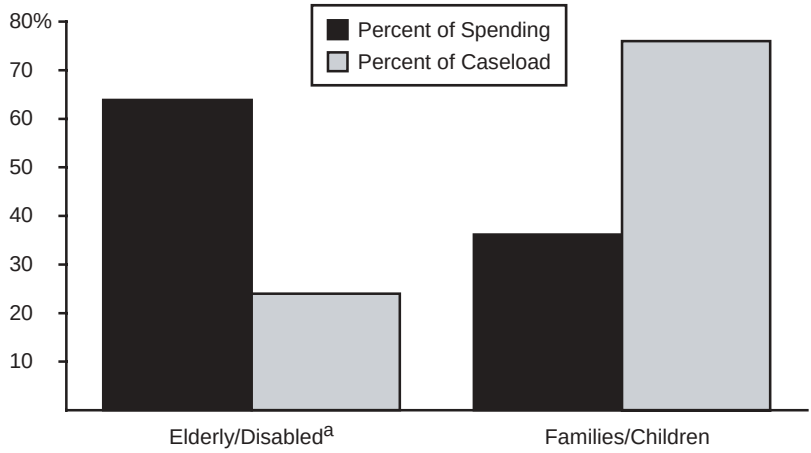
Most Medi-Cal Spending Is for the Elderly or Disabled

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

Figure 2

Most Caseload is Families/Children
Most Spending is for Elderly/Disabled

2002-03



[a]Includes long-term care.

MEDI-CAL EXPENDITURES

Spending Growth in Current Year Despite Cuts

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

The budget estimates that for the current year the General Fund share of Medi-Cal local assistance costs will increase by about $863 million (8.8 percent), compared with 2001-02. The bulk of this increase is for benefit costs, which will total an estimated $10 billion in 2002-03.

Figure 3

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

(Dollars in Millions)

	Revised			Change From 2002-03	
	Actual 2001-02	Estimated 2002-03	Proposed 2003-04	Amount	Percent
Support (state operations)	$86.8	$93.5	$97.8	$4.4	4.7%
Local Assistance					
Benefits	$9,155.3	$9,992.4	$6,295.6	-$3,696.9	-37.0%
County administration (eligibility)	495.6	493.7	606.8	113.1	22.9
Fiscal intermediaries (claims processing)	90.0	111.0	103.1	-7.9	-7.1
Subtotals, local assistance	$9,740.9	$10,597.1	$7,005.5	-$3,591.6	-33.9%
Totals	**$9,827.6**	**$10,690.6**	**$7,103.3**	**-$3,587.3**	**-33.6%**
Caseload (thousands of beneficiaries)	5,914	6,477	6,268	-209.0	-3.2%

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

General Fund Deficiency in 2002-03. The *2002-03 Budget Act* increased General Fund spending only modestly from 2001-02—almost $100 million or 1 percent—and included significant changes intended to hold down the overall growth in expenditures for the Medi-Cal Program. The Governor's January budget proposes a General Fund deficiency in Medi-Cal of $925 million from the levels of spending anticipated in the *2002-03 Budget Act* due to increases in caseload, cost and utilization of services, and other factors discussed below. The Governor's package of mid-year revisions would reduce this by about $170 million to a deficiency of $756 million General Fund in the current year if adopted by the Legislature.

Unanticipated Increases in Caseload. Nearly half of the $756 million increase in program costs is for the purpose of accommodating an addi-

tional 564,000 Medi-Cal eligibles, about a 10 percent increase over the prior year. The major factors driving the caseload upward are continued growth in the medically needy families caseload resulting from policy decisions to simplify enrollment procedures. This includes decisions to provide continuous eligibility for medical benefits to children 19 years of age and younger and persons leaving the CalWORKs program, as well as the elimination of the quarterly status reports.

Caseloads also continue to grow because of the prior decision to expand eligibility for families with children in the so-called 1931(b) category with income at or below 100 percent of the FPL, as well as the decision to provide Medi-Cal benefits without a share-of-cost to aged, blind, and disabled persons with current income equivalent to 133 percent of FPL or less. Other caseload growth is attributable to the settlement of a lawsuit that requires the department to continue benefits to recently terminated SSI/SSP patients.

Unexpected Increases in Cost and Utilization of Services. Increases in the costs and utilization of services are projected to increase spending by about $220 million. These include continued growth of $78 million in mental health services claims, especially for Early and Periodic Screening, Diagnosis and Treatment services for children. Other significant cost increases include a rise in the number of prescriptions and physician visits per beneficiary, and an increase in the cost per unit of these services. Together these account for an increase of approximately $69 million.

Unrealized Savings Increase Costs. The Governor's budget anticipates that some savings proposed in the *2002-03 Budget Act* will not be realized, such as $122 million in projected additional savings from antifraud activities and a $23 million adjustment for caseload savings. The DHS has also determined that there will be a lag in achieving other savings proposals enacted in the 2002-03 budget because of the delay in its passage until September 2002. Specifically, about $81 million was added to 2002-03 spending to reflect savings that cannot be achieved in 2002-03, from various changes in the way the state purchases drugs and certain medical supplies—savings of at least $189 million had been anticipated.

Federal Funds Did Not Materialize. The 2002-03 spending plan assumed that federal legislation would be enacted to provide California with an additional one-time $400 million in federal funds to offset the decrease in the federal cost-sharing ratio (known as the Federal Medicaid Assistance Percentage or FMAP) for the state's Medicaid payments. However, the federal government did not provide such relief to offset state costs. The Governor's budget plan no longer assumes the receipt of these funds.

Other Costs Increasing Current-Year Expenditures. The Governor's restoration in September of a provider rate reduction that was part of the *2002-03 Budget Act* will result in an increase in 2002-03 expenditures of $71 million. (As we discuss below, his January 10 budget plan subsequently proposed to impose a more broadly applied reduction in rates for providers in both the current and budget years.) Also affecting the current-year expenditure total is a policy change to increase county administrative funding by about $36 million in order to process annual redeterminations in a timely manner. The administration estimates that this policy change will result in savings of $194 million in the budget year as a result of reduced caseload.

Mid-Year and January 10 Budget Reduction Proposals. A package of mid-year budget reductions proposed by the Governor as well as additional proposals in the Governor's January 10 budget plan would, if adopted, offset part of the additional current-year Medi-Cal costs by nearly $170 million. As noted earlier, the Governor proposed a provider rate reduction of 10 percent affecting physicians, nursing homes, and certain other providers that is expected to reduce state costs by $90 million in the current year. He also proposed the elimination of various optional services for adult beneficiaries to achieve an estimated savings of $68 million, as well as the rescission of the 1931(b) expansion and reinstatement of quarterly status reports. These latter two proposals, which would achieve $11 million in state savings in the current year, are discussed in more detail below.

Budget-Year Expenditure Reduction

The Governor's proposed budget estimates that total General Fund spending for Medi-Cal local assistance will be $7 billion in 2003-04, a decrease of $3.6 billion, or 34 percent, below the estimated spending in the current year. If $3 billion in Medi-Cal expenditures were not shifted to the counties as assumed under the Governor's budget plan, the decrease in Medi-Cal expenditures from the previous year would be much smaller—a decline of $572 million or 5.4 percent, rather than the much larger reduction shown in Figure 3. The budget estimates that the Medi-Cal caseload will decrease by 209,100 (about 3 percent) in 2003-04 to a total of almost 6.3 million average monthly eligibles—roughly 18 percent of the state's population.

Aside from the shift of costs and revenues to the counties, most of the reduction in 2003-04 expenditures results from various proposals to cut benefits. General Fund spending for Medi-Cal benefits would decrease by $3.7 billion (37 percent) in 2003-04. Figure 4 (see next page) shows the major components of the change in benefit costs, which we discuss below.

Figure 4

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

2003-04
(In Millions)

Realignment	
Funding shift to counties to reduce costs	-$3,020
Savings From Cuts in Rates and Services	
15 percent rate reductions	-$630
Elimination of various optional services	-304
Increased savings from various 2002 proposals to reduce costs for drugs, supplies, and services	-89
New utilization controls	-38
Caseload Reduction Proposals	
Timely annual redeterminations	-$194
Rollback of 1931(b) expansion for parents	-112
Reinstatement of quarterly status reports	-80
Rollback of coverage for aged, blind, and disabled	-64
Caseload Increases	
Continued growth in caseload for working poor and aged, blind, and disabled	$395
Caseload shift due to elimination of the Child Health and Disability Prevention program	112
Changes in Payments	
Loss of Tobacco Settlement Funds	$235
Increases in Price and Utilization of Services	
Increased pharmacy costs	$144
Increased cost for Medicare and Medicare HMO premiums	54

Realignment. The Governor's most significant proposal is a realignment or shift of some of the cost of Medi-Cal services to the counties. Under the Governor's realignment proposal, funding responsibility for 15 percent of the state share of the cost of services provided to Medi-Cal beneficiaries would be shifted to the counties for an estimated state savings of $1.6 billion. The entire state cost for skilled nursing services for

Medi-Cal patients would also be shifted to the counties for an estimated state savings of $1.4 billion. We are advised by the Department of Finance that these savings to the state from realignment are understated by nearly $500 million because budgetary figures do not take into account the effects of other savings proposed in the Governor's budget in the Medi-Cal program. (The realignment proposal is discussed later in this *Analysis* and in "Part V" of *The 2003-04 Budget: Perspectives and Issues*),

Savings From Cuts in Rates and Services. The spending plan takes into account the estimated ongoing effect of several significant budget reductions proposed for the current fiscal year. For example, in addition to a 10 percent provider rate cut imposed in the current fiscal year to save $338 million, the Governor proposes an additional 5 percent rate cut in the budget year to achieve additional state savings of $242 million. The rate reduction would affect nursing home facilities, Intermediate Care Facilities for Developmentally Disabled (ICF-DDs), physician services, pharmaceuticals, dental services, managed care plans, home health care, medical transportation, and certain other medical services. The rate reduction also affects certain non-Medi-Cal programs, including the California Children's Services (CCS) Program; the Family Planning, Access, Care and Treatment Program (Family PACT); the State-Only Family Planning Program; the Genetically Handicapped Persons Program; and the Breast and Cervical Cancer Early Detection Program.

The elimination of various optional services for adults who are not in long-term care, a step proposed by the Governor as a reduction in the current year, would be expanded in 2003-04 to eliminate additional services for increased savings estimated at $304 million. Additional savings of $89 million are expected to result from the full-year implementation in 2003-04 of various strategies included in the *2002-03 Budget Act* to reduce costs for prescription drugs, durable medical equipment, and medical supplies. These proposals are also intended to reduce the utilization of services. Savings from an ongoing drug-rebate program are expected to grow by an additional $79 million in the budget year.

Finally, the budget also assumes that about $38 million in General Fund savings would be captured through new utilization controls and various other strategies to reduce the cost of Medi-Cal services.

Proposal to Reduce Caseload Costs. The budget plan would increase funding for county administration of Medi-Cal eligibility activities—the cost of completing eligibility determinations and annual redeterminations—by $113 million. This augmentation is expected to provide counties with the full amount of funding they would need to hire enough staff to process the annual redeterminations in a timely manner. The budget plan assumes this step-up in the completion of redeterminations would

result in the disenrollment of 560,000 ineligible Medi-Cal beneficiaries by the end of 2003-04. Because this activity would be phased in over the course of the budget year, the projected effect on the Medi-Cal caseload is a decline of 305,000 monthly eligibles and a state savings of $194 million in 2003-04 as summarized in Figure 4.

The Governor's mid-year revision proposed to reduce caseload by tightening eligibility rules, including rescinding the 1931(b) expansion of Medi-Cal eligibility to working poor families and reinstatement of requirements that parents file quarterly reports to reaffirm their eligibility. The continuation of the 1931(b) rescission in the budget year is anticipated to decrease the average monthly caseload by 185,000 for savings of $112 million. Similarly, the continuation of the Governor's current-year proposal to reinstate quarterly reporting of eligibility for adults is expected to decrease the average monthly caseload by 134,000 for savings of $80 million in 2003-04.

Savings of $64 million are expected from the proposed rollback of the 2001 expansion of coverage for the aged, blind, and disabled persons with income up to 133 percent of poverty. Under the Governor's proposal, individuals with an annual income up to about $8,500 and couples with an income up to $14,700 would be eligible for Medi-Cal without a share of cost**.**

Caseload Increases. Without the reduction proposals discussed above, the Governor anticipates that caseload costs would increase in 2003-04 by $395 million. These increases are due in part to continued growth from previous eligibility expansions for the working poor and for the aged, blind, and disabled. Also driving up the Medi-Cal caseload are the continued effects of past simplifications in the eligibility process. These include the implementation of continuous eligibility for children 19 years of age and younger. A portion of this growth in caseload has also been attributed to ineligible beneficiaries not being disenrolled on a timely basis.

Medi-Cal caseload costs are expected to increase by about $112 million due to the implementation of a program that will pre-enroll children in Medi-Cal and the Healthy Families Program who are screened for medical problems through the Children's Health and Disability Prevention program. Caseload increases related to other health programs, such as Adult Day Health Care, Family Pact, and the Breast and Cervical Cancer Treatment Program, are expected to increase Medi-Cal costs by nearly $50 million.

Changes in Payments. Revenue estimates underlying the *2002-03 Budget Act* anticipate the sale of a state bond backed by future revenues coming to the state from the national tobacco settlement. As a result, $235 million that had been used from tobacco settlement funds to sup-

port the Breast and Cervical Cancer Treatment Program and part of the 1931(b) expansion in 2002-03 would not be available in the budget year. Accordingly, the budget plan backfills these lost funds with an increase in support from the General Fund.

Increased Utilization and Cost-of-Services. In line with a continuing trend that has significantly bolstered Medi-Cal Program expenditures in recent years, the 2003-04 budget plan assumes an increase in the cost of pharmaceuticals of $144 million.

Medi-Cal "buy-in" payments for Medicare premiums would also continue to grow. The Medi-Cal Program pays Medicare premiums for Medi-Cal enrollees who also are eligible for Medicare (dual eligibles) in order to obtain 100 percent federal funding for those services covered by Medicare. The budget estimates that the General Fund cost of these so-called buy-in payments will increase by $54 million in 2003-04.

In addition to the cost increases identified in Figure 4, costs are also expected to go up for some of the health programs that are passed through the DHS Medi-Cal budget but actually administered by other state departments. Notably, the cost of mental health services administered by the Department of Mental Health, including children's services provided under the Early and Periodic Screening, Diagnosis and Treatment Program, are expected to increase about $35 million. In addition, costs for the Adult Day Health Care Program administered by the Department of Aging are expected to go up by $32 million because of an increase in the number of persons using these services.

MEDI-CAL COST AND CASELOAD TRENDS

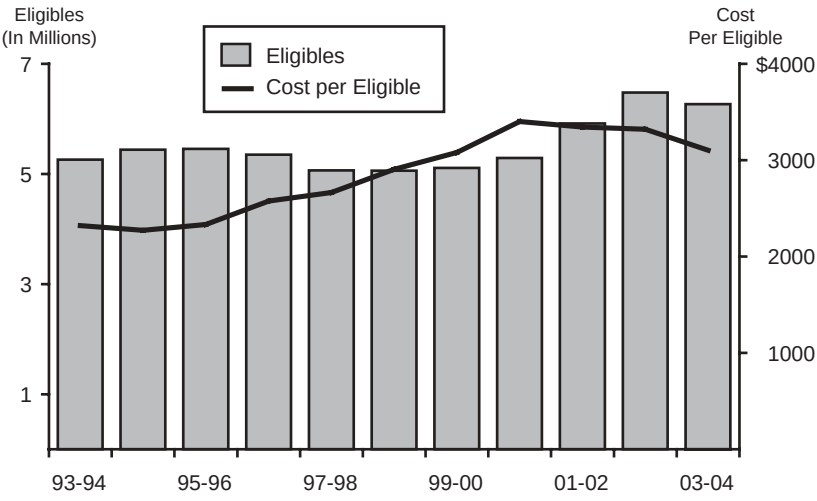
Figure 5 (see next page) illustrates how Medi-Cal caseload and per-eligible costs have changed since 1993-94, along with projections of these measures for 2002-03 and 2003-04 based on the budget estimates.

Budget Forecasts Caseload Decline and Dropping Costs

The budget projects that in the current year the number of eligibles will grow and the cost of benefits per eligible will decline. The decline in the cost per eligible for the program is projected to continue in the budget year. However, the trend in the number of eligibles is expected to reverse and begin to drop.

Figure 5

Medi-Cal Caseload and Cost Per Eligible Would Decline Under Budget Plan



Caseload. Between 1993-94 and 1996-97, the Medi-Cal average monthly caseload was relatively constant, averaging about 5.4 million eligibles. The Medi-Cal caseload subsequently leveled off, and then dropped by almost 300,000 eligibles (5.4 percent) in 1997-98. The change in the Medi-Cal caseload roughly paralleled changes in the CalWORKs welfare caseload. The caseload began a sharp drop at that time in response to the turnaround in the state's economy, and greater emphasis on moving families from welfare-to-work in the wake of the enactment of state and federal welfare reform legislation. Another factor contributing to declining welfare and Medi-Cal caseloads was probably the reluctance among immigrant Californians to make use of public benefits because of concerns about whether such use might adversely affect their ability to naturalize or to sponsor the immigration of family members in the future.

From 1997-98 through 2000-01, the Medi-Cal caseload remained relatively flat even though the CalWORKs caseload continued to decline. The Medi-Cal caseload did not decline during this period primarily because of the backlog of eligibility determinations for former CalWORKs recipients that resulted from the delay in implementation of Section 1931(b) Medi-Cal eligibility by DHS and the counties. In fact, the caseload began to grow

rapidly during 2001-02 and 2002-03 primarily due to a variety of eligibility expansions and simplified eligibility processes. Without the Governor's current-year and budget-year proposals to reduce the caseload, the number of people enrolled would continue to grow in the budget year.

Cost Per Eligible. While the caseload has gone up and down, the cost trend per eligible had been almost steadily upward until 2000-01. The average annual growth rate of the estimated cost of benefits per eligible (excluding pass-through funding to other departments and local governments) is 3.1 percent during the period of 1993-94 through 2003-04. This is greater than the rate of general inflation during this period (1.9 percent) as measured by the Gross Domestic Product deflator.

The temporary dip in the cost per eligible that occurred in 1994-95 and 1995-96 was partly the result of a change in the caseload mix, rather than an underlying drop in health care costs. This is because the rapid increase in the number of families on welfare (whose health care costs are relatively low) temporarily reduced the *proportion* of aged and disabled persons (relatively high-cost groups) in the Medi-Cal caseload, and this change in the mix tended to reduce the average cost per eligible. As the CalWORKs welfare caseload subsequently fell, the elderly and disabled share of the Medi-Cal caseload returned to its earlier level of about 26 percent, and the cost per eligible resumed its growth in 1996-97. Between 1996-97 and 2000-01 the average annual estimated cost per eligible increased by 5 percent.

The slight turnaround in the trend seen in 2001-02 and 2002-03 appears to be the result of an increase in the number of healthy beneficiaries rather than a decrease in health care costs. The simplification that has occurred in the eligibility process means that the Medi-Cal Program probably is retaining a greater number of children and families on its caseload who do not regularly need health care services compared to other beneficiaries, such as the aged, blind, and disabled.

Based on the Governor's budget plan, these costs would decrease by less than 1 percent in the current year but further decrease by nearly 7 percent in the budget year. This sharp decrease can be partly attributed to the Governor's proposals to phase in a provider rate reduction over the current year and budget year of 15 percent, as well as to his proposal to eliminate various optional services for adults.

Overall Caseload Estimate Reasonable

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

Figure 6 shows the budget's forecast for the Medi-Cal caseload in the current year and 2003-04. It reflects the Governor's various proposals to reduce caseload, which otherwise would increase by about 5 percent during the budget year.

Figure 6

Medi-Cal Caseload
Governor's Budget Estimate

(Eligibles in Thousands)

			Change From 2001-02			Change From 2002-03	
	2001-02	2002-03	Amount	Percent	2003-04	Amount	Percent
Families/children	**4,231**	**4,673**	**442**	**10.4%**	**4,480**	**-192**	**-4.1%**
CalWORKs	1,639	1,574	-65	-4.0	1,568	-6	-0.4
Nonwelfare families	2,072	2,485	413	19.9	2,280	-205	-8.2
Pregnant women	176	194	18	10.0	198	4	2.0
Children	343	420	77	22.4	434	14	3.4
Aged/disabled	**1,456**	**1,552**	**97**	**6.7%**	**1,562**	**10**	**0.6%**
Aged	547	589	42	7.8	587	-2	-0.4
Disabled (includes blind)	906	963	57	6.3	976	12	1.3
Undocumented Workers	**227**	**249**	**22**	**9.7%**	**220**	**-30**	**-11.9%**
Totals	**5,913**	**6,474**	**561**	**9.5%**	**6,262**	**-212**	**-3.3%**

The majority of the projected Medi-Cal caseload changes occur in the families and children eligibility categories. The budget estimates that the caseload for this group will increase by 10 percent in the current year but subsequently decrease by 4 percent in the budget year. Nonwelfare families account for most of the changes in Medi-Cal eligible families and children. The budget estimates that the caseload of Medi-Cal eligible nonwelfare families will increase by about 20 percent in the current year, but then decrease by 8 percent in the budget year. While the caseload growth projected in the Governor's budget is significant, our analysis found that recent caseload estimates by DHS have tracked caseload growth fairly closely.

The current-year projected caseload increase for families and children is primarily the result of the continued implementation of continuous eligibility for children, the elimination of the quarterly status reporting requirements for adults, and growth in the 1931(b) program. However, these caseload increases would be reversed in the budget year if the Governor's proposals for the reinstatement of the quarterly status reports

for parents and for the rollback of the 1931(b) expansion were adopted. Some additional budget-year growth in this caseload is projected to result from the implementation of a so-called "gateway" in the Children's Health and Disability Prevention (CHDP) program. The Governor's budget estimates that efforts to expedite the enrollment of CHDP children into more comprehensive health care coverage will add 90,000 eligibles to the Medi-Cal Program during 2003-04.

Caseloads for the aged, blind, and disabled are expected to grow by about 100,000 in the current year and an additional 10,000 in the budget year. The growth in the current year is due to underlying caseload growth trends as well as a projected increase in caseload due to a Superior Court ruling in a case known as *Craig v. Bonta.* This ruling requires DHS to provide Medi-Cal benefits to persons terminated from the federal SSI/SSP program retroactively to June 30, 2002. The slower pace of growth in the budget year is primarily due to a rollback of the January 2001 expansion of eligibility for the aged and disabled.

Major Uncertainty: The Economy. It is highly uncertain at this time whether the caseload trends will be sustained. There are a number of factors that could result in higher caseloads as well as factors that could produce lower caseloads. The biggest single factor contributing to this uncertainty is the continuing softness in the economy. This is the first period of economic sluggishness since the expansion and simplification of eligibility in the Medi-Cal Program and federal welfare reform in 1996. It is possible that a number of the individuals who may have recently become unemployed are already enrolled in Medi-Cal. Although such individuals and their families would shift between Medi-Cal eligibility categories, their impact on overall Medi-Cal caseload and costs would be minimal. Alternatively, children of newly unemployed persons who were not on Medi-Cal previously may now enroll instead in the Healthy Families program.

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

- ***Federal actions*** such as the enactment of laws affecting Medi-Cal eligibility and benefits. For example, the federal Administration recently proposed Medicaid reform that would change Medicaid, State Children's Health Insurance Program, and Disproportionate Share Hospital payments into a formula based allotment.

- ***Further changes in state laws and regulations*** adopted by the Legislature and the Governor or through the initiative process. For example, last year regulations set new minimum nurse-to-patient staffing ratios that will increase hospital and managed care costs.
- ***Effect of the Governor's Budget Proposals***. The Governor's proposal to increase county administrative funding might not have the intended effect of reducing the Medi-Cal caseload. If the assumed caseload savings failed to materialize, the end result could be an increase in administrative funding for the counties. It is also uncertain to what extent caseloads would decrease as a result of adoption of the Governor's proposal to reinstate quarterly status reports for adults, because some individuals disenrolled by this process due to their failure to return the required paperwork might be eligible for re-enrollment in the program.

Analyst's Recommendation. In summary, we do not recommend a specific budget adjustment at this time because we believe that there is both upside and downside risk to the caseload estimate. This is because it is not clear if the economic downturn will continue and it is uncertain if baseline caseloads will continue to increase as rapidly as projected.

Moreover, at the time this analysis was prepared, the Legislature had not taken action on several of the Governor's major December revision proposals that were intended to reduce program eligibility. Proposals to modify Medi-Cal eligibility rules often require federal approval and there is typically some delay before they can be implemented by counties.

Given this situation, we will continue to monitor the Medi-Cal caseload trends and the Legislature's actions on the Governor's December revision proposals, and will recommend appropriate adjustments at the time of the May Revision.

ELIGIBILITY ADMINISTRATION ISSUES

County Eligibility Determinations: Options for Cost Savings

The administration of eligibility rules is one of the most critical functions for the operation of the Medi-Cal Program. However, over the years, the state has had some significant concerns about the increasing cost of these activities and the performance of the counties, to whom the state has delegated these functions. We analyze and comment on the Governor's proposal to increase county funding and establish state

performance standards to ensure that redeterminations of eligibility are completed on a timely basis. We also discuss alternative approaches to reforming the eligibility system. (Decrease Item 4260-101-0001 by $41.3 million and decrease Item 4260-101-0890 by $41.3 million.)

Background

Work Delegated to Counties. One of the most critical functions for the operation of the Medi-Cal Program is the administration of eligibility determinations and redeterminations for applicants and enrollees in the program. The way these functions are carried out has significant ramifications for access for the poor to health care, compliance with federal Medicaid requirements, and overall state costs for the provision of Medi-Cal benefits. The state currently delegates most of this important task to the counties, which are reimbursed by the state for these activities. Counties pay no share of these costs at the present time.

The Governor's budget proposes to provide $494 million from the General Fund ($1.7 billion all funds) in 2002-03 for county administration costs and $607 million from the General Fund ($2 billion all funds) for these activities in 2003-04.

Issues With the Existing System

Our analysis indicates that there are a number of issues regarding the current Medi-Cal arrangement by which the state delegates to the counties the duties and funding for eligibility activities.

Costs Are High and Vary Significantly From County to County. Over the years, the state has had concerns with the increasing costs of eligibility determinations. Notably, the cost per Medi-Cal beneficiary to the state for obtaining these services from the counties has been increasing during the past nine years at an average annual rate of 10 percent, as shown in Figure 7 (see next page). The average annual cost in 2002-03 of Medi-Cal eligibility determinations is expected to be $147.79 per eligible. This amount includes costs related to determining whether applicants are eligible for Medi-Cal, maintenance of case files, outreach activities, and the provision of certain case management services. This cost is significant, especially when compared to the $68.50 average annual cost of eligibility determinations in the state's other major health coverage program for low-income families, the Healthy Families Program.

Our analysis also indicates that the cost of Medi-Cal eligibility administration varies significantly from county to county, even for seemingly comparable counties. The average cost per eligible for the five counties with the largest Medi-Cal caseloads ranges from a high of $353 in

Figure 7

Cost of Eligibility Determinations Keeps Rising

(Dollars in Millions)

Year	Average Cost Per Eligible[a]	Percent Change
1994-95	$78.08	—
1995-96	81.55	4.4%
1996-97	85.64	5.0
1997-98	94.17	10.0
1998-99	112.18	19.1
1999-00	130.31	16.2
2000-01	141.30	8.4
2001-02	134.61	-4.7
2002-03 (estimated)	149.79	11.3
Average annual increase		10.2%

[a] Does not include (1) certain eligibility determination costs in Los Angeles County and (2) some information technology costs. Includes all fund sources.

San Diego County to a low of $181 in Los Angeles County. It is unclear why this wide variation in the cost of a determination exists when these counties have relatively similar sized caseloads.

Some Counties' Performance of These Duties Is a Concern. Despite the significant growth in these expenditures, how well counties are performing their delegated responsibilities is a concern. Federal and state law require that nondisability applications be processed within 45 days and that redeterminations of an individual's continued eligibility for Medi-Cal benefits be conducted annually. A review of county eligibility activities conducted by federal authorities in 2001 found that, of four counties reviewed, most but not all applications were processed within the required 45-day timeframe. However, a state review of the timeliness of redeterminations found that Los Angeles County, with more than half of the Medi-Cal population statewide, is completing only 56 percent of its reviews on time.

This situation puts the state at risk of paying the continued cost for health care for individuals who might be ineligible for benefits but who might nonetheless be remaining on the Medi-Cal rolls. This situation also

puts the state at risk of having to repay the federal government for the cost of health care provided to persons who are ineligible for Medi-Cal.

Single Point of Entry Increases the Cost and Can Delay Medi-Cal Determinations. In 1999, the state implemented what is known as a "single point of entry" to process all Healthy Families applications and some Medi-Cal applications. The purpose of this process was to improve coordination between the Medi-Cal and Healthy Families programs. The single point of entry provides a uniform, centralized process for receiving, processing, and tracking applications for enrollment in one of the programs.

While this approach has simplified enrollment for potential eligibles, it has increased the cost of Medi-Cal determinations and can delay the process. This is because applications have to go through a two-step process. First, they are submitted to a single point-of-entry for an initial eligibility determination. Those applications initially determined to be eligible for Medi-Cal are next forwarded to each individual's county of origin, where county eligibility workers continue to make final eligibility determinations for Medi-Cal beneficiaries. In contrast, applications for individuals initially determined to be eligible for the Healthy Families Program are processed directly by the state. The state pays a contractor about $21 for each application that it forwards to the county for further processing. The state cost of this process is estimated to be nearly $1.4 million in 2003-04. This two-step process can also delay the processing of applications because of the addition of the contractor's processing time and the time it takes to mail the applications to the counties.

Inconsistencies in County Operating Procedures. The same federal review of county eligibility activities in 2001 mentioned earlier also found major inconsistencies in the way counties are deciding whether individuals are eligible for Medi-Cal benefits. The review found that counties sometimes differ in the way they interpret state-issued guidelines for eligibility determinations. The department contributes to this problem in some cases when it issues eligibility rules in a piecemeal fashion, making it difficult for counties to properly implement policy changes. For example, DHS did not issue comprehensive guidance on how counties should implement 1931(b) eligibility determinations. Instead, it issued a series of written instructions along with numerous subsequent changes and clarifications, that made it difficult for county workers to know how to make the determinations properly.

Funding Mechanism May Reward Inefficiency. The DHS has advised us that it does not know why costs for eligibility determinations are so high or why large disparities in these costs exist among the counties. Our analysis indicates that the specific mechanism now being used by DHS to allocate funding for eligibility administration among counties may be

contributing to this situation. This funding mechanism partly bases a county's allocation on the amount of staff it devotes to eligibility determinations. In effect, DHS rewards counties financially for having more staff doing eligibility determination work, while not measuring directly whether those staff are being productive.

The Governor's Proposal to Improve Eligibility Administration

Budget Increases Proposed. The Governor's January budget proposes an additional roughly $41 million from the General Fund to enable counties to hire staff sufficient to ensure that only eligible beneficiaries are enrolled in Medi-Cal. Of this amount, nearly $25 million is for the current year and almost $17 million is in the budget year. In turn, the administration is proposing the adoption of changes in state law that would require counties to meet specified performance standards relating to their duties. Under the Governor's proposal, counties that failed to meet the new performance standards would face a 2 percent reduction in their funding for county administrative activities in the following year.

The DHS estimates that these performance standards will result in offsetting savings to the Medi-Cal Program of $194 million from the General Fund ($388 million all funds) in 2003-04. The savings are based on the assumption that county eligibility workers will complete required annual eligibility redeterminations on time for 560,000 ineligible Medi-Cal beneficiaries who would be disenrolled by the end of 2003-04. Because these disenrollments would occur over the course of the budget year, the projected effect on the Medi-Cal caseload is a decline of 305,000 average monthly eligibles.

