



60 YEARS OF SERVICE

2005-06 Analysis

MAJOR ISSUES

Health and Social Services



Part “D” Stands for “Deficit”: How the Medicare Drug Benefit Affects Medi-Cal

- Part D of the federal Medicare Modernization Act establishes a prescription drug benefit for Medicare recipients and in so doing has major implications for the Medi-Cal Program. It is likely to result in significant net costs to Medi-Cal beyond the budget year. (See page C-105 of this *Analysis*).



Medi-Cal Redesign Sound in Principle but Needs Further Development

- The seven-part administration redesign proposal would result in broad changes in Medi-Cal managed care as well as some more limited changes in benefits, cost-sharing, and eligibility administration. Overall, we find that the Governor’s proposals are conceptually sound but that the Legislature needs more information about some aspects of the package and that refinements are warranted. (See page C-67 of this *Analysis*).



Hospital Financing Plan Could Begin to Right Ailing System

- The state’s hospital system continues to face a variety of fiscal challenges that weigh particularly heavily on public hospitals. The administration is negotiating with the federal government for a comprehensive redesign of hospital financing as part of its Medi-Cal redesign package. Our review of the plan suggests that it could help preserve the financial stability of public hospitals but also raises some significant fiscal and policy issues. (See page C-83 of this *Analysis*).



Medi-Cal Fee Revenues Not Recognized in Budget

- About \$294 million in Medi-Cal revenues from “quality improvement fees” have not been counted as state revenues

in the Governor's budget. We recommend that the Legislature recognize these fee revenues. (See page C-66 of this *Analysis*.)



Social Services Programs Overbudgeted by \$180 Million

- Various social services programs have overstated caseloads and/or estimating errors. For 2004-05 and 2005-06, the budget overstates social services costs by almost \$180 million and we recommend that the Legislature score corresponding savings. (See pages C-206, C-212, C-232, and C-244 of the *Analysis*)



Progress in Reducing Social Worker Caseloads.

- A legislatively mandated study found that for social workers had difficulty providing services or maintaining meaningful contact with children and families because of the large numbers of cases they were carrying. Our analysis indicates California now meets or is approaching three of the five workload standards in child welfare services. We recommend enactment of legislation requiring an annual report on county specific social worker staffing ratios so that the Legislature remains informed about progress in this area. (See page C-234 of the *Analysis*.)



Reducing the Earned Income Disregard

- The Governor proposes to lower the grants for all working CalWORKs recipients, by reducing the amount of earned income which is disregarded (not counted) when determining a family's grant. This results in savings of \$80 million and is likely to have minimal impact on the work incentive. We present alternative approaches which are likely to increase the work incentive but result in less budgetary savings. (See page C-214 of the *Analysis*.)



Child Care Reforms Merit Serious Consideration

- The Governor proposes a number of significant reforms to California's subsidized child care system including eligibility restrictions, a new waiting list system, and tiered reimbursement rates. With certain qualifications, we support proposed eligibility and waiting list changes. Although tying reimbursement rates to quality makes sense, the Legislature may wish to consider alternative approaches which increase reimbursement rates for higher quality care rather than simply reducing reimbursement rates (as the Governor proposes) for lower quality care. (See page C-25 of the *Analysis*.)

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OVERVIEW

Health and Social Services

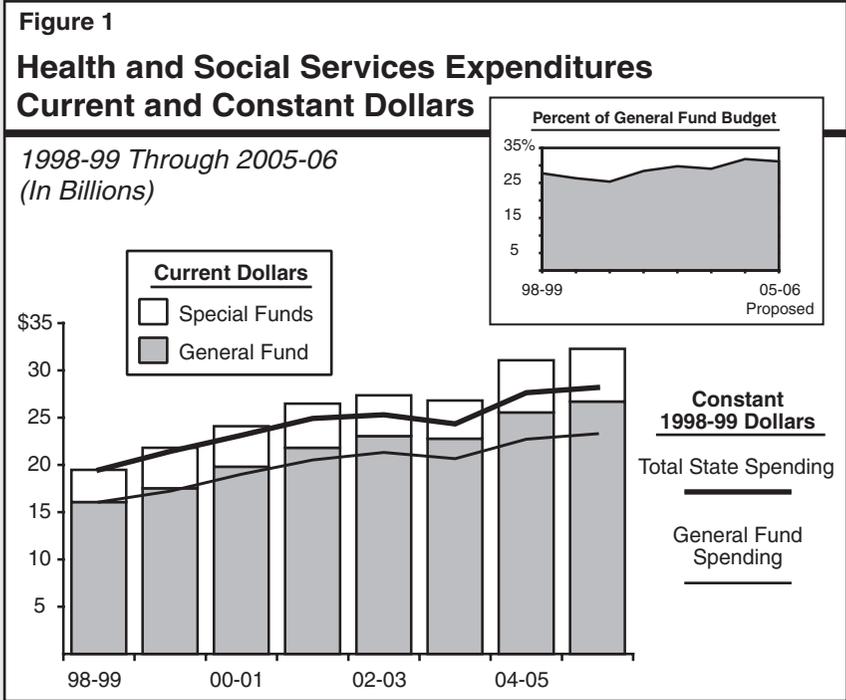
General Fund spending for health and social services programs is proposed to increase by 4.6 percent to \$26.7 billion in 2005-06. This net increase in spending is due primarily to a variety of caseload and cost increases that are partially offset by grant savings in certain social services programs and shifts of some health program funding to federal support.

EXPENDITURE PROPOSAL AND TRENDS

Budget Year. The budget proposes General Fund expenditures of \$26.7 billion for health and social services programs in 2005-06, which is 31 percent of total proposed General Fund expenditures. Figure 1 (see next page) shows health and social services spending from 1998-99 through 2005-06. The proposed General Fund budget for 2005-06 is \$1.2 billion (4.6 percent) above estimated spending for 2004-05. Special funds spending for health and social services is proposed to remain fairly level at about \$5.6 billion.

Historical Trends. Figure 1 shows that General Fund expenditures (current dollars) for health and social services programs are projected to increase by \$10.6 billion, or 66 percent, from 1998-99 through 2005-06. This represents an average annual increase of 7.5 percent. Similarly, combined General Fund and special funds expenditures are projected to increase by about \$12.8 billion (66 percent) from 1998-99 through 2005-06, also at an average annual growth rate of 7.5 percent.

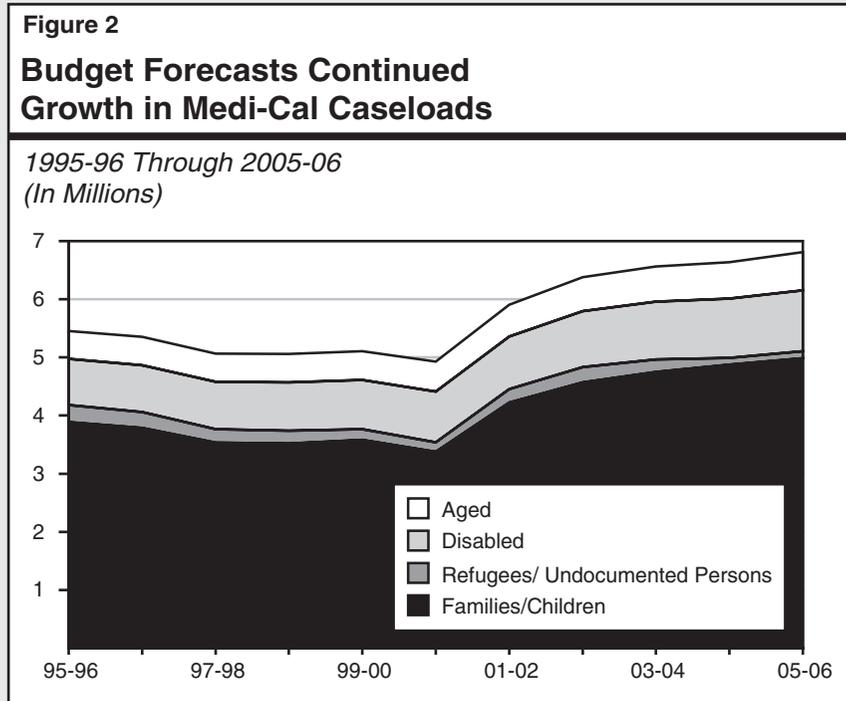
Adjusting for Inflation. Figure 1 also displays the spending for these programs adjusted for inflation (constant dollars). On this basis, General Fund expenditures are estimated to increase by 45 percent from 1998-99 through 2005-06, an average annual rate of 5.4 percent. Combined General Fund and special funds expenditures are estimated to increase by 45 percent during this same period, also at an average annual increase of 5.4 percent.



CASELOAD TRENDS

Caseload trends are one important factor driving health and social services expenditures. Figures 2 and 3 (see page C-10) illustrate the budget’s projected caseload trends for the largest health and social services programs. Figure 2 shows Medi-Cal caseload trends over the last decade, divided into four groups: (1) families and children (primarily recipients of California Work Opportunity and Responsibility to Kids [CalWORKs]); (2) refugees and undocumented persons; (3) disabled beneficiaries; and (4) aged persons (who are primarily recipients of Supplemental Security Income/State Supplementary Program [SSI/SSP]). Figure 3 shows the caseloads for CalWORKs and SSI/SSP.

Medi-Cal Caseloads. As shown in Figure 2, the Governor’s budget plan assumes that a modest increase in caseload will occur during the budget year in the Medi-Cal program. Specifically, the overall caseload is expected to increase by about 171,000 average monthly eligibles (2.6 percent). This would continue a growth trend, although generally at a slightly slower pace than seen in prior years.

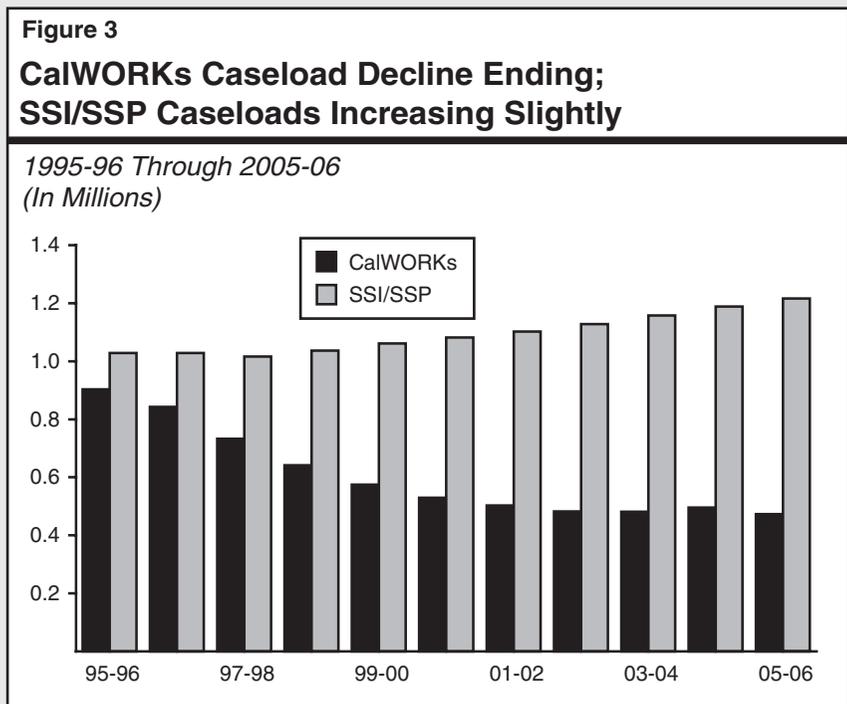


The caseload projections for 2005-06 take into account the following budget proposals and assumptions: (1) an increase in caseload from the continued transfer of children from the Child Health and Disability Prevention (CHDP) program into more comprehensive Medi-Cal coverage; (2) caseload reductions resulting from the requirement that certain adult beneficiaries confirm their eligibility for Medi-Cal twice annually; and (3) continued growth in several eligibility categories, especially nonwelfare families.

Healthy Families Caseload. The Governor's budget plan assumes that the caseload for the Healthy Families Program will continue to grow at a significant rate. The budget plan assumes that the current-year enrollment will fall short by about 60,000 of the number assumed in the *2004-05 Budget Act*. However, the spending plan further assumes that the implementation of various program outreach activities, the continued effects of the CHDP program changes discussed above, and a prior decision to shift children from the state's Access to Infants and Mothers (AIM) program to the Healthy Families Program will have the combined effect of increasing enrollment by more than 75,000 children (10.6 percent) by the end of the budget year (June 2006). At that point, the total estimated caseload is projected to be almost 790,000.

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, both programs serve about 1.2 million persons. (The SSI/SSP cases are reported as individual persons, while CalWORKs cases are primarily families.)

As Figure 3 shows, the CalWORKs caseload declined steadily since 1995-96, essentially bottoming out in 2002-03. For 2004-05, the budget projects a slight increase in caseload due to the expiration of extended unemployment benefits and the recent migration of refugees. In 2005-06, the budget forecasts a slight decline of 0.8 percent, with an additional decline due to the grant reduction proposals' effects on eligibility.



As discussed in our annual *California's Fiscal Outlook* report, the CalWORKs caseload decline shown in Figure 3 was due to various factors, including the improving economy, lower birth rates for young women, a decline in legal immigration to California, and, since 1999-00, the impact of CalWORKs program interventions (including additional employment services). The recent flattening of the caseload may be attributable to the composition of the remaining caseload, part of which includes adults who face substantial barriers to employment.

The SSI/SSP caseload can be divided into two major components—the aged and the disabled. The aged caseload generally increases in proportion to increases in the eligible population—age 65 or older (increasing at about 1.5 percent per year). This component accounts for about 30 percent of the total caseload. The larger component—the disabled caseload—grew rapidly in the early 1990s, but more recently has experienced steady moderate growth of about 2.5 percent since 1997-98.

In the mid-to-late 1990s, the total SSI/SSP caseload leveled off and actually declined in 1997-98, in part because of federal changes that restricted eligibility. Since March 1998, however, the caseload has been growing moderately, between 2 percent and 2.5 percent each year.

SPENDING BY MAJOR PROGRAM

Figure 4 (see next page) shows expenditures for the major health and social services programs in 2003-04 and 2004-05, and as proposed for 2005-06. As shown in the figure, three major benefit payment programs—Medi-Cal, CalWORKs, and SSI/SSP—account for a large share (about 77 percent) of total spending in the health and social services area.

As Figure 4 shows, General Fund spending is proposed to increase in most health programs, while several large social services programs (CalWORKs, In-Home Supportive Services [IHSS], Foster Care, and the Children and Families Commission) would experience budget reductions. The proposed 77 percent General Fund increase provided for Child Support Services is almost entirely due to the deferral of the federal child support automation penalty from 2004-05 to 2005-06.

In general, social services programs would face larger programmatic impacts under the budget plan than health programs. While the decrease in social services programs between 2004-05 and 2005-06 in nominal dollar terms is about \$100 million, the reduction amounts to \$1.1 billion compared to the requirements of current law for these programs. Moreover, an additional General Fund savings of \$260 million is achieved in other social services departments through the substitution of federal funds. In total, social services accounts for almost \$1.4 billion, or 15 percent, of the proposed solution to the \$9.1 billion budget problem identified by the Governor.

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

	Actual 2003-04	Estimated 2004-05	Proposed 2005-06	Change From 2004-05	
				Amount	Percent
Medi-Cal					
General Fund	\$9,879	\$11,965	\$12,948	\$984	8.2%
All funds	27,703	33,848	34,067	219	0.6
CalWORKs					
General Fund	\$2,064	\$2,146	\$1,940	-\$205	-9.6%
All funds	5,207	5,416	4,901	-515	-9.5
Foster Care					
General Fund	\$453	\$487	\$426	-\$60	-12.4%
All funds	918	1,744	1,723	-21	-1.2
SSI/SSP					
General Fund	\$3,124	\$3,444	\$3,523	\$79	2.3%
All funds	8,106	8,353	8,685	332	4.0
In-Home Supportive Services					
General Fund	\$1,091	\$1,184	\$1,024	-\$160	-13.5%
All funds	3,188	3,621	3,105	-517	-14.3
Regional Centers/Community Services					
General Fund	\$1,582	\$1,804	\$1,947	\$143	7.9%
All funds	2,479	2,767	2,954	187	6.8
Developmental Centers					
General Fund	\$355	\$387	\$375	-\$12	-3.0%
All funds	719	734	716	-18	-2.5
Healthy Families Program					
General Fund	\$276	\$292	\$325	\$33	11.4%
All funds	762	807	895	88	10.9
Child Welfare Services					
General Fund	\$603	\$613	\$645	\$32	5.3%
All funds	1,831	2,081	2,192	111	5.3
Children and Families Commission					
General Fund	—	—	—	—	—
All funds	\$606	\$731	\$558	-\$173	-23.7%
Child Support Services					
General Fund	\$433	\$266	\$471	\$204	76.7%
All funds	825	683	949	266	39.0

^a Excludes departmental support.

MAJOR BUDGET CHANGES

Figures 5 (see next page) and 6 (see page C-15) illustrate the major budget changes proposed for health and social services programs in 2005-06. (We include the federal Temporary Assistance for Needy Families [TANF] funds for CalWORKs because, as a block grant, they are essentially interchangeable with state funds within the program.) Most of the major changes can be grouped into five categories: (1) funding most caseload changes, (2) suspending or deleting cost-of-living adjustments (COLAs), (3) grant reductions, (4) shifts of funding and programs so that they are no longer supported from the General Fund, and (5) other policy changes.

Caseload Changes. The budget funds caseload changes in the major health and social services programs. For example, the Medi-Cal budget would be adjusted for significant growth in the baseline costs and utilization of services by various groups of eligibles. General Fund support for community services at Regional Centers would continue to grow due mainly to rapid and ongoing caseload, costs, and utilization increases in these services.

COLA and Grant Reductions. Specifically, the budget proposes to (1) delete the statutory COLA for CalWORKs, (2) suspend the COLA for SSI/SSP, and (3) not provide the discretionary COLA for Foster Care and related programs. Also, the budget proposes to capture General Fund savings equal to the amount of the federal SSI COLA, sometimes referred to as “no pass through” of the federal COLA. In addition, the budget proposes no inflation adjustment for county administration of CalWORKs, Foster Care, Food Stamps, and Child Welfare Services. Finally, the budget achieves significant savings from a 6.5 percent CalWORKs grant reduction.

Funding and Program Shifts. The budget plan includes state savings (as well as some partially offsetting costs) from a shift in responsibility for prescription drug costs now borne by the Medi-Cal Program to the federal Medicare Program. The budget plan also reduces Medi-Cal costs by shifting part of the state cost of coverage of prenatal care services for some beneficiaries to federal funding. The budget plan also shows a net financial gain to the state from collecting so-called “quality improvement fees” from nursing homes and certain other Medi-Cal providers, even after part of the proceeds are used for rate increases for these same providers.

Other health programs would experience significant funding shifts. More Proposition 99 dollars would be used to support state mental hospitals, certain community clinics, breast and cervical cancer screenings, and Medi-Cal nonemergency medical services in order to reduce General Fund expenditures. Meanwhile, support for the AIM Program would be shifted away from Proposition 99 toward support from the General Fund and federal funds.

Figure 5**Health Services Programs
Proposed Major Changes for 2005-06
General Fund**

Medi-Cal	Requested: \$12.9 billion
	Increase: \$1 billion (+8.2%)

- + \$381 million from increases in caseload, costs, and utilization of services by the aged, blind, and disabled beneficiaries
 - + \$302 million from one-time savings from delaying checkwrites to Medi-Cal providers that will not carry forward into 2005-06
 - + \$259 million for rate increases for nursing homes (these costs are offset by "quality improvement fee" revenues)
 - + \$170 million for rate increases for managed care plans (more than offset by "quality improvement fee" revenues)
 - + \$156 million from recent rate increases in Medicare premiums
 - + \$93 million from increases in caseload, costs, and utilization of services for families and children
-
- \$191 million from a shift of prenatal care costs in Medi-Cal from the General Fund to federal funds
 - \$100 million from a one-time gain from implementation of the new Medicare drug benefit for beneficiaries also enrolled in Medi-Cal
 - \$25 million from imposition of \$1,000 annual limit on adult dental services as part of the Medi-Cal reform package

Department of Developmental Services	Requested: \$2.3 billion
	Increase: \$130 million (+5.9%)

- + \$117 million for Regional Center increases in caseload, costs, and utilization
-
- \$60 million from transfer of federal funds from the Department of Social Services

Figure 6

Social Services Programs Proposed Major Changes for 2005-06 General Fund

CalWORKs	Requested: \$1.9 billion
	Decrease: -\$205 million (-9.6%)

- + \$317 million for TANF transfers to achieve General Fund savings in other departments
 - + \$90 million for increased child care costs due to work participation reforms enacted in 2004-05
-
- \$212 million from proposed 6.5 percent grant reduction
 - \$82 million from reducing the earned income disregard
 - \$201 million from increasing maintenance-of-effort countable child care expenditures by the State Department of Education
 - \$63 million from proposed child care reforms

SSI/SSP	Requested: \$3.5 billion
	Increase: \$79 million (+2.3%)

- + \$79 million for caseload increase
 - + \$78 million for annualizing the costs of the April 2005 state COLA
-
- \$85 million from not "passing through" the January 2006 federal COLA

In-Home Supportive Services	Requested: \$1 billion
	Decrease: -\$160 million (-14%)

- + \$108 million for caseload increase
-
- \$195 million from limiting state participation in provider wages to the minimum wage, rather than \$10.10 per hour
 - \$54 million from annualizing savings from the quality assurance reforms enacted in 2004-05

Finally, the budget would achieve substantial savings for social services programs by transferring TANF federal funds into the Title XX Social Services Block Grant and using these funds to offset General Fund costs in Foster Care and Developmental Services. The budget also achieves savings by replacing General Fund support for juvenile probation with TANF federal funds.

Other Policy Changes

Medi-Cal. The administration is proposing a series of changes to the structure of the Medi-Cal Program. These include: (1) expansion of managed care for families and children as well as the aged and disabled, (2) new premiums (generally ranging from \$4 to \$10 per month per person) for certain beneficiaries with higher incomes, (3) imposition of a cap on adult dental services of \$1,000 per year, (4) restructuring of hospital revenue streams, (5) expedited processing of children's applications for health coverage through the so-called "single point of entry" contractor at the state level instead of sending Medi-Cal applications on to counties, and (6) stronger state monitoring of county administration of program eligibility. The budget also is increased in recognition that one-time savings to be achieved in 2004-05 from delaying checkwrites to Medi-Cal providers will not carry forward into 2005-06.

Other Health Programs. The budget plan provides new state funding for a series of health policy initiatives to reduce the incidence of obesity; establish a "California Rx" program by which an estimated five million low- and moderate-income Californians could gain access to discounts on prescription drugs at pharmacies, and to establish a fee-supported program to expand screening of newborns for various genetic diseases. In addition, the budget plan proposes to restore state funding for various outreach activities to assist persons in applying for benefits and proposes additional steps to promote the enrollment of children in the state's Medi-Cal and Healthy Families programs as well as county-supported initiatives for health coverage.

Developmental Services. Additional funds are provided to help patients at Agnews Developmental Center transfer to the community before the closure of the facility in 2007. Some new cost-containment proposals also are assumed to produce some savings in the budget year.

IHSS. The Governor proposes to limit state participation in provider wages to the minimum wage (that is \$6.75, rather than the \$10.10 per hour currently authorized). Under current law, state participation would have increased to \$11.10 per hour in 2005-06.

CalWORKs. The Governor proposes to reduce the earned income disregard for working CalWORKs families. For example, a family earning \$1,000 per month would have their monthly grant reduced by \$93 under this policy. To improve work participation, the Governor proposes to make allocation of a portion of county block grant funds contingent upon meeting specified performance measures.

Child Care. The budget proposes a series of child care reforms similar to last year's proposal. Key features of the proposal include: (1) phasing in a one-year time limit for Stage 3 child care for former CalWORKs recipients, (2) tying reimbursement rates to child care quality, (3) waiting list reforms, and (4) basing income eligibility on the percentage of federal poverty rather than state median income.

CROSSCUTTING ISSUES

Health and Social Services

ACCESSING FEDERAL FUNDS FOR PRENATAL SERVICES

We recommend that the Legislature approve the administration's proposal to draw down federal funds to offset state costs for prenatal services. We also examine the feasibility of expanding this option to include an offset of state costs for prenatal services provided to incarcerated women. We further recommend the enactment of legislation to phase out the Access for Infants and Mothers program and instead provide health coverage for low-income pregnant women in the Healthy Families Program.

Federal Options Open the Door for State Savings

In our *Analysis of the 2004-05 Budget Bill* (page C-161), we discussed how the state could obtain federal funds to partially offset the state's costs for providing prenatal services for poor and pregnant women enrolled in the Access for Infants and Mothers (AIM) and the Medi-Cal programs. In September 2002, the Bush administration issued a regulation that permits states to utilize funding available to the state under the federal State Children's Health Insurance Program (SCHIP) to provide coverage to unborn children (and their mothers) in low-income families. As of January 2005, seven states (specifically, Michigan, Washington, Massachusetts, Rhode Island, Minnesota, Illinois, and Arkansas) had received federal approval under this option to expand their states' SCHIP-funded insurance programs to include pregnant women and unborn children. These states have accessed SCHIP funds to offset the cost of prenatal services provided to undocumented immigrants, incarcerated pregnant women, and

other low-income pregnant women who would otherwise be ineligible for participation in federally funded programs.