The budget also proposes to add $448,000 from the General Fund to establish a new unit within DHS (with nine personnel-years in staffing) to ensure that counties comply with the new performance measures.

Basis for Funding Increases Is Questionable. The administration's projection of $194 million in savings during 2003-04 is based heavily on the premise that certain counties are not completing annual redeterminations of eligibility on time primarily because they lack sufficient funding, and therefore staff, to accomplish this task. However, there is little support for this premise. For example, the DHS recently completed a review of a sample of Medi-Cal cases to determine the extent to which redeterminations of eligibility had not been completed as required. Although Los Angeles County had completed only 56 percent of its redeterminations on time, according to DHS it was not underfunded for the processing of its cases. The DHS also examined ten counties that had experienced significant reductions in funding, and found that most did complete their redeterminations in a timely fashion.

Clearly, the relationship between level of funding provided to counties for these tasks and their performance is complex, and raises questions about whether the Governor's proposal to bolster funding for these activities is the most effective approach for increasing county performance.

Other Components of Governor's Plan Have Stronger Basis. Our analysis indicates that the Governor's proposals to establish state performance measures and a monitoring and penalty process will probably be effective steps to ensure county compliance with state and federal law. In our view, this increased level of oversight also is likely to result in significant savings to the state, because counties would now, for the first time, have a specific financial incentive to complete redeterminations on time and to disenroll individuals who are no longer eligible for Medi-Cal.

Analyst Recommendation. Because there is little evidence that the current- and budget-year funding added to the spending plan for the cost of doing redeterminations will improve county performance, we recommend the Legislature not approve these additional expenditures. However, we recommend that the Legislature adopt some components of the Governor's proposal, including the establishment of performance standards for counties and authorization of the additional state staff needed to monitor counties and take corrective actions if counties fail to meet the new standards. The Legislature should go further than the Governor's proposal and direct the department to adopt workload or productivity standards for county Medi-Cal eligibility workers and tie the level of funding to that individual county's performance in meeting these new standards rather than their eligibility staffing levels.

Other Options for Improving County Eligibility Determinations

In addition to the Governor's proposal, there are two alternative approaches the Legislature may wish to review when considering how to improve the eligibility determination process. Like the Governor's own proposal, each has certain advantages and disadvantages that we discuss below.

Centralizing Eligibility Determinations at the State Level. Instead of delegating the task of processing Medi-Cal applications to counties, the state could assume this responsibility itself. Presumably, such a change would be phased in gradually to avoid disruption of these functions. For example, DHS could begin such a transfer of responsibility by processing all Medi-Cal applications currently coming into the single point of entry. Under this approach, the state would funnel application data into a centralized computer system and authorize state employees to make final determinations of eligibility rather than continuing the present practice of forwarding Medi-Cal applications to the counties for further ac-

tion. Establishment of a state-level system for Medi-Cal eligibility would open the way for a simpler and quicker processing of applications using a new Internet-based system called Health-e-App.

- ***Advantages.*** Under this approach, DHS could achieve administrative efficiencies, such as reduced computer programming costs from changes in Medi-Cal eligibility codes. Instead of 58 counties making the programming changes, only the state would make the modifications. That would reduce the cost per eligible for Medi-Cal eligibility determinations to a level more in line with those of the Healthy Families Program. While the exact level of these savings are unknown, they could be significant. For example, a $50 drop in the cost of each eligibility determination would save about $150 million in General Fund support. Conducting eligibility determinations at the state level would also ensure greater uniformity in processing applications.
- ***Disadvantages.*** Transferring this responsibility from the counties to the state would be a difficult and complex task that would temporarily require an increase in state resources.

Realign a Share of Costs to the Counties. As discussed earlier in this analysis, the Governor's budget proposes to shift 15 percent of Medi-Cal benefit costs to counties along with new revenues to pay for these obligations. Instead of this realignment proposal, the Legislature may wish to consider the alternative approach of realigning a portion of the state costs for eligibility administration to the counties. (The realignment proposal is also discussed in "Part V" of *The 2003-04 Budget: Perspectives and Issues*.)

Such a shift in program and financial responsibility would be consistent with the principles of realignment given that counties already perform these functions. While counties would have little if any control over the costs of the Medi-Cal benefits under the Governor's realignment proposals, counties would continue to have considerable discretion to manage administrative costs for eligibility determinations. Any efficiencies achieved in this way would also have the effect of further decreasing state expenditures, since these costs would continue to be shared.

- ***Advantages.*** The state would directly save about $152 million in 2003-04 if counties were transferred about a 25 percent share of the cost of eligibility administration along with a corresponding amount of new revenue. State savings would be $304 million if a 50 percent share of cost were established. Unknown additional savings to the state could also be realized if the change made the eligibility determination process more efficient. Another advantage is that equalizing the county share of cost for Medi-Cal eligibility with comparable cost-sharing ratios for CalWORKs eli-

gibility workers as we suggest would also reduce the current incentive to shift costs for these activities from the county to the state.

- ***Disadvantages.*** This option does not address the lack of uniformity in processing applications. Moreover, establishing a county share of cost for Medi-Cal eligibility creates a risk that counties would control their costs by reducing their mandated activities, and indirectly increase state costs by allowing the caseload of ineligible (but enrolled) individuals to grow. This problem could only be avoided if the state more closely monitored county compliance with state-established performance and productivity standards, used corrective action plans to improve county performance, and considered other corrective actions when necessary.

Analyst's Recommendations

The Legislature faces some complex choices in determining how it wishes to finance and organize the critical task of eligibility administration of the Medi-Cal Program. Each of the three options discussed (Governor, state administration, and realignment) has its advantages and disadvantages, and some are more easily implemented than others. In our view, the Legislature requires additional information about the feasibility and merit of some aspects of these options before it can choose from among them. The Legislature should request DHS to assess the merit and feasibility of state administration of eligibility and report back at budget hearings.

State Should Assess Shift To Veterans Administration Benefits

Federal survey data suggest that there could be tens of thousands of military veterans in California who could be receiving comprehensive medical services from the Veterans Administration (VA) health care system, but who are enrolled instead in the Medi-Cal Program. If the federal survey data prove accurate, it is possible that the state could eventually save as much as $250 million annually by shifting eligible Medi-Cal beneficiaries to the VA system for their medical services. We recommend that the Department of Health Services be directed to report at the May Revision on the number of veterans eligible for VA health care coverage who are currently enrolled instead in Medi-Cal.

Background

Veterans' Coverage Expanded in 1996. Qualified veterans are entitled to comprehensive medical care and health services through the federal VA health care system. The VA currently operates 11 hospitals and 46 clinics that are located throughout the state in order to serve the needs of the state's veterans.

The *Veterans Health Care Eligibility Reform Act of 1996,* passed by Congress in October 1996, expanded many of the services provided to veterans. Veterans accepted in the VA health care system are now eligible for a full continuum of care called the "medical benefits package" that includes (1) diagnostic and treatment services, (2) rehabilitation services, (3) mental health and substance abuse treatment, (4) respite and hospice care, and (5) pharmaceuticals provided in conjunction with VA medical treatment. The VA indicates that, if it does not have a hospital or clinic available in a community to provide necessary medical care for a veteran, it will make arrangements for that care to be provided in the community at the VA's expense.

Prompted by the decision of Congress to expand health coverage to veterans, the State of Washington's Medicaid program has ceased the purchase of pharmaceuticals for veterans residing in VA-operated nursing homes. We believe comparable opportunities exist in California to use federal VA funding sources.

Medi-Cal Screens for Veterans. As part of the regular Medi-Cal eligibility screening process, county workers are required to ask applicants whether they have served in the armed forces and have veteran's status. The names of applicants who indicate that they are veterans are then referred to County Veterans Services Offices (CVSOs) so that they can be assisted in obtaining the veterans' benefits to which they are entitled. The referral process is intended to ensure that all possible outside sources of income, such as veterans' aid and attendance payments for the support of personal care, are obtained and available to help reduce costs to the Medi-Cal Program.

We also note that some Medi-Cal eligibility determinations are handled on the state's behalf by the U.S. Social Security Administration (USSSA). However, it was not clear to DHS how and if Medi-Cal eligibles are screened for veterans' status by USSSA.

Federal law requires states to obtain reimbursements from individuals who have another legal entitlement to health care (such as VA health care coverage), but instead obtain their medical care through Medicaid (Medi-Cal in California). As a result, the state must either screen out veterans who should be receiving their care from the VA health care system or seek compensation from them for their Medi-Cal services.

Veterans on Medi-Cal Rolls

Data Suggest Many Veterans in Medi-Cal. Notwithstanding the existing Medi-Cal regulations and eligibility procedures designed to screen for veterans, a survey conducted by the U.S. Census Bureau indicates that 117,000 California veterans had reported in 2001 that they were receiving Medi-Cal benefits. If this survey data are correct, the state could be expending significant state General Fund resources for Medi-Cal services for veterans who could be obtaining their medical services instead from the VA system. Given that many of these veterans are elderly and thus more likely to require costly medical services, we estimate that the state could be spending as much as $250 million in General Fund resources annually on Medi-Cal benefits for care that they are entitled to receive through VA hospitals entirely at federal expense.

However, DHS is unable at this time to confirm the actual number of Medi-Cal beneficiaries who are veterans. We are advised that, even though data on Medi-Cal applicants who are veterans are collected by county eligibility workers, DHS does not track these data at the state level.

Veterans' Home Care Should Be Viewed Differently. In our review of the Department of Veterans Affairs budget in the "General Government" chapter of this *Analysis,* we discuss strategies by which the state could enroll additional eligible veterans being admitted to the state's veterans' homes in the Medi-Cal Program. We note that, in the case of these veterans, there is a significant distinction to be made between obtaining *medical services* and *nursing home care* under Medi-Cal. Taking this approach in the veterans' homes might permit the cost of their nursing home care to be split between the state and the federal government, rather than supported entirely with state General Fund resources.

We also believe it makes sense for the state to examine the possibility that veterans across the state obtain their medical care from the VA system, instead of from Medi-Cal. As we have discussed, this might permit them to obtain comprehensive medical care in an entirely federally funded system at no expense to the state.

Analyst's Recommendation

Given the potential fiscal ramifications of this situation, we recommend that the Legislature direct DHS to examine whether veterans constitute a significant portion of the Medi-Cal Program caseload. The DHS has indicated this could involve a review by the department of a sample of Medi-Cal Program casefiles to examine how many persons have been identified on application forms as veterans. The DHS should perform a review to determine the number of veterans eligible for services provided

by the VA system that are receiving Medi-Cal benefits and report its findings to the Legislature at the time of the May Revision.

DISEASE MANAGEMENT COULD REDUCE MEDI-CAL COSTS

One significant factor driving projected future medical costs is the rise in medical costs for chronic diseases, such as asthma, diabetes, and heart disease, that if managed poorly can lead to expensive hospitalizations of patients. Our analysis indicates that the implementation of a disease management program in Medi-Cal could eventually reduce General Fund costs by as much as hundreds of millions of dollars annually and significantly improve care for patients with the most difficult to control health conditions.

What Is Disease Management?

Disease management is a strategy to get individuals to take better care of their chronic health conditions. A chronic condition is defined as one that lasts a year or longer, limits an individual's physical activities, and requires medical care. Many adults suffer from such conditions. It is estimated nationally that more than 25 percent of the adults enrolled in Medicaid have at least one chronic condition. That means that more than 700,000 adult Medi-Cal beneficiaries in California may be living with one or more chronic conditions.

Disease management programs can improve the quality of life of patients by catching health-related problems early, thereby enabling patients to subsequently avoid high cost medical treatments and procedures—especially those associated with hospitalizations. The following chronic conditions are typically covered by disease management programs:

- Coronary artery disease
- Diabetes
- Chronic heart failure
- Chronic obstructive pulmonary disease
- Hypertension
- Asthma

Disease management programs combine the following key approaches to help ensure that patient care is coordinated and that patients adhere to treatment programs: the identification of patients who have or

are at risk of suffering from chronic conditions, use of technology to link patients to the medical system, and the use of patient education programs that promote effective preventive self-care. A more detailed explanation of these activities is provided below.

Identification of Patients. Individuals who are willing to participate are identified by a nurse or physician as someone who could benefit from disease management using information about their use of pharmacy and lab services, clinical data, and patient surveys. After adjusting for the severity of health care needs, appropriate interventions are developed to address the special needs of individuals with severe chronic medical problems.

This is often not a simple process. Obtaining and interpreting patient data from Medicaid enrollees can be challenging because individual beneficiaries often repeatedly enroll and disenroll in the program depending on their need for medical services and frequently change residences.

Technology Linking Patients to Medical Systems. Disease management relies upon the use of telecommunications and computer technology to create a more closely knit and better-coordinated working relationship among patients, their nurses or care managers, and their physicians. Typically, patients are given equipment capable of monitoring their vital signs, such as blood pressure and weight. This information is communicated electronically to nurses or care managers on a regular schedule, usually via the Internet or touch-tone telephone. The data are monitored by computer systems. Nurses are alerted if the data seem to indicate that a patient's vital signs have fallen outside of the normal medical parameters that his or her physician has established. The nurse or physician who contacts the patient when this occurs has a wealth of data immediately available to assist in making care-related decisions. In some cases, patients will also receive visits at home from care managers.

Patient Education to Encourage Self-Care. Patients are taught to better manage their own health care with intensive education aimed at increasing their understanding of their chronic diseases. This educational process includes regularly scheduled phone calls from care managers to patients that provide basic information to patients about their disease, personal coaching on subjects such as nutrition and exercise, and help in identifying for patients how they can modify their behavior in ways that will improve or maintain their good health. For example, a nurse might review with a patient the medications she is taking and the frequency at which she is taking them in order to ensure her compliance with her prescriptions. Under the disease management approach, patients are encouraged to access information about their own vital signs so that they can

easily monitor their own progress in recovering from a disease or maintaining their health.

Disease Management Differs From Medical Case Management. The Medi-Cal program currently does not provide disease management services. In some instances, the state will provide medical case management services to Medi-Cal patients that differ from disease management services. Disease management services are generally less intensive, are more long term in nature, and are applied to a broader population than medical case management.

Typically, under medical case management, nurses provide services to a relatively small number of high-cost patients to reduce their cost of care and to ensure the continuity of their care. Rather than chronic conditions, medical case management is typically provided to patients who are recovering from a catastrophic illness or event, such as an automobile accident. While disease management is ordinarily ongoing, medical case management more typically involves the provision of temporary services that are intended to facilitate a patient's discharge from the hospital and prevention of their readmission.

Potential Benefits of Disease Management

Savings Could Be Significant. Studies of the efficacy of disease management programs have found that monitoring chronic conditions and improving the coordination of care can reduce the number of emergency visits or hospital stays of patients. These studies indicate that health care costs related to chronic conditions could be reduced by as much as 50 percent. These savings would be partly offset by the cost of disease management services, but in a number of cases the implementation of a disease management approach has resulted in a significant net reduction in health program costs.

For example, a 1998 study of a program that involved the interactive home monitoring of Medicaid patients who had previously been treated for congestive heart failure found that it significantly reduced their returns to the hospital for additional medical assistance. The program resulted in a 44 percent decrease in readmissions of patients to hospitals and, despite the intensive nature of the disease management interventions, resulted in a net savings of $460 on average for each patient involved in the program.

Another study of heart failure patients in 1999 found that patients enrolled in an intervention program incurred overall health costs that were significantly less than for comparable patients who were not enrolled in the program. Patients in the intervention program were required

to monitor their blood pressure, pulse, weight, and other symptoms at home and to contact their physician if the results concerned them. Patients also received weekly educational mailings and a ten-minute phone call from a nurse to discuss the materials, new symptoms, medication changes, and physician visits.

The annual health care costs of enrolled patients was approximately $9,800 (including the less than $2,400 annual cost of the intervention program), while patients who were not enrolled cost almost twice as much—about $18,800 per year. These savings were attributed to a reduced number of claims for medical services, a reduction in hospital admissions, and a reduction in the number of days a patient spent in the hospital when they were admitted.

There is evidence that disease management can also reduce the costs of other types of medical conditions besides heart problems. A 1999 study found that Virginia's disease management program for asthma patients enrolled in Medicaid reduced their collective number of emergency visits by about 41 percent. An analysis of the program found it to be cost-effective, with projected direct savings to the Medicaid program of $3 to $5 for every dollar spent for support of the disease management program. That analysis indicated that, had all Medicaid recipients with asthma claims participated in the program, the savings in overall medical costs would have ranged from approximately $218,000 to $1.2 million depending upon the severity of the patients' condition.

Programs Must Be Carefully Designed and Implemented. If disease management programs are not carefully designed and implemented, the evidence indicates that they will not necessarily prove successful. Florida's first efforts a few years ago at implementation of a disease management strategy in its Medicaid program did not achieve the projected savings of $113 million over four years, and may have actually cost the state more money than the program saved. Florida's failure to achieve the projected level of savings has been attributed to two main factors: an initial inability to correctly estimate the potential savings from the program, as well as specific problems in its approach to disease management.

In regard to the second factor, Florida's implementation approach was to contract with a number of disease management vendors, with each one hired to focus its efforts on one particular type of disease. This approach proved unsuccessful primarily because patients often have a combination of chronic conditions. Treating one disease at a time instead of implementing a comprehensive approach to a patient's entire set of chronic conditions appears to have been inadequate to improve patients' health care.

Although Florida's disease management program as a whole did not achieve savings, it should be noted, some of its individual efforts were successful. For example, the chronic health failure program, which has operated for more than two years in a fee-for-service medical system, has achieved 16 percent gross savings in the first year (a net savings of approximately 6 percent according to a preliminary estimate). The program achieved a 40 percent reduction in the utilization of medical services compared to another group of patients who for testing purposes did not receive such services.

Some States Have Focused Their Programs on Prescription Drug Use. Some disease management programs have effectively involved pharmacists in ensuring that patients take their prescription drugs in compliance with doctors' orders. A program for patients suffering from high cholesterol levels—a condition related to heart and other health problems—has demonstrated a positive effect on patients. One study found that, after one year, about 70 percent of patients continue taking their medicine compared to 30 percent nationally and about 85 percent of the same patients have healthy cholesterol levels compared to 45 percent nationally. Ensuring that patients take their medications properly can reduce health care costs by decreasing the number of unnecessary emergency room and hospital visits.

Not surprisingly, the implementation of disease management programs that focus on prescription drugs can result in an increase in drug utilization and expenditures for those medications. In this case, however, this is a desirable result because of the much larger and offsetting savings associated with a reduction in the number of hospitalizations from keeping patients with chronic conditions healthy.

One state is taking an approach that guarantees that it will achieve savings, at least initially, from integrating disease management practices into its Medicaid program. Florida has contracted with a drug manufacturer that has guaranteed the state savings of $15 million in the first year and $18 million in the second year. The state has also contracted with another drug manufacturer for expected further savings of $16 million.

Other State and Federal Authorities Turning to Disease Management. The expansion of disease management programs is now a national trend. A number of states plan to implement disease management programs this year in an attempt to achieve savings in their Medicaid programs. Missouri will implement disease management programs for asthma, congestive heart failure, diabetes, and chronic obstructive pulmonary disease. Mississippi plans to implement such programs for asthma, diabetes, and hypertension. Iowa intends to enhance its existing programs, while the State of Washington recently signed agreements with three dis-

ease management companies providing the state a 5 percent guarantee of net savings (after disease management program costs have been taken into account) for Medicaid patients suffering from asthma, diabetes, congestive heart failure, and kidney disease.

The federal Medicare program launched a three-year disease management pilot project for its chronically ill beneficiaries early last year. The project plans to target patients with advanced-stage congestive heart failure, diabetes, and coronary heart disease. Medicare is paying disease management organizations a monthly premium for coordinating the care of patients in the studies and for the cost of prescription drugs.

Moving California Toward Disease Management

We recommend the enactment of legislation to guide the implementation and evaluation of disease management pilot projects for the aged, blind, and disabled patients enrolled in fee-for-service Medi-Cal. Such pilot projects would enable the Legislature to identify the most cost-effective disease management programs for the Medi-Cal population. We estimate that the implementation of a full-scale disease management program for the aged, blind, and disabled could result in future net savings to the General Fund of up to several hundreds of millions of dollars annually.

Aged, Blind, and Disabled Could Benefit the Most. A growing body of scientific studies and the experiences of other states indicate that the effective implementation of disease management programs could reduce the state's health care costs and improve care for the more than 1 million aged, blind, and disabled Medi-Cal patients currently enrolled in Medi-Cal's fee-for-service health care delivery system. While some children also suffer from chronic conditions amenable to disease management, these older Medi-Cal beneficiaries are the ones most likely to fully benefit from a disease management program. This is because they generally consume the most health care dollars. (They are about 24 percent of the Medi-Cal population, but 64 percent of Medi-Cal program costs) and they are living longer with multiple chronic conditions.

A Fragmented Fee-for-Service System. Despite this situation, most aged, blind, and disabled participants in Medi-Cal are placed in a health care environment poorly designed to meet their complex medical needs—the fee-for-service reimbursement system. Under this system, providers are paid for each examination, procedure, or other service that is furnished and patients can obtain services from any provider who has agreed to accept Medi-Cal payments.

The fee-for-service system is a fragmented and uncoordinated approach to the delivery of care often not well-suited for the care of individuals suffering from chronic medical conditions. For example, physicians participating in Medi-Cal are not required to communicate with one another about the care that they might be providing to the same patient. That could make it very difficult for a patient with significant health care needs to follow multiple treatment plans that include monitoring themselves, taking medication, and making other lifestyle changes.

General Fund Savings Could Be Significant. It is difficult to provide a precise estimate of the savings that would result from the implementation of a full-scale disease management program for aged, blind, and disabled patients enrolled in the Medi-Cal fee-for-service program. This is because the level of savings would depend on the types of disease management services provided and upon which program recipients were targeted to receive the services. However, for illustrative purposes, based upon the range of savings that other states have been able to achieve with disease management, we estimate that the *gross* savings to the General Fund could range from $387 million to $601 million annually.

Our savings assumes that these services are provided to the approximately 440,000 aged, blind, and disabled patients who have at least one chronic illness. The total cost of these patients to the Medi-Cal Program in 2001 was more than $5.3 billion ($2.7 billion from the General Fund), with the annual cost per patient ranging from $6,000 to $76,000 and the average cost being $12,000 per client.

The cost of providing disease management services that could significantly reduce these medical bills is comparatively low—data from other states indicate these costs typically range from $900 to $2,400 per person annually. Our estimate assumes that a program would be designed in a cost-effective manner and thus would have an average annual cost of about $1,650 per person and a total cost of $360 million General Fund for serving the aged, blind, and disabled population. However, management of some diseases is more costly than for others. For example, the average annual cost of providing disease management services for someone with diabetes can cost as much as $9,600 annually. Programs that focus on pharmaceutical use and that directly reimburse pharmacists for providing such services could cost much less.

Figure 8 shows for illustration purposes the probable net savings the state could achieve from such a program after the cost of the disease management services have been taken into consideration. The net savings to the General Fund range from $27 million to $241 million—equivalent to between 1 percent to 9 percent of the cost of the care of these aged, blind, and disabled beneficiaries in 2001. Our savings estimates are in

line with the various levels of net savings that have been achieved in other states that have tested the disease management approach. The actual amount of savings that could be achieved in the Medi-Cal Program will vary significantly depending upon the specific disease management services for which the state contracted, the cost of those services, and the groups of program beneficiaries selected to receive the services.

Figure 8

Significant General Fund Savings Possible From Disease Management

(In Millions)

Percent net savings	1%	3%	5%	7%	9%
Additional cost of disease management services[a]	$360	$360	$360	$360	$360
Savings from implementing disease management[b]	-387	-441	-493	-548	-601
Net savings	**$27**	**$81**	**$133**	**$188**	**$241**

[a] Based on estimated average annual cost of $1,650 per person.

[b] Estimated level of savings is based on the experience of other state Medicaid programs.

Savings Levels Could Be Guaranteed. Using the same general approach as is now being implemented in Florida and Washington, we believe a disease management program could be structured in California in a way that would guarantee savings to the state, or at least ensure that such a program would result in no additional costs to the state if it were unsuccessful. This could be accomplished by contracting for such services in a way that places the disease management contractor's fees at risk depending upon the contractor's ability to achieve an agreed-upon level of savings. If the contractor were unable to achieve that savings level, its fee payments from the state would be reduced or eliminated altogether.

Net Savings Unlikely in the Budget Year. One important consideration for the Legislature is that any net savings from implementation of a disease management program in 2003-04 would probably not be realized until 2004-05. Such programs often require a significant up-front investment of resources for chronic care management services that offset potential savings in the short run. However, they tend to reap significant savings in the long term by reducing hospitalization and other expensive

medical services. A long-term investment in such efforts may nonetheless make sense, given projected increased costs in Medi-Cal over time.

Analyst's Recommendation. As noted above, our analysis suggests that the implementation of a disease management program, if structured correctly, could eventually result in significant net General Fund savings to the state. However, a full-scale implementation of such a program within Medi-Cal may not be feasible at this time because it is not yet clear which specific approaches to disease management in Medi-Cal would work best and be most cost-effective. Also, the large budget shortfall now facing the state makes it difficult to provide the substantial initial investment in disease management programs needed to yield savings. Given these circumstances, we believe it makes sense at this time for the state to take some modest first steps to explore the potential of disease management programs—steps that could eventually set the stage for a full-scale implementation of this approach and significant state savings in the Medi-Cal Program.

Accordingly, we recommend that the Legislature budget the necessary funds and adopt statutory language directing DHS to conduct a few small pilot projects in disease management for three years. These projects would be designed to improve treatment of a variety of chronic conditions such as diabetes, asthma, congestive heart failure, chronic obstructive pulmonary disease, coronary artery disease and hypertension. We estimate that the cost of such pilot projects that focus on a portion of these chronic conditions would be about $650,000**,** with a state General Fund appropriation of $323,000 needed in the 2003-04 fiscal year to get such a project under way. (This amount could be higher or lower depending on the scope of the pilot program.) It is likely that the pilot projects would achieve a small amount of savings initially that could grow to reduce or eliminate the cost to the state of the projects in the future. In addition, based on our analysis, it appears that funding from nonprofit organizations would be available to conduct an evaluation that could lower the state's financial commitment or expand the scope of the pilot projects. Legislation (AB 1949 [Baca]) to initiate a disease management program in Medi-Cal was proposed but not enacted during the 1997-98 legislative session. We recommend that the statutory language adopted at this time include the following provisions:

- A requirement that the pilot projects include statistically significant samples of the Medi-Cal aged, blind, and disabled population with the random assignment of an approximately equal number of patients with similar conditions both to a disease management program and to a "control group" that does not receive disease management services.

- A requirement that DHS test more than one type of disease management strategy, including at least one pilot project focused on intervention strategies and one focused on involving pharmacists in ensuring patient compliance with their drug prescriptions. If feasible, DHS should also consider establishing a pilot project in which a contractor guarantees savings to the state and bears some financial risk for achieving savings from their implementation of disease management services.
- A requirement that DHS evaluate the impact on the quality of care and fiscal effects of the disease management pilot projects and report the results of these pilot projects to the Legislature by December 1, 2006.
- Provisions authorizing the receipt and expenditure of grants from non-profit organizations to help offset the costs of such a study.

We believe that this approach would provide the Legislature with a scientifically valid and relatively low-cost approach to evaluating the potential benefits of disease management for the Medi-Cal Program. Depending on the success of the pilot projects, the disease management services could be expanded to additional Medi-Cal patients in the future when the state may be better able to afford the substantial investment of funds needed to expand such programs.

OTHER BUDGET AND POLICY ISSUES

Funding Request for Medi-Cal Estimate Redesign

We withhold recommendation on a proposal to continue three limited-term staff and to provide increased funding for a planned redesign of the Medi-Cal budget estimate because it is not clear how the Department of Health Services intends to move forward with the completion of the project.

Request for Funding Premature. The Medi-Cal budget estimate is a document that DHS prepares twice a year that forecasts expenditures, eligibility, and the impact of regulatory and policy changes on the Medi-Cal Program. The computer system that is used to help prepare the document is outdated and cannot provide key information that the Legislature needs to assess Medi-Cal spending proposals. An information technology project now underway, scheduled at one point for completion in April 2003 but now delayed, would attempt to remedy these and other problems with the Medi-Cal estimate.

At the time this analysis was prepared, we were advised that the department was considering making significant modifications to its budget request to support the information technology project for the Medi-Cal estimate. The budget proposed to continue three limited-term positions for two years and $232,000 General Fund for consulting services and software. Until the department reaches a final decision about the matter and provides the Legislature with additional information about how it intends to proceed with the redesign of its estimate, the Legislature is not in a position to act on the budget request. Accordingly, we withhold recommendation on the proposal at this time.

Department Needs to Take More Steps to Ensure Fair Prices

The Bureau of State Audits (BSA) has recommended that the Department of Health Services (DHS) do more to ensure that it receives fair and reasonable prices for medical supplies, durable medical equipment, and hearing aids. We recommend that DHS report at budget hearings regarding what steps it is taking to comply with the BSA's recommendations to ensure that it gets the best price for these items.

BSA Audit Findings. A December 2002 report by Bureau of State Audits (BSA) found that DHS does not adhere to its own policies that were intended to ensure that it receives fair and reasonable prices for certain medical supplies and durable medical equipment (DME) that it provides for Medi-Cal beneficiaries. One example cited by BSA involves the purchase of wheelchairs for Medi-Cal beneficiaries. The DHS generally provides reimbursement only for those DME items that have been screened and placed on an approved list, but exceptions are allowed in certain cases. A written policy issued by DHS in June 1998 allows field office staff to approve the reimbursement of wheelchairs which are not on the approved list only if providers provide specific documentation justifying the purchase of the equipment. However, BSA determined that DHS staff are following an earlier policy memorandum that allows the reimbursement for unlisted wheelchairs without additional documentation.

The BSA found other problems, indicating, for example, that DHS lacks product and price comparison data needed to determine whether the costs the state is being charged for DME items, as well as other types of medical supplies, are reasonable.

We are concerned about such practices because they could result in the state paying more than it should for DME items. For example, unlisted wheelchairs cost the state $3,121 each on average, more than five times the $622 average cost of a listed wheelchair. The practice of buying these items without appropriate documentation justifying the purchase, and without the data needed to determine if the prices being charged are

reasonable, increases the risk that the state is purchasing higher-cost unlisted wheelchairs in cases where less expensive listed wheelchairs would be sufficient to meet the needs of Medi-Cal beneficiaries. Notably, since 1998, expenditures for unlisted items have grown faster than expenditures for other listed DME items.

The BSA also found that DHS is unprepared to implement two measures which the DHS has assumed would result in significant savings in Medi-Cal expenditures for DME. First, the department plans to convert its existing billing codes to universal product numbers (UPN), therefore providing more relevant and current information on pricing and products. The department indicates that this change would result in annual savings of $30 million because it would allow the state to obtain rebates from the manufacturers of medical supply items that are identified using UPNs. However, BSA found that this approach may not be viable because DHS has not thoroughly assessed problems in the implementation of this strategy nor its full potential cost.

The BSA also found problems with the way DHS was implementing proposals to achieve General Fund savings in the program by negotiating contracts for DME and medical supplies. The Governor's budget plan assumes that such negotiations would result in an additional $30 million General Fund savings to the state in 2003-04. However, BSA concluded that DHS had not focused on clear objectives and staffing needs or determined the willingness of providers and manufacturers to cooperate in these efforts. The consequences could be lower savings than the amounts assumed in the Medi-Cal Program budget and consequentially higher costs to the state General Fund, and the possibility that some patients who needed DME might find it more difficult to obtain these items through medical providers.

Analyst's Recommendation. We recommend that the Legislature direct DHS to report at budget hearings on the following issues related to implementation of the BSA audit:

- The department's plans to enforce its June 1998 policy that requires appropriate documentation of claims for reimbursement of unlisted DME items.
- The steps DHS will take to ensure that its field office staff can determine whether the prices billed for DME and medical supplies are reasonable.
- The department's progress on its UPN conversion project, including information regarding any barriers to implementation that DHS is encountering, the full projected cost of implementing this change, and the expected date when the project will be completed.

- The status of the effort to negotiate contracts with providers for DME and clinical laboratory services, the projected staffing needs for these efforts, and its updated estimate of the anticipated level of savings that will result from the new procurement method for these items.

PUBLIC HEALTH

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

The Governor's budget proposes $2.5 billion (all funds) for public health programs in the budget year, a 4 percent ($113 million) decrease from the previous year. The budget proposes $412 million from the General Fund in the budget year, a 22 percent ($114 million) decrease from the current year. This decrease is largely due to the realignment of various public health grant programs.

BUDGET PROPOSALS

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

Realignment of "Safety Net" Programs. The budget proposes to shift the administrative and fiscal responsibility for various public health grant programs from the state to the counties. The plan also proposes to provide counties with a dedicated revenue stream for the support of these programs. The proposal would shift $147 million in funding from several sources for public health programs to the counties, and would result in about $68 million in General Fund savings. The following programs are proposed for realignment: Adolescent Family Life, Black Infant Health, Local Health Department Maternal and Child Health, Expanded Access to Primary Care, Grants in Aid for Clinics, Indian Health Program, Rural Health Services Development, Seasonal Agricultural and Migratory Worker, California Health Care for Indigents Program, Rural Health Services, and Public Health Subvention. The counties would assume financial and operational responsibility for the programs and would have discretion to shift funds among programs in keeping with local priorities.

Please see "Part V" of *The 2003-04 Budget: Perspectives and Issues*, for a discussion of realignment and our recommendations in regard to the Governor's proposal.

Child Health and Disability Prevention Program (CHDP). The CHDP provides preventive health, vision, and dental screens to children and adolescents in families with incomes at or below 200 percent of the Federal Poverty Level (FPL). The Governor's budget proposes $16 million ($6.2 million General Fund) in total expenditures for the CHDP. This is an 84 percent ($83 million) decrease in all funds and an 81 percent ($26 million) decrease in General Fund expenditures from the previous year. This dramatic reduction is due to the implementation of the "CHDP Gateway" program.

We provide a more detailed discussion of the CHDP budget proposal later in this section.

Emergency Medical Services Authority (EMSA) Consolidated Into DHS. The EMSA's primary responsibilities include the development and review of local emergency medical services plans; coordination of medical and hospital disaster preparedness; and establishment of standards for the education, training, and licensing of EMS personnel. The agency also administers a program that allocates state funding for the support of trauma care centers. The Governor's budget proposes to consolidate the EMSA into the DHS for a reduction of five positions and $138,000 in General Fund savings in the budget year. Statutory changes are also proposed to shift EMSA operations into DHS. The EMSA will be a new division within DHS, and will maintain its current functions, except that the budget proposes to discontinue support allocations for the trauma care centers which amounted to $20 million from the General Fund in the current year.

AIDS Drug Assistance Program (ADAP). The ADAP is a drug subsidy program for persons with HIV with incomes up to $50,000 annually who have no health insurance coverage for prescription drugs and are not eligible for Medi-Cal. Currently, clients with incomes up to 400 percent of the FPL (about $35,440 for a single childless adult) pay no copayment or premium, while individuals with incomes above that level pay a "sliding scale" copayment that increases with their income level. The budget proposes about $186 million ($61 million from the General Fund) for ADAP in 2003-04. While this would provide a $2.3 million increase in all funds for the program over the previous year, General Fund support for the program would decrease by $6.9 million.

Under the Governor's budget proposal, a General Fund reduction of $15.2 million would be offset by a proposed increase in client copayments. The budget proposes a three-tiered copayment system in which clients

with federal adjusted gross incomes between 201 percent of the FPL (about $11,940 for a single childless adult) and $50,000 pay either $30, $45, or $50 per prescription, depending on income and family size. The ADAP budget also reflects program augmentations due to caseload increases, increases in the cost of drugs, and other factors.

Community Challenge Grant (CCG) Program. The CCG provides grants to community-based organizations for programs intended to reduce the number of teenage and unwed pregnancies and to promote responsible parenting. In the past, the federal funds to support CCG have been included within the budget of the Department of Social Services (DSS) and subsequently transferred to DHS for the operation of the program. However, the 2003-04 DSS budget does not provide the $20 million needed to continue CCG because of continued uncertainty about whether these federal funds will be available. The DSS indicates the matter may not be resolved until July 2003. The administration does not plan at this time to support the program from any other fund source.

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

The Governor's budget proposes $36 million ($28 million General Fund) for GHPP in 2003-04. This is a 7 percent decrease in overall program funding and a 9 percent ($3.6 million) decrease in General Fund spending from the previous year. This includes a funding augmentation of $316,000 for three additional staff and contract services to achieve program efficiencies in the budget year, and an augmentation of almost $2 million to accommodate an increase in the caseload and utilization of these services. The budget plan also assumes that the state will be able to reduce program expenditures due to rebates on its purchases of blood-clotting factor for treatment of persons with hemophilia, implementation of utilization controls for pharmaceuticals, increases in revenue from client fees, and reductions in provider rates.

Poison Control System. The Governor's budget proposes to reduce the Poison Control System budget by $3.6 million General Fund and offset it with an equal amount of funding from the State Emergency Telephone Number Account (911). For additional information and our recommendations regarding the administration's proposal to increase the

911 surcharge rate, please see our discussion of the State Emergency Telephone Number Account in the "General Government" chapter of this *Analysis.*

Consolidation of Domestic Violence Programs. The Governor's budget proposes to consolidate the domestic violence shelter programs currently administered by the Office of Criminal Justice Planning (OCJP) into DHS. The administrative and programmatic responsibility for the programs, as well as $730,000 from the General Fund and $9.1 million in federal funds, would be transferred from OCJP to the DHS Domestic Violence Shelter Program.

Proposition 50 Water Bond Projects. The budget proposes to increase the Division of Drinking Water and Environmental Management's budget by $112 million from the Proposition 50 resources bond approved by voters in November 2002. The funds are to be used for grants and loans to local water agencies to meet safe drinking water standards and for security protection of drinking water systems.

For additional information about the budget's proposal for Proposition 50 expenditures, please see the *Fund Conditions for Resources Programs* write-up in the "Resources" chapter of this A*nalysis.*

Prostate Cancer Program. The Prostate Cancer Program provides prostate cancer treatment for men 18 years of age or older who do not have health insurance or any other means to pay for their care. The program is managed by the University of California (UC) at Los Angeles Department of Urology, which through subcontracts has established sites in several regions of the state to provide prostate cancer treatment services.

The Governor's budget proposes to reduce the $20 million appropriated for the program in the current year by $10 million, due to lower than anticipated program participation, and to revert the amount of funding that would be saved to the General Fund. In the budget year, funding for the program would be further reduced to $5 million, and program support would be shifted from the Tobacco Settlement Fund to the General Fund.

Women, Infants, and Children (WIC) Nutritional Program. The WIC program provides nutritional support and education for low-income women, infants, and children who are at risk for malnutrition. Women can redeem food vouchers at authorized grocery stores throughout the state for specific foods. The WIC program is funded entirely with federal funds. The budget proposes to increase WIC's expenditure authority by an additional $15.5 million in 2002-03 and by $84.4 million in 2003-04 to reflect the availability of additional federal funds.

Cancer Research. The Cancer Research Program provides grant funding to a variety of institutions, including various institutions in the UC system, to help fund research on gender specific cancers, colorectal and other cancers. The DHS contracts with UC Davis to administer the program. The administration proposes to reduce the $12.5 million General Fund appropriation for the program in the current year by about half—$6.3 million—and to eliminate the remaining $6.2 million in the budget year. Funding would be phased out as existing research contracts expire.

CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

Background

Medical Screens and Immunizations Provided. The state CHDP program was established by Chapter 1069, Statutes of 1973 (AB 2068, Brown), to provide preventive health, vision, and dental screens to children and adolescents in low-income families who do not qualify for Medi-Cal. The CHDP program reimburses providers for completing health screens and immunizations for children and youth less than 19 years of age with family incomes at or below 200 percent of the FPL.

The program is jointly administered by the state DHS and county health departments. The DHS provides statewide oversight of the program, including making payments to providers. The county health departments develop local plans to recruit CHDP providers, ensure CHDP provider outreach and education, and handle client referrals and follow-up.

Governor's Budget Proposal. The Governor's budget proposes the allocation of $99 million from all fund sources ($32 million from the General Fund) in the current year for an estimated 1.7 million CHDP health screens. The budget plan would provide $16 million from all fund sources ($6 million from the General Fund) in the budget year for the program, for an estimated 256,000 CHDP health screens. The dramatic decrease in proposed program expenditures is based upon the assumption that the CHDP gateway will be implemented beginning in July 2003 and that its implementation will significantly change the way the CHDP program is operated as discussed below.

CHDP Gateway Proposal

Administration's Revised CHDP Gateway Proposal. Almost all children receiving CHDP services are eligible to enroll either in the Medi-Cal or Healthy Families Programs, unless they are ineligible for these programs mostly because they are undocumented immigrants. As a result,

with the implementation of the Healthy Families Program in 1998 the state established a new role for CHDP as a gateway for eligible children receiving its limited screening and immunization services to enroll in more comprehensive coverage under the Medi-Cal and Healthy Families Programs. However, this gateway was never fully established, as we reported in our January 2001 report entitled, *CHDP Fails as Gateway to Affordable Health Care.*

The *2002-03 Budget Act* provided funding and staffing to DHS for a new proposal intended to improve CHDP's role as a gateway to Medi-Cal and Healthy Families enrollment by establishing an Internet-based system to more systematically identify and bill the Medi-Cal and Healthy Families Programs for services to children who are already enrolled in those programs. The gateway program would also "pre-enroll" children in Medi-Cal who are not already enrolled in Medi-Cal or Healthy Families. For pre-enrolled children, the costs of the CHDP screen, as well as medical services would be paid through the Medi-Cal Program, with costs split equally between the state General Fund and federal funds. If the CHDP health screens and immunizations were paid for under CHDP, the state would pay for almost all of these costs.

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

Budget Assumes the Gateway Reduces CHDP Expenditures. The Governor's budget plan assumes that, as the gateway takes effect, the cost of screenings and immunizations for many children would shift to the Medi-Cal and Healthy Families Programs and would no longer be borne by CHDP. Accordingly, the Governor's budget plan proposes to reduce the state budget for CHDP by $83 million (all funds) in 2003-04.

This reduction in the CHDP budget would be offset under the Governor's budget plan by increased expenses in the Medi-Cal and Healthy Families Programs. The budget provides $259 million in additional funds in the Medi-Cal budget ($126 million from the General Fund) and $20 million in the Healthy Families Program budget ($8 million from the General Fund) to fund these projected additional costs.

Uncertainties in Gateway Implementation

We concur with the Governor's budget proposal to implement the new Child Health and Disability Prevention gateway proposal, but recommend that the Department of Health Services report at budget hearings regarding the schedule for implementing this new system.

Caseload Shifts Could Be Overestimated. The administration estimates that about 1.3 million children will be temporarily pre-enrolled in Medi-Cal, about 296,000 children will be enrolled in ongoing Medi-Cal, and 37,115 children will be enrolled in the Healthy Families Program in the budget year as a result of the new gateway program. Our review indicates that the gateway will be successful in pre-enrolling children in Medi-Cal. We also believe that the administration's estimates of the number of children who would be enrolled in Medi-Cal and Healthy Families on an ongoing basis are reasonable. However, there are several aspects of the gateway implementation plan that could result in fewer children being enrolled than expected. Notably, the gateway process would not simplify application forms or take advantage of a new Internet-based application process, known as Health-e-App, to help move pre-enrolled children to Medi-Cal and Healthy Families. Nor would any new steps be taken to make enrollment assistance available to families of these children in the offices of CHDP providers. If the administration's caseload assumptions are overstated, state fiscal support for the Medi-Cal and Healthy Families Programs could be overbudgeted by tens of millions of dollars combined.

Implementation of the Gateway May Be Delayed. The gateway proposal includes the implementation of new information technology systems. As with major information technology projects, delays are possible. Notably, the Governor's 2003-04 budget plan indicates that the gateway project will experience a three-month delay from April 2003 to July 2003. Any further delay in system implementation would probably result in more health screens and immunizations being provided and funded through CHDP.

Analyst's Recommendation. We recommend approval of the CHDP budget, including the budget requests that are related to implementation of the gateway plan. However, because any variance from the implementation schedule for the gateway project would significantly affect the Medi-Cal, Healthy Families and CHDP Programs, we recommend that the Legislature direct DHS to report at budget hearings on the gateway implementation schedule.

MANAGED RISK MEDICAL INSURANCE BOARD (4280)

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

The budget proposes $972 million from all fund sources ($92 million General Fund) for support of MRMIB programs in 2003-04, which is an increase of $128 million or about 15 percent ($61 million General Fund) over estimated current-year expenditures. This increase is due primarily to projected caseload increases in the AIM and the Healthy Families Programs. In addition, the administration has proposed to shift $10.5 million from MRMIB programs formerly supported by the Tobacco Settlement Fund (TSF) to the General Fund due to the securitization of the TSF revenues. The budget further reflects caseload increases due, in part, to the implementation of the Child Health and Disability Prevention (CHDP) "gateway" program to shift children into other health programs providing more comprehensive medical care.

The administration proposes to implement a plan to transfer infants now enrolled by their families in AIM into the Healthy Families Program, while maintaining health coverage for their mothers through AIM. Under the Governor's budget plan, the Rural Health Demonstration Project (RHDP) would be discontinued in the budget year.

Finally, the budget proposes the enactment of legislation to permanently extend the Healthy Families Program, which by law would otherwise expire on January 1, 2004.

ACCESS FOR INFANTS AND MOTHERS

Background

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

Currently, program participants pay a fee of 2 percent of their family income toward the costs of services received by the mother and an infant up to one year of age (an average of about $790). Infants can receive coverage for a second year for an additional $100, or $50 if their recommended one-year vaccinations are up to date.

Governor's Proposal. As summarized in Figure 1, the Governor's budget proposes about $118 million from all funds ($7 million General Fund) for the AIM program, about a 22 percent increase over program spending in the current year. The growth in expenditures is largely attributable to caseload increases.

Figure 1

Access for Infants and Mothers Program Budget Summary

(In Millions)

	2001-02	2002-03	2003-04
Perinatal Insurance Fund (Proposition 99)	$64.0	$83.2	$97.3
General Fund	—	0.3	7.1
Tobacco Settlement Funds	—	4.3	—
Federal funds	2.9	8.6	13.1
Totals	**$66.9**	**$96.4**	**$117.5**

The Governor's budget proposes to discontinue coverage of infants in AIM, and instead enroll them in the Healthy Families Program. Clients' financial contributions would be reduced from 2 percent of family income to 1.5 percent to offset the premiums families would subsequently pay in the Healthy Families Program.

The Governor's proposal would take advantage of available federal funds, thereby reducing state expenditures by shifting health coverage for infants from the AIM program to the Healthy Families Program. This shift permits a draw down of federal funds for infants with family incomes of 200 percent to 250 percent of FPL. The infants with family incomes between 250 percent and 300 percent of FPL would be funded entirely with state funds. The administration estimates that the proposal will result in budget-year expenditures of about $977,000, due to the decrease in family financial contribution. However, in 2004-05 the anticipated savings is $6.7 million and in 2005-06 savings are estimated to be $10.1 million.

HEALTHY FAMILIES PROGRAM

Background

Healthy Families Is a Relatively New Program. The federal *Balanced Budget Act of 1997* (BBA) made available approximately $40 billion in federal funds over ten years to states to expand health care coverage for children under the State Children's Health Insurance Program (SCHIP). The BBA also provided states with an enhanced federal match as a financial incentive to cover children in families with incomes above the previous limits of their Medicaid programs.

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

Program Expansions. The program began enrolling children in July 1998. In 1999, it was expanded to include children with family incomes up to 250 percent of the FPL, as well as legal immigrant children, who are not eligible to receive federal funds and therefore do not draw federal matching funds.

In January 2002, the state was granted a waiver request by the federal government to expand the Healthy Families Program to uninsured

parents of children eligible for the Healthy Families or Medi-Cal programs up to 200 percent of the FPL. As state statute requires, the administration has indicated its intention to submit in the future to federal officials an amendment to the waiver further expanding eligibility for parents up to 250 percent of the FPL. However, the Governor's budget proposes to delay implementation of the Healthy Families parent eligibility expansion until July 2006 due to the state's fiscal problems.

The Budget Proposal. As shown in Figure 2, the January budget proposes $815 million (all funds) in Healthy Families Program expenditures in the budget year. This is an increase of about 16 percent over estimated current-year expenditures. The budget proposes $85 million in General Fund support for the Healthy Families Program, a $54 million increase above the current-year level. This increase in General Fund expenditures is due to caseload increases and the shift of some program funding from the TSF to General Fund. (This funding shift is discussed in more detail later in this section.)

Figure 2

Managed Risk Medical Insurance Board Healthy Families Expenditures

(In Millions)

	2002-03		2003-04 January Budget
	Budget Act	Revised	
Local Assistance	$651.5	$701.4	$809.7
Children	(649.3)	(701.4)	(809.7)
Parents	(2.1)	—	—
State operations	5.5	5.2	5.1
Totals[a]	**$657.0**	**$706.6**	**$814.8**
Tobacco Settlement Fund	$247.1	$230.4	$220.0
General Fund	1.8	31.0	85.3
Federal funds	398.6	437.2	498.5
Reimbursements	9.5	8.0	11.0

[a] Detail may not total due to rounding.

Budget Reflects Growing Children's Caseload

We withhold recommendation on the administration's request to increase expenditures for Healthy Families for caseload increases and associated expenditures. Although enrollment has been higher than the level projected in last year's budget, recent population trends and other factors indicate that General Fund support for the program may be overbudgeted by more than $20 million in the budget year.

Caseload Estimate. The MRMIB anticipates total enrollment in the budget year of 768,232 children who qualify for federal matching funds—referred to as "federally qualified"—and 26,872 legal immigrant children who do not qualify for federal funds and thus are funded almost entirely with state funds.

Figure 3 shows MRMIB's Healthy Families caseload projections for the current year and budget year. The Governor's budget proposal assumes an increase of 99,715 children in the budget year. Over one-third of this projected increase (37,115 children) would result from the implementation of the CHDP program gateway proposal, which is an effort to help transition eligible children receiving screening and immunizations under CHDP into more comprehensive health care coverage under Medi-Cal and Healthy Families.

Figure 3

Healthy Families Caseload Estimates[a]

	Budget Estimate		
	Revised 2002-03	Proposed 2003-04	Change From 2002-03
Children			
Federally qualified children	646,820	741,360	94,540
Legal immigrant children	21,697	26,872	5,175
Totals	**668,517**	**768,232**	**99,715**

[a] Includes children shifted from the CHDP gateway.

The MRMIB anticipates that enrollment of federally qualified children (including children shifted from CHDP) will grow by about 14 percent, or 94,540 children, in the budget year. The projected growth in en-

rollment of immigrant children (including children shifted from CHDP) in the budget year is 5,175, an increase of about 24 percent.

Budget Plan Reflects Faster Caseload Growth. The Governor's January 2003 budget proposal assumes that the overall caseload for the Healthy Families Program will grow faster than previously expected in both the current and budget years. Figure 4 (see next page) compares the caseload estimates for the Governor's 2003 January budget plan with (1) the caseload assumptions of the *2002-03 Budget Act* and (2) the actual caseload growth which occurred from March 2002 through December 2002. (The figures do not include children that are projected to be shifted from CHDP.)

As the figure shows for this period, the number of federally qualified children who have been enrolling in Healthy Families is above the level assumed in the *2002-03 Budget Act*, while the number of immigrant children is somewhat below the level that was budgeted last year. The administration has revised its current-year caseload estimates in its proposed budget for 2003-04.

The MRMIB estimate of budget-year caseload growth also reflects a significant new assumption regarding the total number of potential enrollees in the Healthy Families Program. This new assumption is based on a comprehensive new statewide survey of over 55,000 randomly selected households on a variety of health related issues known as the California Health Interview Survey (CHIS). In the past, MRMIB had estimated the number of eligible children based on the national Current Population Survey (CPS) prepared by the U.S. Census Bureau.

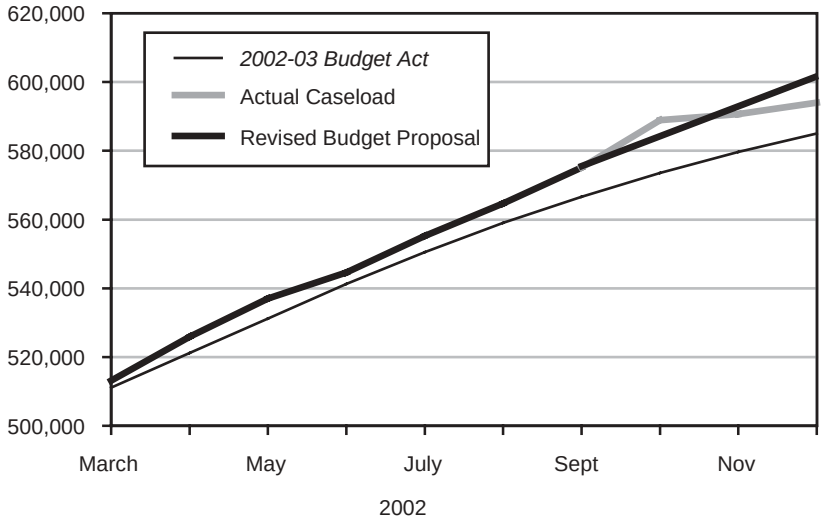
The CHIS survey data, collected by researchers through a collaboration of the University of California at Los Angeles Center for Health Policy Research, the Department of Health Services (DHS), and the private Public Health Institute, suggest that the total number of uninsured children eligible for the Healthy Families Program is larger than previously thought. The caseload projections for the Healthy Families Program were increased to reflect this greater potential for enrollment. The administration intends to further adjust its caseload and cost projections for the Healthy Families Program at the time of the May Revision.

Analysis of the Budget Request. Our analysis of recent caseload trends and other factors suggests that the administration's proposed funding adjustments for the Healthy Families Program may be overbudgeted by about $20 million. Specifically, the costs associated with enrollment of children from the CHDP program may be overbudgeted by as much as $10 million and costs associated with general enrollment trend assumptions may be overbudgeted by more than $10 million. Our review follows.

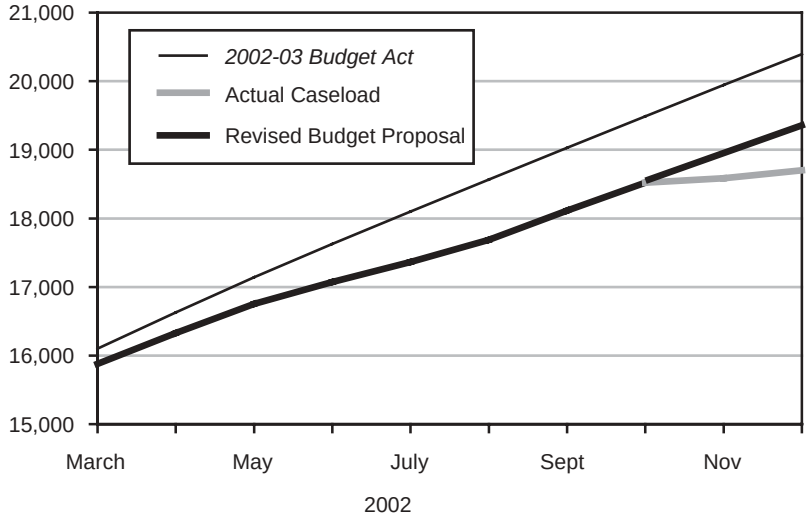
Figure 4

Enrollment Trends in the Healthy Families Program[a]

Federally Qualified Caseload Higher Than Expected



Immigrant Caseload Lower Than Projected



[a]Does not include children shifted from the CHDP gateway.

- ***CHDP Gateway.*** The number of children the administration assumes will enroll in the Healthy Families Program as a result of the CHDP gateway could be less than estimated. As a result, the additional expenditures proposed in the budget for this increased caseload may be overestimated by as much as $10 million in the budget year. (We discuss the implementation of the gateway in the "Public Health" section of this *Analysis*.)

- ***Enrollment Trend.*** As reflected in Figure 4, the last two months (November and December 2002) of available caseload data show a marked drop in the growth of net enrollment. If this trend were to continue, we estimate that the 2003-04 budget proposal would provide more than $10 million above the amount needed for the support of the program. Because caseload data beyond December were not available at the time this analysis was prepared, it is unclear whether this drop represents an ongoing downward shift in the rate of caseload growth or a one-time decrease.

Other Factors Could Affect Caseload. Any projection is at risk of being in error, and there are a number of factors that could influence the accuracy of the projections of the Healthy Families Program caseload and costs. One key factor that could affect the Healthy Families caseload in 2003-04 is the economy. California is experiencing the first soft economy since the implementation of the Healthy Families Program and it is unclear what affect this may have on the rates at which children enroll and disenroll in the program. Enrollment could be greater than estimated to the extent that a family's income decreases to the point that the family becomes eligible for the Healthy Families Program. At the same time, disenrollment in the Healthy Families Program could increase as parents in low-income families already enrolled in the program lose their jobs or enough income such that the family qualifies for the Medi-Cal Program.

Analyst's Recommendation. Because of the uncertainty over the Healthy Families Program projection resulting from the recent slowdown in caseload growth, we withhold recommendation on the administration's request for increased funds for caseload growth and associated expenditures . The administration will update its projections this spring. We will continue to monitor program enrollment trends and recommend adjustments, if necessary, following our review of the May Revision.

Tobacco Settlement Funds Could Fall Short

The amount of tobacco settlement revenues (TSRs) available for support of the Healthy Families Program could be significantly less than the $220 million assumed in the Governor's budget plan. A shortfall in TSRs would put additional pressure on the General Fund to continue support for the program at budgeted levels.

Tobacco Settlement Revenues May Not Materialize. Under the tobacco securitization program adopted last year, the state is raising $4.5 billion in General Fund proceeds by selling revenue bonds backed by the state's future stream of TSRs from cigarette companies. Nevertheless, the budget assumes that $220 million in proceeds from the TSF will be available on a one-time basis in 2003-04 to help fund the Healthy Families Program. The *2003-04 Governor's Budget* assumes that the state can sell a sufficient amount of tobacco bonds to both raise the $4.5 billion in cash and have enough left over to prepay the 2003-04 debt service costs on the bonds. This would result in $220 million in additional funding available on a one-time basis.

At this point, based on the first portion of the bond sale, however, it is uncertain whether the amount of future tobacco settlement payments will be sufficient to support a larger bond sale. Thus, the $220 million in assumed support for the Healthy Families Program from TSRs is at risk. If the assumed TSRs do not materialize, it is likely that this program support would be shifted to the General Fund.

Analyst's Recommendation. We recommend that the Legislature request the Department of Finance to report at the time of budget hearings on the availability of TSRs for the support of the Healthy Families Program in 2003-04.

RURAL HEALTH DEMONSTRATION PROJECTS

The Governor's budget proposes to discontinue the Rural Health Demonstration Project (RHDP), which provides funding for clinics in rural areas and to those that serve certain special populations. In addition, the Governor's budget proposes to include as part of a larger realignment plan, the Indian Health Program and the Seasonal, Agricultural and Migratory Worker Programs. In the event that the Legislature does not approve the realignment of these public health programs, it may want to consider instead the option of consolidating them into RHDP thereby continuing the program. This would maximize the use of available federal funds, and reduce General Fund expenditures by as much as $8.9 million.

Background

The RHDP was enacted into law by Chapter 623, Statutes of 1997 (AB 1126, Villaraigosa). The goals of the program are to improve health care access for rural residents and certain special populations that have limited access to health care services. The program makes funding available to clinics that are geographically isolated in rural areas and to urban and rural clinics serving children of migratory and seasonal farm workers, American Indians, and fishing and forestry workers. The RHDP projects include mobile dental vans, telemedicine centers, school-based dental programs, and nutrition counseling.

Budget Proposal. The funding provided for RHDP in the current year is about $5 million. The program receives about a two-to-one federal-to-state match for program expenditures. Of the total for the program, $1 million in support comes from the General Fund, $683,000 from other state funds, and $3.2 million from federal funds. The budget proposes to discontinue the RHDP in 2003-04. The program is set to expire under existing statute at the end of the current year. A May 2002 report on RHDP outcomes indicated that the RHDP has been successful in expanding access to health care services.

The Governor's budget proposes to eliminate in 2003-04 two state-funded clinic grant programs now operated by the DHS known as the Indian Health Program (IHP) and the Seasonal, Agricultural, and Migratory Workers program (SAMW). As part of a larger proposal for realignment of state and county funding and program responsibilities, an amount of funding equivalent to the current-year allocations for these two programs—about $13.4 million—would be shifted to counties to provide these public health services.

Please see a more detailed analysis of the Governor's realignment proposal in "Part V" of *The 2003-04 Budget: Perspectives and Issues*. In that analysis, we concur with the Governor's proposal to include these programs within a realignment package. In the event that the Legislature does not approve a realignment plan as part of the 2003-04 budget, or chooses not to realign these particular programs, it may wish to consider the option we discuss below that would continue funding for these programs at the state level.

Programs Could Be Consolidated

In the event that the Legislature does not approve the Governor's realignment plan or chooses not to realign these particular programs, it may wish to consider extending RHDP and consolidating into it the IHP and SAMW now run by DHS. Our analysis indicates that, if a shift of

these programs to MRMIB did occur, the state could maintain about the same level of funding for them while also achieving General Fund savings of about $8.9 million.

As we noted earlier, each dollar the state spends in RHDP generates about two dollars in federal matching funds. In contrast, the IHP and the SAMW program are funded entirely from the state General Fund. Thus, consolidating the functions of the two DHS programs into RHDP could allow the state to sustain their overall level of funding while reducing General Fund expenditures.

Figure 5 shows how the funding provided for these programs would change under our option. As the figure shows, the state currently spends a total of $13.4 million for the SAMW and IHP. Under our option, $4.5 million in General Fund support for SAMW and IHP would be transferred to RHDP, thereby drawing down an additional $9 million in federal funds. As a result, the overall level of funding and services provided under the program would remain level even though it would now be less costly to the state.

Figure 5

General Fund Savings Under LAO Consolidation Option

(In Thousands)

	General Fund	Federal Funds	All Funds
2002-03			
IHP[a]	$6,500	—	$6,500
SAMW[b]	6,900	—	6,900
Total	**$13,400**	**—**	**$13,400**
2003-04			
RHDP[c] (including IHP & SAMW)	$4,500	$9,000	$13,500
2002-03 to 2003-04			
Change in funding level	-$8,900	$9,000	$100

a IHP = Indian Health Program

b SAMW = Seasonal, Agricultural and Migratory Worker program

c RHDP = Rural Health Demonstration Project

One reason for consolidating these three programs is that the IHP and SAMW programs serve similar populations and geographic areas as RHDP and grant funds are often awarded to the same clinics. During 2002-03 more than 60 percent of RHDP funding went to clinics that also received funding from either SAMW or IHP.

However, the MRMIB may have to obtain federal approval for these program shifts into RHDP, a factor that could delay the implementation of this option.

Analyst's Recommendation. Given the state's fiscal difficulties, we believe the Legislature should consider the option of consolidating the two DHS clinic grant programs into RHDP in the event that the Legislature does not approve or does not include them within the Governor's realignment plan. The shift of these two programs from DHS to MRMIB would help maximize the use of available federal funds and would result in a logical consolidation of programs serving similar populations and geographic areas.

DEVELOPMENTAL SERVICES
(4300)

A developmental disability is defined as a disability, related to certain mental or neurological impairments, that originates before a person's eighteenth birthday, constitutes a substantial handicap, and is expected to continue indefinitely. The state Lanterman Developmental Disabilities Services Act of 1969 entitles individuals with developmental disabilities to a variety of services, which are overseen by the state Department of Developmental Services (DDS). Individuals with developmental disabilities have a number of residential options. Slightly more than 98 percent receive community-based services and live with their parents or other relatives, in their own apartments or in group homes that are designed to meet their medical and behavioral needs. The remaining 2 percent live in state-operated, 24-hour care facilities.