Prenatal Services Now Largely Supported by General Fund. Currently, the state largely bears the cost of providing prenatal services to pregnant women in two state health programs as well as through state prison institutions. Through AIM, certain low- to moderate-income women receive comprehensive health care throughout their pregnancy, delivery, and 60 days after delivery. The prenatal services available through this program are primarily supported with tobacco tax revenue generated under Proposition 99. Through Medi-Cal, undocumented immigrants receive prenatal, delivery, and post partum services. The prenatal and post partum services provided to these undocumented women are entirely supported with General Fund resources. Lastly, in the state prisons, incarcerated pregnant women receive prenatal and comprehensive health care services either from prison medical employees or from a contracted health care provider entirely supported by the state General Fund.

Governor's Proposal

The Governor's budget plan proposes that the state claim SCHIP funds for certain prenatal services currently provided through AIM and Medi-Cal in order to achieve net state savings of approximately \$287 million in the current and budget years combined. The details of the administration's proposal and its impact on the General Fund, Proposition 99, and the state's receipt of federal funds are described below and summarized in Figure 1.

Figure 1
Funding for Prenatal Services

(In Millions)

	Current Policy		Governor's Proposal		Two-Year Impact	
	2004-05	2005-06	2004-05	2005-06	State	Federal
Medi-Cal Prenatal Services						
General Fund	\$147	\$147	\$51	\$51	-\$191	—
Federal SCHIP funds	—	—	96	96	—	\$191
AIM Prenatal Services						
Proposition 99	\$71	\$78	—	—	-\$148	—
General Fund	—	—	\$25	\$27	52	—
Federal SCHIP funds	—	—	46	51	—	\$96
Totals^a	\$218	\$225	\$218	\$225	-\$287	\$287

^a Detail may not total due to rounding.

Proposed Fund Shift for AIM. In the budget year, in lieu of using Proposition 99 funds to support the AIM program, the state would utilize \$27 million from the General Fund to draw down \$51 million in SCHIP funds for support of the program. This funding switch has been proposed because state law prohibits the use of Proposition 99 funds to leverage federal resources. As seen in Figure 1, by shifting the AIM program to the General Fund, the state would free up approximately \$78 million in Proposition 99 funds that could otherwise be used for other purposes. A similar shift is proposed for the current year. (We describe this and other related shifts in funding in the “Proposition 99 Funding Shifts” section of this chapter.

Proposed Fund Shift for Medi-Cal. Also in the budget year, the administration proposes using approximately \$51 million in General Fund resources to draw down \$96 million in SCHIP funds for prenatal services provided to undocumented immigrants through Medi-Cal. This results in a corresponding General Fund savings of \$96 million. (Absent this change, the state would most likely cover the entire cost of these services with General Fund resources.) A similar shift is proposed for the current year. However, the combined effect of the current- and budget-year shifts, which total \$191 million in savings to the state, is entirely reflected in the budget year.

Assessing the Governor’s Proposal

The federal rules authorizing states to use federal SCHIP funds to provide coverage to unborn children present a substantial opportunity for the state to leverage federal resources for prenatal services that up until now were entirely supported by state resources. However, during our review of this proposal, we have identified additional issues and opportunities for state savings that the Legislature may wish to consider. We discuss these issues below.

Savings Would Be Less in Future Years. The administration is proposing to draw down federal funds to offset General Fund costs in Medi-Cal in the current and budget years. However, the budget plan reflects the entire \$191 million in savings from both fiscal years in just the budget year. As a result, we would note that the savings achieved in future fiscal years from this funding shift in Medi-Cal would be roughly one-half of the amount estimated for the budget year. We estimate that the Medi-Cal savings in 2006-07 from this proposal would drop to approximately \$96 million.

Total Savings May Be Overstated. Our analysis indicates that the administration has a reasonable basis for assuming the level of savings that would result from the proposed shift to SCHIP. However, the Legislature should be aware that there is some risk that federal authorities would interpret their rules in a way that would result in a lesser, although still significant, level of savings for the state.

Specifically, the Governor's proposal assumes that the state would be able to draw down federal funds for all health care services currently provided to pregnant women in AIM and Medi-Cal, including post partum services provided after delivery. Our review of other state programs and federal guidelines indicates that the federal government has explicitly limited the use of SCHIP funds for pregnancy-related services. Nevertheless, federal authorities in some cases have allowed services to pregnant women to be paid for with SCHIP funds through a "bundled rate" that provides reimbursement for a number of different services, including post partum care. However, at least one state established a state-only component for post partum care because the federal government did not authorize its use of SCHIP funds for this purpose.

These conflicting interpretations of federal rules mean there remains some uncertainty about whether federal authorities will allow use of SCHIP funds for all of the expenses the state would claim under the Governor's proposal. As it develops its budget plan, the Legislature should bear in mind that the savings achieved from this proposal could be lower than expected. In this regard, the Legislature could take additional budgetary actions to offset any possible loss of state savings if federal authorities do not concur in the state's approach. We discuss one such action below.

Additional Opportunity for Savings. Our review of related developments in other states indicates that California may have an additional opportunity to leverage the SCHIP funds to cover prenatal services that are currently supported by the General Fund. Notably, Illinois is currently using its SCHIP funds to provide coverage for, among other groups, pregnant incarcerated women. In Illinois, pregnant incarcerated women can apply for health care coverage through the state's Medicaid program. The Illinois Department of Corrections submits the claims it receives from contract providers for prenatal services provided to these women to its Medicaid program, which are then used to draw down additional federal SCHIP funds.

We believe that the state could pursue a similar approach to offset health care costs provided to pregnant prison inmates residing in its correctional facilities. The California Department of Corrections (CDC) has indicated that it does not currently track the health care expenditures for pregnant inmates when services are provided by state medical staff. However, based on conversations with CDC, we estimate that expenditures for services provided by contract providers would be at least \$420,000 in the budget year. If the state were to access SCHIP funds for prenatal services provided to this population, we believe it could achieve at least \$270,000 in General Fund savings. The savings would most likely be significantly higher if the state also obtained federal funding for prenatal services provided by prison employees in the institutions.

In addition to achieving additional state savings, this approach could result in additional benefits. It might better ensure that the pregnant inmate has health care coverage in those instances where she is released from prison on parole prior to the delivery of her child. Under this proposal, the expectant mother would already be enrolled in public health care coverage before her release from state custody.

Opportunity for Program Consolidation. In the 2004-05 *Analysis* discussion of AIM, we proposed that AIM be phased out and consolidated with the Healthy Families Program. The administration's proposal to utilize federal SCHIP funds to cover prenatal services further bolsters the rationale, in our view, for a gradual phaseout of the AIM program and a shift of AIM mothers into the Healthy Families Program. There are several reasons to consider this change.

The AIM program will be serving fewer and fewer individuals in future years, in keeping with prior legislative decisions. By December 2006, AIM will only serve expectant mothers because recent policy changes shifted infants born to AIM mothers into the Healthy Families Program. When this shift is completed, only about 6,000 women (and no infants) will be left in a program that, as recently as June 2004, had a combined caseload of approximately 18,000 mothers and children.

We would note that such a consolidation should not be disruptive for the beneficiaries and the health plans. This is because the health insurance coverage provided to AIM mothers does not differ from the coverage currently provided in Healthy Families. The health plans participating in the Healthy Families Program already cover prenatal and post partum care for individuals enrolled in the program up to age 19. Lastly, the administration's proposal means that the state would be using the same fund source as the Healthy Families Program—SCHIP—to provide prenatal services to this population of expectant mothers. In view of the above, we believe the state could achieve significant administrative savings by folding a program with such a small and declining caseload into one such as Healthy Families that is much larger.

Policy Implications for Women's Access to Services. The administration has indicated that the intent of this proposal is to maximize federal funds, not to change who has access to pregnancy-related services or the scope of such services currently authorized under state law. Should the Legislature wish to formally record the intent of its decision to access federal SCHIP funds for prenatal services, it could consider adopting the following budget bill language for the AIM and Medi-Cal budget items:

Provision X. It is the intent of the Legislature that the state access additional federal State Children's Health Insurance Program funds to offset the state's cost of providing prenatal services provided under the

Access for Infants and Mothers (AIM) and Medi-Cal programs. In so doing, it is not the intent of the Legislature to affect access of women to health services.

If the Legislature has any concerns about the policy implications of accessing SCHIP funds for the support of prenatal services, it may also wish to request a legal opinion from the Office of Legislative Counsel on this matter.

Analyst's Recommendation. We recommend that the Legislature approve the administration's proposal to draw down federal funds for prenatal services. We further recommend that the Legislature direct the administration to report at budget hearings regarding the feasibility, operational ramifications, and potential timetable for expanding this proposal to draw down federal funds for prenatal services provided to incarcerated women. In our view, this information would provide the Legislature with the guidance needed to determine whether the state could begin to achieve savings from the implementation of this change, as we believe possible, beginning in 2005-06.

Lastly, we recommend the enactment of legislation to phase out the AIM program and authorize the coverage of low-income pregnant women in the Healthy Families Program. Given (1) the impending decline in AIM caseload, (2) the similarities in services provided in each program, and (3) the administration's proposed use of similar funding sources for both programs, we believe that a shift of AIM mothers into the Healthy Families Program would result in programmatic efficiencies over time by combining the administrative responsibilities of two similar programs into one.

CHILD CARE

California's subsidized child care system is primarily administered through the State Department of Education (SDE) and the Department of Social Services (DSS). A limited amount of child care is also provided through the California Community Colleges. Figure 1 (see next page) summarizes the funding levels and estimated enrollment for each of the state's various child care programs as proposed by the Governor's 2005-06 budget.

As the figure shows, the budget proposes about \$2.6 billion (\$1.3 billion General Fund) for the state's child care programs. This is an increase of about \$33 million from the estimated current-year level of funding for these programs. About \$1.2 billion (46 percent) of total child care funding is estimated to be spent on child care for current or former California Work Opportunity and Responsibility to Kids (CalWORKs) recipients. Virtually all of the remainder is spent on child care for non-CalWORKs low-income families. The total proposed spending level will fund child care for approximately 488,700 children statewide in the budget year.

Families receive subsidized child care in one of two ways: either by (1) receiving vouchers from county welfare departments or Alternative Payment (AP) program providers, or (2) being assigned space in child care or preschool centers under contract with SDE.

Eligibility Depends Upon Family Income and CalWORKs Participation

CalWORKs and non-CalWORKs families have differential access to child care in the current system. While CalWORKs families are guaranteed access to child care, eligible non-CalWORKs families are not guaranteed access, are often subject to waiting lists, and many never receive subsidized care, depending on their income.

CalWORKs Guarantees Families Child Care. State law requires that adequate child care be available to CalWORKs recipients receiving cash aid in order to meet their program participation requirements (a combination of work and/or training activities). If child care is not available, then

Figure 1 California Child Care Programs

2005-06
(Dollars in Millions)

Program	State Control ^a	Estimated Enrollment	Governor's Budget
CalWORKs^b			
Stage 1 ^c	DSS	98,000	\$498.8
Stage 2 ^c	SDE	94,000	575.4
Community colleges (Stage 2)	CCC	3,000	15.0
Stage 3 ^d	SDE	14,500	87.6
Subtotals		(209,900)	(\$1,167.8)
Non-CalWORKs^{b,e}			
General child care	SDE	88,000	\$632.1
Alternative Payment programs	SDE	71,000	430.0
Preschool	SDE	101,000	325.4
Other	SDE	18,700	54.2
Subtotals		(278,800)	(\$1,441.6)
Totals—All Programs		488,700	\$2,609.4
<p>^a Department of Social Services, State Department of Education, and California Community Colleges.</p> <p>^b California Work Opportunity and Responsibility to Kids.</p> <p>^c Includes holdback of reserve funding which will be allocated during 2005-06 based on actual need.</p> <p>^d Significantly reduced due to Governor's reform proposal to move current Stage 3 recipients to general child care.</p> <p>^e Does not include after school care, which has a budget of \$250 million and is estimated to provide care for 249,500 school-aged children.</p>			

the recipient does not have to participate in CalWORKs activities for the required number of hours until child care becomes available. The CalWORKs child care is delivered in three stages:

- Stage 1.** Stage 1 is administered by county welfare departments (CWDs) and begins when a participant enters the CalWORKs program. While some CWDs oversee Stage 1 themselves, 32 contract with AP providers to administer Stage 1. In this stage, CWDs or APs refer families to resource and referral agencies to assist them with finding child care providers. The CWDs or APs then pay providers directly for child care services.

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

Non-CalWORKs Families Receive Child Care If Space Is Available. Non-CalWORKs child care programs (primarily administered by SDE) are open to all low-income families at little or no cost to the family. Access to these programs is based on space availability and income eligibility. Because there are more eligible low-income families than available child care slots, waiting lists are common. As a result, many non-CalWORKs families are unable to access child care.

GOVERNOR'S CHILD CARE REFORM PROPOSALS

Figure 2 (see next page) shows the child care reforms proposed by the Governor and their fiscal impact. The Governor's reforms fall into two broad categories: (1) eligibility for child care services and (2) provider reimbursement rates. The changes to eligibility feature a redistribution of child care slots to promote greater equity in child care access between CalWORKs recipients and the working poor. At the center of the rate reforms is a quality-driven tiered reimbursement rate structure. Most of the reforms would only affect the voucher program, leaving the SDE contracted programs basically unaltered.

Figure 2	
Administration's Child Care Proposals	
<i>2005-06 (In Millions)</i>	
Reform	Cost/ Savings
Eligibility	
<p>Moving Stage 3 Child Care</p> <p>Permanently expand the general Alternative Payment (AP) program by shifting all current CalWORKs Stage 3 child care recipients, and the associated funding, to the AP program, limiting guaranteed child care to a maximum of eight years and limiting Stage 3 to one year.</p>	—
<p>Creating Centralized Waiting Lists</p> <p>Require counties to create a two-tiered waiting list for all subsidized child care: the first tier for families below 138 percent of the federal poverty level (FPL) and the second tier for families above that level.</p>	\$7.9
<p>Rebenching Child Care Eligibility</p> <p>Shift eligibility determination to FPL measures rather than the current State Department of Education state median income calculations.</p>	—
<p>After School Care for 11- and 12-Year-Olds</p> <p>Designate after school care as the default placement and require parents to submit a reason in writing that they cannot use the available after school program.</p>	-\$23.8
Reimbursement Rates	
<p>Tiered Reimbursement Rates</p> <p>Reduce the amount the state is willing to pay license-exempt providers. Further, create fiscal incentives for all providers to raise the quality of the care they provide and encouraging additional training.</p>	-\$140.1
<p>Equitable Provider Rates</p> <p>Adopt regulations establishing an alternative rate setting mechanism for providers that only serve subsidized families. These regulations have been suspended for the last two years.</p>	-\$8.2

ELIGIBILITY REFORMS

Shifting CalWORKs Families to AP Programs

The Governor proposes to shift Stage 3 California Work Opportunity and Responsibility to Kids (CalWORKs) child care to the State Department of Education's Alternative Payment (AP) program, in addition to creating centralized county waiting lists for subsidized child care. Timing problems under the Governor's proposal may disadvantage current CalWORKs recipients' attempts to receive long-term subsidized child care. To address this issue, we recommend delaying the shift of the Stage 3 program to the AP program until counties have created centralized waiting lists. We also recommend placing current CalWORKs participants on the waiting lists based upon the date that they first had earned income in the program.

Eliminating the Long-Term CalWORKs Child Care Guarantee

Under current law, current and former CalWORKs families are guaranteed child care as long as they meet eligibility requirements and have a need for child care. The Governor proposes shifting all current CalWORKs Stage 3 families (former CalWORKs recipients) into the AP program along with the associated funding and ending the child care guarantee for CalWORKs families. In other words, all families who are receiving Stage 3 child care as of June 30, 2005 would in the future be served by the non-CalWORKs AP voucher program. (Local AP providers assist families in locating child care and distribute vouchers to those families.) This shift would permanently expand the AP program. There would be no impact on families currently receiving service as their child care guarantee would not change. However, any families coming into Stage 3 CalWORKs after this point would be limited to one or two years.

Under this proposal, families who leave CalWORKs after June 30, 2005 would be allowed two years of transitional child care in Stages 1 and 2, and one year in Stage 3. In other words, they would be guaranteed child care for three years after leaving aid. If a family is currently off aid and in Stage 1 or Stage 2, the family would receive two years of Stage 3 child care while they are on the waiting list for a child care slot in the AP child care program. These families' child care guarantee would be for a maximum of four years after leaving aid, depending on the time they have left in Stage 2. Figure 3 (see next page) shows the guaranteed time in child care for current and former CalWORKs families under current law and under the Governor's proposed reform.

Figure 3**CalWORKs^a Child Care
Current Law and Governor's Proposal**

Family Status	CalWORKs Child Care Guarantee		
	Current Law ^b	Governor's Proposal	Centralized Waiting List
Aided family with earnings	Until family's income exceeds 75 percent of SMI ^c or children age out.	Remaining time in CalWORKs plus three years. Same age/income limits.	As soon as list is created.
Aided family without earnings	Same as above.	Same as above.	When parents become employed.
Formerly aided family in Stage 2	Same as above.	Up to two years in Stage 2 and two years in Stage 3.	As soon as list is created.
Formerly aided family in Stage 3	Same as above.	Until family's income exceeds 75 percent of SMI ^c or children age out.	Child care guaranteed. No waiting list.

^a California Work Opportunity and Responsibility to Kids.

^b Current practice has been to fully fund Stage 3 child care, which allows all former CalWORKs families to be served. However, Stage 3 is not an entitlement and is therefore subject to the appropriation of adequate funding.

^c State median income.

This proposal allows all CalWORKs families to place their names on the waiting list as soon as they have earned income. Therefore, CalWORKs families would not have to wait until leaving aid before they can compete for SDE's subsidized child care. However, they would need to wait until they have earned income, which would be problematic for the families nearing their CalWORKs time limits who have been participating in welfare-to-work activities other than employment (such as community service or vocational education). Adults in CalWORKs have a five-year time limit.

We note that in contrast to last year, this proposal preserves the child care guarantee for families already in Stage 3 and allows aided families to place their names on centralized waiting lists as soon as they have earned income. These changes address the major concerns we raised in the *Analysis of the 2004-05 Budget Bill*.

Two-Tiered Waiting Lists

In addition to the changes in Stage 3, the Governor has proposed creating centralized county waiting lists for SDE subsidized child care.

Current Waiting Lists for Subsidized Child Care. There is not enough funding available to serve all of the working poor non-CalWORKs families who qualify for subsidized child care. Therefore, providers create waiting lists for those families seeking subsidized child care. Families place their names on waiting lists in the hopes of receiving assistance with the cost of child care. While there is currently no information on the number of families on waiting lists or the amount of duplication among the lists, it is commonly believed that families place their names on multiple lists in order to increase their chances of receiving subsidized child care. When a provider has a space for a subsidized family, that provider is required to serve the family on their list with the lowest income first, unless the family is referred by child protective services, in which case they receive priority.

Centralized List. The Governor proposes eliminating provider waiting lists and requiring each county to develop a centralized waiting list for all subsidized non-CalWORKs child care. The budget includes \$7.9 million (General Fund) for this purpose. County waiting lists would be split into two different tiers, while maintaining the existing priority for families referred by child protective services. Families earning less than \$2,168 per month (for a family of four) would be placed in the first tier of the waiting list and would be provided with child care on a first-come, first-served basis. This would include all CalWORKs families with earned income because under current law, a family of four is no longer eligible for CalWORKs once they have an income of \$1,951 per month.

The second tier would be for families who have a monthly income above 138 percent of the federal poverty level (FPL), approximately \$2,168 per month for a family of four. These families would be served only after all first-tier families have been served. From this list, families would be served based on income, with the lowest-income family served first.

Advantages to Governor's Proposal

Dismantling Stage 3 Helps Create Parity Among All Working Poor Families. Under the current system, families that receive child care through the CalWORKs system have traditionally been guaranteed subsidized child care until their incomes exceed eligibility limits or their children age out of the child care system. Conversely, working poor families that have not participated in the CalWORKs program must compete for the limited subsidized child care slots in their communities. The Governor's proposal permanently expands non-CalWORKs subsidized child care and effectively limits Stage 3 CalWORKs child care to one year. While the total number of child care slots would not change, this would provide greater access to child care for working poor non-CalWORKs families. Some of these work-

ing poor families may have family income significantly below many of the Stage 3 CalWORKs families.

Centralized Waiting Lists Would Provide Critical Information for Policymakers. As mentioned previously, there are virtually no centralized waiting lists in counties and those counties with centralized waiting lists cannot require providers to participate. Consequently, the Legislature and the administration have no way of knowing how many families need subsidized child care and are not receiving it, or the length of time families remain on waiting lists without being served. Centralizing the waiting lists would allow counties to establish an accurate count of families in their communities that are eligible and waiting for subsidized child care, and would allow them to clean up waiting lists by removing duplicate names or families that are no longer eligible for child care. They would also be able to determine the average length of time a family remains on the waiting lists. Having data provides the Legislature with the information it needs to determine the adequacy of California's subsidized child care system.

Implementation Concerns

Centralized Waiting Lists Should Be Created First. The Governor's proposal moves all of the current Stage 3 child care cases as of June 30, 2005 to general AP child care upon passage of the budget. This shift would not impact the current families in Stage 3. However, families in Stage 2 that would be moving to Stage 3 within the next year or so could be adversely affected during the transition period. This is because it will take time for counties to collect and merge all of the existing provider waiting lists in each county and then to sort through duplicate entries and determine whether a family should be placed on the first tier or second tier of the waiting list and in what order. Until this process is completed, there will not be a centralized waiting list for CalWORKs families on which to place their names. Moreover, to the extent that families leave the general AP program before the lists are created, those child care slots may remain unused or will only be available to working poor families on current waiting lists. In order to avoid this confusion and the delay in families receiving subsidized child care, the centralized waiting lists should be created before Stage 3 child care is dismantled.

CalWORKs Recipients May Be Located at the Bottom of the Waiting Lists. According to the administration, the centralized waiting lists in each county will be established by merging all of the existing lists that subsidized child care providers now maintain. As these lists are merged, families will be placed in the higher second tier (above 138 percent of the FPL) in lowest-income-first order. The remaining families (at or below 138 per-

cent of the FPL) will be placed in first-come, first-served order based upon the length of time they have been on their existing lists.

For the most part, the existing waiting lists do not contain the names of current and former CalWORKs families because those families have been served under the CalWORKs child care program. This means that all current or former CalWORKs families with earned income who need child care and are not currently in Stage 3 will have to place their names on the centralized county waiting lists. Most of them will be eligible for the lower first tier (below 138 percent of the FPL) of the waiting lists. Because the waiting lists would be created by merging existing lists that do not include these families, virtually all of the CalWORKs families will be placed at the bottom of the lists. Depending on the availability of subsidized child care and the length of the waiting lists in each county, CalWORKs families that have exhausted much of their five-year CalWORKs time limit will be at a disadvantage and are less likely to receive subsidized child care once their time in the CalWORKs child care program comes to an end.

In order to address this problem, during the initial development of the lists, CalWORKs families with earned income could be placed on the waiting list according to the date that they began working. Theoretically, non-CalWORKs working poor families placed their names on waiting lists when they had their first child and/or began working. Placing CalWORKs families in a similar position on the waiting lists by their work dates creates parity between the two groups. There may be some slight CalWORKs administrative costs associated with determining the appropriate dates for families. However, those costs should be minimal.

Funding May Grow Slightly Faster Under Governor's Proposal. We would note that funding for these former Stage 3 child care slots may grow faster under the Governor's proposal than under the current program. This is because the cost-of-living adjustments (COLAs) and growth adjustments used for subsidized child care are projected to increase at a greater rate than the caseload and COLAs used for CalWORKs child care.

LAO Recommendation

We believe there is considerable merit to the Governor's proposed changes to subsidized child care for CalWORKs families. Shifting CalWORKs Stage 3 child care to AP child care and creating centralized two-tiered waiting lists will allow more equitable access to subsidized child care for all families with very low incomes, whether they have participated in the CalWORKs program or not. However, in transitioning to this new system and essentially dismantling Stage 3 child care, it is important that current CalWORKs families not be disadvantaged. Accordingly, we recommend delaying the shift from Stage 3 to AP child care by

six months, thereby allowing enough time for counties to develop centralized waiting lists that include CalWORKs families within that six-month period. Once a county has a functioning waiting list, it can then shift its child care program.

In order to avoid placing existing CalWORKs families at the bottom of the waiting lists, we recommend placing CalWORKs families on the waiting list based upon the date they first had earned income in the program. However, CalWORKs families will still be expected to take the initiative of signing up for AP child care. To avoid lingering administrative problems, we recommend that CalWORKs families only be given 120 days once the list is functioning to ask to be placed, based upon their employment date. Once the 120-day period is up, CalWORKs families would be placed on the centralized waiting lists on a first-come, first-served basis.

Making these two adjustments to the Governor's proposal will ensure that existing CalWORKs families will be given a level playing field to compete with other working poor families for subsidized child care.