Community Services Program. This program provides community-based services to clients through the 21 regional centers (RCs) located throughout the state. The RCs are responsible for client assessment and diagnosis, the development of an individualized program plan, case management, and the coordination and purchase of various services, such as residential, supported living, and day program services. Day program services include early intervention services for infants and young children and daytime activity programs for adults. The department contracts with RCs to provide services to more than 183,000 clients each year.

Developmental Centers (DC) Program. The department operates five DCs, and two smaller facilities, which provide 24-hour care and supervision to approximately 3,600 individuals. All the facilities provide residential and day programs as well as health care and assistance with daily activities, training, education, and employment.

Budget Proposal. The budget proposes $3.2 billion (all funds) for support of DDS programs in 2003-04, which is a 9.6 percent increase over estimated current-year expenditures. General Fund expenditures for

2003-04 are proposed at $2 billion, an increase of $131 million or 7.2 percent above the revised estimate of current-year expenditures.

The budget proposes $2.6 billion from all funds ($1.6 billion from the General Fund) for support of the Community Services Program in 2003-04. This represents a $129 million General Fund net increase over the revised proposed level of current-year spending, primarily as a result of caseload growth, higher utilization rates for services, and other program changes.

The increases would be partly offset by several proposed reductions in the budget. These include policy initiatives to adopt unspecified statewide standards for the purchase of services for RC consumers, to shift more support for RCs to federal funds, to establish fees for some parents of children receiving services, to shift habilitation services from the Department of Rehabilitation to RCs, and to limit program eligibility by partially conforming the state's definition of who is considered to have a substantial disability to the federal definition.

The budget proposes $669 million from all funds ($368 million from the General Fund) for support of the DCs in 2003-04. About the same level of DC funding is proposed for the budget year as for the current year despite a projected drop of 70 clients in the overall DC caseload. The savings from the population decline would be offset by a projected increase in costs for caring for DC residents requiring higher levels of medical care or higher levels of staff supervision due to behavioral challenges.

STATE SHOULD RESTRUCTURE DEVELOPMENTAL CENTER SYSTEM

The state's five developmental centers (Agnews, Fairview, Lanterman, Porterville, and Sonoma) and two smaller facilities (Sierra Vista and Canyon Springs) provide 24-hour care to about 3,600 individuals with developmental disabilities. The developmental centers (DC) population has declined significantly over the last forty years. In response to this decline, the Governor's Budget proposes to develop a plan for the closure of Agnews. In this analysis, we examine the DC system's population trends and cost-effectiveness, and provide the Legislature with options and recommendations related to future DC operations.

Introduction

Full Range of Care Provided

Facilities Provide 24-Hour Care. The state's five DCs (Agnews, Fairview, Lanterman, Porterville, and Sonoma) and two smaller, leased

facilities (Sierra Vista and Canyon Springs) provide 24-hour care to about 3,600 individuals with developmental disabilities. The DCs provide a full range of care, including medical and recreational services. More than 8,600 permanent and temporary staff serve the current population at all seven facilities.

According to departmental data, about 30 percent of the current population of the DCs resides in skilled nursing units, about 1 percent receive acute care, and the remainder live in intermediate care units, which include clients with a variety of behavioral, physical, and social needs who do not require 24-hour skilled nursing. Of the total DC population, about 11 percent are designated by the department as forensic / severe behavior residents, who live in the DCs by court order generally because they are at risk of harming themselves or others. Forensic / severe behavior residents generally live in intermediate care units.

Funding

Significant General Fund Support. The Governor's January budget provides for $655 million in total expenditures for the DC system in 2003-04, not including DC-related headquarters costs. General Fund costs are estimated at $361 million. The DCs are generally reimbursed by the federal government under Medicaid (known as Medi-Cal in California) for about half of most costs. However, nine residential units at Porterville (out of 22) were decertified by the state's Department of Health Services (DHS) in September 2001 and are no longer eligible for federal funding. The loss of federal funds amounts to nearly $16 million annually. Also, Canyon Springs has not yet been certified by DHS and therefore remains ineligible for federal financial participation at this time. The DDS expects that Canyon Springs will be certified by March 31, 2003.

A Costly System in Decline

Despite a declining developmental centers (DC) population, the cost of care on a per resident basis has grown significantly and is likely to continue to grow. California and other states' experiences show that community services provide a cost-effective alternative to DCs, and offer an improved quality of life for many individuals. At this time, however, the state has not developed a clear, long-term policy on the future of the DC system that takes this alternative into account.

Population Trends

Population Once Much Larger. The DCs once provided residences and services for many more people than they currently serve. The total

DC campus system (including facilities in Stockton and Camarillo which have since closed) served approximately 10,500 persons at its peak operation in 1959—almost three times as many as are served now.

Through enactment of the Lanterman Act in 1969, the state created the RC system to provide community services for persons with developmental disabilities. As a result, the DC population fell as more individuals were served in community settings. By 1990-91, the DC population was less than 7,000. Most of the population decline of the DC system since that time is the result of the 1994 *Coffelt v. Developmental Services* lawsuit settlement, which required the state to make more community homes available as alternatives to institutions. The DCs initially downsized in population by 2,000 in response to the *Coffelt* settlement.

Population Decline Continues. The total population served in the DC system continues to decline. The proposed budget for 2003-04 assumes that approximately 205 DC residents will be placed in community living arrangements, that 64 DC residents will die, and that 190 individuals will be admitted into the DC system for a net decline of 79 during the year.

As a result of the continuing decreases in the DC population, we estimate that more than 900 beds are now vacant—a 20 percent vacancy rate. Figure 1 indicates the number of beds currently available at each DC, their estimated average population for 2002-03, and the number of staff positions proposed for each facility for 2002-03.

Figure 1

Developmental Centers' Capacity, Population, and Staffing

Developmental Centers (County)	Available Beds[a]	Average Annual Population[b]	Bed Vacancy Rate[b]	Authorized Staff Positions[c]
Agnews (Santa Clara)	773	454	41%	1,341.5
Fairview (Orange)	933	781	16	1,776.5
Lanterman (Los Angeles)	765	640	16	1,500.5
Porterville (Tulare)	974	851	13	1,881.3
Sonoma (Sonoma)	1,004	838	17	2,007.0
Sierra Vista (Yuba)	58	53	9	133.8
Canyon Springs (Riverside)	63	50	21	123.5
Totals	**4,570**	**3,667**	**20%**	**8,764.1**

a As of August 28, 2002.

b As of *2003-04 Governor's Budget*.

c As of 2002-03.

Cost Trend Analysis

Costs Increased 24 Percent. Despite a declining DC population, system costs have grown significantly. As shown in Figure 2, total DC expenditures increased from about $519 million in 1990-91, to $567 million in 1995-96, to about $643 million in 2000-01. Although the overall DC population dropped by 44 percent over this ten-year period, costs still rose by 24 percent.

Developmental Center operating expenditures more than doubled, on a per-resident basis, from about $77,000 in 1990-91, to $118,000 in 1995-96, to about $170,500 in 2000-01. Figure 2 also displays the cost per resident for the two major cost categories: salaries, wages, and benefits; and operating expenses and equipment. The average cost per resident is expected to continue to grow even as the DC population continues to trend downward. The cost per resident is estimated to reach $179,000 in 2002-03 as the average population declines to 3,667.

Figure 2

Annual Costs Per Development Center (DC) Resident Have Increased

	1990-91[a]	1995-96	2000-01[b]
Population			
Average number of residents	6,720	4,806	3,768
DC Costs (In Millions)			
Salaries, wages, and benefits	$422	$438	$463
Operating expenses and equipment	97	129	180
Total costs	**$519**	**$567**	**$643**
DC Costs Per Resident			
Salaries, wages, and benefits	$62,744	$91,210	$122,769
Percent of DC expenditures	81%	77%	72%
Operating expenses and equipment	14,446	26,814	47,769
Percent of DC expenditures	19	23	28
Total DC costs per resident	**$77,190**	**$118,024**	**$170,537**

a Excludes Department of Mental Health programs provided at DCs.

b Past year actual expenditures used to ensure comparability.

Why Costs Have Grown

Per resident costs have grown due to several major factors discussed below.

"Fixed Costs" Remain. Significant areas of expenditures, such as administration and facility maintenance, have not decreased commensurately with the decline in the DC population. Large facilities such as DCs have fixed, physical plant costs, such as utilities, general facility maintenance, insurance, and communications that generally do not change commensurate with changes in their population. As shown in Figure 2, annual operating expenses and equipment costs at the DCs have increased from about $14,500 per resident in 1990-91 to almost $48,000 per resident in 2000-01. The cost per client for 2000-01 was particularly high because it included one-time expenditures for special repairs and start-up costs for the Canyon Springs leased facility. However, the estimated cost per resident of $33,840 for 2002-03, which did not include such significant one-time expenditures, still far exceeds the cost per resident twelve years earlier.

Higher Staffing Levels Due to Federal Mandates. Another major cost-driver in the DC system has been an increased level of staffing driven by a need to comply with federal certification standards and other federal mandates. Such mandates are intended to enhance the health and safety and to protect the rights of the residents. First, the state established new positions at Agnews and Sonoma DCs in the early 1990s as a result of a U.S. Department of Justice finding that those DCs provided inadequate care. Second, the state undertook a major staff augmentation systemwide that was phased in over four years beginning in 1998-99. The latter augmentations included level-of-care workers who deliver treatment programs, such as physicians, psychologists, audiologists, teachers, rehabilitation therapists, nurses, and psychiatric technicians ("psych techs"). The augmentations included some support staff, such as food-service workers and transportation escorts, as well as security staff.

Medical Care Costs. Cost increases in medical care also have significantly driven up DC expenditures in the last ten years. Our estimates show that the costs of medical services per resident grew by 337 percent, from $1,350 per resident in 1990-91 to $5,900 per resident in 2000-01. These costs are projected to reach $6,604 per resident in 2002-03. Most of the cost increases are due to the costs of drugs. While DCs spent as much as $9 million for this purpose ten years ago, they are projected to purchase $20.5 million in prescription drugs and other medication in 2002-03. While they have been growing by 16 percent annually, these increases in drug costs are generally in line with national trends in prescription drug spending.

New Leased Facilities Expensive to Operate. In 2000, the state opened two additional, leased facilities—Sierra Vista and Canyon Springs. These new leased facilities cost more per resident due primarily to more intensive staffing levels. The higher staffing levels are designed to care for individuals who need special assistance in order to adapt to community living. As Figure 3 shows, both Sierra Vista and Canyon Springs are projected to cost the most on a per-resident basis in 2002-03.

Figure 3

Costs Per Development Center (DC)
All Funds

Developmental Center	Estimated 2002-03 Expenditures (In Millions)	Number of Residents	Average Cost Per Resident
Agnews	$95	454	$208,935
Lanterman	101	640	158,336
Sonoma	132	838	157,530
Fairview	115	781	147,690
Porterville	123	851	144,615
Five DCs	**$566**	**3,564**	**$158,840**
Canyon Springs	$11	50	$225,574
Sierra Vista	11	53	213,923
Two Leased Facilities	**$22**	**103**	**$219,579**
Unallocated funds[a]	$67	3,667	$18,227
All facilities	$655	3,667	$178,773

[a] Total expenditures include a budgeted amount not yet allocated to any particular DC.

The higher per resident costs do not necessarily mean, however, that the use of leased facilities is not a cost-effective approach to providing services. The average length of stay of residents of the leased facilities is less than two years. If, as is intended, the length of stay of individuals placed in leased facilities is significantly less than the length of stay of comparable individuals in the DCs, the state could save money through leased facilities placements even if the annual cost per bed is higher. However, at the present time, we are unable to obtain data indicating whether this is in fact the case.

Trend Likely to Continue

Capital Outlay Needed. As the total DC population continues to gradually decline, general facility overhead costs at the five DCs are likely to continue to increase on a per person basis. In addition, expensive capital outlay modernization costs would eventually have to be incurred to continue the operations of the aging DCs (all of which are more than forty years old). In 1998, consultants from Vanir Construction Management, Inc. assessed the condition of the five DCs and recommended nearly $1 billion in capital outlay improvements, most of which have not yet occurred. Special facility repairs or major capital outlays have a significant one-time impact on per resident costs when an institution's population is declining.

Many DC Residents Could Be Served in the Community

What Client Evaluation Data Shows. Some DC residents, namely the forensic residents served at Porterville, are unique among the DC population and not appropriate for placement in a community setting. With this exception, many DC residents, however, could be served in the community.

Client development evaluation reports, which are usually prepared by a person's service coordinator, show that the characteristics of many those served in the DCs are similar to those living in the community. As Figure 4 (see next page) shows, for example, about 3,300 DC clients have medical problems, while nearly 33,000 individuals with such special medical needs are living in the community. As another example, about 1,400 DC clients take behavior modifying drugs, while about 21,000 clients living in the community take such drugs. While it is clear that not all current DC clients are appropriate for community placement, many of the remaining DC residents have characteristics similar to those who have been successfully placed in the community.

Improved Quality of Life. California studies have shown that many residents who have transitioned from the state's DCs to community living arrangements have improved their quality of life. A 1998 study commissioned by the Legislature and conducted by the Center for Outcome Analysis in Pennsylvania assessed the well-being of such persons placed between 1994 and 1998 and found that consumers generally felt safer, had greater control over their lives, and typically were better integrated into their communities. Family members on average also expressed higher satisfaction with their relatives' quality of life in the community than in the DCs.

Figure 4

DC and Community Client Characteristics

Selected Client Characteristics	Number of DC Clients	Number of Community Clients
Need special health care item	2,901	33,856
Have unacceptable social behavior	1,958	33,178
Have medical problems	3,304	32,898
Are not ambulatory	1,610	30,590
Take behavior modifying drugs	1,367	20,667
Must be fed	939	12,204

The studies indicate that these results endure over time. A follow-up study in August 2000 looked at all persons who moved out of DCs between 1993 and 1999 and concluded that they were much better off according to measurements of such factors as behavior, independence, health, friendships, daily activities, and satisfaction. A follow-up study in 2001 indicated that there were some specific measures, such as the number of close friends and access to health care and dental care, in which former DC residents were not as well off as before. But that report concluded that when all factors measured were taken into account, these individuals were better off overall than they were in DCs.

Community Care Can Be Less Costly Than DCs

2001 Study Indicates Community Care Less Expensive. For many individuals, the shift to community living has the potential both to improve their quality of life and to reduce the cost of their care. This will not be true in all cases. Some persons would be more costly to serve in a community setting, particularly if they required more intensive staffing levels for their care. But the evidence indicates that community settings would be appropriate and cost-effective for many other current DC residents. A fiscal analysis of restructuring DC services conducted under contract for DDS in 2001 found that services could be delivered in the community at less cost than in the DCs.

The DDS's own cost data as well as Medi-Cal data indicate that shifting DC residents to the community to be served by one of 21 RCs would generally allow them to receive services at a lower state cost than otherwise. We estimate that a typical community placement would cost the state between $120,000 and $140,000 per year, inclusive of services pur-

chased by RCs, the operational costs of the RCs, and Medi-Cal costs. That is 33 percent to 22 percent lower than the $178,770 average annual cost of serving that same individual in a DC.

Other States Are Downsizing Institutional Care

Major Changes Occurring in Other States. For the reasons discussed above, other states are closing institutions and providing services for the developmentally disabled in community settings. According to a 2002 University of Colorado study, the number of persons with developmental disabilities residing in public institutions declined by 21 percent between 1996 and 2000 (and by 68 percent between 1977 and 2000). The number of people receiving care in settings for six or fewer people grew by 20 percent between 1996 and 2000.

Generally, states that have been successful in such a transition developed community services that include resource networks and crisis response systems to address many of the reasons that caused individuals to become institutionalized in the first place.

Policy Direction on DCs Unclear

The state has conducted several important studies and reviews of the way it delivers services for the developmentally disabled, but has so far not established a clear, long-term policy to guide the future operations of the DC system.

DC Options Study. Chapter 93, Statutes of 2000 (AB 2877, Thomson), directed DDS to identify a range of options to meet the future needs of individuals currently being served in DCs. The DDS hired consultants to study various options for restructuring DC services and a large stakeholder group participated in devising options.

The DDS report concluded that the state should not undertake a large-scale effort to renovate and maintain the current DC system, and suggested that the funds needed for such an effort would better be spent to create a new "service structure" in the community. While the report presented a menu of ways in which the state could continue to play a role in providing services to residents moved from DCs to the community, it did not provide the Legislature with a timeline or specific recommendations for shifting residents from DCs or for developing this new service structure.

Community Placement Planning. The administration has taken steps to move some developmentally disabled individuals from the DCs through what it calls the community placement planning program. That program, implemented with state assistance to the 21 RCs, offers a mecha-

nism for transitioning individuals from DCs and for reducing new admissions to DCs by ensuring the adequacy of resources needed to place them in the community.

Olmstead Compliance Planning. Prompted by the June 1999 U.S. Supreme Court decision *L.C. & E.W. vs. Olmstead ("Olmstead")*, a number of other states are seeking alternatives to institutional care. In the *Olmstead* case, the U.S. Supreme Court ruled that keeping institutionalized persons who could transition to a community setting constituted discrimination under the Americans with Disabilities Act (ADA), notwithstanding state resources and consumer preference. Accordingly, a number of states are conducting assessments of institutionalized persons and devising plans to comply with ADA and *Olmstead* requirements. Chapter 1161, Statutes of 2002 (AB 442, Committee on Budget), directed the Health and Human Services Agency to develop an *Olmstead* compliance plan for California by April 2003. That planning effort is now under way.

Planning, But No Clear Policy-Setting. Because California's *Olmstead* planning process began only recently, it is not yet clear whether that plan will address the future of the DCs. An earlier effort by the Legislature to address the future of the DC system, by commissioning the *Options* report released last year, had inconclusive results. The report was largely silent about what steps should be taken next by the state and did not provide a blueprint for future actions. No specific numerical goals have been set for the number of placements to be accomplished under the existing community placement program, nor is there a parallel and related DDS plan for downsizing the DC system. As a result, the state's policy for the future operation of the DC system remains unclear.

Governor's Budget Includes Agnews Closure Plan. The Governor's budget plan proposes that the DDS redirect existing resources to form a project team that would begin planning efforts to close Agnews by July 2005. In January 2003, the administration began taking initial steps to close the facility. By June 2003, a policy would be established to halt new admissions to Agnews. During 2003-04, under the Governor's proposal, the project team would continue to develop a master plan for Agnew's closure. While this planning process occurred, efforts to place Agnews residents in the community would be implemented in the San Francisco Bay Area and some clients would be transferred to other DCs.

The Governor's plan indicates that a funding request for closure would be included in the 2004-05 budget, and that the completed closure plan for Agnews would be submitted to the Legislature by April 1, 2004. During 2004-05, all remaining Agnews residents would be transferred to other DCs or placed in the community. The facility would shut down by July 2005. During this period, negotiations would also begin for the trans-

fer of Agnews to the Department of General Services as potential surplus property.

Recommendations and Options for Restructuring DCs

We recommend that the Legislature initiate a process to close two developmental centers (DCs). The DC system continues to face a declining population that could be served better and more cost-effectively in a community setting. Although the state would incur significant one-time costs to implement such an action in the short term, these costs would be more than offset by permanent and ongoing savings to the state in the long term. The Legislature should address key issues pertaining to the future of the remaining DC system.

Initiate Closure of Two DCs

We recommend that the Legislature initiate action to phase out two DCs at this time. Specifically, we recommend that the Legislature approve a modified version of the Governor's proposal to initiate closure of Agnews and also take steps to initiate the closure of Lanterman.

Why Close DCs? The current DC system perpetuates a significant misallocation of scarce state resources by keeping open aging facilities with ever-declining populations of individuals who, for the most part, could be better served in a more cost-effective community setting. In our view, a number of facts support the case for closing DCs.

The operating cost per resident of the DCs continues to grow even as the DC population is shrinking at a rate of 1 percent to 2 percent annually. Despite this population decline and the resulting bed vacancy rates equaling 20 percent on a statewide basis, the state has continued to incur the costs of maintaining large facilities. The future offers only more of the same–rising operational costs as measured on a per person basis as well as in total state dollars–as well as a need to invest significant additional state dollars for necessary capital improvements to the DCs potentially costing as much as $1 billion.

The closure of two DCs over the next five years would result in a more efficient DC system and significant net savings of state General Fund resources. We believe DDS and the RCs are capable of managing the transfer of the residents of two DCs at this time. Closure of more than two facilities is not recommended in the near term because of the difficulties involved in transferring DC residents. Although the state would incur significant one-time costs in the short term to close two DCs, our analysis indicates that these costs would be more than offset by permanent and ongoing savings to the state in the long term.

If appropriate plans are made and implemented, the residents shifted from the DC system as a result of the closures would enjoy a life more closely integrated with the community and with greater independence—both key policy goals established in state and federal law.

It is also apparent that, if the state does not follow the path of restructuring its DC system, it will inevitably be placed at risk of being compelled to do so anyway by the courts, at least to the extent allowed by state resources. Lawsuits filed at both the state and federal levels have sought to require the states, including California, to establish community alternatives to DCs in order to ensure that care is provided as the law and caselaw provide in the "least restrictive setting" available.

For these reasons, we recommend that the Legislature direct DDS to initiate a process to phase out two DCs. In particular, we recommend closure of the Agnews and Lanterman DCs.

Why Close Agnews and Lanterman? Agnew's high vacancy rate makes it the leading candidate for closure. As shown in Figure 1 above, Agnews has an estimated vacancy rate in excess of 40 percent. That vacancy rate far exceeds the other four DCs, which have vacancy rates of about 15 percent. Partially because of the high vacancy rate, Agnews also is the most expensive of the five DCs to operate on a per person basis. Agnews costs about $209,000 per resident, while the other four DCs cost on average $152,000 per resident per year.

We recommend the closure of Lanterman rather than Fairview at this time because this older facility would otherwise require greater and more costly capital improvement for its continued operation, and because its population is smaller than Fairview's. According to the 1998 Vanir Report, Lanterman, which is 25 years older than Fairview, would require about $20 million more in capital outlay projects than Fairview. Lanterman has about 150 fewer residents than Fairview. This smaller population would make it easier and faster to close than Fairview, thereby advancing the date at which operational savings could be achieved for the state. In the alternative, the Legislature may wish to consider closing Fairview instead of Lanterman because of Fairview's land value which is almost certainly significantly more than Lanterman's because of its Orange County location.

Closure of Agnews and Lanterman, one Northern California facility and one Southern California facility, would be a geographically balanced approach that would preserve the DC residential option for any individuals who would continue to require such placements in both parts of the state. Under our approach to DC closures, the state would continue, at least for the time being, to operate Sonoma in Northern California and Fairview in Southern California.

We would not recommend at this time the closure of the Porterville DC. That is because that facility serves a unique population within the DC system—individuals who have been committed to state custody through the criminal justice system who currently receive treatment in an environment requiring enhanced security. A significant state investment would have to be made in additional security measures if Porterville were closed and its residents moved to other DCs or other facilities.

Alternative Placements for DC Residents. Closure of two DCs would mean that current residents would have to be placed in alternative residences. The needs of each resident at Agnews and Lanterman first would have to be assessed to determine their appropriate alternative placement.

We believe the capacity exists, or could be developed as needed, to handle the shift to other residential options. The options include: intermediate care facilities (ICFs), most of which are small, four- to fifteen-bed facilities licensed by the DHS and located in the community; community care facilities (CCFs), which provide 24-hour residential care licensed by the Department of Social Services; supported or independent living arrangements; a relative's home; an adult foster home; or other DCs.

We estimate that currently licensed ICFs in the state could accommodate about 1,000 additional residents. The DDS indicated that data is not currently available that would indicate whether any extra capacity is available in CCFs. However, our analysis indicates that additional capacity could be developed in either ICFs or CCFs if it were needed. There are already established procedures by which the state helps to pay the start-up costs of new facilities. The remaining DCs could also accommodate residents of the DCs that were closed. The three remaining DCs would have the capacity to serve nearly 450 additional residents.

Fiscal Effect of DC Closures. Figure 5 (see next page) summarizes our estimates of the fiscal effects of closing the Agnews and Lanterman DCs. As the figure shows, the state would incur initial net annual costs of $10 million to $15 million related to the closure of these facilities. These costs would vary based on the extent to which clients could be placed in community settings instead of the remaining DCs. This additional net funding takes into account: (1) new costs to assess and place DC residents in community programs, (2) costs for relocation of staff, and (3) the savings to DDS operating costs that would result from the movement of individuals from DCs to the community or less expensive DCs.

We estimate that the magnitude of annual long-term net savings to the state from such a change could in five years reach at least $30 million to $75 million annually, with the actual level of savings depending upon the residential options considered. For example, as we discuss further

Figure 5

Fiscal Effect of Closing Agnews and Lanterman Developmental Centers—Summary of LAO Estimates

(In Millions)

All Funds	
Initial Costs	
Estimated annual costs, 2004-05 through 2007-08	$10 to $15
Long-Term Savings	
Estimated annual savings beginning 2004-05	$30 to $75
One-Time Savings	
Avoided capital improvements	$250 to $350
Potential land value	$100 to $120

below, community residential options requiring more intensive staffing levels than currently exist in the community would be more expensive and would reduce the net state savings that could be achieved with DC closures.

In addition to these ongoing savings on state operations, the closure of Agnews and Lanterman would allow the state to avoid an additional $250 million to $350 million in costs for capital improvements that would otherwise probably be necessary for the two closed facilities.

In addition, the land value of Agnews and Lanterman offers potential one-time income for the state General Fund that could be used to offset closure costs, to invest in the development of services for persons moved to the community from the DCs, or to fund other legislative priorities. Based upon data reported by the Department of General Services, we estimate the land value of Agnews, located in the Silicon Valley, to be between $80 million to $90 million. The land value of Lanterman, located west of Ontario on Interstate 10 between the cities of Pomona and Diamond Bar, is more difficult to estimate at this time. The value of that land would depend on a number of factors, including the environmental condition of the site, potential historic preservation issues, and local zoning decisions that would determine the type of development that could take place if the state were to sell the land to the private sector. Based upon a comparison of state property in nearby Chino, now being sold by the state for primarily residential use, Lanterman might be worth $20 million to $30 million.

Analyst's Recommendation. For the reasons discussed above, we recommend that the Legislature approve a modified version of the Governor's proposal to begin planning for the closure of Agnews. As we noted, under the Governor's proposal, a budget request for the resources to move ahead with closure would be included in the 2004-05 Governor's budget in January 2004, with a separate closure plan for Agnews subsequently submitted to the Legislature in April 2004 in keeping with the existing requirements for closure specified in state law.

While we concur with the proposal to close Agnews, we are concerned that the Governor's proposal would not provide the Legislature an opportunity to consider DDS' closure plan (to be submitted April 1, 2004) for the facility at the same time it was assessing the funding request (to be submitted January 2004) for the resources to close Agnews. The closure plan is an integral part of the funding request. Accordingly, we recommend the Legislature adopt statutory language directing DDS to submit its closure plan for Agnews to the Legislature by January 1, 2004. This would allow for legislative review of the closure plan at the same time as the budget request.

We also recommend that the Legislature adopt statutory language directing DDS to submit a closure plan to the Legislature for Lanterman DC by January 1, 2005. The statutory language should direct that both closure plans include detailed implementation steps and an estimate of the short-term costs for the closure of the two DCs. Further, we recommend that DDS begin assessing Lanterman's residents by July 2005, and complete closure by the end of 2007-08.

We believe the Legislature should proceed gradually with the DC closures according to the above schedules in order to ensure the smooth placement and transition of residents to the community. Based on our review, we recommend the closure first of Agnews because that facility has fewer residents, can be closed more quickly, and thus would at an earlier date generate savings for the state.

Planning a Successful Transition to the Community

Maximize Federal Funds. As the state shifts persons with developmental disabilities from state facilities to the community, it must be careful to ensure it is not unintentionally shifting the cost of their services from the federal government to the state. Currently, about half of the costs of DC services are reimbursed by the federal government. However, only about 25 percent of community service costs are currently reimbursed by the federal government under the Medicaid program. Therefore, to the extent that individuals are shifted from closed DCs to the community, the overall costs of providing their services might decline, but their Gen-

eral Fund costs to the state could increase. Therefore, a closure plan should ensure that the department takes the actions necessary to obtain the maximum reimbursements possible.

The Governor's January budget, which proposes to enhance federal funding for Regional Center programs by amending the state's existing Medicaid waiver program, is a good first step in this direction that we recommend the Legislature approve. The Medicaid waiver allows federal financial participation for a broad array of home and community-based services. These services are provided to eligible individuals who, without them, would require institutionalization in an intermediate care facility for the mentally retarded (ICF/MR) or a more restricted setting. The administration's proposal would increase the number of clients covered by the waiver, and would add several new services that the state could bill to the waiver**.**

Selling DC Properties Could Offset Closure Costs. Given the state's current fiscal situation, we recommend that the Legislature consider paying for the additional costs of DC closure with the proceeds of a sale of the DC properties. Specifically, we believe it might be possible for the state to structure a sale of the DCs that would allow some proceeds to be received by the state prior to the actual transfer of property. This approach would enable the state to pay the upfront cost of the proposed closures without putting additional pressures on the state General Fund. We are advised that one such way to accomplish upfront proceeds would be to sell the property with an agreement to lease back the property from the new owner until facility closure is completed.

An alternative approach would be for the state to obtain a short-term loan using the DC properties as collateral. The loan could be repaid immediately upon the sale of the property as the closure process were completed.

State rules governing the disposal of surplus property generally require the Department of General Services to determine whether the property is needed by another state agency before it can be offered for sale. However, the Legislature could consider enacting a statutory exception that would require the sale or partial sale of the DC properties, thereby superseding the state rules on surplus property.

Retaining Staff Expertise. Because DC staff have skills that are needed in other settings to serve people with disabilities, and because the state already has invested in training and licensing certain staff to deliver these services, we believe that efforts are warranted as part of the closure process to retain this staff expertise to the extent possible—either through state service or in community services.

The state could mount efforts to recruit registered nurses, psychiatric technicians, and social workers from the DCs that are being closed to positions in state facilities operated by the Department of Mental Health (DMH) and the California Department of Corrections. State hospitals and prisons run by those agencies often experience staff vacancy rates of 20 percent or more in key clinical positions. A shift of staff from closed DCs could help these other facilities reduce their vacancy problems. The state could also provide special relocation assistance to employees who took hard-to-fill positions in other state facilities.

Second, a number of DC employees could be employed by RCs to monitor the quality of services provided in the community. Our fiscal estimates take into account the costs of shifting DC staff to enhance Regional Centers for these purposes.

Future Restructuring Issues

Once restructuring plans have been set in motion, several other critical issues for the DC system remain that should be addressed by the Legislature in the future to ensure the continued cost-effective operation of services for the developmentally disabled. We outline these issues below.

Future of Three Remaining DCs. The future of the three remaining DCs is one key issue that should be addressed by the Legislature after the closures of Agnews and Lanterman have been set in motion. The Legislature should consider whether the Porterville DC should be operated solely to serve a forensic population (persons committed as a result of actions by the criminal court system), and whether the Sonoma and Fairview DCs should also eventually be closed. Alternatively, the state could consider continuing to operate all of the remaining DCs, but downsizing Sonoma and Fairview to transitional or crisis homes where individuals with developmental disabilities requiring assistance would reside for only a short time.

Future of Two Leased Facilities. Another issue warranting future legislative consideration is whether the state should continue to operate the two leased facilities that serve persons with severe behaviors. As discussed earlier in this analysis, the two leased facilities have the highest operating cost in the DC system on a per person basis. We would recommend that, soon after DC restructuring has commenced, DDS be directed by the Legislature to evaluate the costs and benefits of operating the two leased facilities, including a comparison of the costs of serving similar persons in the remaining DCs.

Because intensive staffing levels appear to be driving the costs of the two smaller facilities, we would further recommend that this cost-benefit

analysis include a review of whether administrative and direct care staff could be reduced at the two facilities without unduly affecting the care provided to residents.

Reorganization of State Hospital Operations. The Legislature should also consider in the future whether state hospital operations should be consolidated into one, separate new department. Such a reorganization might make sense as the populations of DCs continue to dwindle. The population of forensic residents is growing in both systems. A significant portion of the DDS hospital population is dually diagnosed with a developmental disability and mental health needs. Nearly 100 percent of the residents in the two leased facilities have a dual diagnosis, and nearly 50 percent of Fairview's residents and 34 percent of Sonoma's residents have a dual diagnosis.

Because both hospital systems would be providing services to hospital residents with similar or overlapping needs, the state might be able to achieve some savings on administrative costs by consolidating hospital operations into one separate department. (The DDS and DMH could remain as separate departments operating their respective community programs.) Notably, both DDS and DMH hospitals once were a single operation.

Conclusion

During the past ten years, the DC population has dropped significantly. Although the population continues to decline at a slow rate, the cost per resident continues to increase due in part to the fixed costs associated with maintaining large, underused facilities. Consistent with the state's Lanterman Act and the U.S. Supreme Court *Olmstead* decision, we recommend that the state continue to take steps to downsize the DC system by closing the Agnews and Lanterman DCs. The state should ensure cost-effective services are available in the community for individuals relocated from the closed DCs by carefully implementing service delivery options and by maximizing the federal funds available to the state.

COMMUNITY PROGRAM ISSUES

Parents Would Share Costs

The Governor's budget proposes a parental copayment program for children age 3 to 17 who live at home and receive Regional Center services. We support the Governor's proposal in concept, but would recommend

that the Legislature carefully consider clarifying and improving some specific aspects of the plan as it moves forward.

Background

Under the Lanterman Act, the developmentally disabled are entitled to services regardless of their family's economic resources. Less than 1 percent of RCs clients or their families pay any share of the cost of the services they receive. Unlike most other social services or medical services programs, RC services are generally provided at state expense without any requirement that recipients demonstrate that they do not have the financial means to pay for them.

The Governor's Copayment Proposal

Additional State Revenues. The Governor's budget proposes that DDS develop and implement a new copayment program to assess and collect reimbursement from the families of developmentally disabled children who live at home and receive certain services provided by RCs. The DDS' preliminary estimate is that the copayment would result in $29.5 million in additional revenues for the state in the budget year. Under the Governor's approach, these additional revenues would be deposited in the General Fund, and would not be used to directly offset the cost of the RC program to the state.

As proposed, the copayment would be:

- Assessed on families of children age 3 to 17 who live at home and receive services purchased by RCs.
- Assessed based on annual adjusted gross income as reported on California state income tax returns.
- Assessed on families whose adjusted gross income is at least 200 percent of the federal poverty level for a family of four.
- Limited to 10 percent of the family's annual income or the cost of the services, whichever is lower.
- Required to be paid in full within 12 months of the initial assessment through monthly, quarterly, semi-annual, or lump-sum payments.
- Open to appeal within 60 days for billing errors, or changes in gross income.

Some Client Groups Unaffected. Currently, only the families of children under the age of 18 who live out-of-home pay a sliding scale fee

based on the family's ability to pay. The Governor's proposal would add to the list of fee paying families those with children age 3 to 17 living at home (approximately 36 percent of the caseload). The remaining families, those with children age 0 to 3 living at home and age 18 and above, would not be required to pay any share-of-cost, and thus would also be unaffected by the Governor's plan. (These families make up almost 62 percent of the total RC caseload.) Figure 6 summarizes how each group of RC clients would be affected, if at all, by the Governor's fee proposal.

Figure 6

How RC Clients Would Be Affected By Governor's Copayment Plan

	2003-04 RC Caseload			
RC Clients by Age	RC Caseload	Share of RC Caseload	Currently Pay Copayment	Copayment Under Governor's Plan
0-3 in-home	18,070	11.2	No	No
3-17 in-home	65,391	35.7	No	Yes
0-17 out-of-home	7,114	2.5	Yes	Yes
18+	92,663	50.6	No	No
Totals	183,238	100.0	N/A	N/A

Copayments Depend on Income and Family Size. As noted earlier, under the Governor's proposal, families with net gross incomes of less than 200 percent of the federal poverty level (FPL) for a family of four, would not have to make copayments. The Governor's proposal also specifies that no family receiving Medi-Cal would be assessed a copayment.

Cap on Share of Costs. The Governor's plan is also specific as to exactly what costs could be charged to families. Families would be obligated to pay for the full cost of the services purchased by the RC for their child up to 10 percent of their income. For example, a family of four with an annual income of $40,000 would have their annual copayment capped at $4,000, with the RCs paying all additional costs for the services purchased above that amount. Under the Governor's plan, some high-income families whose children did not require costly services might pay 100 percent of the cost of the services the RCs provided for them.

Statutory Changes Needed. Implementation of the Governor's copayment proposal would require a change in state law to allow DDS access to Franchise Tax Board (FTB) information.

Implementation Timeline. In order to begin collection of copayments on January 1, 2004, as the administration proposes, DDS planned to begin development of regulations for the implementation of copayment regulations in February 2003. The administration is requesting the enactment of authorizing legislation by April 2003. Parents would be notified in June 2003 that they would be subject to making copayments, and DDS would begin assessing the amounts of the fees in October 2003.

An Analysis of the Governor's Fee Proposal

Imposition of Fees A Reasonable Approach. In our *Analysis of the 2002-03 Budget Bill*, we noted that the cost of operating RCs had more than doubled since 1995-96. We recommended that the Legislature consider requiring the imposition of additional fees for the support of RC services based upon the ability of a client or the client's family to pay for them. Our review of the Governor's proposal indicates that it is a reasonable approach for the Legislature to consider, especially given the state's current fiscal circumstances.

Revenue Estimate Will Be Revised. Currently, the DDS does not maintain income data on the clients that would be assessed copayments under this proposal. The DDS based its preliminary estimate of revenues upon information in its database relating to the cost of its services and demographic data from the Department of Finance (DOF). In order to provide a more accurate revenue projection, the DDS intends to revise its revenue estimate after it has reviewed FTB income data pertaining to the families of affected RC clients.

We would note that adoption of the administration's budget proposal to implement statewide standards on purchases of services could also affect the amount of copayments that could be collected. If, as has been proposed by the Governor, expenditures for services requiring a copayment are reduced through the implementation of such statewide standards, the amount of copayment collections would also decline. Because the specific standards to be implemented have not been determined, the fiscal impact of such a change on copayment revenues cannot be determined at this time.

Copayments Could Slow Cost Increase Trend. In addition to the revenues that would result from copayments, their very implementation would probably cause a decrease in the demand for RC services. Some

families would probably elect to receive fewer services once they were required to pay for part or all of them in order to lower their copayment.

Copayments would probably have relatively little effect on the demand for services critical to the child's health and welfare, but would probably have more of an effect on utilization of other services that are more discretionary in nature. In other words, so long as copayments are reasonable in their amount and based upon a family's ability to pay them, copayments could help deter excessive use of the available services without deterring their appropriate usage.

The fiscal impact on demand for RC services is unknown, but could result in millions of dollars in General Fund savings annually by 2004-05 after the copayment proposal was fully implemented.

Proposal Lacks Several Key Details. Several components of the Governor's proposal lack sufficient detail for the Legislature to fully assess its potential impact on individual RC clients. For example, the proposal does not clearly indicate whether the schedule used to determine the copayment due from any particular family would be calculated based upon a set percentage of income, based upon a "sliding scale" in which wealthier families would pay a higher percentage of costs than poorer families, or based upon some other mechanism.

It is also unclear whether families would make copayments for the services they receive in the same month they receive them, or whether there would be a time lag between when the services are provided and when families were billed for them. This is a concern for families in cases in which the services provided for a client change significantly from month to month based on client needs.

Income Eligibility Requirements Could Be Adjusted. The FPL is a threshold developed by the U.S. Census Bureau for determining whether individuals or families have poverty status. As Figure 7 shows, the FPL takes into account the size of a family. For example, for a family of four the FPL is $36,204 or less and for a family of five the FPL is adjusted upwards to $42,630. Under the Governor's proposal, minimum family income level requirements for copayments would not be adjusted based on family size. Our analysis indicates that families of five or greater could be required to make copayments although their incomes were below 200 percent.

Proposal Could Be Broadened. As noted earlier, the Governor's proposal would not impose copayments for children age 0 to 3 or adults age 18 and older. Our analysis indicates that it would be possible to impose fees on both groups.

Figure 7

Family Size Income Limits on Copayments 2002 Federal Poverty Level

Family Size	Income at 200% of Poverty Level	
	Monthly	Annual
1	$1,477	$17,724
2	1,990	23,880
3	2,504	30,048
4	3,017	36,204
5	3,530	42,360
6	4,044	48,528
7	4,557	54,684
8	5,070	60,840
9	5,584	67,008
10	6,097	73,164

We are advised that charging a fee to family with children age 0 to 3 would require permission from federal authorities that could take up to one year to obtain. It is not certain whether the copayment would ultimately be approved, given that other states have not yet imposed copayments for this group of children . If it were approved, however, the additional revenue provided to the state would probably be significant, potentially several million dollars on an annual basis.

Relatively few RC clients in the 18 and over age group are likely to have sufficient financial resources to make a copayment for the RC services they receive. However, because this is such a large client group—almost 93,000 or 51 percent of all RC clients—the amount of state revenues the state could generate from charging copayments for this group could nonetheless be significant.

Additional Positions Not Justified. Although we would agree that DDS needs additional positions to implement the proposed fees, DDS has not provided the detailed workload estimates needed to justify adding 25.6 positions to its staff for this purpose. Absent this workload justification, the Legislature does not have sufficient information to evaluate the staffing request.

We would also note that the budget request proposes to make all of the new positions permanent. It is not clear this is warranted. While some billing functions would have to be performed manually during the ini-

tial phases of implementation, fewer would probably be needed as billing processes became fully automated.

Improving the Governor's Copayment Plan

We support the Governor's proposal in concept, but offer a number of recommendations to improve the proposal. These include clarifying the impact of the fees on families, broadening the fees to the Regional Center client groups and ensuring that the new revenues are used to support the program.

We support the Governor's proposal in concept. We believe the imposition of copayments based upon a family's ability to pay for the services its children receive is reasonable and appropriate given the dramatic and ongoing growth in state costs for the support of these services and the state's severe fiscal problems. We would recommend that the Legislature carefully consider clarifying and improving some specific aspects of the plan as it moves forward.

Clarify Impact on Families. We recommend that the Legislature direct DDS to clarify at budget hearings how the fee schedule would be structured and the intended timeframe in which parents would be billed for services purchased for their child.

Based upon the information presented by the department, the Legislature may wish to consider requiring a sliding scale schedule for the collection of the copayments that would go further to ensure that they are affordable to the families which would pay them. The Legislature may also wish to consider ensuring that some time lag is established between when services are incurred and when parents are billed for them to better protect families from excessive fluctuations in copayments that could otherwise occur.

Link Minimum Requirements to the FPL. In order to ensure that copayments are only assessed on those families with the ability to pay, we recommend that minimum family income requirements be linked to the FPL. Specifically, we recommend that copayments only be assessed on families with incomes greater than 200 percent of the FPL after taking into account family size.

Others Should Make Copayments. In order to ensure equity among RC clients, and to help address the state's difficult fiscal problems, we recommend the Legislature consider broadening the copayment proposal to other RC client groups. Specifically, we recommend that DDS report at budget hearings on the feasibility of assessing fees to families with children age 0 to 3 as well as for those age 18 and older.

Obtain Fiscal Estimates. The Legislature should direct DDS to provide the Legislature with its updated estimate of revenues from the Governor's copayment proposal when that information is available. We further recommend that DDS and DOF be directed to estimate the decrease in demand for RC services and the resulting savings to the state that could result from the implementation of its copayment plan, and then to incorporate this information into the DDS budget 2004-05 estimate for the RC system. Accordingly, we recommend the adoption of the following budget bill language:

> Provision X. The Departments of Developmental Services (DDS) and Finance shall estimate the decrease in demand for Regional Center (RC) services and the resulting savings to the state from the implementation of its copayment plan and appropriately adjust the DDS budget estimate for the RC system for this factor beginning in 2004-05.

Review Staffing Requests. We withhold recommendation on the proposed additional staffing requested to implement the copayment proposal until such time as the DDS submits to the Legislature specific workload justification for the new positions.

We further recommend that any positions that are approved be limited to two-year terms. After the initial implementation of the copayment program is complete, DDS, DOF, and the Legislature will be in a better position to review the permanent positions needed to maintain the copayment system.

Revenues Should Support RC Programs. Under the Governor's copayment proposal, the new revenues would be remitted to the State Treasury and deposited into the General Fund, and would not directly offset the costs of the RC program. We recommend instead that additional revenues be a part of the DDS budget and the General Fund appropriation be reduced by an equivalent amount.

We are concerned that the Governor's approach would be inconsistent with the way the DDS's existing fee collections are budgeted. Currently, the existing fees are used to offset the cost of services for the children.

Budget Proposes Efficiencies in Habilitation Services Program

The Governor proposes to shift the Habilitation Services Program (currently in the Department of Rehabilitation) to the Regional Centers effective July 1, 2003. This shift would result in a net General Fund savings to the state of $1.5 million in 2003-04.

Background

Entitlement to Work Experience Services. The Habilitation Services Program (HSP) is an entitlement program that provides sheltered work experience and job skills services to approximately 20,000 developmentally disabled adults who are referred for such services by the RCs. These services are provided by about 210 community-based organizations, approximately 85 percent of which also contract with the RCs to provide other services to RC clients.

State General Fund support for HSP is currently budgeted within the Department of Rehabilitation (DR), and the DR is responsible for the administration of the program. However, program costs are largely determined by the number of referrals of clients to services from the RCs operated under the direction of DDS. Although DR's 15 habilitation specialists monitor overall compliance by community-based organizations with program rules, case managers at the RCs directly monitor participants' progress and service needs.

Governor's Proposal

Shift to Regional Centers Proposed. As part of the December revision budget reduction package, the Governor has proposed the enactment of legislation to consolidate HSP within the RCs effective July 1, 2003. The administration estimates that this shift would result in net state administrative savings to the state in 2003-04 of approximately $1.5 million associated with a net reduction of 11 positions. Specifically, 29 HSP-related positions at DR would be eliminated for a savings of $2.2 million annually from the General Fund, while 18 HSP-related positions would be added at DDS at a cost to the General Fund of $700,000 annually. We believe the proposal would result in a reduction of administrative costs without any disruption in services or program oversight.

Under this proposal, the entire $115 million in General Fund local assistance funding for the support of HSP currently budgeted within DR would be shifted to DDS effective July 1, 2003. The RCs would assume the responsibility now held by DR for monitoring program compliance. The RCs would also monitor the quality of the services provided to HSP clients, as they already do for RC clients receiving other types of services. The budget proposal assumes that the RCs will be able to absorb the additional workload associated with such program monitoring activities, and therefore includes no additional local assistance funding beyond the $115 million for provider payments**.** Given the state's fiscal difficulties, and the additional operating funds provided to the RCs in the current year, we believe it is reasonable to have the RCs absorb these costs.

Analyst's Recommendation

We recommend that the Legislature concur in the administration proposal to consolidate HSP at DDS. Given the significant role that RCs under the direction of DDS already play in the operation of the program, we believe the projected General Fund savings for the proposal should be achieved through more efficient administration of the program without any significant disruption in services to HSP clients.

Community Services Program Deficiency Expected to Increase

The budget requests an additional $13.7 million from the General Fund for 2002-03 to address deficiencies in the funding provided to Regional Centers (RCs) for caseload growth, cost increases, and utilization of services. The department expects that the size of this deficiency will increase as more current data about RC caseload and expenditure trends becomes available. These deficits are occurring despite actions by the Legislature directing the department to implement a $52 million unallocated reduction in RC operations in the current year. We recommend that the department report at budget hearings on the size of the deficit and what actions the department will take to ensure deficits do not occur in the future.

Governor's Proposal

RC Operating Costs Increasing. The DDS periodically estimates future caseload and utilization costs for RCs based upon historical data. The DDS has updated its projection of the cost of RC operations during 2002-03 based upon the most recently available actual RC caseload and cost data, in this case information updated through March 2002. The data suggest that the funding provided for these programs in the *2002-03 Budget Act* will be insufficient by $13.7 million from the General Fund ($40 million all funds). Accordingly, the Governor's January 10 budget plan proposes to increase the DDS budget to address this funding deficit.

The $40 million deficiency (including all sources of funds) consists of several components. Increases in utilization and caseload growth total of $29.9 million. The population of RC clients is estimated to be 1,310 more than expected in 2002-03, driving additional costs of $1.8 million in RC operations costs. The deficiency also includes $2.3 million to restore funding for a current-year rollback in Medi-Cal provider rates that did not occur. The remaining $6 million deficiency reflects greater than expected costs for the habilitation services programs currently operated by the DR.

Assessing the Governor's Request

Deficit Will Probably Grow Larger. Initial data reflecting the trends in expenditures for RC purchases of services through June 2002 suggest that a significantly larger deficit than the one assumed in the Governor's budget plan is likely to occur. The additional General Fund costs could amount to tens of millions of dollars. The DDS is aware of this possibility, and intends to update its deficiency request for the May Revision based upon RC data through October 2002.

Notably, these significant projected increases in the cost of RC operations are occuring despite an attempt by the Legislature to slow the trend. Specifically, it adopted an unallocated $52 million General Fund reduction in the RC budget for the current year in light of the state's fiscal problems. It appears for all intent and purposes that DDS and the RCs have not taken sufficient actions to realize such savings.

Historically RC Forecast Has Been Accurate. Historically, the RC estimate has proven to be relatively accurate. In the past, it has been more typical for the RC budget to be below the budgeted level, with savings in recent years ranging from $8 million to $22 million annually.

We believe the RC deficiency is due in part to the failure to achieve the unallocated reduction. Rapid increases in certain components of the caseload, such as children diagnosed with autism, may have contributed to the problem. Another factor may be the significant time lag in the data upon which DDS is basing its projections of RC caseload and costs. Our analysis indicates that it might be possible for the department to develop reporting systems that would allow its projections to be based upon more recent and probably more accurate data.

Analyst's Recommendation

Based upon the caseload and cost data we have reviewed, we concur in the budget request for additional funding to address the current-year deficiency. In light of the preliminary data suggesting that the deficit could grow significantly larger than the Governor's budget request, we recommend that DDS report at budget hearings regarding (1) the potential size of the deficit and its causes; (2) how such a large deficit is likely to occur despite 2002-03 budget actions directing DDS to achieve $52 million in unallocated reductions; (3) what further actions, if any, DDS is taking to constrain growth in these RC expenditures; and (4) what actions, if any, the department proposes to take to improve its forecasts of RC operating expenditures so that the Legislature can budget more accurately for the true costs of providing community services for the developmentally disabled.

Self-Determination Projects Could Benefit Clients and the State

The Governor's budget proposes to extend and expand the self-determination pilot program through 2005. Our analysis indicates that the projects represent a potential "win-win" situation for clients and the state. Clients could gain greater control over their services and their life while the state could potentially hold down growth in program costs. We recommend the Legislature approve the expansion but take further actions to help ensure these goals are achieved.

Background

Test Authorized in 1998. State legislation (Chapter 1043, Statutes of 1998 [SB 1038, Thompson]) authorized DDS to test the concept of "self-determination" in the delivery of community services for persons with developmental disabilities. The legislation authorized the creation of three-year self-determination pilot programs at RCs and provided an initial allocation of $750,000 for this purpose. The projects were allocated an additional $500,000 in 1999-00. Legislation (Chapter 171, Statutes of 2001 [AB 430, Cardenas]) extended the term of the pilot projects until January 1, 2004.

The three RCs chosen to conduct the pilot projects were Tri-Counties RC, Eastern Los Angeles RC, and Redwood Coast RC. The projects commenced operation in the spring of 1999. Kern RC and San Diego RC subsequently submitted proposals to conduct pilot projects and were approved. Currently there are approximately 145 participants in the five self-determination pilot programs.

Clients Control Services and Funds. The main concept of self-determination is to allow clients to decide for themselves which services they need and to directly control the funds they use to purchase them—with appropriate assistance from their friends, families, and professionals in the field.

Four principles govern self-determination: (1) freedom for clients to plan their own lives with appropriate support instead of having their programs planned for them; (2) authority for a client to control an allocated sum of public funds in order to purchase services; (3) support, meaning the arrangement of resources that will allow a client to live as a participating member of a community; and (4) responsibility for assuming an active role in a community as well as accountability for spending public dollars. Under self-determination, clients may choose to have entities known as support brokers and fiscal intermediaries perform ad-

ministrative functions on their behalf. (For more background on the concept of self-determination, see our *Analysis of the 1999-00 Budget Bill*, page C-72.)

Governor's Budget Proposal. The Governor's budget proposes to extend the pilot projects until June 30, 2005. The budget proposal includes a request for two DDS staff positions and $139,000 from the General Fund in 2003-04 to develop a request for a separate federal waiver program for the pilot projects that could result in an increase in federal funding for the support of these clients. The administration is also proposing to change state law to permit an expansion of the five initial pilot projects into other parts of the state.

The plan also proposes to impose a cap on budgets for individual clients participating in self-determination projects that would be set at 90 percent of their current expenditures. The remaining 10 percent of funds would be set aside to establish a "risk pool" of funding that could be used to meet the unanticipated needs of a client who exceeded his/her individual budget. Any funds remaining in the risk pool at the end of each fiscal year would revert to the General Fund.

Assessing the Governor's Proposal

Benefits of the Governor's Proposal. Our analysis of the Governor's waiver program proposal indicates that it has the potential to eventually generate a significant amount of additional federal funds for the state that could offset General Fund costs for RC services for clients. It could also help to contain future growth in these costs.

Currently, about 25 percent of RC clients are included within a federal waiver program, known as the Home and Community-Based Waiver (HCBW). Under the waiver, the state is able to draw down additional federal Medicaid funds for services aimed at helping to maintain eligible individuals in the community instead of in more expensive institutions. The administration is proposing to establish a new and separate waiver program for self-determination program participants that it believes could be designed to allow the state to draw down even more federal funds.

Under this approach, the state anticipates collecting federal reimbursement for certain costs that now cannot be billed under the existing HCBW. In addition, more clients, or perhaps even all of those participating in the pilot projects, could be included within the new self-determination waiver program, potentially making even more federal funding available to offset General Fund costs.

These changes could allow the state to capture as much as $594,000 in federal funds in 2003-04 that could be used in lieu of General Fund

support of the existing pilot projects. These state savings would grow as self-determination projects expanded. For example, if the projects were expanded to serve 1,000 clients, we estimate the state could offset up to $5.5 million in state General Fund costs with increased federal funds.

As we noted earlier, the Governor proposes that RC clients who choose to participate in self-determination be capped at 90 percent of the funding they have received in the past. We believe this approach has merit and could provide an effective mechanism to control future program costs by limiting growth for this segment of the RC population. According to DDS, Wyoming, Vermont, and Pennsylvania have reduced costs by 5 percent to 20 percent by capping expenditures for their self-determination clients.

Potential Problems With the Governor's Proposal. As we noted earlier, under the self-determination approach to the delivery of community services for persons with developmental disabilities, support brokers and fiscal intermediaries perform some functions that are currently performed by RC personnel. Currently, the state is in effect paying twice for administrative support for clients participating in self-determination projects because RC support funding for this part of the caseload is not currently adjusted to reflect the shift of these activities to brokers and fiscal intermediaries.

The Governor's proposal does not provide sufficient detail regarding how it would calculate the budget for clients participating in the self-determination projects. Absent the establishment of a uniform method to determine the amount of funds a client receives annually, it would be difficult to predict and control costs for services for these clients in the future.

Analyst's Recommendation

We recommend the Legislature approve the Governor's proposal to extend the self-determination pilot program beyond the five existing pilot programs in order to determine the potential for capturing additional federal funds that could offset the state cost of community services.

However, we further recommend the Legislature modify the proposed statutory language for the expansion of the program to make any such expansion conditional on the development and adoption by DDS of a standardized annual budget redetermination method for clients participating in self-determination. We believe this requirement would ensure greater accuracy and consistency in budgeting for the self-determination program and in controlling the future cost of these services to clients.

While we believe self-determination pilot projects can be conducted in a cost-effective manner, we recommend that DDS demonstrate at budget hearings that its self-determination model would not cost more than providing the same services to clients under the existing system. The department should also indicate what adjustments should be made to RC funding to reflect the shift of these activities to brokers and fiscal intermediaries so that the state would not pay twice for certain administrative activities on behalf of the clients in self-determination projects.

DEPARTMENT OF MENTAL HEALTH (4440)

The Department of Mental Health (DMH) directs and coordinates statewide efforts for the treatment of mental disabilities. The department's primary responsibilities are to (1) administer the Bronzan-McCorquodale and Lanterman-Petris-Short Acts, which provide for the delivery of mental health services through a state-county partnership and for involuntary treatment of the mentally disabled; (2) operate four state hospitals; (3) manage state prison treatment services at the California Medical Facility at Vacaville and, beginning in the current fiscal year, at Salinas Valley State Prison; and (4) administer various community programs directed at specific populations.

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

Budget Proposal-Overall Increase. The budget proposes $2.3 billion from all funds for support of DMH programs in 2003-04, which is an increase of more than $80 million and 3.7 percent above estimated current-year expenditures. The budget proposes $787 million from the General Fund, which is a reduction of about $60 million, or 7.1 percent, below the Governor's revised budget plan for the current year. Reimbursements that would be received by DMH—largely Medi-Cal funding passed through to community mental health programs—would increase $142 million, or 10.8 percent.

The overall proposed increase in DMH expenditures is primarily due to the expansion of the Early and Periodic Screening, Diagnosis and Treatment program (EPSDT) for children with emotional problems. The budget reflects a proposed $88 million increase in 2002-03 in the reimbursements received from the Department of Health Services (DHS) for support of EPSDT ($43 million comes from an increase in Medi-Cal General

Fund spending and the balance from county and federal funds). The Governor's budget plan proposes a further increase in EPSDT funding above this revised current-year level of expenditures of $142 million, of which about $70 million would come from the General Fund. We discuss the reasons for the augmentation request and our response to this proposal later in this analysis.

Also contributing to the overall increase in DMH spending is a request in the state hospital budget for an augmentation of about $18 million from the General Fund (as well as a decrease of $2.6 million in reimbursements) primarily to accommodate projected growth in the forensic patient population. The budget plan assumes that the overall number of hospital patients at the end of the budget year will be 4,640, about 400 more patients than were in the hospitals as of December 2002.

The Governor's budget proposes a $3.7 million increase from the General Fund to continue with preparations to open a new state hospital in Coalinga which is now under construction. Also, $3.5 million in additional reimbursement authority is requested so that the department can operate a 20-bed inpatient mental health facility at the Department of the Youth Authority's Southern Youth Correctional Reception Center in Norwalk.

Budget Proposal-General Fund Decrease. The net reduction in General Fund expenditures proposed by the Governor's spending plan results in part from the proposal in the Governor's realignment plan to transfer two of its community mental health programs to the counties along with an equivalent amount of funding. The Governor would realign state funding for Integrated Services for the Homeless, including all $54.9 million in local assistance and $407,000 in funding for state support of the program. The budget would also transfer $20 million for the Children's System of Care plus an additional $209,000 in department support funds.

The budget plan includes several other significant reductions in mental health program spending, including proposals to:

- Defer, for the second year in a row, the payment of more than $100 million in county claims for reimbursement for several state-mandated community mental health programs. The two most significant programs affected are so-called AB 3632 (Brown) services for special education children and a separate mandate for services for seriously emotionally disturbed pupils.
- Eliminate the Early Mental Health Initiative in order to save $15 million in General Fund resources allocated as an education program under Proposition 98.

- Make various caseload and other adjustments for managed care plans providing community mental health services that would result in a net reduction of $6 million from the General Fund (a reduction of $12 million in all fund sources), partly as a result of a proposed 10 percent reduction in the rates paid to providers. A separate augmentation of $1.7 million from the General Fund ($6.2 million all funds) would be provided to ensure that this program complies with new technical program requirements established by federal Medicaid regulations.

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

STATE HOSPITAL ISSUES

Patient Caseload Overbudgeted

The Governor's budget requests a $30 million increase in General Fund support for various state hospital population adjustments. Our analysis of the Governor's proposal and recent hospital census data indicates that General Fund support for the hospital caseload is probably overbudgeted by about $3.6 million in the current year and $14.1 million in the budget year. (Reduce Item 4440-011-0001 by $14.1 million.)

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

For the current fiscal year, the administration has proposed an increase of about $2.9 million in General Fund support relative to the funding previously authorized in the *2002-03 Budget Act*. This increase is based on census counts indicating that the Mentally Disordered Offenders (MDO) caseload is above the level initially budgeted.

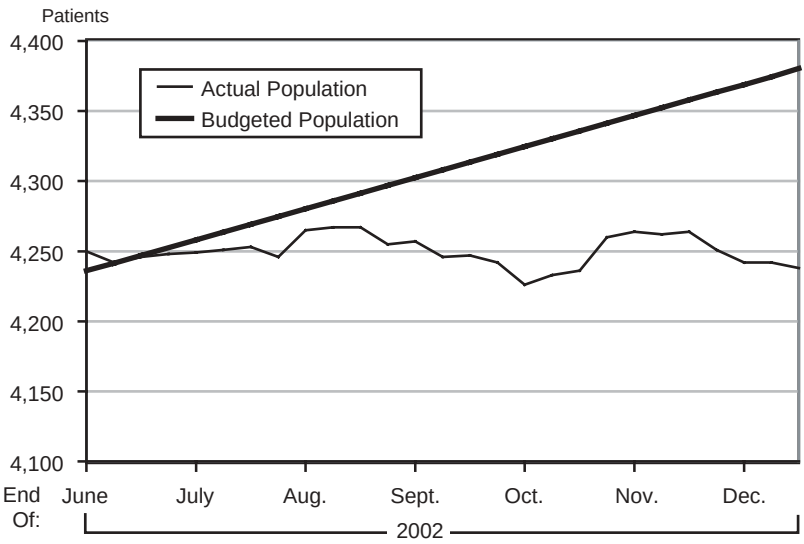
For the budget year, the spending plan requests a net increase in General Fund support of about $30 million compared to the revised proposed level of spending for the state hospital system. This is comprised of: (1) $14.8 million in funding adjustments to account for the full fiscal effect in 2003-04 of population growth which DMH projects will gradually occur in the hospitals during the current fiscal year; (2) an additional $5.6 million to care for a projected net gain of 88 patients during the budget year; and (3) an augmentation of about $9.5 million for deficiencies in funding for operating expenses and equipment. We discuss this last request separately later in this analysis.

The Governor's January 10 spending plan assumes that the population of forensic patients—that is, those transferred to the hospital system because of their involvement with the criminal justice system—would grow during the budget year by 114 patients. The spending plan also assumes an offsetting reduction of 26 patients committed to the state hospital system under the authority of the Lanterman-Petris-Short (LPS) Act and who are financially supported by counties. This would result in a net gain of 88 patients.

Budget Assumptions Off Track. Our review of recent hospital population data indicates that the Governor's January 10 budget plan overstates the patient caseload that is likely to materialize in both the current and budget years. The Governor's spending plan is based on hospital census counts through the beginning of October. Our analysis reflects population data through the end of December that was not available at the time the Governor's budget plan was prepared. As can been seen in Figure 1, the overall population count so far in the current year has remained fairly level and has not grown in line with the caseload funding provided in the *2002-03 Budget Act*.

Figure 1

State Hospital Growth Below Budgeted Level



Some specific categories of state hospital patients have grown in number, and these trends are reflected in the Governor's 2003-04 spending plan. For example, the Governor's budget assumes that the number of MDO patients is above the number assumed in the *2002-03 Budget Act*, and that modest growth in the number of these patients will carry forward into the budget year. Our analysis indicates that these budget assumptions are in line with the hospital census data we have reviewed.