Governor Proposes Further Reforms for 11- and 12-Year-Olds

The Legislature was concerned about the Governor's 2004-05 budget proposal to shift 11- and 12-year-old children to after school programs. Many working poor families, whether CalWORKs or non-CalWORKs, are employed in nontraditional jobs that require working evenings, nights, and weekends. For these families, after school care usually is not a realistic option for their children. Therefore, the Legislature modified the Governor's proposal to encourage, rather than mandate, after school placement. Specifically, families were not required to shift their children to after school care and the Legislature established a reserve to continue to fund child care for these families.

To further strengthen the after school reform from the prior year while recognizing the difficulties faced by some families, the Governor has proposed making after school care the default placement for 11- and 12-year-olds. However, to the extent that this type of care is not acceptable or practical for families, they may submit their reason in writing and receive an alternate form of child care for their children. The budget assumes that 25 percent of families with 11- and 12-year-olds will shift them from child care to after school care.

We believe this modification allows families to continue to have flexibility in their child care decisions and addresses the concerns expressed by the Legislature in the previous budget.

REIMBURSEMENT RATE REFORMS

The Governor's proposal includes two reforms related to provider rates. The first would create a new system of tiered provider reimbursement. The second would revise regulations for determining rates for providers who do not have private pay clients.

Two Types of Service Models— Vouchers and Direct State Contracts

Currently, the state provides child care through two main mechanisms: vouchers and direct contracts with child care centers.

Most Families Receive Child Care Through a Voucher System. The CalWORKs families in any of the three stages of child care receive a voucher from CWD or AP. In addition, the state provides vouchers to working poor families through APs. The combined programs provide about 272,900 children with child care vouchers. The AP or CWD assists families in finding available child care in the family's community, typically placing families in one of three settings—licensed centers, licensed family child care homes (FCCHs), and license-exempt care. The licensed programs must adhere to requirements of Title 22 of the California Code of Regulations, which are developed by DSS' Community Care Licensing Division. These programs are often referred to as Title 22 programs. Currently, Title 22 centers and FCCH providers are reimbursed up to a maximum rate or ceiling of the 85th percentile of the rates charged by private market providers in the area offering the same type of child care. The 85th percentile is determined by the Regional Market Rate's (RMR) survey of public and private child care providers that determines the cost of child care in specific regions of the state. License-exempt care providers are reimbursed up to 90 percent of the FCCHs maximum rate (85th percentile). The relatively high reimbursement level of the vouchers for subsidized care reflects an attempt to ensure that low-income families can receive similar levels of child care service as wealthier families in the same region.

SDE Contracts Directly With Child Care and Preschool Centers. For child care and preschool, SDE contracts directly with 850 different agencies through approximately 2,100 different contracts. These providers are reimbursed with the Standard Reimbursement Rate, \$28.82 per full day of enrollment. These providers must adhere to the requirements of Title 5 of the California Code of Regulations and are generally referred to as Title 5 providers.

In the nearby box, we provide a list of the child care terms and corresponding definitions used throughout the remainder of this section.

CHILD CARE TERMINOLOGY

Types of Providers

Voucher Providers. Providers who serve the California Work Opportunity and Responsibility to Kids (CalWORKs) and non-CalWORKs families who receive vouchers for child care.

- **License-Exempt.** Relatives or friends without a license for providing childcare.
- **Title 22 Family Child Care Homes (FCCHs).** Licensed providers caring for a small number of children typically in their own homes.
- **Title 22 Centers.** Licensed centers.

State Department of Education (SDE) Contractors/Title 5 Providers. Providers who contract directly with SDE to provide child care and preschool for primarily non-CalWORKs working poor families.

- **Title 5 FCCHs.** Licensed providers caring for a small number of children typically in their own homes. These FCCHs have not only obtained a license, but also meet SDE standards.
- **Title 5 Centers, Including Preschool.** Licensed centers that also meet SDE standards.

Other Terms

- **Alternative Payment (AP) Program.** The SDE-administered voucher program for non-CalWORKs working poor families.
- **Standard Reimbursement Rate (SRR).** The per child rate paid to Title 5 providers that contract with SDE.
- **Regional Market Rate (RMR).** Regionally-based market rates used to determine reimbursements to voucher providers.
- **Maximum Rate.** The rate ceiling for voucher providers. If they serve private pay clients, providers receive reimbursements equal to their private pay rates, up to the maximum rate. If they do not serve private pay clients, providers are reimbursed at the maximum rate.
- **FCCH Maximum Rate.** The 85th percentile of the maximum rate paid to Title 22 FCCHs. Serves as the basis for the license-exempt care rates.

Figure 4 shows the major care types and associated regulations offered through voucher providers and SDE contractors for preschool-aged children. Moving from the left-hand side of Figure 4 to the right, the requirements to provide the specific type of child care become more difficult to meet and suggest a higher level of quality.

Figure 4				
Subsidized Child Care Providers				
Safety and Educational Requirements				
<i>Current Law for Preschool-Aged Children</i>				
	Voucher Providers			SDE Contractors
	License-Exempt Providers	Title 22 FCCHs	Title 22 Centers	Title 5 Providers Including Preschool
Provider/teacher education and training	None.	None.	Child Development Associate Credential or 12 units in ECE/CD.	Child Development Teacher Permit (24 units of ECE/CD plus 16 general education units).
Provider health and safety training	Criminal background check required (except relatives). Self-certification of health and safety standards.	15 hours of health and safety training. Staff and volunteers are fingerprinted.	Staff and volunteers fingerprinted and subject to health and safety standards.	Staff and volunteers fingerprinted and subject to health and safety standards.
Required ratios	None.	1:6 adult-child ratio.	1:12 teacher-child ratio or 1 teacher and 1 aide for 15 children.	1:24 teacher child ratio and 1:8 adult-child ratio.
Accountability, monitoring, and oversight	None.	Unannounced visits every five years or more frequently under special circumstances.	Unannounced visits every five years or more frequently under special circumstances.	Onsite reviews every three years. Annual outcome reports, audits, and program information.
FCCHs = family child care homes; SDE = State Department of Education; and ECE/CD = Early Childhood Education/Child Development.				

The minimum standards for child care offered through the voucher, especially those for license-exempt providers, are generally lower than the standards for Title 5 providers contracted with SDE. For example, license-exempt providers, who are typically relatives, friends, or neighbors of the family needing child care, are *not* required to have any training or to adhere

to adult-to-child ratios. The Title 22 FCCH providers are required to meet minimal health and safety standards, adhere to an adult-to-child ratio, and require a site visit every five years for licensure. Title 22 centers require providers to have some college-level education. The Title 5 providers require a Child Development Teacher Permit, which is issued by the California Commission on Teacher Credentialing. In addition, they have annual program outcome reports and are required to have onsite reviews every three years.

Proposal Creates a Tiered Reimbursement Rate Structure for AP Providers

The Governor proposes to implement a tiered reimbursement rate structure for the voucher child care programs. Tiered reimbursement for child care provides differential reimbursement rates that encourage providers to improve program quality by obtaining additional training and education and improving outcomes as measured by independent standards of quality. We believe that the Legislature should first consider whether tiered reimbursement is desirable, and then decide upon specific levels of reimbursement.

Below, we (1) describe the Governor's proposal, (2) examine the merits of tiered reimbursement, and (3) discuss the appropriate levels for the rates in tiered reimbursement.

Governor's Tiered Reimbursement Proposal

The Governor's proposal creates a five-tiered child care reimbursement rate structure that reimburses voucher providers from 55 percent to 100 percent of the current maximum rates, depending on independent quality ratings, licensing, accreditation, education, and health and safety training. The proposal is summarized in Figures 5 and 6. The intent of the proposal is to provide higher reimbursement rates to providers that exhibit higher quality. Figures 5 and 6 show the reimbursement rates for three categories of care—license-exempt, family home care, and center-based care. The figures also show the education and training requirements for the various levels of rates under the Governor's proposal. For license-exempt care, there are two levels: license-exempt and license-exempt plus. The FCCHs and centers are rated according to a three-star system whereby the highest quality providers receive three stars and the lowest one star. Please note that Figure 6 uses the term "environmental rating scale," which is explained below.

Figure 5**Governor's Tiered Reimbursement Proposal
For License-Exempt Providers**

	Percent of FCCH ^a Maximum	Additional Requirements
License-exempt	55 percent	None.
License-exempt plus	60 percent	License-exempt training, assistant teacher permit, or health and safety training.

^a Family child care homes.

Figure 6**Governor's Tiered Reimbursement Proposal
For Licensed Providers**

Star Rating	Maximum Rate	Additional Requirements	
		FCCHs ^a	Centers
*	75 percent of the 85 th percentile RMR. ^b	None.	None.
**	85 percent of the 85 th percentile RMR. ^b	Environmental rating scale average of 4 or associate teacher permit.	Environmental rating scale average of 4 or all teachers have teacher permit.
***	85 th percentile RMR. ^b	Environmental rating scale average of 5.5, teacher permit, associates degree, or accreditation.	Environmental rating scale average of 5.5, all teachers have bachelor's degree, or accreditation.

^a Family child care homes.

^b Regional Market Rate (RMR) survey of providers in the area offering the same type of child care. The RMR will vary by care type.

License-Exempt Rate Reduction of \$140 Million. The Governor's entire 2005-06 savings estimate for the tiered reimbursement proposal is based on reductions to license-exempt care rates for the voucher program (CalWORKs Stages 1, 2, and 3 and AP). Under the proposal, the rates of

license-exempt care providers with no training would be cut to 60 percent of the 85th percentile. This reduction would take effect on July 1, 2005. These providers would then have 90 days to obtain the specified training for the second reimbursement tier, license-exempt plus, or their rates will be further cut to 55 percent of the 85th percentile. Figure 7 shows how the changes would affect license-exempt provider rates in a sample of counties in various geographic regions throughout the state. In these counties, license-exempt providers' rates would be reduced by between \$182 and \$303 per child per month.

Figure 7**Monthly Child Care Maximum Reimbursement Rates***License-Exempt Providers*

Percent of FCCH ^a Maximum	Sacramento	San Francisco	Los Angeles	Contra Costa	Fresno	Shasta
90 percent ^b	\$526	\$780	\$585	\$624	\$488	\$468
60 percent ^c	351	520	390	416	325	312
55 percent ^d	321	476	357	381	298	286
Potential Reduction	-\$205	-\$303	-\$227	-\$242	-\$190	-\$182

^a Family child care homes.
^b Current license-exempt rate limits are based on 90 percent of the FCCH rate maximum (85th percentile) for full-time monthly care for a child age two through five.
^c Reflects the maximum reimbursement rates if exemptions are limited to 60 percent of the 85th percentile of the FCCH rate maximum.
^d Reflects the maximum reimbursement rates if exemptions are limited to 55 percent of the 85th percentile of the FCCH rate maximum.

License-exempt providers also would have the option to become licensed as FCCHs. If current license-exempt providers obtain the 15-hour health and safety training in order to meet the license-exempt plus rating, they will have completed the educational and training component of the FCCH licensing requirements. If licensed, providers would have their rates increased significantly, as shown in Figure 6.

Reimbursement Reforms for FCCH and Center-Based Providers Would Not Affect Rates for Two Years. Currently, FCCHs and centers are reimbursed up to the 85th percentile of the RMR. Under the Governor's proposal, providers' rates would be reduced starting in 2007-08 unless the providers demonstrated high program quality through (1) educational at-

tainment, (2) program quality review, or (3) accreditation. Available data suggest that most providers would need to make significant investments to attain either a two-star or three-star rating.

Educational Attainment Options for Providers. The FCCH providers could achieve a three-star rating (highest rating) by completing 24 units in Early Childhood Education or Child Development, or obtaining a child care teacher permit (which requires 24 units). A two-star rating would require an associate teacher permit. For centers, the education requirements are more stringent. Teachers must have permits (24 units) for a two-star rating center or bachelor's degrees for a three-star rating.

Program Quality Review Options. The FCCH and center providers could agree to an independent assessment of their program through an environmental rating scale system. (See nearby box for a description of environmental rating scales.) Providers would need to score an average of 4 out of 7 on all the subscales for two stars or an average of 5.5 for three stars. The feasibility of meeting rating scale standards is difficult to assess since currently there is no system for independent assessments using environmental rating scales in California.

Program Accreditation. To receive three stars, the FCCHs also could become accredited through the National Association for Family Child Care, and centers could become accredited through either the National Association for the Education of Young Children or the National After School As-

Environmental Rating Scales

Environmental rating scales are used to assess the quality of child care programs. There are numerous such assessments specific to the different ages of children served and the type of care provided. The Early Childhood Environmental Rating Scale (ECERS) has been designed for use in preschool, kindergarten, and child care classrooms which serve children ages two and one-half through five. The ECERS evaluates 43 specific items in seven main categories related to the quality of care: physical environment, basic care, schedule structure, program structure, curriculum, interaction, parenting classes, and staff education. For each of the 43 items, centers are rated on a 7-point scale ranging from inadequate (1) to excellent (7).

Assessment of a single classroom by an experienced rater requires approximately three hours. Generally, anyone can receive training to become a rater. Raters typically are evaluated on a regular basis to calibrate their scoring against standard benchmarks and against scores given by other raters.

sociation. Accreditation can be an arduous and costly process. Currently, less than 1 percent of the FCCH and less than 5 percent of the center-based programs in California are accredited.

The Governor's proposal does not include any savings estimates for the proposed changes to FCCH and center reimbursement maximum rates because they will not take effect for two years. At that point, savings could reach tens of millions of dollars annually.

Proposal to Create Incentives for Quality Makes Sense

We recommend the Legislature consider the Governor's tiered reimbursement proposal in two parts. First, the Legislature should determine if a tiered reimbursement rate structure that provides incentives for quality makes sense. Then the Legislature should determine the appropriate rates for the tiers.

The policy of tying reimbursement rates to a provider's level of training, education, and other factors has merit in that it (1) attempts to promote what research suggests are the characteristics of high quality care; (2) better reflects the cost of providing care; and (3) creates a rating system that is transparent, allowing parents and other stakeholders to easily identify quality options.

Reform Could Promote Child Development

The number of families utilizing nonparental child care has increased significantly in part due to enactment of the 1996 federal welfare reforms and the expansion of federal child care vouchers for low-income families. One federal study in 2000 suggested that the number of families receiving public child care support has increased by over one million nationwide since the 1996 reforms. The voucher system that has emerged in this context reflects an attempt to respond to increasing demand by offering parents choice and flexibility so that they can transition off cash aid and/or maintain employment.

The effort to provide parents with a variety of child care options, however, can result in tension with efforts to provide age-appropriate development and early learning to children served through child care. For example, some families may choose license-exempt care for reasons of convenience and availability. (Many centers and FCCHs have shortages of infant care slots and/or do not operate during nontraditional work hours.) Also, certain regions, especially rural areas, tend to have limited center-based and FCCH providers. At the same time, as we discuss below, placing children in exempt care may result in the children not receiving the learning and

development opportunities to which their peers in center-based care and, to some extent, FCCHs have access. While the child care system should strive to meet the needs of poor and working parents, it should also take into consideration the important early learning and development needs of their children.

Research Suggests Quality Differences by Care Type. Several small demonstration programs, such as the Perry Preschool Project and the Chicago Parent-Child Centers, have established a positive relationship between enrollment in the center-based preschool programs and children's cognitive development. While these studies provide preliminary evidence of the benefits of high quality preschool programs, it is difficult to generalize their findings to the larger child care and preschool market because of their unique qualities as demonstration programs. However, recent academic studies investigating the relative benefits of different child care types in existing settings have provided evidence that center-based programs offer a higher quality of care relative to FCCHs and license-exempt care. Exposure to the higher quality care appears to have significant positive cognitive effects on young children. Particularly important factors in the quality of care are (1) provider education and training, and (2) the stability of the environment (including provider turnover). Stability of care is often problematic when parents must rely on license-exempt providers. Data from Alameda County showing a two-thirds turnover rate among exempt providers in the span of one year suggest that lack of stability may be a significant problem in license-exempt care.

One-Half of Children in Lowest Quality Care. As shown in Figure 8 (see next page), in California's voucher programs, close to one-half (48 percent) of the children are cared for by license-exempt providers. While the percentage of children enrolled in license-exempt care is highest in Stage 1 (60 percent), the percentage in license-exempt care remains close to 50 percent through Stages 2 and 3. Data from SDE for Stages 2 and 3 and AP show that among the children cared for by licensed providers, less than one-third are enrolled in center-based care. (Data showing the Stage 1 distribution by care type of children in licensed care were not available from DSS.)

Incentives Weighted Toward Lowest Quality Care. As discussed above, Title 5 providers have the highest standards. Yet, in some counties, providers with the lowest standards (license-exempt) are paid at a higher reimbursement rate than the Title 5 providers. Figure 9 (see next page) compares child care reimbursement rates for the voucher system with the state contracted system. While statewide average rates are similar across care types, in some high-cost counties voucher providers can receive significantly higher reimbursements than the Title 5 contract providers.

Figure 8
Proportion of Children Served in
Each Care Type by Program

Care Type	CalWORKs ^a Stage 1	CalWORKs Stage 2	CalWORKs Stage 3	Alternative Payment	Totals
License-exempt	60%	50%	47%	28%	48%
FCCHs]—40 ^b	29	27	39]—52% ^b
Centers		21	26	33	
Totals	100%	100%	100%	100%	100%

^a California Work Opportunity and Responsibility to Kids.
^b Family child care homes. The Stage 1 distribution between centers and FCCHs was not available from the Department of Social Services.

Figure 9
Regional Reimbursement Rates for
Voucher and Title 5 Providers

	Vouchers			
	License-Exempt Rate	Family Care Maximum Rate	Center Maximum Rate	Title 5 Providers
High-cost county	\$780	\$866	\$988	\$586
Low-cost county	384	427	355	586
Average statewide	505	561	556	586

In fact, in eight Bay Area counties, the current reimbursement rate for license-exempt care providers is greater than the rate for the Title 5 providers. In 21 counties, the rate maximum for Title 22 centers is higher than the rate for Title 5 providers.

These rate differentials are particularly prevalent in some of the most populous regions in the state, thus affecting a disproportionately large number of children. Fifteen percent of children in license-exempt care are cared for by providers who are reimbursed at rates higher than

Title 5 providers. Similarly, more than one-half of the children cared for in Title 22 centers and FCCs have rate maximums that are higher than the Title 5 reimbursement rate. Under current law, most FCCs only serve subsidized children, and are thus reimbursed at the maximum rate (please see discussion on the “Pick-Five” regulations below). Data are not available showing the actual rates that Title 22 centers receive, only that the rate maximum exceeds the Title 5 rate for two-thirds of the kids. Given the higher program requirements of Title 5 providers (as discussed in Figure 4), it seems counterintuitive that their reimbursement rates would be lower than the voucher programs.

Tiered System Would Reflect Real Cost of Service Differences

Tiered reimbursement would reflect the differences in the costs associated with providing care and the providers’ differential investments of time and money for required training and education. As noted, license-exempt providers’ investments and costs, particularly in terms of education and training, are minimal. In contrast, Title 22 centers have to maintain a facility and materials as well as a qualified staff. Title 5 providers not only have significant overhead and operating costs but also have the additional responsibility for student learning and development outcomes through SDE’s Desired Results System. The Desired Results System is an evaluation and accountability system to measure the achievement of identified results for children and families.

A Star Rating System Would Make Quality Differences Transparent

The APs and Resource and Referral Networks (R&Rs)—local agencies that help parents place their children in child care settings—currently do not have the authority to recommend one provider over another because of the subjective assessment that such recommendations would involve. A rating system similar to that proposed by the Governor would create a set of transparent and objective criteria that APs and R&Rs could provide to parents attempting to find the best settings for their children. The simplicity of the star-rating system would enhance parents’ ability to distinguish between different child care options and give the public at large access to information about the quality of child care offerings.

A Tiered Reimbursement Could Address Significant Problems in the Current System

The current system of reimbursements creates the wrong incentives for providers. Not only is lower quality care often reimbursed at higher rates than higher quality care, these rate differentials can reach in excess of

\$200 per child per month. Moreover, the current system only creates a limited impetus for child care providers to seek the higher levels of training and education that research suggests can promote cognitive development in young children. Also, the state does not differentiate the reimbursement rate provided to those with higher educational/quality attainment, and therefore the nonsubsidized public may have a difficult time measuring the quality of a program.

Rate tiers would create a way to address these problems by providing reimbursements that better reflect differences in the cost of care and provide incentives for providers to seek higher levels of education and training. In doing so, tiered reimbursement would also create transparency in the child care system by giving stakeholders an objective basis for making child care placements and holding providers accountable for the quality of the care they offer. Finally, if California adopts a tiered system, it would be following in the footsteps of many other states that have adopted such reforms. According to a national clearinghouse for child care information, 34 states had implemented a tiered rating system for improving child care quality as of 2002. Almost all of them provide financial incentives for higher levels of quality. For these reasons, we recommend that the Legislature transform the current reimbursement rate structure into a tiered reimbursement structure.

Transition Title 5 Provider Reimbursement to RMRs

We recommend the Legislature transition reimbursement rates for Title 5 providers to be based on the rate provided to voucher providers.

As discussed above, Title 5 providers have the highest expectations of the state's subsidized child care programs. However, in some counties the Title 5 reimbursement rates are substantially lower than the market rates. This makes it difficult for Title 5 providers in these areas to compete for qualified teachers and to maintain the quality care that is expected of them. In many counties, these centers would be better off if they became Title 22 centers with lower quality expectations and potentially higher reimbursement rates. In other counties (primarily rural ones), Title 5 providers are reimbursed at rates that are substantially above local market rates. To address this differential treatment of Title 5 providers, we recommend the Legislature transition Title 5 providers to the RMR structure and that they receive the maximum RMR for their region. These changes to the Title 5 provider rates would promote parity with the voucher providers' rates and would help ensure that Title 5 provider rates better reflect regional cost variations. Under this system, many Title 5 providers' rates would increase, while some may decrease.

Reimbursement Rates Should Reflect a Systematic Approach to Improving Quality in Child Care

We recommend the Legislature consider an approach to reimbursement rates that promotes quality and child development while preserving family choice.

As the Legislature considers child care reimbursement rate options, we recommend weighing the Governor's rate reductions and corresponding savings against the potential benefits of alternative approaches to reimbursement rates. We suggest a structure that adheres to the following guiding principles:

- **Promote Quality and Child Development.** Reimbursement rate structures should promote quality child care through a system of tiered reimbursements that rewards providers with more advanced training and education, accreditation, and/or higher independent ratings of quality within and across care types. This approach should specifically incorporate SDE contracted Title 5 providers.
- **Maintain Choice.** Any modifications to current rates should aim to preserve families' ability to choose from a variety of child care options. Families opt for different child care settings for a variety of reasons and rates should be sufficient to preserve the current range of options, including exempt care.

The first principle appears to generally undergird the Governor's proposal. However, as noted above, the proposal does not address inequities between the Title 5 and the voucher providers.

With regard to the second guiding principle, it is unclear how the Governor's proposal would affect families' choices. Specifically, we are unable to predict how the Governor's proposal would influence child care supply because we do not know how the proposed license-exempt rate reductions would affect license-exempt providers' decisions to leave the child care market, continue providing care at lower rates, or seek licensure as a means to access higher rates. However, we suggest that the Legislature devote attention to these issues as it balances any reductions in child care spending against other K-12 priorities.

There are many different possibilities for rate reforms that could incorporate these guiding principles and also meet other objectives—such as generating savings or maintaining current child care funding levels. If the Legislature wants to implement a reform that is cost neutral, it could pursue a strategy that would implement the proposed five-tiered system while

modifying the proposed rates. Such an approach could preserve current reimbursement rates for FCCH and center-based providers who meet two-star standards and enhance funding for those that attain three-star quality. Reductions in the current license-exempt care rates and one-star providers could offset the increased costs of funding enhancements for the three-star providers. This approach would ensure that centers and FCCHs are able to maintain current levels of service and at the same time offer incentives for improving quality. Under this rate structure, license-exempt care providers could choose to pursue advanced training to enhance their rates as exempt providers or obtain FCCH licensure.

The practices of other states suggest that lowering the license-exempt care reimbursement maximum rate is a reasonable mechanism for generating savings to offset increased rates for higher quality providers. Several other large states reimburse license-exempt care providers at lower rates than California does currently. Most reimburse license-exempt providers between 50 percent and 80 percent of the licensed FCCH rate.

“Pick-Five” Regulations Would Enhance Rate Equity

We recommend the Legislature adopt the Governor’s proposal to implement regulations for an alternative rate setting methodology for subsidized child care provider reimbursements when they serve no private pay customers.

Statute requires the state to provide reimbursement rates for voucher programs that do not exceed the local market rates for a provider’s community. Also, providers cannot charge the state more than they charge a private paying customer. For providers that serve no private pay customers, it is difficult for the state to determine an appropriate reimbursement rate level. Under current practice, the state reimburses providers without private pay customers at the RMR’s maximum rate. This approach likely overpays many providers, especially FCCH providers, and creates negative incentives to serve private pay customers.

Because of these factors, statute directed SDE to develop regulations to determine an alternative reimbursement approach. The State Board of Education adopted regulations for the 2003-04 fiscal year. These regulations, commonly referred to as the Pick-Five regulations, determine the rate for a provider with no private pay customers based on the rates charged by five randomly selected providers in the same or comparable zip codes that have private pay customers. Nevertheless, the Legislature enacted legislation to suspend implementation of these regulations. We believe, however, that the regulations have merit in creating rates for providers without private pay clients. Below, we explain the rationale for the regulations.