However, our analysis of that data indicates that the population growth assumed in the Governor's budget plan for certain other categories of patients is not materializing. These more recent trends suggest that both the current-year and budget-year requests for additional funding for the hospital system are significantly overstated. Specifically, the Governor's budget assumptions are not in line with the actual census count of patients classified as being Incompetent to Stand Trial, Not Guilty by Reason of Insanity, as well as county-supported LPS commitments. The data also indicate that the number of patients classified as Sexually Violent Predators is modestly above the levels assumed in the Governor's budget plan.

In summary, the Governor's budget plan assumes that the overall hospital population will reach 4,552 by June 2003 and 4,640 by June 2004. This seems unlikely, given the actual census count at the end of December of 4,238—a net drop of 12 patients since the current fiscal year began—and the modest decline seen in the hospital population during the past two years.

If this disparity between actual hospital census counts and the caseload assumed in the Governor's January 10 budget plan were to continue, the spending plan would provide the state hospitals significantly more money for this purpose than is needed in both the current and budget year. We estimate that the Governor's spending plan may provide as much as $3.6 million more from the General Fund for support for hospital caseload adjustments than is needed in the current year. (Instead of the $2.9 million General Fund augmentation requested by the Governor for the current year, the existing General Fund budget appropriation for 2002-03 appears to exceed the department's hospital caseload needs by about $700,000.) We also estimate, based on review of more recent caseload data, that the Governor's proposed 2003-04 expenditures from the General Fund for state hospital caseload are overbudgeted by about $14.1 million (about $20.7 million all funds).

Analyst's Recommendation. Given the continuing disparity between the actual census count in the state hospitals and the caseload assumptions in the Governor's budget, we recommend that the Governor's request for additional caseload funding for 2003-04 be reduced by $14.1 mil-

lion from the General Fund. We are advised that the administration will update its hospital population projections this spring to reflect more recent hospital population trends. We will continue to monitor the hospital caseload and recommend further changes, if necessary, following our review of the May Revision.

Funding for Operating Expenses Requires Further Review

The budget requests a $9.5 million augmentation from the General Fund for caseload-related operating expenses for state hospitals. We withhold recommendation on this funding request pending further administration review of the proposal, and recommend that the Legislature examine restructuring how such operating expenditures are budgeted to improve legislative accountability.

Expense Adjustment Requires Further Review. As noted earlier, the budget plan proposes an augmentation of $9.5 million from the General Fund ($11.4 million all funds) for the stated purpose of adjusting the DMH budget for operating expenses and equipment (OE&E). The budget request indicates that, in 2001-02, DMH spent $11.4 million more from its OE&E budget than expected for drugs, utilities, outside medical services, and other purposes. However, it is unclear whether DMH will need these additional resources in 2003-04. We are advised that the administration considers the requested amount to be preliminary and that it intends to review and potentially revise this proposal at the time of the May Revision.

Our office is also continuing to review the proposal in light of the number of authorized but vacant positions in its state hospital operations. The DMH data we have reviewed indicate that more than 1,150 of the hospital system's nearly 8,700 authorized positions—about 13.3 percent of the total—were vacant as of January 2003. This large a number of vacancies raises a question as to whether the department would have a significant amount of unspent personnel funds that could be shifted instead to meet its OE&E needs. The Department of Finance (DOF) has estimated that, in 1999-00, when a similar situation was occurring, DMH shifted $39 million in savings from vacant positions to other purposes.

We note that, in our *Analysis of the 2002-03 Budget Bill*, we had proposed that a number of the vacant state hospital positions be abolished, and that surplus funding for personnel be permanently shifted to the OE&E component of the department's budget as justified to meet DMH's operational needs. We proposed this restructuring of the DMH hospital budget with the purpose of restoring accountability by DMH to the Legislature for the use of these funds. In our view, the current situation makes it difficult for the Legislature to hold DMH accountable for spending the money in the way it was budgeted.

However, we also note that the request for a special augmentation for OE&E funds is further evidence that the current standard caseload funding methodology for the state hospital system does not allocate the additional resources actually needed for such items as food and medications for patients. The $11,000 that is added to the budget for these purposes for each new patient (on a full-year basis) is probably insufficient to keep pace with the added costs of growth in the hospital population. The administration is aware of this problem and is considering possible remedies.

More accurate budgeting for caseload-related increases in OE&E costs would probably reduce the need for special OE&E augmentations, such as the current request for $9.5 million, which have periodically been requested and granted to DMH. Improvement of the standard caseload budgeting formulas could also further efforts to restructure the state hospital budget so that it more accurately reflects the level of expenditures that will actually occur, a step toward enhanced accountability to the Legislature on the use of its funds.

Analyst's Recommendation. We withhold recommend at this time on the proposed OE&E augmentation, pending the administration's further review of the proposal and possible changes to the request at the time of the May Revision. The Legislature may also wish to consider directing DMH and DOF to report at budget hearings regarding: (1) how, if at all, the OE&E augmentation should be offset with excess funding from vacant positions in the state hospital system, (2) how the state hospital budget could be restructured to more appropriately align the funding needed for personnel and OE&E needs, and (3) the fiscal ramifications of improving the standard caseload budgeting methodology to more accurately reflect hospital system needs for OE&E funding.

Another Delay for Salinas Valley Facility

The scheduled opening of a new mental health facility at Salinas Valley State Prison has been delayed repeatedly due to construction problems. We recommend that the current-year budgets of the Departments of Corrections (CDC) and Mental Health be adjusted at the time of the May Revision to reflect the savings of at least $1.5 million in operating costs for the new facility that will result from the delay in its activation. We further recommend that an additional $100,000 in funding for CDC operating expenses be deleted because it is unclear why these resources are needed at this time.

Background. The *2002-03 Budget Act* and a subsequent budget adjustment provide about $5.4 million in General Fund support to CDC, with an equivalent amount of reimbursement authority to DMH, to open

a new 64-bed psychiatric facility at Salinas Valley State Prison. (This sum includes $544,000 for recruitment and retention bonuses for the facility's new staff.) The Governor's budget plan proposes to provide full-year funding of $7.2 million for the operation of the facility during 2003-04, plus an augmentation to the CDC budget of $100,000 for various additional operating expenses.

Comparable to a longstanding arrangement between the two departments at the California Medical Facility at Vacaville, the new Salinas Valley facility will be staffed and managed by DMH to exclusively serve CDC inmates at the prison.

Staff In Place, But No Place to Accomplish Their Work. The level of funding provided to CDC and DMH to open the Salinas Valley facility during 2002-03 takes into account construction-related delays that postponed the date DMH was to assume control of the new building from April 2002 until September 2002. However, since that time, the building project has encountered further delays. The DMH indicates that it has been notified by CDC that the building will not become available for occupation by its staff until February 2003 and would not receive its first CDC patient until April 2003.

Amid this series of delays, we are advised that DMH nevertheless proceeded to hire 61 of the 103 authorized staff positions for the facility. The latest construction delays mean that this newly hired DMH staff will temporarily have no place to accomplish the work for which they were hired. We are advised by DMH that, until this situation is resolved, perhaps by March, the new hires are being directed to perform other medical and nonmedical work at the prison.

The DMH estimates that, as a result of the slowdown in the activation schedule, it will not spend about $1.5 million of the funds allocated for the operation of the Salinas Valley facility in the current fiscal year. The Governor's January 10 budget plan did not propose any financial adjustment to either the CDC or the DMH budgets to reflect the delay in the activation of the Salinas Valley facility. The CDC budget for Salinas Valley State Prison also has not been adjusted to reflect the additional funding available to them as a result of the delay in the opening of the mental health facility but not accounted for in the budget of that institution.

Basis for OE&E Augmentation Unclear. As noted earlier, the CDC budget requests an additional $100,000 for various estimated operating expenses for the Salinas Valley facility.

While these funds were provided within the CDC budget, these same funds have not been included as additional reimbursements within the DMH budget for the support of the mental health facility. Moreover, DMH

was unaware of this budget request. Thus, at the time this analysis was prepared, we were unable to clarify why these additional funds are needed at this time.

Analyst's Recommendation. We recommend that the Legislature direct that the General Fund budget for CDC for the current year be reduced by at least $1.5 million, with an equivalent reduction to reimbursements in the DMH budget, to reflect savings from the delay in the activation of the new mental health unit at Salinas Valley. At the time of the May Revision, the current-year spending level for the two departments should be further adjusted to reflect an updated projection of these savings, including any additional savings that could accrue in the current year and the budget year if there are any further delays in the opening of the facility. In response to our inquires about this matter, we have been advised by CDC that such adjustments will be presented at the time of the May Revision.

In addition, the CDC budget should be adjusted at that time to reflect any savings to the department that will result from the availability in the current year of unbudgeted additional DMH staff. We recommend deletion of the proposed $100,000 augmentation for OE&E expenditures because it is unclear why these resources are needed at this time.

COMMUNITY PROGRAM ISSUES

New Projection Method Increases EPSDT Costs

The Governor proposes a significant increase in state support for community mental health services for certain children in both the current and budget years based on a revised projection method for the costs of the program. We believe there is merit to the Department of Mental Health's effort to budget more accurately for the program, but recommend funding adjustments to correct for apparent overbudgeting for these costs. (Reduce Item 4260-101-0001 by $11.7 million.)

Background. The EPSDT, a federally mandated program, requires states to provide a broad range of screening, diagnosis, and medically necessary treatment services to Medi-Cal beneficiaries under age 21, even if the treatment is an optional service under a state's Medicaid plan. The requirements apply to mental health as well as physical health.

As we noted in the *Analysis of the 2001-02 Budget Bill* as well as in analyses of the state budget in previous years, the state's expenditures for EPSDT mental health services had been growing dramatically—as much as 30 percent annually.

In response to these concerns, the administration is requiring counties, which were previously obligated to provide a base level of funding but bore no share of the cost of the growth of the program, to be financially responsible for a 10 percent share of the nonfederal cost of program growth. In addition to this intended cost-control mechanism, the Legislature also adopted statutory language last year directing DMH to assist counties in implementing managed care principles that would help slow the growth in the program. The DMH is taking some steps to implement these provisions that its believes will have an unspecified future impact on the growth in program costs.

Budget Request Based on New Projection Method. Despite these changes, the Governor's budget plan again proposes significant increases in General Fund resources for EPSDT. The spending plan would augment the state budget by $43.4 million in the current year and an additional $69.7 million above that current-year spending level in the budget year. By 2003-04, the total state cost for the program would reach $381 million, an increase of about 16 percent above the proposed 2002-03 level of spending. (General Fund and federal fund support for the program are budgeted within the DHS budget, and budgeted as reimbursements in the DMH budget.)

The DMH indicates that the budget proposal reflects its collection of more recent information about the costs and caseload of EPSDT, an expected slowdown in program growth due to cost-containment efforts at the county level, and a change in the department's method for estimating future program costs. In the past, DMH has noted, its projections of EPSDT costs often turned out to be significantly below the actual level of expenditures. Once these funding deficiencies were later recognized, the administration has requested additional state funding—sometimes in the tens of millions of dollars—to "catch up" with underbudgeted amounts for EPSDT. For example, in January 2001, the DMH budget requested an additional $61 million for the EPSDT program primarily for this reason.

The 2003-04 budget plan is based on a new projection method that DMH believes more fully reflects the base level of funding needed for EPSDT services. One key change is that DMH's revised method takes into account specific data on EPSDT growth trends in each county, while the previous expenditure projection method was based on cost data that was aggregated on a statewide basis.

Projections Consistently More Accurate, But Consistently Higher. We believe there is merit to the DMH's attempt to budget more accurately for EPSDT, and agree that the new projection method of looking at county-by-county expenditure trends is likely to prove more accurate than its previous approach. However, we are concerned the new projection

method has a tendency to err on the side of overbudgeting for EPSDT rather than providing less money than would be needed.

The DMH attempted to validate its new projection model by reviewing how accurate its new approach would have been had it been used in the past. As can be seen in Figure 2, projections made using the new method were significantly more accurate. For example, the DMH had initially believed that about $179 million (from all fund sources) was needed for support of EPSDT in 1998-99. The actual costs turned out to be almost $300 million. Had the new projection method been used, the Legislature would have been asked to budget about $333 million, much closer to the actual amount of funds needed.

Figure 2

New DMH Projections More Accurate But Exceed Funds Actually Needed

(In Millions)

Fiscal year	Total Actual Claims Paid	Estimate With:	
		Previous Method	Proposed Method
1998-99	$299.8	$178.6	$332.6
1999-00	395.5	369.5	423.6
2000-01	525.5	469.2	540.0

However, we would note that, as can also be seen in Figure 2, while the new method was consistently more accurate in projecting prior year spending needs, it also consistently erred on the side of providing more money for the program than was actually needed. For the three years tested in the validation of the projection, the average error amounted to about $25 million for all fund sources.

There is no way to know at this time, however, whether this is a flaw in the projection model or just a coincidental result of other factors affecting the three years of EPSDT expenditures that were reviewed. Further testing of the model in the future should resolve this issue.

Analyst's Recommendation. We believe it makes sense at this time to rely upon DMH's new projection method as a basis for revising the 2002-03 spending plan and planning the budget for EPSDT services for 2003-04. It is in the state's fiscal interest to budget more accurately for the costs that will be incurred for this program.

However, given the uncertainty that remains about this new projection method, we would recommend that the Legislature consider making adjustments to offset its apparent tendency to allocate somewhat more money for this program than would actually be needed. While we would acknowledge that this increases the risk that the Legislature will need to provide additional funding for EPSDT, we believe it is more fiscally prudent for the Legislature to err on the side of not providing more money than is needed for the program.

Specifically, we recommend that the proposed funding allocations in the Governor's budget plan for EPSDT (within both DHS and DMH) be reduced, both in the current year and the budget year, by the average amount of the error shown in DMH's attempt to validate its projection model—about $25 million when all sources of program support have been considered. Taking into account county and federal support for the program, this would result in a $12.3 million reduction in the revised current-year level of spending provided for EPSDT in the Governor's budget plan. The proposed 2003-04 appropriation for EPSDT would be reduced by about $11.7 million. Further adjustments to these funding levels could be made, if warranted, as DMH obtains additional caseload and cost data indicating the actual expenditure levels that have occurred.

In addition, we discuss the possibility of including EPSDT mental health services within a proposed state-county realignment of funding and program responsibilities in "Part V" of the *2003-04 Budget: Perspectives and Issues.*

DEPARTMENT OF COMMUNITY SERVICES AND DEVELOPMENT (4700)

The Department of Community Services and Development (DCSD) administers various programs that serve low-income individuals and families through a network of approximately 200 community-based agencies. Federal programs administered by the department include the Low-Income Home Energy Assistance Program (LIHEAP) Block Grant, the Department of Energy Weatherization Assistance Program (DOE WAP), and the Community Services Block Grant (CSBG). The department also administers California LIHEAP, the Mentoring Program, and the Naturalization Services Program.

The budget proposes no funding for the department in 2003-04, a reduction of $5.4 million compared to 2002-03.

Budget Proposes Eliminating the Department

The Governor's budget proposes to consolidate the department's federal programs within the Department of Social Services. This would result in a net reduction of nine positions and a corresponding redirection of $0.9 million in federal funds from state operations to local assistance.

As part of the December revision to the *2002 Budget Act*, the Governor proposed to eliminate all state-funded programs administered by DCSD effective July 1, 2003, resulting in General Fund savings of $3.9 million. (These programs include the Naturalization Services Program [$2.9 million] and the Mentoring Program [$1 million].)

The December revision further proposed consolidating the department's remaining programs within the Department of Social Services (DSS) effective July 1, 2003. We are advised that these programs—the federal DOE WAP, CSBG, and LIHEAP block grants—would constitute a stand-alone division within DSS. This consolidation would result

in the elimination of nine positions, and a corresponding redirection of approximately $0.9 million in federal funds from state operations to local assistance. Specifically, the community-based organizations that use the block grant funds to deliver various low-income energy, housing, nutrition, and other services would receive an additional $0.9 million (approximately 0.6 percent of total local assistance funding). We believe the Governor's consolidation proposal is workable.

DEPARTMENT OF REHABILITATION (5160)

The Department of Rehabilitation (DR) provides basic vocational rehabilitation and habilitation services to persons with disabilities. The purpose of vocational rehabilitation services is to place disabled individuals in suitable employment, while habilitation services help individuals who are unable to participate in vocational rehabilitation programs achieve a higher level of functioning. Services are provided in sheltered workshops under the Work Activity Program (WAP) and to groups or individuals at job sites through the Supported Employment Program (SEP).

In addition, the department helps legally blind clients support themselves as operators of vending stands, snack bars, and cafeterias throughout the state; provides prevocational rehabilitation services to newly blind adults; develops cooperative agreements with school districts, state and community colleges, and county mental health programs to provide services to mutually served clients; and assists community-based rehabilitation facilities such as the independent living program, halfway houses, and alcoholic recovery homes.

The budget proposes an appropriation of $344 million from all funds for support of DR programs in 2003-04. This is a decrease of $137 million, or 28 percent, compared to estimated current-year expenditures. The budget proposes $43 million from the General Fund, which is $112 million, or 72 percent, below estimated current-year General Fund expenditures. This General Fund reduction is attributable to (1) shifting the Habilitation Services Program to the regional centers and (2) provider rate reductions.

Budget Achieves Savings From Rate Reductions and Freezes

The Governor's budget proposes to (1) reduce rates for the Supported Employment Program and the Work Activity Program (WAP) by 5 percent, effective April 2003, and (2) suspend the statutory WAP rate adjustment for three years. Together, these actions result in combined General Fund savings and cost avoidance of $19 million in 2003-04.

The Governor's December revision to the *2002-03 Budget Act* proposed reducing SEP and WAP rates by 5 percent, effective April 1, 2003. This would result in lower payments to SEP and WAP service providers of approximately $2.1 million (all funds) in 2002-03 and $8.8 million (all funds) in 2003-04. The Governor's budget reflects this proposal, which would result in General Fund savings of $1.5 million in the current year and $6.3 million in the budget year.

The Governor's budget also reflects the December revision proposal to suspend the statutory WAP rate adjustment for three years. Current law requires the department to adjust rates for WAP providers every two years, based on actual service provider cost statements. The July 1, 2002, rate adjustment was suspended, and the next adjustment is scheduled to take effect July 1, 2003. Based on preliminary estimates, the department projects that WAP rates would increase by approximately 20 percent if the rate adjustment were provided. This would result in increased payments to WAP service providers of approximately $17 million ($12 million General Fund). The Governor proposes budget trailer bill language to suspend the statutory rate adjustment through 2005-06, resulting in a General Fund cost avoidance of $12 million in 2003-04.

Budget Shifts Habilitation Services Program to Regional Centers

The Governor proposes to shift the Habilitation Services Program from the Department of Rehabilitation (DOR) to the regional centers effective July 1, 2003. This proposal would result in (1) a shift of $115 million in local assistance funding from DOR to the Department of Developmental Services (DDS) and (2) net General Fund savings of $1.5 million in 2003-04, associated with a net reduction of 11 positions. Please see the DDS section of this *Analysis* for our discussion of the Governor's proposal.

DEPARTMENT OF CHILD SUPPORT SERVICES (5175)

The Department of Child Support Services (DCSS), created on January 1, 2000, administers California's child support program by overseeing 58 county child support offices. The primary purpose of the program is to collect from absent parents, support payments for custodial parents and their children. Local child support offices provide services such as locating absent parents; establishing paternity; obtaining, enforcing, and modifying child support orders; and collecting and distributing payments.

The *2003-04 Governor's Budget* proposes expenditures totaling $1 billion from all funds for support of DCSS in the budget year. This is a decrease of $19 million, or 1.8 percent, from estimated current-year expenditures. The budget proposes $438 million from the General Fund for 2003-04, which is an increase of $3.7 million, or 0.9 percent, compared to 2002-03. Most of the increase is attributable to an estimated increase in the federal penalty, largely offset by a reduction in basic administration costs.

Legislature Needs Better Budget Information

Currently, the Department of Child Support Services (DCSS) budget for county administration is based on estimated collections, rather than estimated county costs and does not display recent initiatives designed to improve program performance. We recommend that DCSS revise its budget to display its initiatives separately, rather than continue to include them in basic county administrative costs.

Background. In an effort to improve the program performance of the child support services program, the Legislature removed the Child Support Services Office from the Department of Social Services and created the DCSS effective 2000. Since that time, DCSS has shifted the focus of child support collection toward a new "customer friendly" approach. Among the components developed over the last few years to improve

customer service are the following "initiatives:" (1) an ombudsperson program, (2) informal inquiry and response timeframes, (3) a complaint resolution and state hearing process, (4) customer satisfaction surveys, (5) a statewide outreach program, and (6) quality assurance and program improvements.

Current Budgeting Practice. Under its current budgeting methodology, the administration estimates the amount of child support it anticipates collecting during the year. Once it has determined the total collections, it calculates 13.6 percent of those funds. (The 13.6 percent figure is based on historical incentive payments to counties prior to creation of the new department and is contained in the enabling legislation.) This amount effectively becomes a "placeholder" budget level for local administration of the program. Once the placeholder is established, the administration then decides how much General Fund it is willing to commit to running the child support collection program. This amount becomes the budget for the local child support agencies, and is typically lower than the placeholder.

Initiative Funding Levels Set Through Individual County Allocations. Independent of the budgeting process, DCSS develops the amount of the available administrative funding that it recommends counties spend on their various initiatives. The funding for the initiatives is implemented through individual county allocations. For fiscal years 2001-02 and 2002-03, DCSS allocated $84.9 million for initiatives. The level of funding for initiatives was based upon the amount of unspent funds in 2000-01.

While DCSS allocates the funding for the initiatives separately, it has not established a claiming process to track the amount that counties are actually spending on initiatives. This lack of expenditure information makes it difficult for DCSS to (1) ensure that counties have implemented the initiatives and (2) develop a methodology that allows DCSS to estimate the actual county costs for the initiatives.

The Problem. The budget display provided by the administration does not distinguish between (1) the discretionary administrative funding that counties may use to operate their basic programs and (2) the funding for the initiatives. For example, the costs of the ombudsperson and outreach services are indistinguishable from the estimated costs for county staff and other general operating expenses. Since all administrative costs are included in one basic line, there is no way to determine which aspects of the program, including the various initiatives, are being augmented or reduced in the budgets proposed by the administration for DCSS. As their budget is currently displayed, for example, it is unclear to what degree the Governor's proposed cuts affect the various initiatives that have been established by DCSS.

While the budget display makes legislative oversight of the DCSS budget difficult, of equal concern is the methodology used by the department to set the administrative funding level. Merely establishing a benchmark of 13.6 percent, based on estimated collections, and then funding the program below that level based upon the amount of General Fund the administration is willing to devote to the program, means that the proposed funding level is not built on any assessment of actual program costs. Therefore, the impact of any budget change (reduction or augmentation) to the program cannot be measured because there is no established cost for the core program. Moreover, without separate tracking of expenditures, it becomes impossible for the Legislature to determine (1) the cost of the initiatives and (2) the degree to which counties are implementing the recommended initiative programs.

Building a Better Budget. In order to improve legislative oversight of the DCSS budget, DCSS should develop an administrative budget that separates basic administrative costs from the estimated cost of its initiatives. The basic administrative funding estimate should be based on actual county expenditures and adjusted for an assessment of workload changes or any increase in the cost of doing business. Once the basic administrative funding is established, DCSS should estimate the cost of each initiative and display them separately.

Analyst's Recommendation. We recommend that the Legislature direct DCSS to (1) revise its budget display to separate the funding for basic administration and initiatives; and (2) base the core administrative budget on actual county expenditures, estimated workload changes, and any cost of doing business increases.

County Share for Federal Child Support Penalty

Since 1998, California has been subject to penalties for failing to implement a statewide child support automation system. The penalties, estimated to be $188 million in 2002-03 and $207 million in 2003-04, are levied in the form of a reduced federal share of child support administrative expenditures. Effective April 2003, the Governor proposes that counties pay one-quarter of the penalty.

Current Law. The federal government usually pays two-thirds of a state's total child support administrative expenditures. However, pursuant to the Child Support Performance and Incentive Act of 1998 (Public Law 105-200), California has been subject to federal automation penalties, which are levied, in the form of a reduced federal share in these administrative costs. Chapter 479, Statutes of 1999 (AB 150, Aroner), provides that the distribution of penalties between the state and counties be determined through the annual budget process. Through 2001-02, the

Legislature has approved about $370 million from the General Fund to hold the counties harmless with respect to the penalty.

Recent Action. For 2002-03, the administration (1) assumed that federal legislation would be passed to provide the state with 50 percent penalty relief and (2) proposed that counties be responsible for half of the remaining cost of the penalty. The Legislature adopted the assumption of 50 percent federal penalty relief, but rejected the administration's proposal to establish a county share of the penalty. To date, there has been no penalty relief from the federal government, so the administration has submitted a deficiency notification letter asking for an additional $98.4 million to cover the cost of the entire penalty.

Governor's Proposal. The *2003-04 Governor's Budget* proposes a 25 percent county share of cost for the federal penalty to be implemented prospectively, beginning in April 2003. Under this proposal, counties would be responsible for $6.2 million in 2002-03 and $52 million in 2003-04.

DEPARTMENT OF SOCIAL SERVICES
CALWORKS PROGRAM
(5180)

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

The budget proposes an appropriation of $5.1 billion ($1.5 billion General Fund, $718 million county funds, $21 million from the Employment Training Fund, and $2.8 billion federal funds) to the Department of Social Services (DSS) for the CalWORKs program. In total funds, this is a decrease of $893 million, or 15 percent. This decrease is primarily attributable to savings from (1) adults reaching their time limits on cash assistance, (2) the Governor's grant reduction proposal, and (3) no new funding for county performance incentives. (These issues are discussed below.)

The budget proposes a reduction in General Fund spending of $553 million (26 percent). This decrease is possible while still meeting the federal maintenance of effort (MOE) spending requirement because, under the Governor's realignment proposal, the county share of costs (with a corresponding amount of revenues) would increase by $561 million. Specifically, the Governor proposes to increase the county sharing ratio for employment services and administrative costs from an effective

rate of about 5 percent to 50 percent. (Please see *The 2003-04 Budget: Perspectives and Issues* for our discussion of the realignment proposal.)

The General Fund savings in CalWORKs due to realignment are partially offset by the $66 million cost associated with satisfying the remaining Welfare-to-Work match obligation, which must be satisfied by July 2004.

We note that Congress extended funding for the Temporary Assistance for Needy Families (TANF) block grant through September 30, 2003. The Governor's budget assumes that the block grant will eventually be reauthorized at current funding levels ($3.7 billion annually for California).

CASELOAD AND GRANTS

Caseload Projection is Overstated

We recommend that proposed spending for California Work Opportunity and Responsibility to Kids grants be reduced by $250 million (federal Temporary Assistance for Needy Families funds) in 2002-03 and $100 million in 2003-04 because the caseload is overstated. (Reduce Item 5180-101-0890 by $100 million.)

The CalWORKs caseload has declined every year since 1994-95, when caseloads reached their peak. During 2001-02, the average monthly caseload decreased by approximately 3 percent from the prior year. However, the Governor's budget projects that the caseload decline will end in 2002-03, resulting in a 2 percent caseload increase compared to 2001-02. Caseloads are projected to essentially level off by the end of the budget year, resulting in a modest year-over increase of 0.5 percent in 2003-04.

In fact, as shown in Figure 1, actual caseload data through October 2002 (the last month for which actual data are available) indicate that the overall caseload decline has continued. As a result, the budget's caseload forecast for the first four months of 2002-03 is well above the actual caseload for those months, as indicated in the figure. Our review of caseload trends, birth rates, and unemployment rates provides no reason to believe that the caseload decline will end in the current year or the budget year. Thus, we believe the budget overstates the caseload for both 2002-03 and 2003-04.

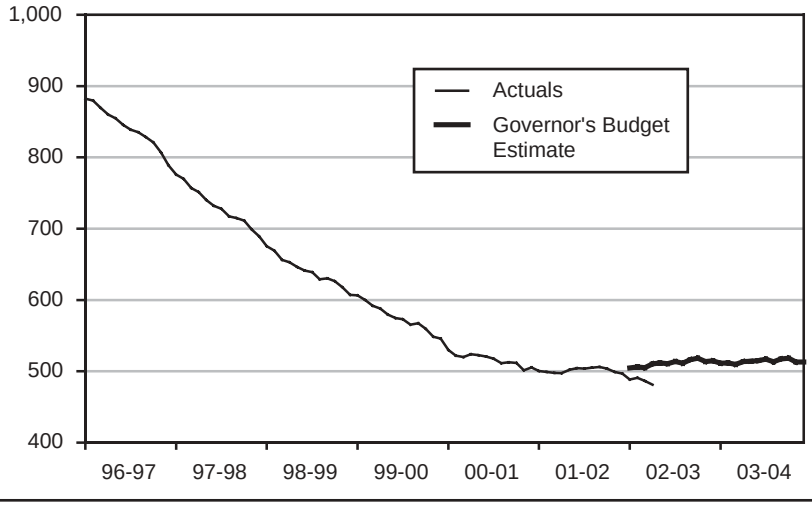
As a result, we believe the budget overstates CalWORKs costs by about $250 million in 2002-03 and by an additional $100 million in 2003-04, for a total of $350 million (federal TANF funds) over the two-year period. We believe our estimate is conservative in that it takes into account the uncertain impact of time limits on the caseload by adjusting for po-

tentially lower time limit savings than assumed in the budget. Therefore we recommend that the budget be reduced to reflect the savings associated with lower caseloads. This would increase the TANF reserve by $350 million. Recognizing this higher TANF reserve ($550 million—$200 million Governor's budget plus $350 million) creates options for the Legislature, which we present later in our CalWORKs analysis.

Figure 1

Budget Overestimates CalWORKs Caseload Decline Has Continued

(Cases in Thousands)



Budget Suspends Statutory Cost-of-Living Adjustments and Reduces Grant Payments

The Governor's budget proposes to (1) suspend the statutory cost-of-living adjustments and (2) reduce grant payments by 6.2 percent. Compared to current law, these proposals result in combined General Fund/federal Temporary Assistance for Needy Families block grant savings of $502 million in 2002-03 and 2003-04.

Cost-of-Living Adjustment (COLA) Suspensions. The Governor's budget proposes to suspend the statutory COLAs effective June 2003 and October 2003. Compared to current law, suspending the June 2003 COLA results in General Fund / TANF savings of approximately $12 million in 2002-03 and $146 million in 2003-04. Suspending the October 2003 COLA

results in General Fund / TANF savings of $106 million in the budget year. The June COLA is based on the change in the California Necessities Index (CNI) from December 2000 to December 2001 (3.7 percent). The October 2003 COLA is based on the CNI change from December 2001 to December 2002 (3.5 percent).

Grant Reduction. In addition to the COLA suspensions, the Governor proposes to reduce the maximum monthly aid payments by 6.2 percent, effective July 1, 2003. This reduction results in General Fund / TANF savings of approximately $238 million. Together, the grant reduction and COLA suspensions result in General Fund / TANF savings of $12 million in 2002-03 and $490 million in 2003-04.

Figure 2 shows the maximum CalWORKs grant and food stamps benefits for a family of three under current law, and what the maximum grant and benefits would be under the Governor's proposals. As the figure shows, under the Governor's proposals, in October 2003 grants for a family of three in high-cost counties would be $637, compared to $728 under current law. Grants for a family of three in low-cost counties would be $607 under the Governor's proposals, compared to $694 under current law.

As a point of reference, the federal poverty guideline for 2002 (the latest reported figure) for a family of three is $1,252 per month. (The federal poverty guidelines are adjusted annually for inflation.) Under current law, in October 2003 the combined maximum CalWORKs grant and food stamps benefits in high-cost counties would be $1,007 per month (80 percent of the poverty guideline). Under the Governor's proposals, combined benefits in high-cost counties would instead be $957 per month (76 percent of poverty). Combined benefits in low-cost counties would be $988 per month (79 percent of poverty) under current law, compared to $937 (75 percent of poverty) under the Governor's proposals.