There are some communities where it would be difficult for providers to find private paying customers. At the same time, there are many communities where providers could enroll private pay customers, but choose not to because the state will reimburse them at higher-than-market rates if they do not serve private pay customers. This practice appears common in the FCCCH environment. Under these circumstances, the state is providing a reimbursement rate that exceeds local market rates. While the Pick-Five regulations do not provide a perfect estimate of the local market costs, they do provide a reasonable proxy. We believe that the Pick-Five system is an improvement on current practice because it does not overpay providers and eliminates the incentive to discourage private pay customers. Accordingly, we recommend that the Legislature permit the existing suspension to expire on June 30, 2005, thus allowing the Pick-Five regulations to be implemented in the budget year. The Department of Finance (DOF) estimates that these regulations would save \$8.2 million annually.

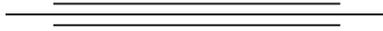
New RMR Survey Methodology Shows Promise

We recommend the Legislature require the State Department of Education to report at hearings on the new Regional Market Rate methodology, including how the new survey may improve the accuracy of the Pick-Five regulations.

The SDE has contracted with an independent research firm for a new RMR survey methodology. The new methodology would address problems in the current RMR survey. By reducing nonresponse rates and using a sophisticated new method of grouping providers based on demographic variables, the approach is expected to increase the accuracy of the estimates of market costs of child care in particular communities. The SDE is currently in the process of final reviews and adjustments to the methodology and aims to secure the required approval for adoption from DSS and DOF during the current year. The SDE is planning to implement the new RMR survey in 2005-06.

In setting reimbursement rates for child care, the Legislature should strive to use the most accurate data possible. It appears that the new methodology may offer some distinct advantages over the previous survey approach. We recommend that the Legislature request a complete report on the new RMR survey methodology at hearings. While we support the new methodology in concept, we believe it requires substantial review because it is likely to significantly affect reimbursement rates providers receive in the budget year. We also think that this new methodology may improve the quality of the information used to meet the Pick-Five regulations, especially in communities with limited numbers of providers serving private

pay customers. For these communities, the new methodology may be able to use information on provider rates in demographically similar communities in other parts of the state.



DEPARTMENTAL ISSUES

Health and Social Services

HEALTH AND HUMAN SERVICES AGENCY (0530)

SECRETARY FOR HEALTH AND HUMAN SERVICES

The Secretary oversees the Health and Human Services Agency (HHSA). This agency, through its various departments, boards, offices, councils, and commissions, is responsible for administering various state and federal programs for health services, social services, public assistance, and rehabilitation. The following departments and organizations are under HHSA:

- Department of Aging
- Department of Alcohol and Drug Programs
- Department of Community Services and Development
- Department of Health Services
- Department of Child Support Services
- Department of Mental Health
- Department of Rehabilitation
- Department of Social Services
- Office of Statewide Health Planning and Development
- Managed Risk Medical Insurance Board

- Long Term Care Council
- Health Care Quality Improvement and Cost Containment Commission

The budget requests \$230 million from all fund sources for the Secretary in 2005-06, an increase of \$223 million, or 33 times larger than the revised budget for the agency for the current fiscal year. This significant change in the agency spending level is due entirely to the proposal, discussed below, to transfer several large information technology (IT) projects, and their associated special funds and staffing, from the Health and Human Services Agency Data Center (HHSDC) to HHSA. General Fund support for HHSA would remain level in the budget year at about \$4.9 million

OFFICE OF SYSTEM INTEGRATION

The administration proposes to transfer several large IT projects from HHSDC to HHSA. This transfer is the result of the proposed consolidation of HHSDC and the Stephen P. Teale Data Center into the new Department of Technology Services (DTS) (please see the “General Government” Chapter for a discussion of this proposal). Specifically, the budget requests to transfer to HHSA: (1) ten projects (nine social services projects and one unemployment insurance project), (2) the HHSDC revolving fund with a balance of \$223 million, and (3) 176 positions.

Background

Department of Social Services (DSS) Projects. Prior to 1995, DSS managed all of its own IT projects. Due to numerous project management problems on the largest DSS projects, however, the *1994-95 Budget Act* transferred five projects (another project was also transferred but later terminated) to HHSDC. These projects were:

- Child Welfare Services/Case Management System.
- Statewide Automated Welfare Systems (SAWS), which consists of four separate projects—Consortium IV; Interim SAWS; Los Angeles Eligibility Automated Determination, Evaluation, and Reporting System; and Welfare Client Data System.

Since that time, the state has transferred four additional DSS projects to HHSDC. Figure 1 identifies the nine DSS projects currently managed by HHSDC, the projects’ status, and proposed budget-year costs.

Figure 1

**Department of Social Services Projects
Managed by Health and Human Services Agency
Data Center**

(In Millions)

Project Name	Current Activities	2005-06 Costs
<p>Child Welfare Services/Case Management System (CWS/CMS) Provides a statewide data base, case management tools, and a reporting system for the state's CWS program.</p>	<p>Status: project undergoing major modifications.</p> <ul style="list-style-type: none"> • Transferring CWS/CMS equipment to Department of Technology Services. • Conducting procurement for new software maintenance contract. • Maintaining and operating current CWS/CMS. 	\$121.1
<p>Electronic Benefit Transfer Uses debit card technology and retailer terminals to automate benefit authorizations, delivery, redemption, and financial settlement for food stamp program.</p>	<p>Status: implementation.</p> <ul style="list-style-type: none"> • Completing implementation within counties. 	20.8
<p>In-Home Supportive Services (IHSS)/ Case Management Payrolling System Provides case management and payroll services for the IHSS program.</p>	<p>Status: development.</p> <ul style="list-style-type: none"> • Conducting procurement for the development, maintenance, and operation of replacement system. 	13.7
<p>Statewide Automated Welfare System Consists of four separate projects. Provides uniform information technology capability to county welfare offices. Counties belong to one of four consortia.</p>	<p>Status: implementation, and maintenance and operations.</p> <ul style="list-style-type: none"> • Implementing new system in certain counties. • Maintaining and operating remaining consortium systems. 	237.0 ^a
<p>Statewide Fingerprint Imaging System Automates the collection, interpretation, and storage of fingerprints for persons applying for public benefits.</p>	<p>Status: maintenance and operation.</p>	8.0
<p>Welfare Data Tracking Implementation Project Determines time-on-aid for CalWORKS program.</p>	<p>Status: maintenance and operation.</p>	3.9

^a Some of these costs are included in the Department of Social Services' budget.

HHSDC Oversees Employment Development Department (EDD) Project. Chapter 157, Statutes of 2003 (AB 1765, Oropeza), appropriated \$85 million in federal funds to EDD to implement the Unemployment In-

surance (UI) Modernization Project. Chapter 157 requires the project to include (1) a redesign of the UI continued claims system, (2) an upgrade of the UI call centers, and (3) implementation of fraud detection in UI computer systems. To meet federal requirements, EDD entered into an agreement with the federal government to (1) encumber \$85 million in the HHSDC revolving fund and (2) require HHSDC to oversee the project. Under the agreement, EDD provides the day-to-day project management, manages the project's governance structure, and provides the policy and program guidance to the project. The HHSDC participates in one of the project's steering committees and helps ensure that the project uses best practices. Upon project implementation, EDD plans to maintain and operate the completed system.

Governor Proposes to Transfer Projects to HHSA

Under the administration's proposal, DTS' primary purpose would be the day-to-day operation of computers and telecommunications systems. The administration, therefore, proposes to transfer the project management responsibilities for HHSDC projects away from the new data center. According to the administration, the reason it selected HHSA for project placement is that some of the DSS projects interface with other departments' programs under HHSA's oversight. The administration asserts that placing the projects at HHSA offers the best solution to minimize project disruptions and ensure the ongoing success of the projects.

Below, we first discuss the placement of the EDD project and then the placement of the DSS projects.

EDD's Project Should Remain With Data Center

Since the Employment Development Department (EDD) project funds need to remain encumbered consistent with the federal agreement and the Health and Human Services Agency does not have program oversight responsibility for EDD, we recommend that the Unemployment Insurance Modernization Project remain with the data center.

EDD's Special Circumstances. The UI Modernization Project's agreement with the federal government creates a unique circumstance that needs to be considered when placing the project. The project funds need to remain encumbered consistent with that agreement. If the terms of that agreement are not met, EDD possibly could lose the federal funds. In addition, EDD reports to the Labor and Workforce Development Agency, rather than the HHSA. Unlike the other projects, therefore, HHSA does not have any program responsibilities for EDD's project.

EDD's Project Should Remain With Data Center. In recognizing the unique circumstances of EDD's project, we believe the best alternative for this project is to place it at DTS. Since EDD performs the day-to-day project management functions, the project should not affect the DTS consolidation efforts. In addition, by placing the project at DTS, the Legislature would continue the federal agreement.

Remaining Projects Should Be Placed at DSS

We recommend that the Legislature transfer the remaining projects to the Department of Social Services (DSS) rather than the Health and Human Services Agency because DSS should be held accountable for the projects' success and agencies are designed to provide policy direction and oversight rather than carry out day-to-day operational responsibilities.

For the DSS projects, we considered placing the projects at DTS, HHSA, and DSS. We discuss these options below.

Placing Remaining Projects at DTS Is Not a Good Choice. One alternative would be to place the projects with the new consolidated data center. According to the administration's DTS proposal, in 2005-06 the primary focus of the DTS executive team will be managing the consolidation effort. This could detract from the guidance provided by DTS executives to the DSS projects. In addition, DTS is proposed to be placed in the State and Consumer Services Agency, which does not have oversight responsibility for DSS programs.

Concerns With Projects at HHSA. We have two concerns with the administration's proposal to place the DSS projects at HHSA:

- ***Agencies Do Not Typically Manage Programs or Projects.*** The chief responsibility of agencies is providing policy guidance to departments. Agencies primarily review department policy proposals, forward issues to the Governor's office, and participate in budget reviews with the Department of Finance (DOF). Agencies do not typically have operational responsibility for programs nor do they have any particular expertise in managing state IT projects.
- ***Departments Can Manage Projects With Interfaces.*** Many state computer systems interface with another department's computer systems. For example, some of the Franchise Tax Board's tax systems interface with EDD systems. Both departments manage their own projects and interact with each other when necessary. To date, the Legislature has not directed agencies to manage these types of projects for departments. It is not clear why the DSS projects could not follow this same approach—with one department taking the lead and coordinating with others when appropriate. For this rea-

son, the administration's major factor for placing the projects at HHSA—the necessary cross-department communication—is not sufficient justification alone for the placement decision.

Place Projects at DSS. One of the important factors in project success is ensuring program accountability. The Legislature holds departments accountable for ensuring that computer systems meet the state's program and policy needs. Given the need to hold departments accountable for project success and the concerns described above, the best solution for the remaining HHSDC projects would be to transfer them to DSS. This solution would provide the most program accountability and recognizes that agencies do not have particular expertise in managing state IT projects or operating programs on a daily basis. For this reason, we recommend that the Legislature transfer the remaining HHSDC projects to DSS.

While DSS unsuccessfully managed some of these projects roughly a decade ago, the projects' HHSDC management structure would also be transferred to the department which should ensure project continuity. Under this recommendation, we would also expect HHSA to perform its traditional oversight role and ensure that DSS coordinated with other affected departments. To address any remaining risks to a successful transition, we recommend that the Legislature take two actions. First, we recommend that the Legislature adopt budget bill language that requires DSS to provide on a quarterly basis copies of project status reports and independent oversight reports. (The projects already file these reports with DOF.) In addition, we recommend that the Legislature direct DOF's Office of Technology, Oversight, and Security to review the projects over the next year to ensure that DSS is providing adequate guidance and direction to the projects consistent with state policies and procedures. This type of review has been requested by the Legislature in the past for high-risk projects. This review should be completed and a report provided to the Legislature by March 2006 in order for the Legislature to address any deficiencies during 2006-07 budget hearings.

OTHER PROJECT ISSUES

Child Welfare Services/Case Management System Go Forward Plan

We withhold recommendation on the Child Welfare Services/Case Management System Go Forward Plan pending the review of the cost/benefit analysis of meeting federal requirements.

The budget proposes \$48.8 million (\$24.4 million General Fund) for the Child Welfare Services/Case Management System (CWS/CMS) Go Forward Plan. The CWS/CMS provides a statewide database, case manage-

ment tools, and a reporting system for the state's CWS program. The system has been in operation for eight years and is currently maintained and operated by an independent contractor for about \$70 million annually. (These annual CWS/CMS maintenance and operations costs are funded separately.)

CWS/CMS Federal Funding Background. In 1993, the federal government offered funding to any state that agreed to develop a Statewide Automated Child Welfare Information System (SACWIS). A SACWIS system performs certain functions such as processing child abuse investigations and preparing foster care case plans. If a state chose to develop such a system, then the federal government provided "incentive funding" at 75 percent of total costs for the first three years of the project's development and then 50 percent for the subsequent years. In 1994, California received federal approval to develop CWS/CMS as SACWIS-compliant. In 1997, the state announced the completion of the CWS/CMS system when it became operational in all counties.

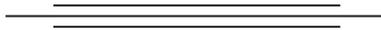
Federal Government Expresses Concerns About CWS/CMS. The federal government, however, did not consider CWS/CMS complete because the system did not meet all the SACWIS requirements. Starting in 1999, the federal government raised concerns about the inability of the CWS/CMS system to meet SACWIS requirements. In June 2003, the federal government notified the state that it did not consider CWS/CMS to meet SACWIS requirements. As a result of that decision, the federal government reduced its share of funding for CWS/CMS from roughly 50 percent to 30 percent. In addition, the federal government notified the state that it would not provide *any* federal funding for the current contract after August 2005.

Go Forward Plan Is State's Strategy to Address Federal Concerns. Starting in March 2004, the administration began developing a strategy to address the federal government's concerns about achieving SACWIS compliance. In August 2004, the administration provided its SACWIS compliance strategy—the Go Forward Plan—to the federal government. The total costs for the Go Forward Plan are currently estimated to be \$82 million (all funds) over four years. The plan consists of three components:

- Conducting a Technical Architecture Alternatives Analysis (TAAA) to determine the costs and benefits of achieving SACWIS compliance versus non-SACWIS compliance.
- Developing a Request for Proposal for a contractor to maintain the CWS/CMS software.
- Transferring the CWS/CMS hardware from the current contractor's site to DTS.

In October 2004, the federal government approved the CWS/CMS Go Forward Plan and restored SACWIS funding to the project. In addition, the federal government retroactively provided SACWIS funding for July 2003 to September 2004.

Withhold Recommendation Pending Review of TAAA. The 2004-05 Budget Act requires the administration to complete the TAAA by April 1, 2005. The budget assumes that a SACWIS compliant alternative will be proposed. Since the TAAA will provide additional information about the costs and benefits of the SACWIS and non-SACWIS compliance alternatives, we withhold our recommendation on the Go Forward Plan funding pending the review of the TAAA and its proposed alternatives.



MEDI-CAL (4260)

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

OVERVIEW OF MEDI-CAL BUDGET PROPOSAL

The DHS budget proposes Medi-Cal expenditures totaling \$34 billion from all funds for state operations and local assistance in 2005-06. The General Fund portion of this spending (\$13.1 billion) increases by about \$1 billion, or 8.2 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 \$19 billion, or 2.3 percent less than estimated to be received in the current year.

Figure 1 (see next page) displays a summary of Medi-Cal General Fund expenditures in the DHS budget for the past, current, and budget years. The budget estimates that the General Fund share of Medi-Cal local assistance costs for the budget year will increase by about \$984 million, or about 8.2 percent, compared with 2004-05. The bulk of this increase is for benefit costs, which will total an estimated \$12 billion in 2005-06. The majority of the overall increase in General Fund spending results from (1) payments proposed for health care providers that will be offset by fees assessed on those providers, which are not included here; and (2) cost increases that occur because certain one-time savings actions taken in 2004-05 will not

reappear in 2005-06. After adjusting for these effects, the underlying growth in General Fund expenditures for Medi-Cal caseload and costs is projected to be about \$350 million, or 2.9 percent, in 2004-05.

The spending total for the Medi-Cal budget includes an estimated \$1.9 billion in local government funds for payments to DSH hospitals. About \$4.6 billion of total Medi-Cal spending consists of funds budgeted for programs operated by other departments, counties, and the University of California.

Figure 1					
Medi-Cal General Fund Budget Summary^a					
Department of Health Services					
<i>(Dollars in Millions)</i>					
	Expenditures			Change From 2004-05	
	Actual 2003-04	Estimated 2004-05	Proposed 2005-06	Amount	Percent
Local Assistance					
Benefits	\$9,278	\$11,250	\$12,193	\$940	8.4%
County administration (eligibility)	541	621	654	33	5.3
Fiscal intermediaries (claims processing)	60	93	101	8	8.9
Totals, local assistance	\$9,879	\$11,965	\$12,948	\$984	8.2%
Support (state operations)	\$94	\$112	\$121	\$9	7.9%
Caseload (thousands)	6,565	6,639	6,810	171	2.6%
^a Excludes General Fund Medi-Cal budgeted in other departments. Detail may not total due to rounding.					

Key Changes in Current-Year Spending

Modest Surplus Projected. The Governor's budget projects a \$58 million General Fund surplus in the current year relative to funds budgeted by the 2004-05 Budget Act and Chapter 875, Statutes of 2004 (AB 1629, Frommer). Lower-than-expected caseload for certain managed care plans known as

County Organized Health Systems has decreased projected spending by \$66 million General Fund, and the Governor's proposed use of Proposition 99 tobacco funds is expected to additionally reduce spending by \$54 million General Fund.

Unanticipated delays in obtaining federal approval of "quality improvement fees" that are to be imposed on Medi-Cal managed care plans also contributes to the projected budget surplus in the current year. The delay means a reduction in Medi-Cal expenditures of \$79 million General Fund due to the postponement of rate increases that had been budgeted to take effect for these providers in the current year. While the state Medi-Cal budget reflects these savings, we note that there is also a corresponding loss of state revenue related to the postponed imposition of those fees. (As we discuss later in this analysis, the administration now projects that both the rate increases and the fee revenues will take effect in the budget year.)

These and other lowered budget projections more than offset other changes that would increase General Fund expenditures, such as reduced savings estimates associated with antifraud efforts.

Governor's 2005-06 Budget Proposals

The Governor's proposed budget estimates that total General Fund spending for Medi-Cal local assistance will be \$12.9 billion in 2005-06, a net increase of about \$1 billion, or 8.2 percent, above the estimated spending in the current year. As summarized in the "Health and Social Services Overview" of this chapter of the *Analysis*, the spending plan proposes a number of significant adjustments and policy changes that are reflected in the budget year totals:

- **Baseline Estimates.** The budget plan reflects a proposed \$381 million increase in expenditures for "baseline" costs—those unrelated to any change in state policy—due to estimated increases in caseload, costs, and utilization of services by aged, blind, and disabled beneficiaries. An additional \$93 million was added to the budget for projected increases in baseline spending for caseload, costs, and utilization of services for families and children.
- **Quality Improvement Fees.** The proposed 2005-06 budget includes General Fund costs totaling \$429 million for rate increases granted to both managed care plans and skilled nursing facilities that are to be offset by new revenue from quality improvement fees assessed on these providers. The Governor's budget projects that these revenues will result in a net gain to the state of \$35 million General Fund in the budget year.

- ***Reversal of Savings From Checkwrite Delays.*** The estimated 2004-05 budget includes savings of \$302 million General Fund generated by delaying the weekly Medi-Cal checkwrite one week on two separate occasions. These savings will not reoccur in 2005-06, and therefore these costs must be added back into the budget.
- ***Prenatal Care Funding Shift.*** The Governor's budget proposes to claim increased federal funds for prenatal care by providing these services to undocumented immigrants through the State Children's Health Insurance Program, which receives 65 percent federal funding, rather than through the current state-only program. This change is expected to result in \$191 million in General Fund savings in Medi-Cal.
- ***Onetime Gain From Federal Medicare Reform.*** The recent federal Medicare Modernization Act, which we discuss in more detail later in this *Analysis*, is expected to shift prescription drug coverage for eligible Medi-Cal beneficiaries to the federal Medicare program effective January 1, 2006. The Governor's budget projects that, as a result of certain one-time factors, this shift in coverage will generate net Medi-Cal savings of about \$100 million General Fund for 2005-06. However, the administration estimates that the new federal law will result in net General Fund costs to Medi-Cal beginning in 2006-07 and continuing for at least the next several years.
- ***Medicare Premiums.*** The Medi-Cal Program pays the Medicare premiums for Medi-Cal beneficiaries who also are eligible for Medicare, thereby obtaining 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 \$156 million in 2005-06 due primarily to increases in Medicare premiums.
- ***Cost-Cutting Actions for Pharmaceuticals.*** The state's increasing costs for prescription drugs would be partly offset in the 2005-06 budget plan with an expected increase in savings from pharmacy reimbursement reductions initially implemented in the current year as well as efforts to increase the rebates on drugs paid by drug manufacturers. Together these actions are expected to generate \$94 million in additional General Fund savings in 2005-06.
- ***Specialty Mental Health Services.*** The DHS Medi-Cal budget includes costs for some programs that are primarily administered by other state departments. Notably, General Fund expenditures for specialty mental health services provided under the Early and

Periodic Screening, Diagnosis and Treatment Program administered by the Department of Mental Health are projected to increase by about \$43 million due to increases in both caseload and program costs.

- **Medi-Cal Redesign Efforts.** As part of the Governor's proposal to redesign Medi-Cal, the 2005-06 budget proposal includes estimated savings of \$25 million from a \$1,000 annual limit on dental services provided to adults. Other reform proposals would initially add administrative costs to the Medi-Cal Program. Other components include expansion of managed care, the imposition of new premiums for higher-income beneficiaries, and restructuring of hospital revenue streams. We discuss these and other components of the Medi-Cal reform plan later in this analysis.

Budget Forecasts Increased Caseload and Costs

While the administration's overall Medi-Cal caseload projection is reasonable, we believe that the population component of nonwelfare families and children could be significantly higher or lower than budgeted due to the contradictory effects of various policy changes. We will monitor caseload trends and recommend appropriate adjustments at the time of the May Revision.

Administration's Cost and Caseload Projections. The budget projects that both the average monthly caseload of individuals eligible for Medi-Cal and the cost of benefits per eligible will grow in the current and budget years. The Governor's budget plan estimates caseload growth to be about 1 percent in 2004-05 and about 3 percent in 2005-06. The estimate for the current year is somewhat less than the overall estimated growth of California's population, while the Governor's estimated growth rate for the budget year is projected to somewhat exceed the overall state population growth rate.

The cost of benefits per eligible (excluding pass-through funding to other departments and local governments) would increase by about 4 percent in the current year according to the Governor's budget plan, and further increase by about 10 percent in the budget year. These increases can be partly attributed to higher rates for nursing facilities and managed care plans, and to the effect of one-time savings actions that reduced costs in previous years but do not recur.

Most Growth Among Nonwelfare Families. Figure 2 (see next page) shows the budget's forecast for the Medi-Cal caseload in the current year and 2005-06. The majority of the projected Medi-Cal caseload increase occurs in the families and children eligibility categories. The budget plan

estimates that the caseload for this group will increase by 3 percent in the current year and an additional 2 percent in the budget year. Within this category, nonwelfare families account for most of the changes. The budget estimates that the caseload of Medi-Cal eligible nonwelfare families will increase by about 8 percent in the current year and by an additional 5 percent in the budget year.

Figure 2
Medi-Cal Caseload Continues to Increase
Governor's Budget Estimate

(Eligibles in Thousands)

			Change From 2003-04		Change From 2004-05		
	2003-04	2004-05	Amount	Percent	2005-06	Amount	Percent
Families/children	4,751	4,873	122	2.6%	4,983	111	2.3%
CalWORKs	1,451	1,356	-94	-6.5	1,310	-47	-3.4
Nonwelfare families	2,632	2,853	220	8.4	3,004	151	5.3
Pregnant women	197	187	-10	-5.3	190	3	1.4
Children	471	477	6	1.3	481	4	0.7
Aged/disabled	1,603	1,648	45	2.8	1,701	53	3.2%
Aged	607	630	22	3.7	655	26	4.1
Disabled (includes blind)	996	1,018	23	2.3	1,046	28	2.7
Undocumented persons	211	119	-92	-43.6	126	7	5.6
Totals	6,565	6,639	74	1.1%	6,810	171	2.6%

Detail may not total due to rounding.

Some of the projected current-year and budget-year growth in the nonwelfare families and children caseload is the result of the continued implementation of a "gateway" in the Child Health and Disability Prevention (CHDP) program. The Governor's budget estimates that efforts to expedite the enrollment of CHDP children into more comprehensive health care coverage will result in the addition of nearly 134,000 eligibles to the Medi-Cal Program over the current and budget years.

The overall projection of nonwelfare families and children caseload growth is consistent with past trends. However, the effect of ongoing changes in the Medi-Cal Program is hard to predict, and significant revisions to the projection could occur for various reasons. For example, Medi-Cal enrollment from the CHDP gateway is now projected to grow by less

than anticipated in the 2004-05 budget. The budget year caseload could also be lower than projected. The continued implementation of modifications of eligibility determination procedures approved in recent budgets, which were intended to more quickly identify and disenroll individuals who become ineligible for Medi-Cal, also adds uncertainty to the 2005-06 budget projection.

The same is true for a 2005-06 budget proposal to modify eligibility for CalWORKs. One major effect of such a change would be to shift some existing Medi-Cal beneficiaries from one eligibility category to another, but the implementation of such a change could have additional, unknown effects on the future growth rate of the Medi-Cal caseload.

Significant Growth in Medically Needy Aged and Disabled. Caseloads for the aged, blind, and disabled are expected to grow by about 45,000 beneficiaries or about 3 percent in the current year and by an additional 53,000 beneficiaries or about 3 percent in the budget year. The increase in the current year is consistent with underlying caseload growth trends. Caseload increases for the aged and disabled are being driven primarily by those aged and disabled individuals who qualify as medically needy. (The medically needy category includes those who do not qualify for, or choose not to participate in, Supplemental Security Income/State Supplementary Program (SSI/SSP), such as low-income noncitizens or individuals who must pay a certain amount of medical costs themselves before Medi-Cal begins to pay for their care.) The aged caseload in this eligibility category is expected to grow by about 20,000 or 11 percent in 2005-06, and the disabled caseload is expected to grow by about 9,600 or 10 percent. The public assistance and long-term care eligibility categories for the aged, blind, and disabled all are projected to grow by less than 2 percent in 2005-06.

Analyst's Recommendations. Our analysis indicates that the Governor's budget request is reasonable and is generally in line with available Medi-Cal caseload data. Accordingly, we recommend approval of the budget request. However, we note that there is both upside and downside risk to the budget estimate as presented. While it is possible that the CHDP gateway program will result in fewer eligibles than assumed in the Governor's budget plan, it is also possible that recently enacted revisions to eligibility determination procedures will not reduce caseload by as much as the Governor's budget has estimated. Given this situation, we will continue to monitor Medi-Cal caseload trends and will recommend any appropriate adjustments to the budget estimate at the time of the May Revision.

QUALITY IMPROVEMENT FEES

Fee Revenues Not Recognized in Governor's Budget.

Our analysis indicates that about \$294 million in revenues from so-called quality improvement fees that have been imposed on certain classes of health care providers have not been counted as state revenues in the Governor's budget. We recommend that the Legislature recognize these fee revenues as it drafts its budget plan.

Quality Improvement Fees. Federal Medicaid law permits states to impose quality improvement fees on certain health care service providers and, in turn, offset the increased cost to the providers from the fee through increased reimbursements. (We discussed in detail how such fees can be imposed, and their potential benefit to the state, in the "Crosscutting Issues" section of the Health and Social Services chapter of the *Analysis of the 2004-05 Budget Bill*.) The revenues from these fees are to be deposited into the state General Fund.

The Legislature has approved and the state has fully implemented with federal approval a quality improvement fee for Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs). With the further approval of the Legislature, the state is currently in the process of seeking federal approval to implement a separate quality improvement fee on Medi-Cal managed care plans as well as another fee affecting nursing homes which serve Medi-Cal patients.

Implementation of such fees can be a lengthy process because it generally involves seeking federal approval of a Medicaid State Plan amendment, a federal waiver of Medicaid law, or both. As a result, implementation of the fee for Medi-Cal managed care plans has previously been delayed, and under the Governor's 2005-06 budget plan would be further delayed until July 2005. Our analysis suggests that it is a reasonable assumption that the new fee finally will be implemented on that projected date, and that it is appropriate that the budget plan presented by the Governor assumes that the associated revenues will be deposited in the General Fund during 2005-06. We note that the Bush administration has recently proposed to limit these types of fees and change how they are applied.

Budget Plan Does Not Account for All Fee Revenues. The schedule of estimated state revenues for the Governor's budget plan reflects an assumption of \$120 million in collections of the nursing home fees in the current fiscal year and an additional \$257 million in the budget year. However, a review of state revenue projections indicates that the revenues from the quality improvement fees for ICF-DDs and Medi-Cal managed care plans have not been included in the schedule of revenues for the Governor's

budget plan. That means that General Fund revenues are currently understated in his budget plan by a combined total of \$294 million for the current and budget years.

Analyst's Recommendation. We recommend that the Legislature recognize in its budget plan (1) the \$58 million in fee revenue projected to result from the quality improvement fee on ICF/DDs in the current year, (2) \$29 million more from the ICF/DD fee expected in the budget year, and (3) \$207 million expected from the fee for Medi-Cal managed care plans anticipated in the budget year. We will continue to monitor DHS' progress towards implementing the fees and recommend any appropriate budget adjustments.

REDESIGN SOUND IN PRINCIPLE, BUT NEEDS FURTHER DEVELOPMENT

The 2005-06 Governor's budget plan includes a package of seven proposals intended to redesign the Medi-Cal program. The proposal would result in broad changes in Medi-Cal managed care and hospital financing as well as some limited changes in benefits, cost-sharing, and eligibility administration. Overall, we find that the Governor's proposals are conceptually sound but that the Legislature needs more information about some aspects of the package and some refinements of the proposals are warranted. (Reduce Item 4260-001-0001 by \$602,000.)

A Multifaceted Medi-Cal Redesign Plan

In January 2004, the administration outlined a broad concept for redesign of the Medi-Cal Program and indicated that most of the detailed legislative and budget proposals to implement the proposal would be forthcoming. After a couple of postponements, the Governor's 2005-06 budget plan presents a package of seven proposals to redesign the program. The administration indicates that the purpose of its proposal is to maintain health care coverage for eligible Californians while containing state costs and making the program more efficient.

We summarize below the major components of the Governor's Medi-Cal redesign proposal, along with the administration's estimate of their annual net fiscal effect on the General Fund after they have been fully implemented:

- ***Expand Medi-Cal Managed Care.*** Enroll additional individuals who currently receive services through the fee-for-service system (which we explain later in this analysis) into managed care health

plans or acute and long-term care integration projects in selected counties. Estimated savings: \$85 million.

- **Restructure Hospital Payment System.** Stabilize the financing of “safety-net” hospitals through a comprehensive restructuring of the manner in which Medi-Cal pays for hospital services. Estimated cost: \$1 million.
- **Set Dental Benefit Limit for Adults.** Modify the Medi-Cal dental benefit by capping dental benefit expenditures to \$1,000 annually for certain adults. Estimated savings: \$26 million.
- **Establish Enrollee Premiums.** Impose beneficiary cost-sharing through monthly premiums for certain individuals with incomes above 100 percent of the federal poverty level (FPL) and for aged and disabled individuals with incomes above the level needed to enroll in SSI/SSP. Estimated savings: \$22 million.
- **Streamline Eligibility Processing for Children.** Modify the Medi-Cal eligibility determination process for children whose applications are submitted through the Healthy Families Program vendor, known as the “single point of entry.” Estimated savings: \$7 million.
- **Monitor County Administration.** Monitor county compliance with federal and state performance standards pertaining to initial eligibility determinations and annual redeterminations. Estimated cost: \$2 million.
- **Alter Enrollment for Health Care Providers.** Improve the provider enrollment process. (Details of this proposal will not be available until spring 2005). Estimated cost or savings: Unknown.

Redesign Will Take Years to Fully Implement. Compared to the broad concepts for Medi-Cal redesign outlined in the *2004-05 Governor’s Budget*, the new proposal is more limited. Earlier concepts contemplated the establishment of broad tiers of beneficiaries who would pay varying copayments and premiums for different benefit packages. Other previously discussed concepts have also been dropped from the plan.

Nevertheless, the administration estimates that its current proposal for Medi-Cal redesign would take several years to implement fully. That is because some proposals would require approval by federal authorities, the development of new or modified information technology systems, and hiring and training of new departmental staff.

Below, we separately discuss each of the major components of the redesign package, and then comment on the proposal as a whole. We separately discuss the financial problems facing California hospitals, and how

they would be addressed by the component of Medi-Cal redesign involving hospital finances, later in this analysis.

Managed Care Expansion

Overall, we find that the Medi-Cal redesign proposal to expand managed care is conceptually sound and that the projected state savings from these changes are achievable and may even be understated. However, we recommend that the Department of Health Services provide the Legislature with more detail about how it plans to strengthen the existing managed care system and ensure a smooth transition of beneficiaries into managed care in order to fully evaluate its merit.

Three Major Components

The box (see next page) provides a description of the existing fee-for-service and managed care systems of care for Medi-Cal beneficiaries. The Medi-Cal redesign plan has three major components relating to an expansion of managed care: (1) a geographic expansion of managed care into new counties, (2) a shift of a significant portion of the Medi-Cal caseload from fee-for-service into managed care in both existing and new locations, and (3) projects to integrate long-term care services for enrollees in three counties. A number of the changes proposed by the administration require federal approval, or changes in state law and regulations, or both. A more detailed explanation of these proposals is below.

Geographic Expansion. The budget plan proposes to expand managed care into 13 or 14 counties in addition to the 22 where it is already provided. The COHS model would be expanded into six or possibly seven of these counties and the GMC model would be expanded into six or seven of these counties. The remaining counties would continue to provide Medi-Cal services under the fee-for-service model. A caseload of about 262,000 families and children would be affected by these changes.

Shifts of Aged and Disabled Beneficiaries. The redesign proposal would mandate enrollment into managed care for aged or disabled in the 13 or 14 expansion counties and the 14 counties where managed care is already an option but where the aged and disabled are not currently required to participate in managed care. Eventually, this would result in a shift in the source of care for about 554,000 individuals. Some aged and disabled would be excluded from mandatory enrollment into managed care. For example, the Two-Plan and GMC plans would exclude so-called “dual eligibles” who are also enrolled in Medicare.

Medi-Cal Fee-for-Service and Managed Care at a Glance

Different Payment Systems. Under the traditional fee-for-service arrangement, providers are reimbursed for every service that they provide and assume no financial risk. Under the managed care system, DHS reimburses health care plans on a “capitated” basis. A predetermined amount is paid by the state for health coverage on a per-person, per-month basis, regardless of the number of services, if any, a Medi-Cal beneficiary receives. The health plans, in return, assume financial risk, in that it may cost them more or less money than the capitated amount paid to them to deliver the necessary care. There are three major types of Medi-Cal managed care plans:

- **County Organized Health System (COHS) Plans.** Under this model, there is one health plan run by a public agency and governed by an independent board that includes local representatives. All Medi-Cal enrollees residing in the county receive care from this system.
- **Geographic Managed Care Plan (GMC).** The GMC system allows Medi-Cal beneficiaries to choose one of many commercial HMOs operating in a county.
- **Two-Plan Model.** In the Two-Plan Model, the department contracts with only two managed care plans. Generally, one must be locally developed and operated, while the second is a commercial health plan.

Medi-Cal managed care plans operate in 22 of the state’s 58 counties—generally those with greater populations. The COHS plans operate in eight counties, the Two-Plan model in 12 counties, and GMC systems in two counties. Managed care is currently not available in 36 mostly rural counties.

Participation in Managed Care. Most families and children residing in counties with Medi-Cal managed care health plans are required to receive care from such plans. The aged or disabled in those same counties generally have the option of participating in fee-for-service or managed care. The exception is the eight COHS counties, where nearly all Medi-Cal beneficiaries are required to receive their care from a COHS plan. As a result, aged and disabled are about 42 percent of the population receiving fee-for-service care statewide, but only 10 percent of those enrolled in managed care.

Expanding Options for Long-Term Care. The redesign proposal includes the development and implementation of Acute and Long-Term Care Integration plans in San Diego, Orange, and Contra Costa Counties. The plans would provide all Medi-Cal and Medicare services to enrolled individuals, including primary care, acute care, drugs, nursing facility care, and home and community-based services. Enrollment of the aged or disabled in the plans would be mandatory. San Diego and Contra Costa County enrollees would have the option of choosing from among two or more plans. In Orange County, the plan would be administered by the existing COHS. It is unknown at this time how many Medi-Cal beneficiaries would participate in these plans.

Combined Fiscal Impact of All Three Components. No state savings are assumed in the budget year from the expansion of managed care as only planning for these changes will occur in 2005-06. Savings would begin to accrue in 2006-07 as new enrollees were placed into managed care and others were phased in upon their annual eligibility redeterminations. The administration estimates that by 2008-09, the proposed expansion of managed care would result in General Fund savings of approximately \$89 million (\$177 million all funds).

Assessing the Governor's Proposal

The Advantages of Managed Care. Our analysis has found that, if implemented well, managed care has the potential to both improve health care outcomes for beneficiaries while reducing costs for the state. Managed care provides beneficiaries with a primary care physician who has access to each patient's medical history and better coordinates their health care. Preventative care and better overall access to care become more likely. Beneficiaries are ensured access to a network of primary care physicians and specialists. The DHS conducts reviews annually to measure the quality of services provided by health plans; no such reviews take place for Medi-Cal fee-for-service care. These changes can save the state money by preventing health problems and reducing the expensive hospitalization of patients.

Some Key Strategies Included, Others May Be Missing. In a policy report released by our office in March 2004, *Better Care Reduces Health Care Costs for Aged and Disabled Persons*, we provided a "blueprint" for expanding managed care that included key strategies to ensure a smooth transition of the aged and disabled into a managed care setting. Our analysis indicates that the administration's redesign proposal incorporates a number of these strategies, which are primarily intended to make sure that conditions are right for a shift of beneficiaries to managed care before such a shift occurs.

The DHS indicates that it intends to conduct “readiness reviews” of all new Medi-Cal managed care plans prior to these health plans becoming operational. For example, DHS would ensure that networks of doctors and other medical providers are adequate to meet patients’ medical needs, that care is coordinated for consumers who need specialized services, and that the quality of services is monitored. The DHS also indicates that it will research the “lessons learned” from similar enrollments in other states, and identify “best practices” for providing managed care for the aged and disabled based on the experiences of the COHS plans.

Our report outlined needed improvements in the existing managed care system that should be part of any major expansion. Among other improvements, we recommended that DHS ensure that the data collection system the state uses to monitor managed care is working effectively, and that DHS develop quality indicators for the aged and disabled. However, during our review of the redesign proposal we were unable to determine what steps DHS would take to improve the existing managed care data collection systems or the capitation rate-setting process. Nor is it clear what new indicators will be implemented to measure the quality of care of aged and disabled persons. Generally, it appears that the redesign proposal intends to address these issues. However, until further detail is forthcoming, the Legislature will not be in a position to determine whether this is the case.

Savings Estimate Appears to Be Conservative. The administration estimates that expansion of managed care would result in net savings of \$89 million for the General Fund by 2008-09. Our analysis indicates that these estimates are achievable and may understate the potential savings. The administration estimate is based on an assumption of 5 percent savings relative to estimated fee-for-service expenditures. However, additional savings could result from improved coordination of care and a greater emphasis on preventative care that could reduce expensive hospitalizations. The amount of these additional state savings is unknown, but could be in the low tens of millions annually.

Expansion of Managed Care Could Go Further. The Governor’s redesign plan does not propose to expand managed care in any form to most rural counties, effectively leaving Medi-Cal beneficiaries in the fee-for-service system.

In a report titled *HMOs and Rural California*, released in August 2002, we examined the reasons for the withdrawal of health plans from California’s rural areas, a situation that poses a major barrier to any expansion of Medi-Cal managed care to these communities. We recommended a number of steps to create a more attractive health care marketplace for health plans in these areas, and state assistance to rural counties to estab-

lish locally controlled health care systems that could have some of the benefits of managed care.

Analyst's Recommendations

In concept, we support the Governor's proposal to expand managed care, given its potential to both achieve state savings and to improve the quality and access to care in Medi-Cal. We note that the shift of beneficiaries to managed care could be impractical without successful implementation of another significant proposal in the redesign package—hospital payment restructuring—for reasons that we will explain later in this analysis. In any event, the Legislature should await more detailed information from DHS before it acts on the budget request and legislative changes that are proposed to carry out this component of the Governor's plan. Specifically, DHS should advise the Legislature on how it will strengthen the existing managed care system and what other measures it will take to ensure a smooth and successful transition of beneficiaries into managed care.

We further recommend that the Legislature explore other steps it could take at this time to make managed care an option in the future for Medi-Cal beneficiaries in rural counties. Some steps may not be possible to accomplish now because of their costs. However, others, such as enactment of a statutory model for locally controlled health plans or clarification of anti-trust regulations in rural areas, have little cost and could move ahead.

Limitations on Adult Dental Benefits

We recommend that the Legislature defer action on the administration's proposal to limit adult dental benefits and direct the Department of Health Services to provide additional information on the proposed limit's potential impact on beneficiaries.

Annual Spending Cap Proposed for Adults

The Medi-Cal redesign proposal would establish an annual limit of \$1,000 for certain dental services provided to adult Medi-Cal enrollees. In addition to excluding all children's dental benefits from this limit, this restriction would not apply to certain other dental services for adults, such as emergency services or services provided in hospitals. The DHS estimates that about 95,000 Medi-Cal adult enrollees would be affected by the limit (including 54,000 aged, blind, or disabled eligibles) and that it would result in net General Fund savings of about \$26 million (\$51 million all funds).

Assessing the Governor's Proposal

Proposal Seeks to Imitate Private Insurance. The administration's proposal seeks to more closely align Medi-Cal benefits with those offered by

private dental insurance coverage, although the amount of the cap would differ from private sector coverage. Delta Dental, a private insurer that accounts for a majority of the private dental insurance market in California, limits benefits to \$2,000 annually for its coverage for state workers. The DHS contends the proposed Medi-Cal limit is roughly equivalent to Delta's because Medi-Cal pays substantially lower rates to dentists, allowing the program to obtain dental services similar to private plans with a lower spending limit.

In concept, imposing a limit to contain Medi-Cal Program costs makes sense. The proposed limit would affect a relatively small group—about 3 percent of adult beneficiaries. While all Medi-Cal recipients have dental benefits, as many as 44 percent of Californians are estimated to have no dental coverage. For many, direct payment for basic dental services is viewed as a less expensive option than paying for insurance. The administration proposal could be implemented fairly easily in comparison to other Medi-Cal redesign components.

Some Complications Could Arise. The specific approach proposed by the administration raises some concerns. Some procedures such as root canals and tooth restorations that are commonly performed together could put Medi-Cal patients over their annual limit. The DHS has not provided information regarding how these proposed limits would affect dental services for the 95,000 affected beneficiaries. For example, it is possible that all 95,000 would lose a similar, moderate number of services each year under the proposed limit. However, another scenario could be that a small portion of the 95,000 would lose a significant number of services, while the rest would see only a modest reduction in services. Alternative approaches could provide Medi-Cal patients greater flexibility in use of their dental benefits while offering the state some significant savings. For example, a higher dollar limit established over a longer period of time (such as two years) could provide some savings while permitting more one-time procedures such as dentures that would exceed a lower limit.

Dental Managed Care Option. In addition to the administration proposal, or as an alternative, the Legislature could explore the concept of expanding dental managed care coverage for Medi-Cal beneficiaries. The state now provides dental services through capitated arrangements for beneficiaries in some areas. One study suggests that dental managed care plans both improve care and reduce state costs below the amounts paid for dental services on a fee-for-service basis.

Analyst's Recommendations

We concur generally with the concept of tailoring the Medi-Cal dental benefit for adults to conform more closely to private coverage. However, we

believe the administration should provide the Legislature with additional information on the proposal's impact on beneficiaries. Accordingly, we recommend that the Legislature direct DHS to present the Legislature with more information regarding how its proposed limit would affect the services of Medi-Cal beneficiaries. The DHS should also provide the Legislature with an estimate of the potential savings from alternative approaches, such as a higher two-year cap or an expansion of dental managed care plans, that might provide additional flexibility to beneficiaries while still achieving some state savings.

Establishment of Enrollee Premiums

Another Medi-Cal redesign component would charge certain enrollees monthly premiums to participate in the program. While we support the imposition of premiums in concept, we recommend that the Legislature defer action on the administration's proposal and direct the Department of Health Services to present it with updated projections on the caseload and fiscal effects of the proposal and an analysis of alternatives.

Monthly Premiums Would Be Similar to Healthy Families

Poorest Beneficiaries Would Be Exempt. Under the Governor's budget proposal, certain Medi-Cal enrollees would pay monthly premiums of \$4 per month for a child and \$10 per month for adults, with a monthly cap of \$27 for each family. Individuals with incomes greater than the federal poverty level (about \$15,700 a year for a family of three) would be required to pay the premiums, as would aged, blind, and disabled enrollees with incomes above the CalWORKs eligibility level (about \$9,700 per year for individuals and about \$17,100 per year for a couple). Certain individuals would be exempt from the premiums, including infants under one year of age, and Medi-Cal "share-of-cost" enrollees who must already pay out of their own pocket for some of their medical expenses before receiving Medi-Cal coverage.

These premiums would be generally consistent with those charged by the Healthy Families Program, which also provides health insurance coverage for children. Similar to Healthy Families, the newly established Medi-Cal premiums would not be charged for coverage provided retroactively. Enrollees could pay the premiums through the mail, over the phone, at certain collection points, or through automated payroll deductions and bank withdrawals, with discounts of about 25 percent for payment of three months in advance. Medi-Cal would disenroll beneficiaries who did not pay the premiums for two consecutive months.

Timetable for Changes. Under the Governor's budget plan, enrollees would not begin paying premiums until January 2007. In the interim, the

state would obtain necessary federal approval, contract with a vendor to collect the premiums, and identify the Medi-Cal enrollees required to pay them. The administration estimates that about 460,000 children and nondisabled adults and 90,000 aged and disabled individuals would be subject to premiums and that the change would result in annual General Fund savings of about \$22 million (\$43 million all funds) beginning in 2007-08.

Assessing the Governor's Proposal

Enrollment Decrease, But Extent of Drop Unclear. Research on the effects of cost-sharing in health programs indicates that some decrease in enrollment is almost certain to result from the imposition of premiums in programs such as Medi-Cal. However, the extent of the enrollment drop, and which income groups would most be affected, is unclear. Academic research on these points has been contradictory, for example, in regard to whether cost-sharing strategies such as premiums have more of an effect on those families with higher incomes or those with lower incomes.

Oregon has been cited as an example of a state where such changes greatly depressed program enrollment. However, Oregon's Medicaid program imposed premiums on certain enrollees with incomes below the federal poverty level, including enrollees with no reported income at all, and individuals were removed from the program for just one month of nonpayment. Because the design of the Oregon program is different from the Governor's proposal, its results may not apply to California.

Administration Reviewing Its Estimates. When it prepared its premium proposal, the administration estimated that the proposed premiums would result in a 20 percent reduction in enrollment among the affected eligibility categories. However, the actual decline in utilization of medical services is expected to be substantially less because many enrollees would rejoin the program as they needed medical services. Even so, disenrollment effects would account for over one-third of the estimated gross savings. However, DHS now indicates that it is reviewing whether its estimates of disenrollment, and its associated savings, are too high. Thus, the caseload and fiscal effects of the administration proposal are unclear.

Cost-Sharing Proposal Reasonable. The establishment of premiums is a reasonable cost-containment option for the Legislature to consider. Notably, many enrollees who would be subject to premiums were not eligible at all for Medi-Cal until eligibility for the program was expanded about five years ago. Could these Medi-Cal beneficiaries afford to pay premiums? One recent study by the Kaiser Commission on Medicaid and the Uninsured indicates that low-income families typically spend 7 percent of their income on health care and a combined 22 percent on entertainment, ap-

parel, and other miscellaneous items. The administration's proposed premiums would amount to between 1 percent and 2 percent of the enrollees' incomes.

Finally, some research has indicated that some individuals may prefer to enroll in health programs that have characteristics, such as premiums, that make them comparable to private insurance plans. For these enrollees, there might be less of the stigma than they may otherwise attach to participation in public health coverage.

Are Premiums the Best Approach to Cost-Sharing? It is not clear that the form of cost-sharing proposed by the administration would be the most effective way to hold down costs in the Medi-Cal Program. Premiums required for participation in Medi-Cal are more likely to reduce utilization for all types of services, potentially reducing the use of preventive medical services (like regular doctor's checkups) that could catch medical problems early and prevent more costly medical problems later. One alternative approach would be to seek a federal waiver to impose meaningful copayments for a targeted list of services, such as the nonemergency use of emergency rooms. However, we note that some attempts by other states to impose such copayments have been blocked in the courts. Nonetheless, the Kaiser Commission indicates that new or increased copayments were imposed by 20 states in fiscal years ending in 2004 and nine states in fiscal years ending in 2005.

Analyst's Recommendation

While we support the imposition of premiums in concept, we recommend that the Legislature defer action on the administration's proposal and direct DHS to present updated projections on the caseload and fiscal effects of the premium proposal, and DHS' analysis of the alternative of imposing copayments for a targeted list of services.

County Administration Monitoring

One component of Medi-Cal redesign requests additional resources to monitor county administration of eligibility. We recommend approval of part of the requested staff to monitor counties' performance. The Legislature could further consider requests for additional monitoring resources after the Department of Health Services has provided the Legislature with (1) an accounting of the progress that has been made to date in improving county eligibility activities and (2) the required report on the county operating guidelines.

Eligibility Determinations Have Been a Problem

Counties Handle Processing Work. The state currently delegates most administration for Medi-Cal eligibility determinations and redeterminations to the counties and reimburses them with state and federal funds for this work. Federal and state laws require the counties to complete initial eligibility determinations within 45 days of application and to annually redetermine enrollees' eligibility. The state has recently taken steps to improve the process, including the establishment of county performance standards for completing eligibility determinations and redeterminations, and the imposition of requirements that counties more regularly reconcile their eligibility rolls with the state's central eligibility system. The DHS is also working with counties to develop operating guidelines covering staffing levels, overhead, and wage increases to control costs while also enabling timely eligibility processing.