Grant Reduction Proposal—Budget Internally Inconsistent

We recommend a technical adjustment to reduce proposed expenditures for California Work Opportunity and Responsibility to Kids (CalWORKs) administration by $7.3 million (federal Temporary Assistance for Needy Families funds) because the budget does not reflect the administrative savings from the Governor's proposal to reduce CalWORKs grant payments. (Reduce Item 5180-101-0890 by $7.3 million.)

As discussed above, the Governor proposes to reduce CalWORKs grants effective July 1, 2003. Specifically, the Governor proposes to reduce the maximum aid payment (MAP) levels by 6.2 percent. Reducing the MAP levels has the effect of lowering the income threshold at which working families become income-ineligible for cash assistance. This means

Figure 2

CalWORKs Maximum Monthly Grant and Food Stamps Governor's Budget and Current Law

Family of Three

	Current Law	Governor's Budget	Change From Current Law
High-cost counties			
January 1, 2003 actual grant	$679	—	—
2003-04 grant assuming:			
Implement June 1, 2003 COLA (3.7 percent)	$704	—	—
Reduce grants by 6.2 percent effective July 1, 2003	—	$637	—
Implement October 1, 2003 COLA (3.5 percent)	728	—	—
Plus Food Stamps[a]	$279	$320	—
Totals	**$1,007**	**$957**	**-$50**
Low-cost counties			
January 1, 2003 actual grant	$647	—	—
2003-04 grant assuming:	—	—	—
Implement June 1, 2003 COLA (3.7 percent)	$671	—	—
Reduce grants by 6.2 percent effective July 1, 2003	—	$607	—
Implement October 1, 2003 COLA (3.5 percent)	694	—	—
Plus Food Stamps[a]	$294	$330	—
Totals	**$988**	**$937**	**-$51**

[a] Based on maximum food stamps allotments effective October 2002. Maximum allotments are adjusted annually each October by the U.S. Department of Agriculture.

that families with relatively high earnings would lose aid more quickly under the Governor's proposal than under current MAP levels. As families leave aid, administrative costs decrease. The department's estimate of savings from the grant reduction does not account for the administrative savings associated with working families leaving aid as a result of this change.

Based on our estimate of cases with relatively high earnings and low monthly grant payments (averaging about $50 or less), we estimate that the Governor's grant reduction proposal would result in administrative savings of approximately $7.3 million. Without regard to the merits of this proposal, we recommend that the amount proposed for CalWORKs administration be reduced by $7.3 million in order to make the budget consistent with its own assumptions.

MAINTENANCE-OF-EFFORT SPENDING REQUIREMENT AND TANF SURPLUS

Achieving General Fund Savings While Meeting MOE Requirement

The Governor's budget proposes to spend the minimum amount of General Fund monies needed to meet the maintenance-of-effort (MOE) spending requirement for the California Work Opportunity and Responsibility to Kids program in 2003-04. Because of the MOE requirement, any net augmentation to the program will result in General Fund costs, while any net reduction will generally result in federal Temporary Assistance for Needy Families (TANF) savings, not General Fund savings. However, we identify two methods by which TANF savings may be converted into General Fund savings.

Maintenance-of-Effort Requirement. To receive the federal TANF block grant, states must meet a MOE requirement that state spending on assistance for needy families be at least 75 percent of the federal fiscal year (FFY) 1994 level, which is $2.7 billion for California. (The requirement increases to 80 percent if the state fails to comply with federal work participation requirements.) Although the MOE requirement is primarily met through state and county spending on CalWORKs and other programs administered by DSS, $377 million in state spending in other departments is also used to satisfy the requirement.

Proposed Budget Is at MOE Floor. For 2003-04, the Governor's budget for CalWORKs is at the MOE floor. The budget also includes $66 million to satisfy the remaining state matching obligation for federal Welfare-to-Work funds. However, these funds cannot be counted toward the MOE because they are used to match other federal funds.

The Governor's budget also proposes to spend all but $200 million of available federal TANF funds in 2003-04, including the projected carryover of unexpended funds ($262 million) from 2002-03. The $200 million will be held in a reserve for unanticipated future program needs. Any net

augmentation to the CalWORKs program above the reserve amount would result in additional General Fund costs above the MOE requirement.

Because the budget proposes to spend the minimum amount of General Fund monies required by federal law, any net program *reductions* would generally result in TANF savings rather than General Fund savings in the CalWORKs program. However, below we identify two ways by which TANF savings may be converted into General Fund savings.

Method 1: Recognize Other MOE-Countable Expenditures. As noted above, the Governor's budget assumes that $377 million in spending in other departments and programs will be used to satisfy the MOE spending requirement in 2003-04. If additional non-CalWORKs MOE-countable expenditures were identified, the required level of CalWORKs MOE spending would decrease by the same amount. Thus, General Fund spending in CalWORKs could be reduced while still maintaining MOE compliance. Achieving General Fund savings in this way would require either (1) a program reduction in CalWORKs or (2) drawing on the TANF reserve in order to keep the program whole. Later in our analysis of this program, we recommend that additional current state spending for subsidized child care be counted toward the MOE requirement.

Method 2: Transfer TANF Funds Into the Child Care and Development Fund (CCDF) Block Grant. The federal TANF block grant provisions allow California to transfer up to $961 million in TANF funds to the CCDF. Once transferred, the funds become subject to CCDF spending requirements. The Governor's budget proposes to transfer $344 million in TANF funds to the CCDF in 2003-04, to be used for child care assistance for former CalWORKs recipients. Up to an additional $617 million in TANF funds could be transferred to the CCDF ($961 million less $344 million).

The Governor's budget proposes to realign most child care programs to the counties. If the Legislature were to adopt the Governor's proposal, we believe that about $400 million of TANF funds transferred into the CCDF could be used to replace a like amount of proposed realignment revenues for child care programs. Converting those freed-up realignment revenues into General Fund savings could be accomplished in one of two ways. One option is to maintain the Governor's proposed level of realignment revenues designated for the counties, but shift to counties an additional $400 million in proposed General Fund spending in other programs, thus freeing up General Fund revenues. The second option is to "capture" $400 million of the proposed realignment revenues designated for the counties. Due to the interaction with Proposition 98 spending requirements, we estimate that roughly $200 million of the freed-up revenues could be used to offset General Fund spending for non-Proposi-

tion 98 programs, while the remaining $200 million would have to be spent on K-14 education, without suspension of Proposition 98.

Alternatively, rather than using the $400 million in freed-up realigned revenues to achieve General Fund savings, the Legislature could reduce the Governor's proposed tax increases for realignment by $400 million.

In the event the Legislature rejects the Governor's realignment proposal, the fund shift described above could be modified so as to achieve a similar level of state savings.

Issue for Consideration. Both the TANF and the CCDF block grants are due to be reauthorized during 2003. Using a relatively large amount of federal block grant funds to replace state spending on child care may hinder efforts to persuade Congress to increase states' TANF or CCDF block grant allocations.

Count Additional Spending Toward MOE Requirement

We recommend that the department count toward the California Work Opportunity and Responsibility to Kids (CalWORKs) maintenance-of-effort requirement additional General Fund expenditures for subsidized child care. We estimate such countable expenditures to be in the range of $50 million to $100 million. Counting such expenditures would increase legislative flexibility in allocating General Fund monies for CalWORKs.

Countable MOE Funds. Pursuant to the federal welfare reform legislation, California may count all state spending on families eligible for CalWORKs, even if they are not in the CalWORKs program, for purposes of meeting the MOE spending requirement. To be countable, such spending must be consistent with the broad purposes of federal welfare reform. These include providing assistance to needy families so that families can become self-sufficient. The federal regulations specifically identify child care assistance as an allowable MOE expenditure.

Subsidized Child Care. As indicated earlier in our analysis of this program, state expenditures for subsidized child care in 2003-04 are estimated to be approximately $1.5 billion. Of that total, the budget recognizes approximately $315 million as countable towards the MOE spending requirement. This amount generally reflects only expenditures for families who are current or former CalWORKs recipients. However, as noted above, spending for families that are *eligible* but not receiving assistance is also countable towards the MOE requirement. We estimate that between $50 million and $100 million of the $1.5 billion total estimated expenditures in 2003-04 will be for such eligible families, and therefore would be countable towards the MOE requirement.

Analyst's Recommendation. We recommend that the CalWORKs budget reflect all child care expenditures that are countable toward the MOE requirement in 2003-04. Recognizing additional MOE-countable spending increases legislative flexibility in allocating General Fund monies for CalWORKs, which we discuss below.

Additional Maintenance-of-Effort Expenditures And TANF Surplus Create Options

We identify several options available to the Legislature for spending federal Temporary Assistance for Needy Families reserve funds.

Earlier in our analysis of the CalWORKs program, we recommended that the budget for grant payments be reduced by $350 million (TANF funds) to reflect savings associated with lower caseloads. This would increase the TANF reserve to $550 million ($350 million plus $200 million proposed by the Governor's budget). Below we present various options for spending TANF funds, two of which would result in General Fund savings.

Achieving General Fund Savings. One option for achieving General Fund savings is to reduce General Fund spending in CalWORKs by the same amount by which recognized MOE-countable child care expenditures increase ($50 million to $100 million as identified earlier in our analysis). Achieving such General Fund savings without reducing the level of CalWORKs grants or services would require backfilling the General Fund reduction with funds from the TANF reserve.

The second option for achieving General Fund savings is to transfer some TANF reserve funds to the CCDF block grant, as described earlier in our analysis of this program. The new CCDF funds could then be used to replace about $400 million in proposed realigned revenues for subsidized child care. In our earlier write-up we describe how some or all of these freed-up revenues could be converted into General Fund savings.

Increasing Child Care Access. Alternatively, the Legislature could use TANF funds transferred to the CCDF to *supplement* current resources available for subsidized child care. We note that the Governor's December revision proposed to reduce funding for CalWORKs Stage 3 child care in the current year by approximately $100 million. (The Stage 3 "set-aside" was created to provide continuing child care for former CalWORKs recipients.) Compared to the Governor's budget, fully funding Stage 3 in 2003-04 would require about $100 million more than proposed under the Governor's realignment proposal. To the extent that the broader subsidized child care system is unable to absorb families who will lose child care as a result of these reductions, some former CalWORKs recipients

may return to aid due to a lack of child care. The costs to the CalWORKs program could increase as a result.

Restoring Grant Reductions. The Legislature could also use the freed-up TANF funds to restore the Governor's proposed 6.2 percent grant reduction, described earlier in our analysis of this program. Compared to the Governor's budget, fully restoring the grant reduction would cost approximately $238 million.

TANF Reserve Outlook. Our forecast of CalWORKs costs indicates that the TANF reserve will remain above $400 million through the end of 2004-05 under specified assumptions. Namely, our projections assume (1) a TANF reserve of $550 million by the end of 2003-04, as indicated above; (2) all of the Governor's budget proposals are adopted; (3) caseloads will continue to decrease, though at a slower rate than in 2003-04; and (4) the statutory COLA is provided July 1, 2004. However, by the end of 2005-06, the reserve will be exhausted, and funding CalWORKs at the same service level will require General Fund spending above the MOE requirement. Given our projections of the TANF reserve, using TANF funds either (1) for program augmentations or restorations or (2) to reduce General Fund spending, may not be sustainable in the long term.

At least two factors increase the uncertainty inherent in any spending forecast. These are (1) the still uncertain impact of time limits on caseload trends and (2) pending federal welfare reform reauthorization, which could result in a higher work participation mandate, a decrease in the annual TANF block grant level, or both.

Given the potential for unanticipated future costs in the CalWORKs program, we believe that maintaining a TANF reserve is prudent. Thus, whichever option, or combination of options the Legislature chooses to pursue, we recommend preserving some TANF savings as a reserve against potential future cost pressures within CalWORKs.

OTHER BUDGET AND POLICY ISSUES

Update on County Performance Incentives

The Governor's budget proposes no funding for county performance incentives in 2003-04. During 2002-03, the budget redirected $297 million in incentive funds to basic program costs, thus increasing the state's unpaid obligation to the counties for performance incentives to $394 million.

Background. Prior to 2000-01, the CalWORKs statute provided that savings resulting from (1) exits due to employment, (2) increased earnings, and (3) diverting potential recipients from aid with one-time payments would be paid to the counties as performance incentives. The 2000-01 budget trailer bill for social services—Chapter 108, Statutes of 2000 (AB 2876, Aroner)—changed the treatment of performance incentives in several important ways. Among these changes, it:

- Prohibited counties from earning new incentives until the estimated prior obligation owed to the counties had been paid by the state.
- Subjected future performance incentive payments to annual budget act appropriations, rather than being treated as an "entitlement."

By the end of 1999-00, the last year for which an appropriation for new performance incentives was made, counties had earned approximately $1.2 billion in performance incentives, and had been paid $1.1 billion (approximately $97 million less than what they had earned).

Budget "Recaptures" Unspent Incentives. The *2002-03 Budget Act* provided that (1) any paid incentive funds that remained unspent at the end of 2001-02 would be recaptured; (2) $297 million of the recaptured funds would be redirected away from performance incentives to pay for grants, basic services, and administration; and (3) the remaining balance would be reappropriated as performance incentive funds for 2002-03.

The unspent balance at the end of 2001-02 was about $760 million. After redirecting $297 million for basic program costs, the department allocated $385 million to the counties as reappropriated performance incentives. The department indicates that the balance—about $78 million—will eventually be allocated to the counties in the current year. Thus, by the end of 2002-03, counties will have received approximately $463 million in reappropriated performance incentives. We note that in 2001-02, counties spent approximately $190 million in performance incentives.

Budget Proposal. The Governor's budget proposes no funding for performance incentives in 2003-04. Once the remaining balance of unspent prior-year incentive funds is allocated in the current year, the state's unpaid obligation to the counties for previously earned incentives will be $394 million ($97 million in previously unpaid incentives plus $297 million in redirected incentive funds).

Withhold Recommendation on Time Limit Savings

We withhold recommendation on the estimated savings due to adult California Work Opportunity and Responsibility to Kids recipients reaching their lifetime limit on cash assistance, pending review of the Governor's May Revision of the budget.

CalWORKs Time Limit. Under CalWORKs, adults are generally limited to 60 months of cash assistance. Adults began hitting the CalWORKs time limit in January 2003. The Governor's budget projects that by the end of 2003-04, a total of 123,000 cases will have reached their time limit.

Withhold Recommendation. The budget estimates that the program savings resulting from time limits in 2003-04 will total approximately $440 million (including grants, employment services, and child care savings). Based on limited available information, we believe that this estimate probably (1) overstates the child care savings but (2) ignores the administrative savings associated with families with low grants losing aid altogether. We therefore withhold recommendation on the budget's estimate of time limit savings pending review of the Governor's May estimates, when more complete information will be available.

Prospective Budgeting: Delay in Federal Approval Creates Budget Uncertainty

The federal government has not approved the department's original proposal to implement a prospective budgeting system for the CalWORKs and Food Stamps programs. Please see the "Food Stamps" section of this *Analysis*, where we recommend that the department report at budget hearings on (1) the status of its negotiations with the federal government and (2) the cost implications associated with alternative approaches to prospective budgeting.

Legislature Needs Better Participation Data

In creating the California Work Opportunity and Responsibility to Kids (CalWORKs) program, the Legislature required the Department of Social Services (DSS) to implement a system of performance outcomes for evaluation purposes. The current outcome reporting system for work participation is unreliable and incomplete, thereby making it difficult for the Legislature to monitor program performance. We recommend enactment of legislation requiring DSS to submit to the Legislature a master plan for CalWORKs data needs, particularly with respect to participation data.

Background. The CalWORKs program requires able-bodied adult recipients to work or engage in some type of work-related activity in exchange for cash assistance. Nonexempt individuals who fail to comply with participation requirements are subject to a financial sanction equal to the adult portion of the family's grant payment.

Just as CalWORKs recipients must meet individual participation requirements, California must meet statewide participation rate requirements set forth by the 1996 federal welfare reform legislation. (We note that California's participation standards differ from federal requirements—in general CalWORKs hourly requirements are higher, but the number of countable activities is greater.) States that fail to meet the federal requirements are subject to a financial penalty of up to 5 percent of the state's block grant. The penalty increases each consecutive year of noncompliance, up to a maximum of 21 percent of the block grant (up to about $750 million in California). In addition, noncompliant states are also subject to a higher maintenance-of-effort spending requirement (in California, this represents a potential additional cost of $180 million).

California's performance in meeting both the federal participation rates and the CalWORKs goal of universal participation among able-bodied adults is a mixed story, as we reported in our *2002-03 Perspectives and Issues*. On the one hand, California has met the federal requirements each year, avoiding federal penalties. Further, California's rate of participation, particularly in unsubsidized employment, is higher than ever before. On the other hand, only 33 percent of able-bodied adults are meeting their participation requirements, and over 40 percent are not participating at all. These figures contrast with CalWORKs' goal of universal engagement among able-bodied adults. We concluded that the state clearly has room for improvement in terms of both engaging more recipients, as well as increasing the work effort among those who are currently participating, but are doing so for too few hours to satisfy their participation requirements. As discussed below, we believe that better participation reporting could eventually result in improved program outcomes.

Funding for the CalWORKs welfare-to-work component, which includes employment services and child care assistance, totals $2.5 billion in the current year. This represents approximately 40 percent of the total CalWORKs budget.

Statewide Participation Data Necessary for Program Monitoring. Information on the extent to which recipients are participating in welfare-to-work activities is important for three reasons. First, participation data can help the Legislature and the administration prioritize expenditures within the program. For example, decisions about the overall level of funding for employment services, as well as individual county fund-

ing levels, could be informed by data indicating county success in moving their caseloads into employment and other welfare-to-work activities. Second, information on rates of participation, noncompliance, and sanction status can give the Legislature a sense of how counties are enforcing program requirements, whether recipients are receiving the work services they need before they reach their five-year lifetime limit on aid, and whether any program adjustments are appropriate. Third, in order to avoid federal penalties, California must ensure that it meets the federal participation requirements. This is especially critical given pending Congressional welfare reform reauthorization proposals which could result in higher participation mandates.

CalWORKs Statute Required State-Level Monitoring. Anticipating the need for participation and other program data to evaluate CalWORKs, the program's enabling legislation required DSS to develop and implement a system of performance outcomes. Among other goals, the performance outcome system was meant to provide information that would (1) ensure compliance with the federal TANF participation requirements and (2) assist the counties, the Legislature, and state agencies in determining what program adjustments, if any, would be appropriate. With respect to participation outcome information, we believe the current data system does not meet these goals, as discussed below.

Current Participation Data Are Limited. The department currently maintains three sources of participation data, all of which have certain limitations. Figure 3 summarizes the strengths and weaknesses of each source. The "Q5" survey provides reliable *state-level* information on whether or not California met the federal participation rate requirements in the previous year. However, given the survey's sample size and sampling methodology, the Q5 does not allow county-by-county or regional comparisons. The Q5 data are only available on an annual basis, and it typically takes more than one year for the data to be compiled into a report that is available to the federal government and the Legislature.

The *Work Participation Rate Monthly Report*, or WTW 30, was created to monitor individual county success in meeting the federal participation rate requirements. However, although the WTW 30 was implemented in October 1999, DSS has yet to release the report, due to concerns about data inconsistencies. Even if the WTW 30 reliability problems were solved, the report is limited to the overall percentage of adult recipients meeting the federal requirements. It would provide no information about which activities recipients are engaged in or the number of weekly hours completed in each activity.

Further, neither the Q5 nor the WTW 30 capture the extent to which recipients are meeting their hourly *CalWORKs* participation requirements.

Figure 3

CalWORKs Participation Data Reports

Report/Description	Strengths	Weaknesses
Q5		
Annual statewide survey designed to calculate California's federal participation rates. (CalWORKs has different participation requirements than federal law.)	Captures California's statewide *federal* participation rates.	• Does not capture the *state's* participation rates. • Available only on an annual basis, typically at least one year after the reporting year. • Sampling methodology does not permit county-by-county or regional analysis.
WTW 30		
Monthly report designed to monitor county success in meeting federal participation rates.	Captures individual county performance with respect to meeting federal participation rates.	• Has not yet been released due to data inconsistencies. • Does not capture *how* recipients met the federal participation requirements. • Does not report how many recipients met their hourly CalWORKs requirements.
WTW 25		
Monthly report designed to provide information on how many recipients participate in welfare-to-work activities.	Captures number of recipients who participate in federally and CalWORKs-allowable welfare-to-work activities.	• Does not capture actual hours of participation. • Does not report number of recipients who are meeting their individual participation requirements.

This is because both data sources were designed to reflect the *federal* definition of participation, rather than the CalWORKs definition. These definitions differ both in terms of the hours required (state requires more hours than federal government for single-parent families) and allowable welfare-to-work activities (state counts more activities).

The *Welfare-to-Work Monthly Activity Report*, or WTW 25, was designed to provide county level information on how many CalWORKs recipients are participating in welfare-to-work activities, the types of activities in which recipients are engaged, and nonparticipation status. Although this report does capture participation in CalWORKs-specific activities, it does not capture either (1) the actual hours of participation or (2) the number of recipients who are meeting their individual participation requirements.

In summary, the current statewide participation data and reports do not permit a timely and accurate county-by-county analysis of whether and how recipients are meeting their participation requirements. In fact, the data used to determine compliance with federal participation requirements are derived from an annual survey, rather than a monthly or quarterly administrative report prepared by the counties.

New Automation Systems Will Increase Data Capabilities. The Statewide Automated Welfare System (SAWS) was developed to provide uniform data reporting and case management capabilities to county welfare departments. Counties belong to one of four SAWS consortia. Currently, counties in two of the four consortia are in the process of replacing their separate eligibility and welfare-to-work systems with one of two single case management systems (one system is in the piloting phase; the other is under development). All remaining counties except Los Angeles are scheduled to eventually replace their current systems with one of the two new integrated systems.

County officials we talked to indicated that the new case management systems will improve case management capabilities because they will integrate the eligibility and benefit information with welfare-to-work participation data. The new systems will also improve counties' automated participation data reporting capabilities. For example, the systems could automatically generate reports on employment and other welfare-to-work activity status, including the number of hours of participation and whether or not recipients are meeting the requirements of their individual welfare-to-work plans.

Opportune Time to Reexamine Data Needs. Given the lack of reliable, comprehensive statewide participation data, we believe the phase-in of new case management systems with greater data reporting capabilities presents an opportunity for the Legislature and the department to reexamine the state's data needs. We believe the new automated case management *systems* themselves do not require any changes at this point. Rather, as these systems are implemented, the Legislature should assess which CalWORKs performance outcome data should be part of the automated reports that these systems are capable of generating.

Further, as mentioned above, certain pending Congressional welfare reform reauthorization proposals would increase the federal work participation mandates. We believe the prospect of higher participation mandates—and the associated increased risk of incurring federal fiscal penalties—makes reliable participation data important for three reasons.

First, knowing which activities recipients are participating in, and for how many hours, would assist the Legislature in making appropriate program adjustments in order to meet new federal requirements. For example, if recipients were generally participating in federally allowable activities but for insufficient hours, the CalWORKs hourly requirements could be adjusted. If, on the other hand, too few recipients were participating in *any* activity, the Legislature could amend the sanction process in order to increase participation.

Second, reliable county-by-county participation rate information would allow for comparisons of counties' success in increasing participation—in terms of both the number of recipients who participate, and the hours for which they participate. We believe that such comparisons would naturally focus the attention of state level policymakers, county officials, and CalWORKs case managers on improving these participation outcomes, and may thereby lead to better program results. As noted earlier, the rate of participation in the CalWORKs program is relatively low given the program's goal of near-universal engagement.

Finally, the CalWORKs statute specifies that if California were subject to a federal penalty, counties that did not meet the federal rate requirements may be subject to a share of the penalty. Without reliable county-by-county data, it would be difficult for DSS to implement this penalty sharing provision.

Analyst's Recommendation. Given the concurrent timing of federal welfare reform reauthorization and the phase-in of new automated case management data systems, we believe the Legislature should reexamine CalWORKs data needs. Specifically, we recommend enactment of legislation requiring DSS to prepare and submit to the Legislature a master plan for California's CalWORKs data needs. The CalWORKs Steering Committee, comprised of senior DSS staff, members of the Legislature, and representatives of the counties and the public, would provide policy direction for the preparation of the plan. We believe that this committee, which was established by the CalWORKs statute, could accomplish this task at no cost. The Master Plan would have at least three required elements. These are:

- An assessment of the state's data needs in light of CalWORKs program goals. (These goals could include outcomes related to participation as well as poverty and family well-being.)

- An outline for a new participation report that could include, but not be limited to, the number of hours of participation, how many recipients are meeting their CalWORKs participation requirements, the types of activities in which recipients participate, and how many recipients use support services.
- Guidelines for county automation improvements so as to ensure consistency with the goals of the Master Plan. (Future funding of automation improvements would be contingent on meeting the objectives of the Master Plan.)

In developing the Master Plan, the state will need to strike a balance between comprehensive and accurate data reporting, which could require additional case worker time, and maximizing case worker time with CalWORKs recipients. Given the improved data capabilities of the new automated case management systems that will come on-line over the next few years, we believe a new report—which would either replace both the WTW 30 and the WTW 25, or improve the existing reports—could be implemented with minimal additional burden on county case workers, and therefore minimal cost to the CalWORKs program. To this end, the steering committee should consider whether this report should be published monthly, quarterly, or even semiannually.

SUPPLEMENTAL SECURITY INCOME/ STATE SUPPLEMENTARY PROGRAM

The Supplemental Security Income/State Supplementary Program (SSI/SSP) provides cash assistance to eligible aged, blind, and disabled persons. The budget proposes an appropriation of $2.3 billion from the General Fund for the state's share of SSI/SSP in 2003-04. This is a decrease of $700 million, or 23 percent below estimated current-year expenditures. This decrease is due primarily to a proposed 6.2 percent grant reduction effective July 1, 2003 and shifting all costs for the Cash Assistance Program for Immigrants (CAPI) to the counties pursuant to the Governor's realignment proposal. For a discussion of the Governor's realignment proposal, please see "Part V" *of The 2003-04 Budget: Perspectives and Issues*.

In December 2002, there were 334,614 aged, 21,361 blind, and 746,943 disabled SSI/SSP recipients. In addition to these federally eligible recipients, the state-only CAPI was estimated to provide benefits to about 10,800 legal immigrants in December 2002.

Budget Proposes Grant Reductions and COLA Suspensions

By proposing to reduce grants by 6.2 percent, the budget achieves General Fund savings of $662 million. In addition, the budget achieves cost avoidance of $372 million by suspending the June 2003 and January 2004 state cost-of-living adjustments.

Background. Under current law, both the federal and state grant payments for SSI/SSP recipients are adjusted for inflation each January. The cost-of-living adjustments (COLAs) are funded by both the federal and state governments. The state COLA is based on the California Necessities Index (CNI) and is applied to the combined SSI/SSP grant. The federal COLA (based on the Consumer Price Index for Urban Wage Earners and Clerical Workers) is applied annually to the SSI portion of the grant. The remaining amount needed to cover the state COLA on the entire grant is funded with state monies. Chapter 1022, Statutes of 2002 (AB 444,

Aroner), delayed the January 2003 state COLA until June 2003, resulting in a five-month General Fund savings of $112 million compared to prior law.

Governor's Proposals Achieve $1.1 Billion in Savings. Figure 1 summarizes the Governor's grant reduction and COLA suspension proposals, which result in combined General Fund savings in 2002-03 and 2003-04 of nearly $1.1 billion compared to current law. Specifically, deleting the state June 2003 COLA results in savings of $24.1 in 2002-03 and $280.8 million in 2003-04. Reducing grants by 6.2 percent results in saving of $662.4 million in 2003-04. Finally, deleting the January 2004 state COLA results in a six-month savings of $91.5 million in the budget year. (We note that the Governor proposes to apply these reductions and COLA suspensions to CAPI grants as well.) Under the Governor's proposal, recipients would receive an estimated 2.4 percent federal COLA in January 2004.

Figure 1

SSI/SSP Savings From Governor's Grant Proposals General Fund

(In Millions)

Proposal	2002-03	2003-04	Total
Delete June 2003 state COLA	$24.1	$280.8	$304.9
Reduce grants by 6.2 percent	—	662.4	662.4
Delete January 2004 state COLA	—	91.5	91.5
Totals	**$24.1**	**$1,034.7**	**$1,058.8**

Impact on Recipients. Figure 2 shows grants for individuals and couples under both current law and the Governor's budget at four points in time. In January 2003, recipients received a 1.4 percent federal COLA ($7 for individuals and $12 for couples). As the figure shows, the January 2003 maximum monthly grant for an individual is $757 (about 103 percent of the 2002 federal poverty guideline), and the grant for a couple is $1,344 (about 135 percent of the federal poverty guideline). Under current law, the June state COLA would increase grants by $21 for an individual and $38 for each couple; raising individuals and couples to 105 percent and 139 percent of the poverty guideline, respectively. The Governor's budget proposes to delete these increases.

Figure 2

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

January 2003 Through January 2004

	January 2003	June 2003	July 2003	January 2004
Individuals				
Current Law				
SSI	$552	$552	$552	$566
SSP	205	226	226	239
Total	**$757**	**$778**	**$778**	**$805**
Percent of Poverty[a]	103%	105%	105%	109%
Governor's Budget				
SSI	$552	$552	$552	$566
SSP	205	205	156	156
Total	**$757**	**$757**	**$708**	**$722**
Percent of Poverty[a]	103%	103%	96%	98%
Change From Current Law				
SSI	—	—	—	—
SSP	—	$21	$70	$83
Total	**—**	**$21**	**$70**	**$83**
Couples				
Current Law				
SSI	$829	$829	$829	$848
SSP	515	553	553	582
Total	**$1,344**	**$1,382**	**$1,382**	**$1,430**
Percent of Poverty[a]	135%	139%	139%	144%
Governor's Budget				
SSI	$829	$829	$829	$848
SSP	515	515	396	396
Total	**$1,344**	**$1,344**	**$1,225**	**$1,244**
Percent of Poverty[a]	135%	135%	123%	125%
Change From Current Law				
SSI	—	—	—	—
SSP	—	$38	$157	$186
Total	**—**	**$38**	**$157**	**$186**

[a] 2002 U.S. Department of Health and Human Services Poverty Guidelines. We note that the guidelines are adjusted each year for inflation.

July Grant Reduction. In July, the Governor proposes to reduce grants by 6.2 percent compared to their January levels, and about 8.9 percent compared to current law. Under the Governor's proposal, the maximum monthly grant for an individual would be $708.40 (about 96 percent of the federal poverty guideline) and the grant for couples would be $1,225.20 (about 123 percent of poverty).

January 2004 State COLA Suspension. Under current law, recipients would receive a state COLA of 3.5 percent in January 2004. This would raise the maximum monthly grants to $805 for an individual (109 percent of poverty) and $1,430 for a couple (about 144 percent of poverty). Under the Governor's proposal, the state COLA would be suspended, but recipients would receive the "pass through" of the federal COLA—$14 for an individual and $19 for couples. The pass through of the federal COLA would raise total maximum monthly grants under the Governor's proposal to $722.40 for individuals (98 percent of poverty) and $1,244.20 for couples (125 percent of poverty).

At the time this analysis was prepared, the Legislature had not completed action on the Governor's proposed COLA suspensions or the 6.2 percent grant reduction.

IN-HOME SUPPORTIVE SERVICES

The In-Home Supportive Services (IHSS) program provides various services to eligible aged, blind, and disabled persons who are unable to remain safely in their own homes without such assistance. An individual is eligible for IHSS if he or she lives in his or her own home—or is capable of safely doing so if IHSS is provided—and meets specific criteria related to eligibility for the Supplemental Security Income / State Supplementary Program (SSI / SSP).

The IHSS program consists of two components: the Personal Care Services Program (PCSP) and the Residual IHSS program. Services provided in the PCSP are federally reimbursable under the Medicaid program. The PCSP limits eligibility to categorically eligible Medi-Cal recipients (California Work Opportunity and Responsibility to Kids and SSI / SSP recipients) who satisfy a "disabling condition" requirement. Personal care services include activities such as: (1) assisting with the administration of medications; and (2) providing needed assistance with basic personal hygiene, eating, grooming, and toileting. The following cases are excluded from the PCSP and, therefore, receive services through the Residual (state-only funded) IHSS program: cases with domestic services only, protective supervision tasks, spousal providers, parent providers of minor children, "income eligibles" (generally recipients with income above a specified threshold), "advance pay" recipients (eligible for payments prior to the provision of services), and recipients covered by third party insurance.

The budget proposes $16 million from the General Fund for the IHSS program, which is a decrease of about $1 billion compared current-year expenditures. This decrease is attributable to the Governor's proposal to realign the IHSS program to the counties. (The $16 million General Fund cost for 2003-04 is for automation improvements and one-time costs to make certain individuals federally eligible for PCSP.) For our discussion of the Governor's realignment proposal, please see "Part V" of *The 2003-04 Budget: Perspectives and Issues*.

Governor Proposes to Suspend State Participation in Wage Increase

The Governor proposes trailer bill language to suspend the In-Home Supportive Services (IHSS) revenue "trigger" for state participation in higher wages for certain providers. This legislation would only impact program costs if (1) the Legislature rejects the Governor's proposal to realign IHSS to counties and (2) revenue growth in 2003-04 is greater than 5 percent. We recommend that the Legislature's action on this issue be consistent with its policy on IHSS realignment.

State Participation in Wage Increases. Chapter 108, Statutes of 2000 (AB 2876, Aroner), authorizes the state to pay 65 percent of the nonfederal cost of a series of wage increases for IHSS providers working in counties that have established "public authorities." The wage increases began with $1.75 per hour in 2000-01, potentially to be followed by additional increases of $1 per year, up to a maximum wage of $11.50 per hour. We note that state participation in wage increases since 2000-01 are contingent upon General Fund revenue growth exceeding a 5 percent threshold. Chapter 108 also authorizes state participation in health benefits worth up to 60 cents per hour worked. As of 2002-03, the state participates in provider wages of $9.50 per hour plus 60 cents per hour worked for health benefits.

Governor Proposes Suspending Trigger Mechanism. Even though the Governor's budget does not estimate that a 5 percent revenue growth will be achieved in 2003-04, the Governor proposes to suspend the application of this trigger. This suspension results in no savings because of the separate proposal to realign the IHSS program to the counties. Thus, this proposal would have no practical effect unless the revenue growth estimates increase substantially in May, and the IHSS realignment proposal is not approved.

Action on Wage Trigger Should Be Consistent With Realignment. If the Legislature adopts the Governor's proposal to realign IHSS to counties, then the Legislature should repeal the wage trigger legislation. Without such a repeal, legislative intent as to whether the state would participate in future wage costs would be unclear. If the Legislature rejects the realignment proposal, then a decision about whether to suspend the trigger in 2003-04 would depend on the Legislature's revenue and expenditure priorities.

FOSTER CARE

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

The 2003-04 Governor's Budget proposes expenditures totaling $1.7 billion from all funds for foster care payments. Due to foster care's inclusion in the proposed realignment, there are no General Fund dollars budgeted for 2003-04. This constitutes a decrease of $447 million, or 100 percent, compared to 2002-03. (For a discussion of the Governor's realignment proposal, please see "Part V" of *The 2003-04 Budget: Perspectives and Issues*.)

The caseload in 2003-04 is estimated to be approximately 75,432, a decrease of 1.3 percent compared to the current year. This decrease is the net effect of children residing in foster family homes exiting from foster care to the Kinship Guardianship Assistance Program, which is part of the California Work Opportunity and Responsibility to Kids program, partially offset by an increasing number of children in group homes and foster family agencies.

California Fails Foster Care Program Performance Assessment

New federal performance reviews of state child welfare services and foster care programs were conducted in California for the first time in the fall of 2002. California failed to meet any of the seven safety, permanency, and well-being outcomes measured by the federal government. The state also failed five of the seven "systemic factors" that measure the quality of services provided to children and families. At this point, the state is in the process of preparing a program

improvement plan to avoid financial penalties. Failure to make progress toward reaching the federal measures could eventually result in reduced federal funding. We recommend that the Department of Social Services report at the budget hearings on the status of their program improvement plan.

Federal Government Has Reviewed 28 States Under Its New System. The federal Adoption and Safe Families Act (AFSA) of 1997 made the most sweeping changes to state child welfare services (CWS) and foster care programs since 1980. The principles of AFSA were to achieve child safety, permanency, and well-being. One significant requirement was that the federal Department of Health and Human Services develop a set of outcome measures and overhaul the state performance review processes in the CWS and foster care programs. Toward that end, the federal government developed the Child and Family Service Reviews (CFSR), which it has been conducting for the last two years. The reviews include seven measures for safety, well-being, and permanency. They also cover seven systemic measures that examine training for foster parents and caseworkers, the status of the statewide data system, the quality assurance process, and the state's case review system.

Results of First Two Rounds of CFSRs. Of the 28 states reviewed in 2001 and 2002, none have "passed" all components evaluated during the reviews. California, along with nine other states, failed all seven safety, well-being, and permanency outcomes. Of the seven systemic measures, California is the only state that has failed more than four. Figure 1 outlines the results for the six largest states that the federal government has reviewed to date.

What Happens Now That California Has Not Met the Federal Review Standards? The federal government has acknowledged that it has intentionally set high standards for its reviews. The expectation is not that states will be able to pass their initial review but that all states will begin improving and moving toward the national standards that have been set. The ultimate goal is that all states will eventually attain and surpass the national standards.

Through Program Improvement Plans California Can Avoid Federal Penalties. While the new federal review process establishes fiscal penalties, states will not be immediately assessed a penalty upon failing the review. Before the assessment of a penalty, states will have the opportunity to submit program improvement plans (PIPs) designed to move them toward meeting the federal outcome measures. Each state has 90 days in which to submit a plan following the release of its final federal report. With a goal of continued quality improvement, states whose performances remain below the national standard in subsequent reviews will be required to establish new benchmarks of improvement, moving those states

Figure 1

Children and Family Services Reviews Results in Six of the Largest States

	Seven Measures of Safety, Well-Being, and Permanency		Seven Systemic Measures	
	Passed	Failed	Passed	Failed
California	0	7	2	5
Georgia	0	7	4	3
Florida	1	6	5	2
Pennsylvania	1	6	6	1
Texas	1	6	7	0
New York	2	5	4	3

closer toward the attainment of the national standard. As long as states continue to meet their agreed upon benchmarks, the penalties will be held in abeyance.

Since California has failed to meet the national standards on the seven performance indicators and five of the seven systemic factors, it could face fiscal penalties in future years. At the time this analysis was prepared, DSS was unable to provide information on the nature and timing of the state's PIP. Nevertheless, we assume that the PIP will provide a satisfactory plan for improvement that will move California closer to the national standards. As long as the state continues to make progress toward the ultimate goal, it is unlikely that any fiscal penalties will be incurred. Even though we are not anticipating any penalties, we expect that there may be costs associated with the PIP in 2003-04.

Legislature Needs More Information. In order to facilitate legislative oversight of this program, we recommend that DSS report at the budget hearings on the status of California's PIP, any additional costs associated with improving California's performance, and how funding for PIP activities will be addressed in the Governor's realignment proposal.

ADOPTIONS PROGRAMS

The department administers a statewide program of services to parents who wish to place children for adoption and to persons who wish to adopt children. Adoptions services are provided through state district offices, 28 county adoptions agencies, and a variety of private agencies. Counties may choose to operate the Adoptions Program or turn the program over to the state for administration.

There are two components of the Adoptions Program: (1) the Relinquishment (or Agency) Adoptions Program, which provides services to facilitate the adoption of children in foster care; and (2) the Independent Adoptions Program, which provides adoption services to birth parents and adoptive parents when both agree on placement. The *2003-04 Budget Bill* ends state support for independent adoptions, however, for a savings of $2.8 million.

In addition to the Adoptions Program, the Adoptions Assistance Program (AAP) provides grants to parents who adopt "difficult to place" children. State law defines these children as those who, without assistance, would likely be unadoptable because of their age, racial or ethnic background, handicap, or because they are a member of a sibling group that should remain intact.

The Governor's budget proposes expenditures of $93 million ($51 million General Fund) for the Adoptions Program in 2003-04. This represents a 2 percent increase in General Fund expenditures from the current year. This increase is primarily attributable to a workload increase, partially offset by the elimination of the independent adoptions program.

The Governor's budget proposes expenditures of $503.7 million for the AAP in 2003-04. Due to AAP's inclusion in the proposed realignment, there are no General Fund dollars budgeted for 2003-04; this constitutes a decrease of $194 million, or 100 percent, compared to 2002-03. (For a discussion of the Governor's realignment proposal, please see "Part V" of *The 2003-04 Budget: Perspectives and Issues*.)

Adoptions Assistance Program Caseload Overstated

We recommend that proposed General Fund spending for the Adoptions Assistance Program be reduced by $2.6 million for 2002-03 and $4.6 million for 2003-04 because the caseload is overstated. (Reduce Item 5180-101-001 by $4,586,000.)

Historical Growth Rates. The AAP caseload has been growing steadily and rapidly since 1995-96. Until recently, the caseload was growing at an increasingly larger percentage rate each year, peaking in 2000-01 at a 21 percent growth rate. For 2001-02, the increase slowed slightly to 16 percent. However, an analysis of the last 12 months of caseload data shows that the growth has slowed even further to 10.5 percent.

Current- and Budget-Year Projected Growth. The department's most recent forecast projects that the caseload will grow by 13 percent in 2002-03 and 12 percent for 2003-04. In fact, the budget's monthly caseload forecasts for the first five months of 2002-03 are above the actual caseloads for those months. Our review of the last 12 months of caseload data suggests that the caseload growth is moderating more quickly than the Department of Social Services anticipates.

Although the most recent data suggest caseload growth will be 10.5 percent per year, in order to be conservative we have adjusted the current-year numbers to actual caseload levels and have assumed a 10.9 percent growth thereafter. Based on our forecast, we believe that the budget overstates AAP costs by $2.6 million in General Funds for 2002-03 and an additional $4.6 million in General Funds for 2003-04.

Impact of Realignment. If our recommendation is adopted and the Legislature also adopts the administration's realignment proposal for AAP, then the amounts shown represent reductions in the amount of revenue that could be transferred to the counties.

CHILD WELFARE SERVICES

California's state-supervised, county-administered Child Welfare Services (CWS) program provides services to abused and neglected children, children in foster care, and their families. The CWS program provides (1) immediate social worker response to allegations of child abuse and neglect; (2) ongoing services to children and their families who have been identified as victims, or potential victims, of abuse and neglect; and (3) services to children in foster care who have been temporarily or permanently removed from their family because of abuse or neglect. The *2003-04 Governor's Budget* proposes $2.1 billion from all funds and $69 million from the General Fund for CWS. This represents a decrease of 89 percent from the General Fund over current-year expenditures mostly due to the administration's proposal to include Child Welfare Services in its realignment proposal. (For a discussion of the Governor's realignment proposal, please see "Part V" of the *2003-04 Budget: Perspectives and Issues.)*

Budget for Child Welfare Services Does Not Reflect Savings From Projected Caseload Decline

We recommend that the proposed expenditures for the Child Welfare Services (CWS) program be reduced by $11 million from the General Fund because the budget does not reflect savings from its projected caseload declines. Further, we recommend that the Department of Social Services abolish the "hold harmless" method of budgeting the basic CWS workload. (Reduce Item 5180-151-0001 by $11,069,000.)

Current Budget Practice. In preparing the budget for CWS, the Department of Social Services (DSS) adjusts proposed funding upward when the caseload increases, but does not adjust funding downward when the caseload actually decreases. The practice of not adjusting the budget to reflect caseload decline is known as the "hold harmless" approach. This hold harmless method was established by DSS with the inception of the CWS Case Management System (CWS/CMS) that tracks the CWS caseload. Initial caseload data from the CWS/CMS system showed a dramatic reduction in the CWS caseload. Because of uncertainty about the accuracy

of the CWS/CMS data, DSS decided to use 1997-98 pre-CWS/CMS caseload data as their base and have not allowed the number of budgeted social workers to drop below those base levels over the last five years. However, as of January 1999, DSS determined that the CWS/CMS data were "cleaned up" and reliable. Despite that determination, DSS has retained the hold harmless methodology for their CWS estimate.

Continued Decline in CWS Caseload. Since its peak in 1998-99 at approximately 198,000 cases, the CWS caseload had dropped by almost 35,000 cases, or 18 percent by the end of 2001-02. The DSS projects an additional decline of 2.2 percent in 2003-04.

No Savings From Caseload Decline. Because of the way the hold harmless provision works, the number of social workers funded for the counties remains unchanged despite workload decreases. In other words, if an individual county's caseload is declining, its number of caseworkers are held at the prior-year level. At the same time, if another county's caseload is increasing, the state provides that county with funds to hire additional caseworkers. Therefore, on a statewide basis, despite an overall caseload decline, the funding for CWS continues to grow. While DSS projects that caseloads will have declined by approximately 13 percent overall since 1998, CWS basic funding has increased by 33 percent in the same period.

Analyst's Recommendation. We recommend that the Legislature maintain Child Welfare Services case-management funding per child at its 2002-03 level. This would result in a General Fund savings of $11 million while not reducing the level of care and service provided to the children and families in the child welfare system in the budget year. (We note that this program, like all other social services programs, will not receive an inflation adjustment for higher costs of doing business in the budget year.) Further, we recommend that DSS adopt a method of budgeting future CWS that reflects the trends of the actual caseloads.

We recognize that the *SB 2030 Child Welfare Services Workload Study* did find that CWS caseworkers are overburdened and carrying much larger caseloads than are ideal. To address this issue, the Legislature has separately budgeted "augmentations" to CWS. Should the administration decide to move toward the updated standards outlined in the SB 2030 study, we believe that it should be done through a proposed augmentation budgeted separately from the basic workload. Further, by increasing the separate augmentation, rather than the basic funding, workload relief for caseworkers would be applied to all counties, not just those with declining caseloads.

Impact of Realignment. If our recommendation is adopted and the Legislature also adopts the administration's realignment proposal for CWS, then the amounts shown represent reductions in the amount of revenue that could be transferred to the counties.

FOOD STAMPS PROGRAM

The Food Stamps Program provides food stamps to low-income persons. With the exception of the state-only food assistance program (discussed below), the cost of the food stamp coupons is borne by the federal government ($1.8 billion). Under current law, administrative costs are shared between the federal government (50 percent), the state (35 percent), and the counties (15 percent). However, under the Governor's realignment proposal, the county share of administrative costs would increase to 50 percent, or 100 percent of the nonfederal costs. (Please see *The 2003-04 Budget: Perspectives and Issues* for a discussion of the realignment proposal.)

Federal Eligibility Restorations Reduce California Food Assistance Program (CFAP) Costs

Pursuant to the Farm Security and Rural Investment Act of 2002 (Public Law, 107-171), federal food stamp eligibility will be restored for most legal noncitizens by October 2003. As a result, CFAP expenditures will decrease in 2003-04 to $15 million, which is $73 million less than estimated current-year expenditures.

Prior Federal Restrictions on Benefits for Noncitizens. Until October 2002, federal law generally limited noncitizen food stamp eligibility to legal noncitizens who immigrated to the U.S. prior to August 1996, and were under the age of 18 or were at least 65 years old as of August 1996.

State Program for Noncitizens. In response to these federal restrictions, CFAP was created in 1997 to provide state-only funded food stamp benefits to (1) pre-August 1996 legal immigrants who are ineligible for federal benefits (essentially individuals 18 to 64 years old), and (2) a very limited number of post-August 1996 legal immigrants whose sponsors are dead, disabled, or abusive. In 1999 and again in 2000, CFAP eligibility was temporarily expanded to include all post-August 1996 legal immigrants who were otherwise eligible but for the fact they arrived after

August 1996. Chapter 111, Statutes of 2001 (AB 429, Aroner), made this expansion permanent.

The CFAP purchases food stamp coupons from the federal government and distributes them to eligible recipients. Adult recipients are subject to a specified work requirement.

Federal Restorations Reduce CFAP Costs. Pursuant to the Farm Security and Rural Investment Act of 2002 (Public Law, 107-171), hereafter the Farm Bill, federal food stamp eligibility will be restored for most CFAP recipients by October 2003. Specifically, the Farm Bill restored eligibility for (1) all disabled legal noncitizens, effective October 1, 2002; (2) all legal noncitizens who have lived in the United States for at least five years, effective April 1, 2003; and (3) all legal noncitizen children regardless of date of entry, effective October 1, 2003. Together, these groups represent over 90 percent of the current CFAP caseload. The remaining federally ineligible recipients are adult legal noncitizens who have lived in the United States for less than five years. As a result of these federal eligibility restorations, CFAP costs in 2003-04 are estimated to be approximately $15 million, which is about $73 million, or 83 percent, below estimated current-year costs.

Governor's Realignment Proposal Would Shift CFAP Costs to Counties. As part of the budget's realignment proposal, the Governor proposes to shift the entire CFAP costs to the counties effective July 1, 2003. This would result in state savings of $15 million in 2003-04. (Avoided state costs would be somewhat lower in 2004-05 due to the full-year impact of the federal eligibility restorations discussed above.) Please see *The 2003-04 Budget: Perspectives and Issues* for a full discussion of the Governor's realignment proposal.

Withhold Recommendation on Reprogramming Costs

We withhold recommendation on the estimated reprogramming costs associated with implementing recent federal eligibility and other changes, pending review of the Governor's May Revision of the budget.

In addition to the food stamp eligibility restorations discussed above, the 2002 Farm Bill made certain changes to the methodology used to calculate food stamp benefits. Implementing these eligibility and benefit calculation changes will require reprogramming counties' automated eligibility systems. The Governor's budget estimates reprogramming costs will total $7 million ($3.5 million General Fund and $3.5 million federal funds) in 2003-04. The department indicates that this is a "placeholder" estimate and may not accurately reflect the actual costs the state will in-

cur. We therefore withhold recommendation on the estimated reprogramming costs pending review of the Governor's May estimates.

Prospective Budgeting: Delay in Federal Approval Creates Budget Uncertainty

We recommend that the department report at budget hearings on (1) the status of its negotiations with the federal government on its proposed prospective budgeting system for the Food Stamps and California Work Opportunity and Responsibility to Kids (CalWORKs) programs and (2) the cost implications associated with alternative approaches to prospective budgeting.

Background. Currently, CalWORKs and food stamps recipients are required to submit income and eligibility reports every month. County welfare departments must review each monthly report for changes and adjust grants accordingly. In making such adjustments, counties may make payment errors which result in recipients being either overpaid or underpaid. Compared to quarterly or semi-annual reporting, monthly reporting increases the number of opportunities for the county welfare departments to make payment errors, thereby increasing the state's risk of high payment error rates. Because California's food stamp error rate exceeded the national average rate for federal fiscal years (FFYs) 2000 and 2001, the U.S. Department of Agriculture's Food and Nutrition Service (FNS), which administers the federal Food Stamp Program, imposed penalties totaling roughly $126 million ($12 million for FFY 2000 and $114 million for FFY 2001). The department is currently negotiating a settlement of the FFY 2001 penalty with FNS.

Legislature Requires Prospective Budgeting System. In response to concern about (1) California's high food stamp payment error rates and associated penalties and (2) the administrative workload—for both recipients and county welfare departments—associated with monthly reporting, Chapter 1022, Statutes of 2002 (AB 444, Aroner), required the department to implement a quarterly reporting system for both the CalWORKs and Food Stamps programs. The *2002-03 Budget Act* assumed that such a system, otherwise known as "prospective budgeting," would be implemented by April 1, 2003. (Under prospective budgeting, a recipient's grant payments are based on a prospective estimate of monthly income over a three-month period.)

Governor's Budget. The Governor's budget proposes approximately $14 million ($4.5 million General Fund, $8 million Temporary Assistance for Needy Families block grant funds, and $1.5 million county funds) in 2002-03 for the reprogramming costs associated with implementing the

quarterly reporting system. The budget assumes statewide implementation by September 1, 2003. Net state costs (grant costs less administrative savings) in 2003-04 are estimated to be approximately $48 million for ten months of implementation. The department estimates that once prospective budgeting is fully phased in by the end of 2003-04, annual administrative savings will exceed grant costs, resulting in ongoing net annual savings of about $20 million beyond the budget year.

Delay in Federal Approval of California's Proposal Creates Fiscal Uncertainty. In December 2002, FNS notified the department that it would not approve the department's original prospective budgeting proposal. The department is currently working with FNS to develop an acceptable alternative approach. The department indicates that adopting an alternative approach may mean (1) higher ongoing net state costs than those assumed under the original proposal or (2) implementing prospective budgeting as a five-year demonstration project, which could be cancelled by FNS at any time. In the event FNS cancels the demonstration project, the department would have to either implement the current monthly reporting system or a federally acceptable alternative, which would result in new reprogramming costs. Thus, proceeding with a demonstration project would represent a risk to the General Fund of about $12.5 million for such costs.

Analyst's Recommendation. We believe the Legislature should be informed of the costs and benefits of the alternative approaches to implementing prospective budgeting. Specifically, as part of the budget process, we believe the Legislature should weigh (1) the potential of higher ongoing General Fund costs associated with an alternative prospective budgeting approach against (2) a potential future risk to the General Fund associated with reprogramming costs in the event a demonstration project is cancelled. We recommend that the department report at budget hearings on (1) the status of its negotiations with FNS and (2) the costs associated with the various approaches it is considering.

FINDINGS AND RECOMMENDATIONS

Health and Social Services

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California Children's Services

C-20 ■ **Missed Opportunities for General Fund Savings in the CCS.** We find that the California Children's Services (CCS) is missing opportunities to control increasing costs and save General Funds. We offer recommendations and options that the Legislature should consider to improve the operation of the CCS program and save General Funds.

Department of Aging

C-36 ■ **Shift All Aging Programs to the Department of Social Services. Reduce Item 4170 by $31,910,000, and Increase Item 5180 by $31,002,000.** Recommend eliminating the Department of Aging and shifting all of its functions to the Department of Social Services. This consolidation results in net savings of 37 positions and $3,420,000 ($908,000 General Fund).

California Medical Assistance Program

C-53 ■ **Caseload Estimate Reasonable.** We find that the budget's caseload estimate for the California Medical Assistance Program (Medi-Cal) caseload is reasonable, but there are significant risks to this estimate that could result in the projection being overestimated or

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underestimated. Accordingly, we will monitor caseload trends and recommend appropriate adjustments at the time of the May Revision.

C-56 ■ **County Eligibility Determinations: Options for Cost Savings. Reduce Item 4260-101-0001 by $41.3 Million and Reduce Item 4260-101-0890 by $41.3 Million.** Reject proposed augmentation for county administration because the budget has not demonstrated that county failure to complete annual redeterminations is the result of inadequate funding. Recommend adoption of the budget proposal to implement performance standards for the counties. Recommend the Legislature go further and adopt workload or productivity standards for county eligibility workers and tie the level of funding to that individual county's performance in meeting the new standards.

C-63 ■ **State Should Assess Shift to the Veterans Affairs Benefits.** Recommend that the Legislature direct DHS to examine the extent to which veterans who are eligible for comprehensive health care through federally supported Veterans Administration health care system are receiving services at state expense through the Medi-Cal Program.

C-66 ■ **Disease Management Could Reduce Medi-Cal Costs**. Recommend adoption of necessary funds and supplemental report language directing DHS to conduct a few small pilot projects in disease management for three years.

C-75 ■ **Funding Request for Medi-Cal Estimate Redesign.** Withhold recommendation on proposal to continue three limited-term staff and to provide increased funding for a planned redesign of the Medi-Cal budget estimate because it is not clear how DHS intends to move forward with the completion of the project.

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C-76 ■ **Department Needs to Take More Steps to Ensure Fair Prices.** Recommend Legislature direct the Department of Health Services (DHS) to report at budget hearings on issues related to the Bureau of State Audits December 2002 report. Issues include plans to enforce 1998 policy guidelines related to unlisted medical equipment, progress on the universal product number conversion projects, and progress on negotiations with medical equipment and laboratory services providers.

Public Health

C-83 ■ **Child Health and Disability Prevention Program.** Concur with the Governor's budget proposal to implement the new Child Health and Disability Prevention "gateway" proposal, but recommend that the Department of Health Services report at budget hearings regarding the schedule of the implementation of this new program.

Managed Risk Medical Insurance Board

C-90 ■ **Healthy Families Program.** Withhold recommendation on the administration's request to increase expenditures for caseload increases and associated expenditures. Although enrollment has been higher than the level projected in last year's budget, recent population trends and other factors indicate that General Fund support for the program is at risk of being overbudgeted by more than $20 million in the budget year.

C-94 ■ **Rural Health Demonstration Project.** The Governor's budget proposes to discontinue the Rural Health Demonstration Project (RHDP). We suggest that the Legislature may wish to consider maintaining the RHDP by shifting funding from the IHP and SAMW and reducing funding to these programs. This would be an

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alternative to the Governor's proposal to realign these programs.

Department of Developmental Services (DDS)

C-99 ■ **Developmental Center (DC) Closures**. Recommend approval of a modified version of the Governor's proposal to begin planning for the closure of Agnews DC. Also recommend the Legislature adopt statutory language directing DDS to submit a closure plan to the Legislature for Lanterman DC by January 1, 2005.

C-116 ■ **Parental Copayment for Regional Center (RC) Services**. While we agree in concept with the Governor's proposal to impose a parental copayment program for children age 3 to 17 who live at home and receive RC services, we recommend the Legislature carefully consider clarifying and improving some specific aspects of the plan.

C-123 ■ **Habilitation Services Program (HSP).** Recommend approval of the Governor's proposal to shift the HSP from the Department of Rehabilitation to the DDS.

C-125 ■ **Community Services Program Deficiency**. Recommend approval of the $13.7 million General Fund deficiency for caseload growth, cost increases, and utilization of services. Also recommend the department report at budget hearings on the size of the deficit and what actions the department will take to ensure deficits do not occur in the future.

C-127 ■ **Self-Determination Projects Could Benefit Clients and the State.** Recommend approval of Governor's proposal to expand the self-determination pilot program through 2005 with statutory language requiring the department to adopt standardized annual budget redeterminations for pilot program participants. Also recommend that the

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department demonstrate at budget hearings that its proposal to provide services to clients under the self-determination model would not cost more than providing the same services to clients under the existing system.

Department of Mental Health

C-133 ■ **Patient Caseload Overbudgeted. Reduce Item 4440-011-0001 by $14.1 Million**. Given the disparity between the actual census count in the state hospitals and the caseload assumptions in the Governor's budget, we recommend that caseload funding be reduced at this time.

C-136 ■ **Operating Expenses Require Further Review.** Withhold recommendation pending the administration's further review of a proposal for a $9.5 million augmentation from the General Fund ($11.4 million all funds) for caseload-related operating expenses at state hospitals and possible changes to the request at the May Revision.

C-137 ■ **Another Delay for Salinas Valley Facility.** Recommend that the current-year budgets of the Department of Corrections (CDC) and the Department of Mental Health be adjusted to reflect the savings of at least $1.5 million in operating costs for a new mental health facility at Salinas Valley State Prison that is opening later than expected. Also recommend an additional $100,000 in funding for CDC expenses be deleted because it is unclear why these resources are needed at this time.

C-139 ■ **New Projection Method Increases Early and Periodic Screening, Diagnosis and Treatment Costs. Reduce Item 4260-101-0001 by $11.7 Million**. While there is merit to the effort to more accurately budget the costs of these children's mental health services, we recommend

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funding adjustments at this time to correct for apparent overbudgeting for this program.

Department of Community Services and Development

C-143 ■ **Budget Proposes Eliminating the Department.** The Governor proposes consolidating the department's federal programs within the Department of Social Services. This would result in the elimination of nine positions and a corresponding redirection of $0.9 million federal funds from state operations to local assistance.

Department of Rehabilitation

C-146 ■ **Budget Achieves Savings From Rate Reductions and Freezes.** The Governor's budget reflects the December revision proposals to (1) reduce rates for the Supported Employment Program and the Work Activity Program (WAP) by 5 percent, effective April 2003, and (2) suspend the statutory WAP rate adjustment for three years. Together, these actions result in combined General Fund savings and cost avoidance of $19 million in 2003-04.

Department of Child Support Services

C-147 ■ **Legislature Needs Better Budget Information.** Recommend that Department of Child Support Services (DCSS) revise its budget to display its initiatives separately, rather than continue to include them in their basic administrative funding.

C-149 ■ **County Share for Federal Child Support Penalty.** Since 1998, California has been subject to penalties for failing to implement a statewide child support automation system. The penalties are estimated to be $188 million in 2002-03

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and $207 million in 2003-04. Effective April 2003, the Governor proposes that counties pay one-quarter of the penalty.

Department of Social Services CalWORKs Program

Caseload and Grants

C-152 ■ **Caseload Projection is Overstated. Reduce Item 5180-101-0890 by $100,000,000.** Recommend that proposed spending for California Work Opportunity and Responsibility to Kids (CalWORKs) grants be reduced by $250 million (federal Temporary Assistance for Needy Families [TANF] funds) in 2002-03 and $100 million in 2003-04 because the caseload is overstated.

C-153 ■ **Budget Suspends Statutory Cost-of-Living Adjustments and Reduces Grant Payments.** The Governor's budget proposes to (1) suspend the statutory cost-of-living adjustments and (2) reduce grant payments by 6.2 percent. Compared to current law, these proposals result in combined savings of $502 million in 2002-03 and 2003-04.

C-154 ■ **Grant Reduction Proposal—Budget Internally Inconsistent. Reduce Item 5180-101-0890 by $7,300,000.** Recommend a technical adjustment to reduce proposed expenditures for CalWORKs administration by $7.3 million (federal TANF funds) because the budget does not reflect the administrative savings from the Governor's proposal to reduce CalWORKs grant payments.

Maintenance-of-Effort (MOE) Spending Requirement and TANF Surplus

C-156 ■ **Achieving General Fund Savings While Meeting MOE Requirement.** The Governor's budget proposes to spend the minimum amount of General Fund monies needed to

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meet the MOE spending requirement for the CalWORKs program in 2003-04. Because of the MOE requirement, any net augmentation to the program will result in General Fund costs, while any net reduction will generally result in federal TANF savings, not General Fund savings. However, we identify two methods by which TANF savings may be converted into General Fund savings.

C-158 ■ **Count Additional Spending Toward MOE Requirement.** Recommend that the department count toward the CalWORKs MOE requirement additional General Fund expenditures for subsidized child care. We estimate such countable expenditures to be in the range of $50 million to $100 million. Counting such expenditures would increase legislative flexibility in allocating General Fund monies for CalWORKs.

C-159 ■ **Additional MOE Expenditures and TANF Surplus Create Options.** We identify several options available to the Legislature for spending TANF reserve funds.

Other Budget and Policy Issues

C-160 ■ **Update on County Performance Incentives.** The Governor's budget proposes no funding for county performance incentives in 2003-04. During 2002-03, the budget redirected $297 million in incentive funds to basic program costs, thus increasing the state's unpaid obligation to the counties for performance incentives to $394 million.

C-162 ■ **Withhold Recommendation on Time Limit Savings.** Withhold recommendation on the estimated savings due to adult CalWORKs recipients reaching their lifetime limit on cash assistance, pending review of the Governor's May Revision of the budget.

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Supplemental Security Income/ State Supplementary Program

In-Home Supportive Services

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Adoptions Programs

Child Welfare Services

Food Stamps Program

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C-185 ■ **Prospective Budgeting: Delay in Federal Approval Creates Budget Uncertainty.** Recommend that the department report at budget hearings on (1) the status of its negotiations with the federal government on its proposed prospective budgeting system for the Food Stamps and California Work Opportunity and Responsibility to Kids programs and (2) the cost implications associated with alternative approaches to prospective budgeting.

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