The administration proposes that the state contract with a vendor to monitor compliance with the state performance standards for counties that were established in 2003. In effect, DHS is asking for resources in the 2005-06 budget to perform activities for which it was previously granted staff. In the 2003-04 budget, the Legislature authorized nine new DHS positions for this purpose. However, DHS selected these positions and the related funding for elimination as part of that year's mandated statewide reductions in state operations.

The current Medi-Cal redesign proposal is estimated to cost \$1.5 million from the General Fund (\$3.4 million total funds) once fully implemented. No additional savings from the proposed monitoring effort are assumed beyond those previously budgeted.

Assessing the Governor's Proposal

An Inconsistent Process. As we noted in our *Analysis of the 2003-04 Budget Bill* (see page C-56), state costs for the county eligibility processing have increased rapidly since the mid-1990s. Counties have been inconsistent in the way they interpret eligibility rules, in what they spend on making eligibility determinations, and in the time they take to process applications. The state's method of allocating funding for eligibility administration, which is partly based on county staffing levels, does not assess county productivity and may actually reward inefficient counties. The 2003-04 *Analysis* discusses several options for improving the county eligibility determination process.

Proposal May Be Premature. The Medi-Cal redesign proposal may be premature in that it requests additional resources to improve county eligibility administration before the effects of current efforts are known. For

example, DHS is now working with seven counties that reportedly failed to meet the state's new performance standards. Also, the DHS has not yet submitted to the Legislature, as required, a progress report on the operating guidelines for county eligibility offices. Thus, a full accounting of the improvements achieved to date from these prior actions has not yet been provided to the Legislature.

Analyst's Recommendation

Absent a full report on the status of current reform efforts, the administration proposal to provide funding for a vendor for a full statewide monitoring effort is not justified. Nonetheless, some limited monitoring on a targeted basis may be prudent given that DHS currently relies on self-reporting by counties on their performance. The Legislature may wish to consider providing resources to monitor the limited number of counties that process most Medi-Cal applications or that may have encountered problems carrying out these duties in the past. Accordingly, we recommend approval of four two-year limited-term positions to monitor selected counties' performance on an exploratory basis. The Legislature could consider requests for additional monitoring resources after DHS has provided (1) a complete accounting of the progress made to date in improving county eligibility activities and (2) the required report on the county operating guidelines.

Streamlining Children's Eligibility Processing

Another component of the proposed Medi-Cal redesign would modify the way the state processes applications for Medi-Cal received through its single point of entry program. We recommend that the Legislature approve this proposal and provide on a limited-term basis a portion of staffing requested.

Single Point of Entry System

Some Applications Forwarded to Counties. In 1999, the state implemented a single point of entry (SPE) to process Healthy Families applications and some Medi-Cal applications to improve coordination of the two programs. An SPE contractor reviews certain applications and makes an initial determination when an applicant appears to be eligible for Medi-Cal. The application is then forwarded to the individual's county of residence, where a county eligibility officer makes the final determination. The DHS estimates that 83,000 applications will be handled this way in 2005-06.

While the SPE provides a uniform, centralized process for receiving, processing, and tracking health program applications, some current practices result in delays and increased Medi-Cal costs. For example, after the SPE determines a child to be initially eligible for Medi-Cal, he or she is placed on the Medi-Cal rolls on an interim basis. If the county later finds that the child is actually ineligible for Medi-Cal, the child is removed from the Medi-Cal rolls. In the interim, however, the state will have paid medical costs for an ineligible child.

State Savings Possible. One component of the Medi-Cal redesign would expand the SPE's role in making Medi-Cal eligibility determinations. After making its initial eligibility determination, the SPE would complete income and immigration status verifications and prepare an eligibility recommendation for the state. State workers, rather than county eligibility offices, would then make the final determination. The case would still be forwarded to the county for ongoing case management and future redeterminations of eligibility.

The DHS estimates that this would reduce state costs by shortening the time during which ineligible children were enrolled in Medi-Cal and by reducing county administration costs. Once fully implemented, the proposal is estimated to generate net General Fund savings of about \$7 million (\$9 million all funds) annually. It could further benefit the state by allowing eligibility rules to be applied in a more consistent fashion. Adoption of this change would also provide an opportunity to evaluate a centralized process for broader use in Medi-Cal. In our *2003-04 Analysis*, we recommended that the Legislature study such an approach. We estimated that a \$50 drop per eligibility determination could result in \$150 million in General Fund savings statewide.

Analyst's Recommendation

Given the significant problems in the existing system for processing applications for Medi-Cal, and the prospects for testing the merit of centralizing all eligibility processing at the statewide level, we recommend that the Legislature approve this proposal and provide a portion of the staffing requested on a limited-term basis.

Alter Enrollment of Health Care Providers

The administration's Medi-Cal redesign plan provides little information about a proposal to expedite the processing of medical providers so that they may participate in the Medi-Cal Program. We withhold recommendation until a complete proposal is submitted to the Legislature.

Backlog in Medi-Cal Provider Enrollments

Health care providers who wish to participate in the Medi-Cal Program must undergo an application process and be certified. The state performs background checks to ensure they are high-quality providers and to reduce the risk of provider fraud. Processing has slowed in recent years, however, leading to a backlog of these applications. The Medi-Cal redesign package includes a proposal to improve automation and tracking systems, establish a call center to answer provider questions, and hire additional state staff to address the backlog. Information explaining this proposal is to be submitted to the Legislature this spring.

Analyst's Recommendation

We recommend that DHS be directed to submit its proposal to the Legislature no later than April 1 (concurrent with April Finance letters) to provide sufficient time to evaluate this proposal. We withhold recommendation pending receipt and review of the proposal.

Requested Support Resources Appear Excessive

The Department of Health Services has requested \$19,410,000 (\$7,141,000 General Fund) and 86.5 positions to implement its Medi-Cal redesign proposals. These requests include funding for staff, information technology consulting services, and contract services. Our analysis indicates that some of the proposed positions and related funding are unnecessary at this time. As such, we recommend that the Legislature approve 68.5 of the requested positions and \$5,847,000 (\$2,391,000 General Fund) of the related funding.

Request for Personnel. Figure 3 (see next page) summarizes the positions requested to implement the proposed Medi-Cal Redesign components. Our analysis indicates that some of the positions requested exceed the number which are justified on a workload basis at this time. In addition, some positions appear to be a modification of continuing DHS workload rather than a true increase in workload. Others are not likely to be needed until the redesign proposals reach later stages in their proposed implementation, or will no longer be needed once the transition period of making these changes is over.

Analyst's Recommendations. We recommend that the Legislature approve 39 permanent positions and 29.5 limited-term positions in order to implement the Medi-Cal redesign proposals, for General Fund savings of about \$600,000 in 2005-06 from a reduction in the requested positions. Our findings and recommendations regarding the requested staffing are summarized as follows:

Figure 3**Summary of Requested and Recommended Positions**

	Positions Requested	LAO Recommendations		
		Permanent	Limited-Term	Total
Expand managed care	47.5	38.0	4.0	42.0
Restructure hospital payment system	12.0	1.0	4.0	5.0
Dental benefit limit for adults	1.5	W	W	—
Establish enrollee premiums	3.5	W	W	—
Streamline eligibility processing for children	19.5	—	17.5	17.5
Monitor county administration	2.5	—	4.0	4.0
Totals	86.5	39.0	29.5	68.5

W: Withhold recommendation pending further information.

- *Expand Medi-Cal Managed Care.* The additional workload necessary to implement this proposal does not justify the establishment of all 47.5 requested positions. We recommend approval of 42 positions, four of which should be limited-term.
- *Restructure Hospital Payment System.* The workload for some of the requested positions would replace existing tasks rather than be new workload. Other requested positions would likely be needed only in transition to a new system. We recommend approval of five of the 12 requested positions, four of which should be limited-term.
- *Dental Benefit Limit for Adults.* We withhold recommendation at this time pending additional information from the administration.
- *Establish Enrollee Premiums.* We withhold recommendation at this time pending additional information from the administration.
- *Streamline Eligibility Processing for Children.* We believe that this proposal should be viewed as a pilot program, the results of which should be reviewed at a later date. Much of the proposed workload would not begin until DHS prepares to implement the proposed process in early 2006, and it is unclear that all requested positions are necessary. As such, we recommend approval of 17.5 limited-term positions, four of which should be effective beginning July 1, 2005. The remaining 13.5 positions should be authorized beginning January 1, 2006.

- **Monitor County Administration.** We believe it would be more efficient for state staff to perform the proposed monitoring on a targeted basis rather than contracting out this function. Also, it is unclear at this time that the proposed workload is necessary on a long-term basis. We recommend authorization of four limited-term positions to perform this work in lieu of the staff and contract resources requested.

We withhold recommendation at this time on the request for staff and contract resources to move forward with information technology (IT) projects related to the redesign efforts. As we discuss in our analysis of the DHS state operations budget, the IT-related budget request was submitted to the Legislature without following state administrative procedures that ordinarily require completion of an approved feasibility study report (FSR) before such a project can be budgeted. No FSR is available at this time for these projects.

Conclusion

The administration's redesign proposals warrant careful consideration by the Legislature, given our projections of continued caseload and expenditure growth in the Medi-Cal Program and the state's fiscal difficulties. The Governor's approach for long-term changes to Medi-Cal addresses some of the key factors affecting the quality of services and the continuing growth in the cost of the program to the state.

Except with respect to the proposed managed care expansion and restructuring of hospital finances, the administration's redesign proposal is relatively modest. For this reason, the Legislature may wish to view the package as a starting point to implement a broader reform of the program.

HOSPITAL FINANCING PLAN COULD BEGIN TO RIGHT AILING SYSTEM

California's hospitals continue to face a variety of fiscal challenges that weigh particularly heavily on public hospitals. In response to continuing financial troubles for hospitals and recent federal steps to alter central aspects of federal funding provided for them, the administration is negotiating with the federal government for a comprehensive redesign of hospital financing. Our review of the plan now under development suggests that it could help preserve the financial stability of California's public hospitals, but the plan also raises some significant fiscal and policy issues.

Public Hospitals Continue to Face Significant Fiscal Pressures

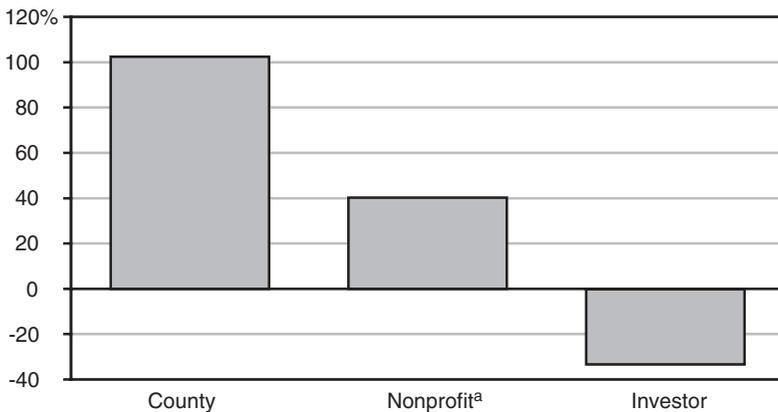
Three major groups of hospitals account for almost all hospital revenue in California. The first group consists of investor-owned hospitals, such as Tenet Healthcare, which generally are shareholder-owned businesses. A second group is the nonprofit hospitals, which include organizations such as Sutter Health and Catholic Healthcare West. Public hospitals comprise the third group, which, for purposes of this discussion, consists of hospitals owned and operated by county governments or the University of California (UC). In our *Analysis of the 2002-03 Budget Bill* (see page C-38), we described various financial pressures facing California hospitals. Our analysis indicates that these problems continue today.

The cost of providing uncompensated care—which is incurred whenever a patient is unable to fully or even partially pay for their care—is a major factor that has created financial pressures for many hospitals. This is particularly the case for public hospitals that serve large numbers of low-income patients. State-collected data indicate that California hospitals collectively incurred more than \$4.7 billion in uncompensated care costs during 2003. County hospitals experienced the largest increase in uncompensated care costs per hospital during the past five years, as shown in Figure 4, and today bear the greatest share of these costs, as shown in Figure 5.

Figure 4

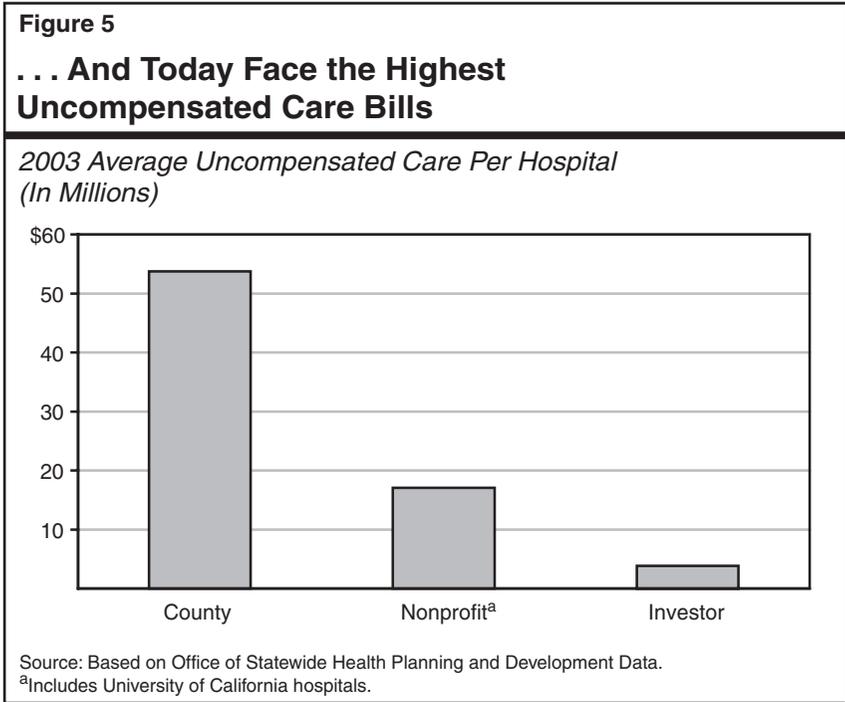
County Hospitals Have Seen Greatest Increases In Uncompensated Care Costs. . .

*Change in Hospital Uncompensated Care Costs
1999 Through 2003*



Source: Based on Office of Statewide Health Planning and Development data.

^aIncludes University of California hospitals.



Regulations mandating hospitals to staff one nurse for every six patients on general medical floors, and a state law requiring that hospital buildings meet specified earthquake-safety standards in the future, are also adding to financial problems.

Key Federal Mechanisms Significantly Influence Hospital Financing

The federal government closely regulates Medicaid transactions with hospitals through the federal Centers for Medicare and Medicaid Services (CMS), the main federal agency responsible for the Medicaid Program (Medi-Cal in California). Two financial mechanisms permitted under federal law have had particularly significant influence on California hospital operations in recent years: waivers and intergovernmental transfers. We provide more detailed information below on what these financial mechanisms are, how they work, and what they mean for California hospitals.

Federal Medicaid Waivers Integral to Hospital Financing

The federal government authorizes state governments to operate outside the standard Medicaid rules by approving requests by states to waive specific requirements of the federal program. Two such Medi-Cal waivers—the Selective Provider Contracting Program (SPCP) waiver and the Los Angeles County (LA County) demonstration project waiver—govern the majority of Medi-Cal fee-for-service hospital inpatient care in California. By fee-for-service care, we mean that the state reimburses a hospital or other medical provider on the basis of billings submitted for each service provided to a Medi-Cal patient. In comparison, managed care organizations operate under a “capitated” arrangement, in which they receive a predetermined level of compensation each month for agreeing to provide care for each Medi-Cal patient who enrolls in their plan.

Selective Provider Contracting Program. Under the SPCP waiver, the California Medical Assistance Commission (CMAC) negotiates daily rates for general acute care hospital inpatient services on behalf of the Medi-Cal Program. By picking and choosing the hospitals that get most of the state’s Medi-Cal business, and bargaining with them for the best rates, the state is generally able to negotiate lower rates for hospital services through CMAC than if it simply allowed all hospitals to serve Medi-Cal patients and bill the state for services.

The SPCP waiver is now a central component of the Medi-Cal program. For example, in 2002-03 (the most recent year for which complete data are available), hospitals with SPCP contracts provided 2.2 million days of inpatient care, about 90 percent of all fee-for-service inpatient hospital days for Medi-Cal patients and 18 percent of all general short-term hospital inpatient days in California. The SPCP hospitals also received 84 percent of all money spent under Medi-Cal in 2002-03 for fee-for-service general hospital inpatient days.

The SPCP waiver is ordinarily subject to renewal by federal authorities every two years. Medi-Cal recently received a six-month extension for its current two-year SPCP waiver, which is now set to expire June 30, 2005.

LA County Demonstration Project. The current LA County waiver, which we discuss in more detail later in this *Analysis*, provides an alternate reimbursement mechanism for certain county health care providers in order to financially stabilize the county’s safety net for indigent health care. Under the terms of the waiver, LA County will have received an extra \$900 million in federal funds and an extra \$150 million in state funds over five years. Specifically, Medi-Cal (using federal and state funds) reimburses 100 percent of “reasonable costs” for 30 health care providers in LA County, including six hospitals that collectively received \$1.2 billion (total funds) in Medi-Cal payments during 2003. This five-year waiver—the second such

demonstration project for LA County permitted by federal authorities—will expire June 30, 2005.

Intergovernmental Transfer Funding for Public Hospitals

Various Intergovernmental Transfers. California uses so-called “intergovernmental transfers,” or IGTs, as a means to obtain additional federal funds for payments to both public and private hospitals. Under an IGT mechanism, public entities, including county and UC hospitals, transfer funds to the state, which then pays the money back to hospitals, along with the matching federal funds available under the Medicaid Program. Variations of this mechanism have been employed in California since the early 1990s. As shown in Figure 6 (see next page), IGT arrangements typically result in net financial gains to both the state government and, typically, to the local entities that put up the local funds used to draw down federal matching funds.

Medi-Cal makes use of IGT funding for two key hospital funding programs:

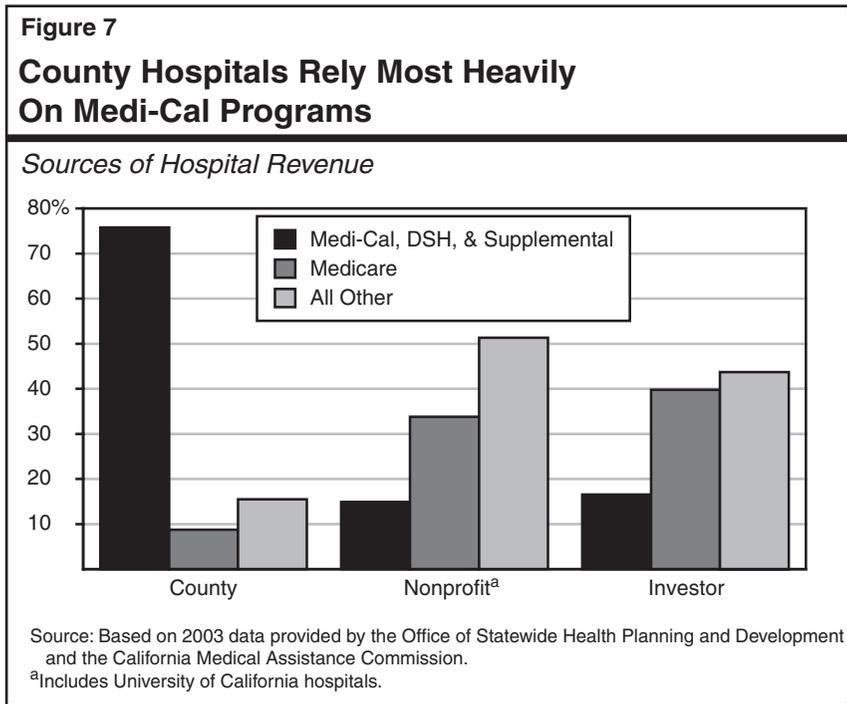
- ***Disproportionate Share Hospital (DSH) Program.*** The state began the DSH program in 1991 to obtain federal funds through IGTs to supplement public and private hospitals that serve a particularly high share of Medi-Cal and other low-income individuals. The DSH funds help to offset hospitals’ uncompensated care costs. A hospital’s eligibility for DSH funding is determined annually according to federal requirements and is based on the percentage of Medi-Cal and other low-income patients the hospital serves relative to its total number of patients. State law allocates DSH funds based on the number of Medi-Cal inpatient service days provided by each hospital. In 2003-04, 126 California hospitals received \$990 million in federal DSH funds. In keeping with federal statute, Congress has allocated about \$1 billion annually in DSH funds for California in federal fiscal years 2004 (October 2003-September 2004) and 2005 (October 2004-September 2005).
- ***Senate Bill 1255 Program.*** The Emergency Services and Supplemental Payments Fund, commonly called the SB 1255 program, also relies upon an IGT funding mechanism. Under this program, hospitals negotiate supplemental payments with CMAC as part of their contracts to provide inpatient services to Medi-Cal patients. To be eligible for SB 1255 funds, hospitals must contract with Medi-Cal for inpatient services, qualify for DSH funding, and generally provide certain emergency care services. The state provided SB 1255 payments totaling about \$1.7 billion (state and federal funds) to 82 hospitals in 2003-04.

Figure 6

An Illustrative Example of an Intergovernmental Transfer

	Federal Government	State Medicaid Program	Public Hospital	Private Hospital
<p>1. Public Hospital Transfers Funds. A county or UC hospital transfers funds to the state Medicaid Program.</p>		+\$100 ←	→ -\$100	
<p>2. State Pays Public Hospital. The state Medicaid program receives federal funds; provides a match with the funds received in Step 1; and pays combined amount to the public hospital.</p>	-\$75 →	(\$75) →	→ +\$75	
		-\$75 →	→ +\$75	
<p>3. State Pays Private Hospital. At this point, the state has an additional \$25 that it could distribute. In this illustrative case, the state chooses to make a \$20 payment to a private hospital (which draws down an additional \$20 federal match) and to withhold the remaining portion for other uses.</p>	-\$20 →	(\$20) →	→ +\$20	
		-\$20 →	→ +\$20	
<p>4. Financial Gain. The net result — each hospital and the state Medicaid program gains in the transaction.</p>	-\$95	+\$5	+\$50	+\$40

Funding Sources Vary Among Hospitals. Different categories of hospitals vary widely in the degree to which they rely on Medi-Cal, DSH payments, and SB 1255 or other supplemental payments. As shown in Figure 7, county hospitals receive about three-quarters of their total revenue from these three sources, corresponding to their status as safety net health care providers. Nonprofit and investor-owned hospitals, meanwhile, rely to a much greater extent on the federal Medicare program (described in detail later in this *Analysis*), which generally pays higher reimbursement rates than Medi-Cal. Private insurance payments (included under “All Other” in Figure 7) also make up a higher share of revenue for these hospitals.



Federal Rules Establish Limits for Federal Funding

Federal regulations establish various payment ceilings on how much Medicaid programs can pay hospitals for inpatient and outpatient services. One such limit, the federal upper payment limit (UPL), generally limits payments for the services provided under Medi-Cal to the equivalent rate that Medicare would pay for the same services. The UPLs apply to each of three major hospital categories: (1) state-owned hospitals, principally the UC hospitals; (2) nonstate government hospitals; and (3) privately owned hospitals, including both nonprofit and investor-owned fa-

cilities. The UPLs apply to each category in the aggregate, a situation that has effectively caused county and UC hospitals to increasingly rely on supplemental payments in recent years.

The UPL does not apply to Medicaid DSH payments, but other federal rules do limit these payments. Federal statute establishes, on a statewide basis, the total amount of federal funds available under DSH. In addition, federal law limits the DSH payments that can be made to any particular hospital. In California, an exemption in federal statute sets the limit at 175 percent of a hospital's uncompensated care costs.

Market and Regulatory Factors Threaten Status Quo

Public Hospital Performance Worsening Under Current System. Our review of financial data for hospitals for 2003 (the most recent year for which data are available) indicates that disparities exist in the financial health of different types of hospitals. Public hospitals are not generally faring as well financially as other categories of hospitals, primarily because of their heavier costs for uncompensated care and greater reliance on state and county health programs.

Notably, on average public hospitals reported an operating margin of negative 25 percent in 2003 as compared to negative 19 percent in 2000. (A negative operating margin indicates an operating loss, which eligible hospitals often seek to offset using nonoperating revenue such as SB 1255 supplemental payments or DSH payments.) While the general financial condition of public hospitals worsened, the operating margin for nonprofit hospitals improved, rising from a negative 2 percent operating margin in 2000 to roughly the break-even point (neither an operating profit nor a loss) in 2003. Investor-owned hospitals reported significant improvement as a group, reporting a positive operating margin of nearly 11 percent by 2003, compared to a positive operating margin of 2 percent in 2000.

Federal Steps to Eliminate Key Aspects of Current System. Recent trends in federal policy indicate that states' continued use of the current system for financing their hospitals may be short-lived. Reports of abusive practices by some states in the use of IGTs, as well as federal budget pressures, have prompted CMS to take a more aggressive approach in examining and challenging states' IGT practices. Federal auditors have documented that some states structured their IGT transactions in a way that inflated the federal share of Medicaid costs without really spending state or county dollars to draw down the federal funds. In some cases, states used the extra federal Medicaid funds for purposes unrelated to health care.

In response, the federal government has taken steps in recent years to restrict the use of IGTs. For example, until 2001, CMS applied its calculations of the UPL only to all hospitals in the aggregate, giving states greater flexibility to transfer IGT funds among the hospitals within their state. Now, as noted above, a separate UPL applies to each of three hospital categories within each state. More recently, CMS has begun to systematically evaluate the appropriateness of IGT programs in each state. The CMS has identified possible cases of “recycling” (in which federal funds are inappropriately drawn down without a real state or local match) in 30 states.

Financing Plan Primarily Targets Public Hospitals

Background

Federal Negotiations Continuing. In November 2004, the administration publicly released a draft framework the Governor is considering to restructure public financing of all hospitals in California that contract with Medi-Cal. The *2005-06 Governor's Budget* plan does not present any new details for this proposed arrangement because negotiations with federal authorities over the proposal are still in progress. As negotiations continue, the department has not yet submitted an official waiver application to CMS to implement the new system. The Governor's 2005-06 budget does not propose any funding changes for Medi-Cal local assistance related to the hospital finance redesign. (We discuss staffing changes related to the hospital proposal as part of our overall assessment of the Medi-Cal redesign package earlier in this chapter.) However, the DHS indicates that without implementing a new waiver for hospital financing, hospitals in California would lose as much as \$900 million in annual federal funds following the expiration of the current waivers that affect hospital finances.

At the time this analysis was prepared, the administration had indicated that the November 2004 plan was still the basis for its negotiations with CMS. For this reason, our analysis below is based primarily on the information available on how the state's public hospital finances would change if the November 2004 draft plan were implemented.

The administration indicates that it will present the Legislature with an official proposal as soon as DHS obtains preliminary approval of its plan from CMS. State legislation would be required to implement many components of the proposal. Depending upon when federal approval of the DHS plan is forthcoming and when that plan is submitted to the Legislature, there may be little time for legislative review and action before the June 30, 2005 expiration of the state's existing waivers for hospital financing.

Overview of Governor's Plan

The Governor's plan to redesign hospital financing would eliminate General Fund support for county and UC hospitals and replace it with federal DSH funds taken from private hospitals. More specifically, county and UC authorities would use a new claiming process, referred to as certified public expenditures (CPEs), in place of General Fund resources to draw down federal Medi-Cal funds, federal supplemental funds, and all of the federal DSH funds available to California. Some of these funds could be used to provide care for indigent patients and undocumented immigrants. Private hospitals would receive the General Fund money now used for county and UC hospitals in exchange for the DSH funds the private hospitals would lose to those hospitals.

According to the administration the proposal would result in additional federal funds in three areas. First, overall General Fund support for private and public hospitals in total would remain the same, but the redirection of DSH funds from private to county and UC hospitals would allow for an increase of about \$226 million per year in federal funds to California. Second, about \$180 million per year in additional federal funding would be made available to pay for county or UC indigent care. Finally, up to \$50 million in additional federal funds would become available to adjust hospital finances for inflation in medical costs each year, with the potential to negotiate further hospital rate increases with the federal government in the future. The total potential increase in federal funds received each year would initially be about \$450 million, with later increases possible that would bring the total to \$700 million a year.

The proposed new financing structure seeks to cover hospitals' uncompensated care costs while addressing federal concerns about current funding practices. The administration states that its plan would (1) leave no hospital financially worse off than it is under the current system, and (2) improve the financial condition of some hospitals. The expiring SPCP and LA County waivers would be replaced by one new five-year waiver. We discuss the major components of the plan below. The key differences between the current and the proposed system are summarized in Figure 8.

Certified Public Expenditures Replace General Fund

A key component of the Governor's plan is to shift most public hospitals to a form of cost-based reimbursement known as CPEs. Twenty-one selected public hospitals, including the five UC hospitals, would be financed primarily on the basis of CPEs through claims of federal Medi-Cal, DSH, and supplemental funds. These CPEs, which would consist entirely of county or UC health care expenditures, would take the place of the General Fund in the Medi-Cal, DSH, and supplemental programs. In other

words, federal funds would be matched directly to “local” expenditures, rather than to the state General Fund in the form of a negotiated payment to a hospital.

Figure 8 Hospital Financing—Comparison of Major Components Of the Current and Proposed Systems	
Current System	Proposed System
State General Fund	
Used to make Medi-Cal inpatient payments for both public and private hospitals.	Used mostly to make Medi-Cal payments for private hospital inpatient services.
Disproportionate Share Hospital (DSH) Funds	
Used for all eligible private and public hospitals based on intergovernmental transfers (IGTs).	Used mostly for public hospitals or indigent care programs—generally not private hospitals—based on certified public expenditures (CPEs), with some limited use of IGTs.
Certified Public Expenditures (CPEs)	
Not used for hospital inpatient services or indigent care programs.	Certain public hospitals and indigent care programs could use CPEs to draw down federal Medi-Cal funds, federal DSH funds, or federal supplemental funds.
Intergovernmental Transfers (IGTs)	
Used to draw down all federal DSH and supplemental funds for eligible public and private hospitals.	Use of IGTs decreases significantly—generally limited to drawing down a portion of federal DSH funds.
Public Indigent Care	
Generally provided through programs run by some counties and the state without federal funding.	Federal DSH and supplemental funds would be available for state and county indigent care programs, primarily through the use of CPEs.
Undocumented Immigrant Care	
May be provided through state or county indigent care programs without federal funds, or considered uncompensated care in hospitals.	Certain public hospitals and indigent care programs could include costs for undocumented immigrants as CPEs to draw down federal funds.

The selected 21 hospitals would claim CPEs based upon the annual cost data they submitted to the state, which they would certify as accurately representing their expenditures. These certified costs would be considered the “seed” money that drew down federal funds under the Medicaid Program rather than state General Fund. The DHS would reduce the federal funds generated in this way by some amount—perhaps 10 percent—and pass along the remainder of the federal funds to the hospitals. The 10 percent that was withheld would be kept until the end of the year so that the state could ensure that no hospital exceeded the upper payment limits established under federal rules.

A comparable system of certified costs would also become the basis for these public hospitals to obtain additional funding through other payment mechanisms to cover uncompensated care costs. Specifically, the 21 selected public hospitals would include their uncompensated care costs in their CPEs, thereby establishing the seed funds needed to obtain additional federal funding that can be generated through DSH and supplemental reimbursements. The DSH and supplemental payments made to the hospitals would be limited to ensure the hospitals did not exceed applicable federal limits. Also, the state would ensure that the same medical costs were not counted twice to claim both DSH and supplemental payments.

The remaining five or so public hospitals (those not among the 21 in the CPE reimbursement system) and all private hospitals, including non-profit and investor-owned facilities, would not participate in the CPE system. They would continue to negotiate fee-for-service reimbursement rates with CMAC according to the current practice.

Use of IGT Payments Could Decrease

The use of the proposed CPEs would decrease, but not eliminate, the use of IGTs to finance DSH and supplemental payments to public and private hospitals. The administration is seeking confirmation that federal authorities will allow them to retain IGTs to reimburse these 21 public hospitals for the portion of their uncompensated care costs that exceeds the amount they can obtain through the CPE claiming process. The state contends it should be permitted by CMS to retain use of limited IGTs because of current federal law recognizing California’s IGT arrangements.

Plan Could Expand Payments for Care for Indigents

The proposed use of a CPE claiming system creates new possibilities for expanding the collection of federal funds to pay for health care for indigents. In addition to the costs that would be claimed in the CPE process described above, counties and the UC system would separately claim

CPEs for indigent care costs that are currently funded without a federal share. For example, costs from a county-operated clinic which provided medical assistance for indigent persons would be certified and used to claim federal funding. This would be comparable to an arrangement already in place for LA County under its federal waiver program.

Plan Could Obtain Funds for Undocumented Immigrant Costs

The restructuring plan would also obtain federal funds to pay the costs of caring for undocumented immigrants now otherwise prohibited under the regular Medicaid Program.

Currently, federal reimbursement is available under Medicaid for undocumented immigrants only for the costs of emergency services. Solely at its own expense, the state provides some additional nonemergency services for undocumented immigrants in its Medi-Cal Program. The proposed waiver would secure federal approval to include among the CPEs claimed by the selected county and UC hospitals the costs of providing care to undocumented immigrants. These costs constitute a significant portion of uncompensated care costs for many hospitals and county indigent programs.

Private Hospitals Would Shift to General Fund

Private hospitals would see more of their base of state support shifted to the General Fund under the Governor's plan. Under the present system, some private hospitals currently receive both DSH and SB 1255 supplemental funding, although these payments account for a relatively small share of their total revenue. Under the planned new hospital financing system, private hospitals would give up their DSH funding and instead receive General Fund resources that would in effect be freed up because they were no longer being used for the selected county and UC hospitals.

The exact means by which these state General Fund resources would be funneled to private hospitals is still undetermined. It could take the form of increased daily inpatient hospital reimbursement rates or other types of supplemental payments. In theory, private hospitals could receive the same level of payments overall that they now receive, but with all funding coming from the state General Fund. None of their support would henceforth come from DSH, and a much smaller portion, if any, would come from supplemental payments. It is unclear, however, whether the eligibility requirements now in place for the DSH and supplemental programs, namely serving Medi-Cal or indigent patients, would continue once General Fund payments replace funds from those programs.

As discussed above, complex federal hospital financing rules mean that this shift of DSH funding to the 21 county and UC hospitals and out of private hospitals could allow the state to claim additional federal funding for indigent care costs in the public hospital system that would otherwise receive no federal reimbursement. The administration estimates that the net gain from this complex set of transactions is about \$226 million annually, which would go mainly to the 21 public hospitals.

Federal Payment Limits Would Accommodate Managed Care

The administration plan would change the way the federal UPLs are calculated to provide greater incentives for placing more Medi-Cal patients into managed-care health plans.

The current method for calculating the federal UPLs harms hospitals financially whenever Medi-Cal beneficiaries are shifted to managed care. That is because, in its current form, the calculation of the UPL includes Medi-Cal hospital service days provided on a fee-for-service basis, but not the days provided to patients in Medi-Cal managed care plans. The Governor's plan would seek federal approval to change the way the UPL is calculated for California so that a future reduction in the public hospital UPLs that would otherwise result from a switch to managed care would not hinder the state's ability to pay for indigent care.

Plan Could Move California Forward, But Presents Concerns

In General, Some Positive Steps

Our analysis indicates that, in its current form, the Governor's plan takes some positive steps toward establishing an improved hospital financing structure for California. If approved by CMS, it could allow hospitals to address their uncompensated care costs in a manner that (1) leaves no hospital worse off than it is under the current system and (2) improves the financial viability of some hospitals.

However, many key details of the plan are unclear at this time. As noted earlier, when negotiations with federal authorities have been completed, a more detailed plan prepared by the department will be presented to the Legislature. At that time, we recommend the Legislature assess the proposal primarily in light of the answers that are forthcoming to the following key questions:

- How much funding does the plan provide for the hospital system as a whole?
- How does the plan distribute funding among hospitals?

- Does it establish a reliable revenue stream for hospitals over time?
- Does it establish appropriate incentives to provide care in the most cost-effective manner?
- Does the plan allow for a reasonable implementation period?
- Does it take advantage of all available opportunities to leverage additional federal funding for the support of the state’s health care system?

Below, we provide our preliminary comments on these matters based on what is known so far about the administration’s hospital finance restructuring plan.

How Much Funding Is Generated Overall?

We find it likely that DHS will be able to obtain at least \$275 million of the planned increase. The amount of additional federal funds assumed beyond that level involves uncertainty. Nonetheless, we believe that the plan’s projected increase in federal funds of up to \$700 million per year when fully implemented is a reasonable working assumption as the Legislature considers the administration’s proposal.

Under federal rules, any state applying for a federal waiver must demonstrate “cost-neutrality” for its proposal, meaning that the federal government would end up paying no more for the affected public programs if the waiver is approved than it would without such a waiver. Cost-neutrality requirements for any waiver must take into account the possible growth in federal costs over its duration. As noted earlier, the department projects that its proposed new five-year waiver will generate up to \$700 million a year in additional federal funding for the state’s hospital system.

Despite this anticipated increase in federal resources, the administration’s plan assumes that it will nonetheless meet the federal test of cost-neutrality requirements. The plan assumes that federal expenditures would grow just as much, if not more, if the current hospital financing system were kept in place. How this cost-neutrality issue is ultimately resolved in state and federal government negotiations is a key issue that should be central to the Legislature’s consideration of a final waiver proposal.

How Would Funding Be Distributed Among Hospitals?

One key question is how the plan allocates funding among hospitals and whether this allocation would enable them to be financially stable. The proposed new method for distributing state and federal funding to UC and county hospitals is probably no less equitable than the existing sys-

tem. The UC and county hospitals will be reimbursed through a mix of daily rates, and other sources of negotiated payment, over which the state has some discretion. As a result, the administration could ensure that no hospital would be worse off than under the current system, and that the financial condition of some hospitals could improve. However, this aspect of the Governor's plan also creates the potential for "winners" and "losers" among individual hospitals.

The Legislature should also consider whether the plan is equitable with respect to the five or so smaller public hospitals that would not be included among the 21 shifted to a new payment system. These smaller public hospitals may be struggling to meet the same financial challenges as their larger counterparts. The department has not clearly explained why it excludes them from this aspect of its plan. Absent such justification, the Legislature may wish to consider whether these other public hospitals should also be granted the option of participating in a revised hospital financing system.

The intent of the current plan means that no hospital would receive less funding under the new system than under the current structure. In any final proposal, however, the Legislature may wish to review the extent to which the department and CMAC would be granted discretion to allocate funding to hospitals, and to what extent these allocations should be based upon policies set by the Legislature.

Would the Revenue Stream Be Reliable Over Time?

Whether the Governor's plan would result in more reliable revenue streams for hospitals over time is difficult to assess because it would depend on future decisions at both the state and local levels regarding whether funding for hospitals was a priority. Our assessment is that county hospitals would probably become more dependent on local government decision making, while the state would likely have more discretion over the level of support provided for private hospitals.

Under the current system, the General Fund provides the seed money to obtain federal matching funds for all Medi-Cal fee-for-service hospital inpatient payments. The Governor's plan would instead require the selected county hospitals to put up their own resources as the seed money for this reimbursement. Thus, county governments would bear responsibility for providing funding to draw down regular federal Medi-Cal funds, not the state. (The UC hospitals would also use their CPEs to draw down federal funds, but since these are state entities the source of control would not shift as it would for county hospitals.) As discussed above, counties that have not committed as much of their own money to their health care systems would need to either increase their own funding commitment or ob-

tain funds that the state would have the discretion to distribute. Also, if overall county funding for health care decreases, then the total federal funds available for California public hospitals could decrease.

Although the Governor's plan would likely make the affected county hospitals more reliant on local government decision making, it would also provide these hospitals with more certainty about the overall level of funding provided specifically to address their uncompensated care costs. This is because the total new federal funding to help offset uncompensated care costs would be dependable so long as the hospitals as a group could certify expenditures for their care.

Does the Plan Provide Incentives for Cost-Effective Care?

The Governor's plan would probably improve the cost-effectiveness of the state's medical care system in some respects. First, it would generate additional Medi-Cal reimbursement for indigent care provided in more cost-effective settings, such as clinics and other nonhospital locations. This new federal Medi-Cal money would allow county or UC providers to shift some care from relatively costly hospitals to clinics or other nonhospital locations without automatically losing federal funds.

Second, the Governor's plan would provide California with relief from a federal provision that would otherwise penalize the state for shifting more Medi-Cal beneficiaries into managed care. We believe that expansion of Medi-Cal managed care could generate significant state savings while also improving the quality of care and access to care for the affected beneficiaries. (See our discussion earlier in this chapter regarding the Governor's proposed managed care expansion.)

The new system would likely have some mixed results with respect to encouraging efficiency in hospital operations. The planned system would reduce the current incentive for hospitals to retain patients longer to increase revenues. However, the new financing structure likely would not encourage efficiency in certain other hospital operations in that there would be little incentive in the new cost-based system to reduce the cost of each day of a hospital stay. The net result of these effects is unclear.

Does the Plan Allow a Reasonable Period for Change?

The numerous changes to the structure of hospital finances planned by the administration are, in total, quite substantial. Given the large sums of money involved, and the current financial condition of some public hospitals, a slower pace of implementation of these changes may be advantageous both to the state and the hospital system.

The proposal to shift away from IGTs may be difficult to carry out at the pace suggested by the administration and may underestimate the willing-

ness of the federal government to permit IGTs to be phased out over a longer time. A more incremental approach could shed light on unforeseen difficulties that could be corrected as the shift of financing was phased in. Also, hospitals might be more willing to “buy in” to a process of more gradual change.

The department has indicated that CMS will not permit states to continue using IGTs past the end of the states’ current fiscal years unless they have an exemption in federal statute. However, a recent letter from CMS to Congress indicates that some states are being granted a longer phase out period. This appears to leave open the possibility that CMS would be amenable to retaining certain IGTs for a year or two more if the state made a firm commitment to a phase out of the practice.

Does the Plan Take Advantage of All Opportunities For Additional Federal Funds?

Although the Governor’s plan could generate a significant amount of additional federal funds for California hospitals, we note that it overlooks the potential additional revenue that could be generated by imposing a “quality improvement fee” on hospitals.

We discussed how quality improvement fees could be used to increase the state’s drawdown of federal Medicaid funds in the Crosscutting Issues section of the “Health and Social Services” chapter of our *Analysis of the 2004-05 Budget Bill* (page C-52). In summary, we found that federal Medicaid law permits state to impose fees on certain health care service providers and in turn repay the providers through increased reimbursements. Because the costs of Medicaid reimbursements are split between states and the federal government, this arrangement provides a mechanism by which states can draw down additional federal funds for the support of their Medicaid programs. These funds can then be used to offset state costs.

Some other states, such as Illinois and Missouri, have implemented such fees for hospitals, and our analysis suggests this approach might also be possible in California. We have estimated, for illustrative purposes, that the imposition of a 0.5 percent quality improvement fee on the gross inpatient revenue of all hospitals in the state could achieve a net financial gain to the state of as much as \$100 million while providing California hospitals which serve Medi-Cal patients with about a 5 percent increase in funding for acute inpatient services.

A quality improvement fee for hospitals that was applied across the board could result in some “winners” and “losers.” For example, a large private hospital that served few Medi-Cal beneficiaries would pay a relatively large fee but get a small return in increased Medi-Cal reimbursements. In addition, under the current system, county and UC hospitals that

contract with Medi-Cal are less likely to benefit from a rate increase because these facilities are already operating at or above the federal maximum reimbursement amounts allowed for Medi-Cal patients. However, the Governor's planned system could enable the state to better use some portion of the fee revenue to assist these hospitals.

Notably, many private hospitals are not above the federal limits and thus would be able to benefit from such increases in reimbursements, especially if they served more Medi-Cal patients. A quality improvement fee could thus provide private hospitals a greater incentive to serve Medi-Cal beneficiaries. The state might also be able to seek a waiver (as it is now doing in regard to a fee for nursing homes) that would selectively target such a fee at private hospitals that served a substantial number of Medi-Cal patients.

Conclusion

The Legislature should give serious consideration to the Governor's hospital financing plan as presented to date. The declining financial health of public hospitals, the potential for changes in federal Medicaid policy, and the upcoming expiration of California's current waivers mean that changes in the way the state finances its hospital system are inevitable and unavoidable. Although key details remain to be explained and evaluated, we believe the administration's plan offers some positive steps toward preserving and expanding the fiscal stability of the state's public hospitals.

At the same time, the details that have emerged so far raise a number of important fiscal and policy questions, such as whether the new approach will provide better incentives to hold down health costs and encourage preventative care. Getting answers to the key questions we have outlined above can assist the Legislature in determining whether the major changes under consideration make sense.

FINANCIAL ASSISTANCE TO LA COUNTY ENDING

To ensure that the Legislature receives necessary information to minimize the risk of future budget shortfalls for the Los Angeles County (LA County) health care system, we recommend that the Legislature withhold \$29 million in administrative funding for both the state Department of Health Services (DHS) and LA County until it receives already completed monitoring reports relating to the county's Medicaid Section 1115 Waiver. We also recommend that the Legislature require DHS to report at budget hearings on the fiscal impact on LA County of the proposed hospital financing waiver and Medi-Cal redesign.

Background

Collapse of "Safety Net" Feared. In 1995-96, LA County faced a \$655 million budget deficit in health services operations and the potential collapse of its health "safety net" programs for the poor and uninsured if means were not found to close that financial gap. In response to this situation, state, federal, and county officials collaborated to develop a five-year plan that was intended to address the crisis by financially stabilizing the county health system and, over time, moving the county's safety net system away from expensive hospital-based services toward community-based outpatient primary care and preventative services. The federal government approved the plan as a Medicaid Section 1115 Waiver that ended June 30, 2000. The waiver provided LA County an additional \$1.2 billion in federal funds for the initial waiver period.

The federal waiver was renewed for another five years for the period of 2000-01 through 2004-05 and provided for the commitment of an additional \$900 million in federal funds, \$150 million in state funds, and \$400 million in county funds. The current waiver will expire June 30, 2005. The county estimates that, absent a further extension of its federal waiver, it would incur an annual deficit of at least \$148 million in 2006-07 and a cumulative deficit of \$630 million by 2007-08.

Where Does the LA County Situation Stand Today?

Monitoring Reports Completed, but Not Released. The DHS has hired an independent contractor, PricewaterhouseCoopers, to measure LA County's compliance with the current waiver's goals. The contractor was to assess LA County's performance in increasing its utilization of outpatient health care services and increasing the number of persons enrolled in Medi-Cal, Healthy Families, and other health coverage programs, among other measures. The contractor submitted its monitoring reports relating to the progress made by the county during the first two years of the current waiver period to DHS on December 31, 2003 for what was supposed to be a 60-day review period prior to public release. One year later, at the time this *Analysis* was prepared, the reports had not been released. The DHS' review, and a subsequent review by LA County, have taken much longer than anticipated due to disagreements about the manner in which the consultant's work was conducted and the validity of their findings. The DHS has advised us that the reports will be publicly released in February.

Budget Proposal Funds Monitoring Contract at a Reduced Level. The DHS terminated the monitoring contract in November 2003 as part of a budget reduction authorized under Control Section 4.10 of the *2003-04 Budget Act*. The *2004-05 Budget Act* restored a portion of the funding for monitoring by shifting \$2 million in county administration funds that oth-

erwise would have been provided to LA County for making Medi-Cal eligibility determinations. The Governor's 2005-06 budget proposes to shift \$1 million to pay for the cost of the contract. The level of funding provided for monitoring the waiver through its duration was originally estimated to be nearly \$29 million. Now it is anticipated that approximately \$9 million will be spent through 2005-06, or about 69 percent less.

State Continues to Play Role in Addressing LA County's Financial Problems. Under the terms and conditions of the current waiver, the state has been providing financial assistance to LA County by paying essentially 100 percent of "reasonable" costs for nonemergency room hospital and clinic outpatient services delivered to Medi-Cal patients. Prior to the current waiver, these providers were paid a comprehensive "per visit" rate for services that was less generous. As a result, according to DHS, it has paid LA County an additional \$56 million (\$28 million General Fund) over the first four years of the current-waiver period. The enhanced reimbursement is scheduled to end on June 30, 2005 when the waiver expires.

The state is also taking other steps, anticipated to benefit the entire state, that would probably also have the effect of addressing, at least partially, the financial problems in LA County. Specifically, DHS is seeking a new federal Section 1115 waiver that would replace the state's current system for contracting for hospital services. (An analysis of this waiver is discussed elsewhere in our review of the Medi-Cal Program.) Under this new waiver, certain counties would be eligible to receive federal reimbursement—which they do not now receive—for health care expenditures incurred for indigents whose health care is the responsibility of the counties. Such reimbursements are intended to help provide financial stability for the county-based indigent care programs that are currently in place. We are advised that, at this time, neither LA County nor DHS are seeking a separate waiver that would provide financial assistance solely to LA County.

We are also advised that DHS is reviewing how hospital outpatient services in LA County (and other counties that operate safety net hospitals) could be affected by the proposal the administration is developing to redesign Medi-Cal. (The Medi-Cal redesign is discussed in more detail earlier in this analysis of the Medi-Cal Program.)

Analyst's Recommendations

Contractor Reports Needed by Legislature. Because the LA County waiver monitoring reports are a year overdue, we recommend that a total of \$29 million (General Fund) proposed in the 2005-06 budget for administrative funding be withheld until the Legislature receives copies of these reports. (The \$29 million is the equivalent of the original amount estimated

for the monitoring contract.) Given the state's prior decision to provide additional funding to LA County, it is important that the Legislature receive the monitoring reports that have been prepared by the state's contractor, but never released publicly. These reports will enable the Legislature to assess LA County's progress in complying with the terms and conditions of the waiver. The Legislature also needs these reports to determine the merit of the Governor's budget request for additional funding for monitoring activities.

We propose that the Legislature adopt the following budget bill language to withhold administrative funding of \$14.5 million (General Fund) each from DHS and LA County until the reports are received:

4260-001-0001: Of the amount appropriated under Schedule (4) of this item, \$14,500,000 shall not be provided to the department until such time as the Legislature receives the monitoring reports prepared by PriceWaterhouseCoopers and the response from Los Angeles County regarding the Los Angeles County Section 1115 waiver in effect from July 1, 2000, to June 30, 2005.

4260-101-0001: Of the amount appropriated under Schedule (1) of this item, \$14,500,000 intended for Los Angeles County administrative costs shall not be provided to the department until such time as the Legislature receives the monitoring reports prepared by PriceWaterhouseCoopers and the response from Los Angeles County regarding the Los Angeles County Section 1115 waiver in effect from July 1, 2000, to June 30, 2005.

Fiscal Impact of Administration's Proposals on LA County Needed. At this time, there remains significant uncertainty surrounding the potential impact of the proposed hospital financing waiver and Medi-Cal redesign upon the financial condition of LA County. Accordingly, we further recommend that the Legislature direct DHS to provide the appropriate budget subcommittees with an update at budget hearings on the status of the federal hospital financing waiver that it is seeking and with an estimate of the financial assistance that LA County would receive under its proposal over the next five years.

We also recommend that the Legislature direct DHS to estimate, and report to the Legislature at budget hearings, the fiscal impact of Medi-Cal redesign on LA County. This information would enable the Legislature and LA County to determine the potential impact of proposed changes and enable the Legislature to assess the need for additional strategies to ensure the financial stability of LA County's safety net health system.

PART “D” STANDS FOR “DEFICIT”: HOW THE MEDICARE DRUG BENEFIT AFFECTS MEDI-CAL

The Medicare Prescription Drug, Improvement and Modernization Act, also referred to as the Medicare Modernization Act (MMA) makes significant changes to the federal Medicare program. The implementation of the Medicare drug benefit component of MMA, known as Part D, is likely to cause significant net financial losses to the state for years and have other major programmatic impacts on Medi-Cal. We recommend some limited actions and strategies the Legislature can take to address these potential problems.

Introduction

The Medicare Prescription Drug, Improvement and Modernization Act, also referred to as the Medicare Modernization Act (MMA), became law on December 8, 2003. The MMA makes significant changes to the federal Medicare program. The scope of the legislation is so broad that it may be years before all of its initiatives are fully implemented and its overall ramifications are completely understood. The measure will have a number of significant fiscal effects, positive and negative, on various state programs.

This analysis examines the major policy and fiscal implications the establishment of the Medicare prescription drug coverage plan has for the state’s Medicaid Program, which is known as Medi-Cal in California. In particular, this analysis focuses on the impact implementation of the Medicare Part D drug benefit will have on dual eligibles—beneficiaries who are fully eligible for both Medicare and Medi-Cal benefits—since they will be the Medi-Cal beneficiaries that are most directly affected by Part D. We also analyze the potential fiscal effect on the state of providing “wrap-around” coverage to the dual eligibles, the requirement under Part D that the state make “clawback” payments to the federal government, and other aspects of the new federal law.

In addition to the Part D prescription drug benefits, the MMA also includes a number of other benefit changes, such as additional preventative care benefits. However, an analysis of all of the changes made by MMA and their implications for state health programs is beyond the scope of this report.

Background

Medicare at a Glance

Medicare is a federal health insurance program overseen by the Centers for Medicare and Medicaid Services (CMS) that provides coverage to eligible beneficiaries at federal expense through fee-for-service (FFS) and

managed care arrangements. The FFS model is the traditional arrangement for health care in which providers are paid for each examination, procedure, or other service that they furnish. Medicare also contracts with selected managed care plans to provide services to beneficiaries. Medicare consists of four parts:

- **Part A.** The hospital insurance program that covers inpatient hospital, skilled nursing facility, hospice, and home health care.
- **Part B.** Optional supplementary medical insurance that covers physician and outpatient hospital care, laboratory tests, medical supplies, and home health care. About 95 percent of Part A recipients voluntarily enroll in Part B.
- **Part C.** These are managed care plans (referred to as Medicare Advantage) that provide both Part A and Part B benefits. Some of the plans provide prescription drug benefits, although many enrollees face restrictions on these benefits such as an annual cap on pharmaceutical expenditures or limitations on which drugs may be purchased.
- **Part D.** The new outpatient prescription drug benefit that will be implemented January 1, 2006.

Medicare Basics. Most individuals 65 and over are automatically entitled to Medicare Part A if they or their spouse are eligible for Social Security payments. People under 65 who receive Social Security cash payments due to a disability generally are eligible for Medicare after a two-year waiting period.

Medicare beneficiaries pay for their benefits through premiums, deductibles, coinsurance, and copayments which are defined below in Figure 9.

Figure 9 Insurance Terms—Definitions	
Premium	An amount paid, often in installments, to purchase an insurance policy.
Deductible	An initial specified amount that an enrollee has to pay before the insurer begins to contribute towards medical costs.
Coinsurance	A set percentage of medical costs that enrollees must pay towards the cost of their medical care.
Copayment	A fixed fee that enrollees of a medical insurance plan must pay for their use of specific medical services provided by the plan.

Medicare Drug Coverage Begins Soon. Medicare Part D will go into effect beginning January 1, 2006. As of that date, Medicare will begin to pay for outpatient prescription drugs through prescription drug plans (PDPs) or Medicare Advantage plans. Beneficiaries can remain in the traditional Medicare FFS program and enroll separately in PDPs, or they can enroll in integrated Medicare Advantage plans for all of their Medicare-covered benefits, including standard drug coverage. The PDPs and Medicare Advantage plans may also offer supplemental drug benefits beyond what is covered under the standard plan for an additional premium.

How Medicare and Medicaid Interact

The Two Major Federal Health Programs. The two major federal health insurance programs are Medicare and Medicaid. Above, we discussed who is eligible for Medicare. Medicaid (known as Medi-Cal in California) provides health care services to welfare recipients and other qualified low-income persons (primarily families with children and the aged, blind, or disabled). Medi-Cal is administered by DHS. The cost of Medi-Cal services is shared about equally between the state General Fund and federal funds.

Dual Eligibles. So-called “dual eligibles” are individuals who are entitled to Medicare Part A and/or Part B and who are also eligible for some form of Medicaid benefit. In California, there are about 1.1 million dual eligibles in the Medi-Cal Program. Dual eligibles tend to be in fair or poor health due to chronic illnesses and conditions such as heart problems or high blood pressure that require ongoing treatment.

Eligibility Determinations. Under federal law, state Medicaid programs are required to conduct eligibility determinations for certain Medicare programs in which the state shares in the cost, such as the Qualified Medicare Beneficiary program. Under the Medicare cost-sharing program, Medicaid programs may pay an individuals’ Medicare costs. Because the medical care provided under Medicare is paid for at 100 percent federal expense, and because the federal government shares about 50 percent of the costs of Medicaid programs, this arrangement is favorable to the states.

In California, eligibility determinations for Medicare cost-sharing programs is delegated to county welfare offices. As we discuss later in this analysis, the implementation of the new Medicare Part D prescription drug benefit will require the county welfare offices to take on new eligibility determination responsibilities.

Medi-Cal Drug Benefits

Medi-Cal Offers a Wide-Ranging Prescription Drug Benefit. In order to remain in compliance with federal law, the Medi-Cal Program provides

coverage for a wide range of prescription drugs. It currently spends about \$3.3 billion total funds annually (net of rebates) on drug benefits, not including the significant additional but unknown cost of drugs provided to beneficiaries enrolled in Medi-Cal managed care health plans. The cost of prescription drugs for dual eligibles now accounts for about \$1.8 billion total funds annually (net of rebates) or about 55 percent of total drug expenditures within the Medi-Cal fee-for-service program.

Preferred Drug Lists and Supplemental Rebates. Medicaid programs are permitted to have formularies or preferred drug lists (PDLs) that have the effect of establishing state preferences for the prescription of certain drugs, usually because they are deemed to be more cost-effective than other drugs in the same class. However, Medicaid formularies and PDLs are considered “open” because beneficiaries can still access nonformulary drugs that are not among those preferred if their doctor receives prior authorization from the state.

The PDL is a key tool that is often used by the state to bargain with drug manufacturers for supplemental rebates. The DHS so far has established contracts with nearly 100 manufacturers for supplemental rebates. When DHS and the manufacturer agree to a state supplemental rebate, the drug is placed on DHS’ PDL which tends to increase the frequency of Medi-Cal prescriptions.

An Overview of the Medicare Prescription Drug Benefit

Eligibility and Enrollment. The MMA created the new Part D prescription benefit. Medicare will begin to pay for outpatient prescription drugs through private plans as of January 1, 2006. Medicare beneficiaries entitled to Part A or enrolled in Part B are eligible to enroll in part D and receive the new prescription drug benefit. For most Medicare beneficiaries, the initial open enrollment period will run from November 15, 2005 through May 15, 2006. Medicare beneficiaries who prefer not to have prescription drug coverage can choose not to sign up for the new benefit. Signups for drug coverage will be permitted after the May date. However, beneficiaries who choose to pass on enrolling during this initial period may face a late enrollment penalty.

Special Enrollment Requirements for Dual Eligibles. Because dual eligibles are eligible for Medicare, they are the Medi-Cal recipients most significantly affected by Part D. Dual eligibles are subject to special enrollment requirements under Part D. The enrollment period for dual eligibles begins November 15, 2005 and ends on December 31, 2005. During this voluntary enrollment period, dual eligibles may choose the PDP or Medicare Advantage plan that they determine best meets their needs. Any dual eligibles who have not enrolled in Part D during the voluntary enrollment

period will automatically be enrolled in one of these plans as of January 1, 2006, and a Part D provider will be assigned to them. This automatic assignment of dual eligibles to drug plans will generally be made without any review as to whether a drug plan's formulary is the most appropriate one for them. However, dual eligibles will be permitted to transfer to another PDP or Medicare Advantage plan if they find that another provider would better meet their needs.

Drug Formularies and the Part D Benefit. The drugs covered under the Part D benefit would include biological products and insulin (such as medical supplies associated with injections) and some vaccines. However, drugs for which benefits are payable under Medicare Parts A and B are excluded from the Part D benefit. Also excluded from Part D coverage are certain categories of medication, such as, weight loss or fertility drugs.

The CMS contracted with United States Pharmacopoeia to develop a model drug classification system. The group recommended that prescription drug plans offer beneficiaries at least two drugs in each of 146 listed categories and classes. According to the CMS, the model guidelines provided by U.S. Pharmacopoeia are a starting point for PDPs and Medicare Advantage plans to use when structuring formulary categories and classes. The CMS will review individual formularies to ensure the adequacy of the drug benefit offered and prevent discriminatory practices. In addition, CMS has the authority to disapprove a PDP or Medicare Advantage plan with a benefit structure that would have the effect of discouraging the enrollment of certain groups of beneficiaries—for example, those who are mentally ill or who have AIDS.

The PDPs and Medicare Advantage Plans have the option of offering additional plans with richer benefits for an additional premium. In some cases, these plans with enriched benefits may better meet the needs of dual eligibles.

Appeals Process. The MMA requires that PDPs and Medicare Advantage Plans have in place grievance procedures and an appeals process in the event of disputes over which drugs they cover. Only beneficiaries can file an appeal and a physician or representative, such as a family member, can help in the appeals process. Beneficiaries could appeal a decision to deny them a drug that is not on a plan's formulary only in cases where the prescribing physician finds that all of the drugs on the plan's formulary for treatment of that medical condition would not be as effective or would have adverse effects on the patient.

How Part D Benefits Will Be Delivered. As noted earlier, Medicare Part D will be delivered through PDPs or Medicare Advantage health plans, under contract with the U.S. Department of Health and Human Services. The CMS is required by MMA to ensure that every Medicare beneficiary

has a choice of at least two prescription drug plans, one of which must be a PDP. The CMS has established 34 separate regions of the nation in which PDPs will operate—every PDP must serve an entire region. California has been established as a separate region.

Effective January 1, 2006, PDPs and Medicare Advantage plans that choose to offer Part D benefits must offer at least one plan in each region that includes standard Part D coverage. To be standard, benefits must be offered to beneficiaries on the following terms:

Beneficiaries will on average pay:

- An estimated \$35 per month in premiums in 2006, although premiums paid under any particular plan may vary.
- The first \$250 in total drug costs (which constitutes the deductible).
- 25 percent of total drug costs from \$251 to \$2,250.
- 100 percent of total drug costs from \$2,251 to \$5,100 (a gap in drug coverage widely called the “doughnut hole”).
- Once total drug costs for an individual exceed \$5,100, they would be subject to copayments (\$2 for generic drugs and \$5 for brand-name drug prescriptions) or coinsurance costs of up to 5 percent of their drug costs.

Low-Income Assistance for Part D. The MMA provides varying types of assistance to low-income individuals who meet certain income and asset level requirements in obtaining their Part D drug coverage. For example, dual eligibles who are residents of nursing homes will have their drugs covered 100 percent by Medicare and will face no premium, deductible, copayments, or coinsurance. Dual eligibles who are not in nursing homes will pay no premiums or deductibles, but will pay copayments. Specifically, those dual eligibles with incomes under 100 percent of the federal poverty level will pay \$1 to \$3 copayments; those dual eligibles with higher incomes will pay \$2 to \$5 copayments.

Certain other low-income beneficiaries, including some who are not dual eligibles, would also receive various types of assistance with their premiums, copayments, coinsurance, and deductibles.

Aggressive Implementation Schedule Planned. The CMS has established an aggressive timeline for choosing the providers that will deliver Part D benefits:

- ***June 6, 2005.*** Deadline for submitting bids to the CMS to establish Medicare Advantage prescription drug plans and PDPs.

- **September 2005.** The CMS awards bids to Medicare Advantage plans and PDPs.
- **November 15, 2005.** Enrollment period begins for Part D benefits.

This tight schedule could complicate the rollout of the new drug benefit to consumers. Under CMS' timetable, efforts to disseminate information about Part D coverage to Medicare beneficiaries to encourage their enrollment would begin just six weeks after PDPs and Medicare Advantage plans are selected to deliver the new drug benefit. Moreover, the specific drugs that would be included in the formularies of the PDPs and Medicare Advantage plans are not likely to be known until a few weeks before the enrollment period opens on November 15. Whether or not a particular prescription drug is covered by a PDP or Medicare Advantage plan could significantly affect the decisions of individuals as to which Part D provider they choose.

Informing Beneficiaries About Their Part D Benefits. The CMS is increasing its efforts to provide information to beneficiaries about the new Part D drug benefit. The CMS indicates that it plans to mount an education campaign that will include the distribution of printed materials, a toll-free phone number, a Web site, and direct mailings to Medicare beneficiaries. The CMS also plans to work with the Social Security Administration and other federal agencies, states, employers, providers, pharmacists, and other health care providers to inform Medicare beneficiaries about the new benefit that will be available to them.

Governor's Budget Proposal

The Governor's budget plan would reduce General Fund expenditures for the Medi-Cal Program by about \$747 million (\$1.5 billion all funds) in the budget year in recognition of the savings to the state from no longer providing a drug benefit to the dual eligibles under Medi-Cal. These savings would be partially offset by a new payment that the state will have to make to the federal government known as a "phased-down state contribution" or, more commonly, as a "clawback" (we discuss the clawback provision in more detail below). This clawback payment is estimated to be \$646 million General Fund in the budget year. As a result, the General Fund effect upon the Medi-Cal Program from the new Part D drug benefit is projected to result in net savings of about \$100 million General Fund in 2005-06. As we discuss later in this analysis, this estimate of net savings is misleading when other factors relating to implementation of Part D have been taken into account.

Net Financial Losses Likely for Years

Savings Appear Short-Lived. Federal authorities, in their recent announcement of their new regulations to implement the new Medicare Part D benefit, have emphasized the potential savings that would accrue to the states under the new law. These savings to the states, they have indicated, would result primarily from a shift in drug coverage for Medicaid beneficiaries to the Medicare Program. Under Medicaid, their drug coverage is paid for partly at state expense. Under the Medicare Program, their costs would be borne primarily by the federal government.

Our analysis indicates, however, that the new Part D drug benefit will result in savings of about \$100 million General Fund in 2005-06, but will probably be a losing proposition for the Medi-Cal Program beyond the budget year. This is partly due to the so-called clawback provision written into the new federal law, and the specific way this provision is being interpreted and implemented by CMS. The clawback provision and other important changes resulting from MMA probably mean that, after a short-lived one- to two-year gain, the Medi-Cal Program will end up experiencing large net financial losses for at least several years afterward.

For example, the \$100 million net savings figure identified above for 2005-06 is misleading. As noted above, the state currently collects rebates from drug companies under the Medi-Cal Program about one year after the drugs are purchased. The reduction in the level of drug purchases made in 2005-06 as a result of Part D means the amount of rebates that DHS collects will drop by about \$273 million in 2006-07. This loss of rebate revenues would more than offset the \$100 million net gain that will show up on the Medi-Cal Program books in 2005-06.

We estimate that the combined effect of the reduction in drug expenditures, the clawback payments, and the loss of drug rebates associated with the dual eligibles will result in cumulative additional General Fund costs to the state through 2008-09 of about \$758 million. Figure 10 provides our estimates of the fiscal effect that the MMA will have on Medi-Cal Program finances over the next four years.

Complications for Dual Eligibles. As pointed out above, dual eligibles are the Medi-Cal beneficiaries that are most directly affected by the implementation of Medicare Part D. Our analysis indicates that the new program has some potential pitfalls for dual eligibles whose drug coverage would be shifted from Medi-Cal to Medicare. In some cases, these individuals may not be able to get the same drugs under Medicare that they now get under Medi-Cal, with unknown medical consequences. As a result, the state faces the difficult choice of whether to continue their state-

supported drug benefits without any further financial support from the federal government. We outline our concerns over the potential impact of the new federal law below.

Figure 10

**Fiscal Impact of New Medicare Drug Benefit
As Reflected in the Governor's Budget Plan^a**

(In Millions)

	2005-06 (Half-year)	2006-07	2007-08	2008-09
Reduced Drug Costs	-\$747	-\$1,617	-\$1,818	-\$2,043
Clawback	646	1,428	1,574	1,737
Reduced drug rebates	—	273	620	705
Annual Impact	-\$101	\$84	\$376	\$399
Cumulative Impact		-\$17	\$359	\$758

^a 2006-07, 2007-08, and 2008-09 figures are LAO estimates.

In the sections that follow, we also discuss various factors related to Medicare Part D implementation that could increase cost pressures on the state. These are summarized in Figure 11 (see next page).

Federal Clawback Formula Disadvantages California

State Becomes a Revenue Source for Federal Government. Effective January 1, 2006, Medicare Part D will offer outpatient prescription drug coverage to the approximately 1.1 million dual eligibles in California. As noted earlier, the proposed Medi-Cal budget assumes that state General Fund costs will decrease by \$746 million in 2005-06 due to this shift in their coverage.

However, MMA does not allow California or other states to keep all of these savings. The measure includes a clawback provision that requires states to pay back most of their estimated savings to the Medicare program to help pay for the Part D benefit. States are required to pay the federal government 90 percent of their estimated savings in calendar year 2006. During the following nine years the clawback percentage is reduced by 1.66 percent per year until it reaches 75 percent, then remains set at that level.

Figure 11	
How the Medicare Part D Benefit Could Be Costly to Medi-Cal	
	Annual Cost
Wrap-Around Under existing state law, the state provides wrap-around coverage.	Unknown, potentially low hundreds of millions of dollars.
Clawback Effect Provision requires the state to pay the federal government back most of the state's savings from no longer providing drug coverage to dual eligibles.	\$646 million in 2005-06.
Reduced Drug Rebates The state's drug rebates will be reduced because fewer drugs will be purchased.	\$273 million beginning in 2006-07, and larger amounts thereafter.
Supplemental State Rebates The state's ability to negotiate supplemental drug rebates with pharmaceutical manufacturers may be negatively affected when the volume of drugs that the state purchases decreases.	Unknown, potentially up to tens of millions of dollars.
County Administration Creates additional workload in county welfare offices by requiring them to do eligibility determinations for Medicare Part D low-income assistance.	Unknown.
Woodwork Effect May result in increased Medi-Cal caseloads because county welfare offices will have to screen people applying for low-income Medicare Part D assistance for some Medi-Cal low-income assistance programs.	Unknown, probably relatively small.

Beginning in January 2006, California is required to make a monthly clawback payment that is to be deposited into a federal government account. The amount of each state's monthly payment is determined by a complex formula with several components, including the amount the state spent on drugs covered by Part D for dual eligibles in calendar year 2003 on a per-person basis and the rebates received by a state from drug manufacturers.

Federal Clawback Reduces Savings to States. The CMS has issued final regulations that will determine how the clawback formula will be applied to each state. The DHS concluded that the regulation adopted by CMS unduly disadvantages California by overstating the true net costs it had incurred in the past for providing prescription drugs to dual eligibles—a key component of the federal clawback formula. The DHS found that the

proposed clawback formula inaccurately calculates the rebates collected from drug suppliers for 2003 by using the dollar amount of rebates collected in 2003. The department indicates a more appropriate calculation, which would have taken into account rebates collected in 2004, would reduce the state's clawback payments by \$91 million a year. Although the regulations have been finalized, the CMS has not yet determined the amount of the state clawback payment. The deadline for the CMS to announce state clawback payments is October 15, 2005.

MMA Creates New Eligibility Administration Costs

New Federal Mandate. The MMA requires state Medicaid agencies and federal Social Security Administration offices to accept and evaluate the applications of Medicare beneficiaries seeking assistance under Medicare's Part D low-income assistance program. These agencies must also periodically recertify that the low-income beneficiaries are still eligible to receive the additional assistance from Medicare. In California, the responsibility for making Medicaid eligibility determinations has generally been delegated to county welfare offices, who receive state and federal funding under the Medi-Cal Program to carry out these duties. As a result, it appears all but certain that counties will incur at least some new administrative costs to carry out these new duties mandated under MMA. The Governor's budget plan does not propose any additional funding to the counties to reimburse them for this additional workload. At the time this analysis was prepared, the availability of federal funds to reimburse the counties for the additional workload was not clear.

The DHS has entered into discussions with federal authorities regarding how these costs might be minimized, such as by having the county welfare offices bundle together multiple Part D applications and forward them to Social Security Administration offices for eligibility determinations. However, at the time this analysis was prepared, no specific steps to reduce county costs had been announced.

These costs could be low if the public response to outreach efforts for the new Medicare Part D benefit is weak. If the public response is strong, however, the counties' new administrative duties under Medicare Part D could translate into cost pressures for the state.

"Woodwork Effect" Another Risk to State

The availability of low-income Part D drug subsidies could also indirectly increase state costs for the Medi-Cal Program in another way, often referred to as the woodwork effect. We noted earlier that state Medicaid programs are required to conduct eligibility determinations for certain

Medicare cost-sharing programs under which Medicaid programs may pay an individual's Medicare costs. As county welfare offices perform eligibility determinations for Part D low-income assistance, they must also screen for eligibility for the Medicare cost-sharing programs. This could result in increased Medi-Cal caseload and costs for participants in these programs.

The exact effect on state Medi-Cal caseloads and expenditures is hard to predict and will depend largely on the effectiveness of the forthcoming federal campaign to encourage applications for Part D drug benefits. The additional costs will probably not be great compared to the current overall Medi-Cal Program enrollment—perhaps even as little as hundreds of new applicants on a statewide basis.

State's Leverage to Negotiate Rebates May Be Reduced

We noted earlier that DHS' budget proposal assumes that the rebates the state receives from drug manufacturers will decrease by about \$273 million in 2006-07 as a result of the implementation of the Part D benefit and dual eligibles receiving their drugs under Medicare instead of Medi-Cal. That \$273 million decline in rebates represents only the partial-year effect of Part D implementation. We estimate that the full annualized loss of Medi-Cal rebate revenues could be more than \$620 million in 2007-08.

In addition to the direct reduction in rebates, the implementation of Part D could reduce the state's bargaining power with drug manufacturers for drug rebates under the Medi-Cal Program. The anticipated decrease of more than 50 percent in the amount of drug purchases being made under the fee-for-service component of Medi-Cal as a result of dual eligibles shifting from Medi-Cal drug coverage to Medicare drug coverage could weaken DHS' ability to successfully negotiate supplemental rebates with drug manufacturers, potentially increasing program costs by tens of millions of dollars annually.

Drug Coverage for Some Dual Eligibles Might Be Disrupted

Shift in Drug Coverage Could Be Disruptive. As we have discussed, the PDPs and Medicare Advantage Plans who begin to deliver the Part D drug benefit will not be obligated to cover all available drugs. They will be permitted to adopt formularies that pick and choose the most cost-effective drugs, within federal constraints, so long as those formularies comply with CMS rules. Thus, it is possible—even likely—that some Medi-Cal dual eligibles who currently receive a relatively wide-ranging drug benefit may not be permitted by their Medicare provider to continue to receive the same medication they are now taking.

The extent of this potential problem cannot be predicted at the time of this analysis because the CMS has not selected its Medicare Part D providers and those providers have not yet adopted their formularies.

A change in copayment requirements could also potentially disrupt the drug coverage now provided to Medi-Cal dual eligibles. In theory, Medicaid beneficiaries are obligated to make copayments toward the cost of their prescription drugs (as well as for other types of medical services). Medi-Cal requires a copayment of 50 cents to \$3 per prescription. However, under federal Medicaid law, pharmacies (as well as other types of medical providers) are not permitted to deny access to prescription drugs to beneficiaries who indicate that they are unable to make a copayment. We are advised that for these reasons, pharmacies frequently do not collect these copayments. However, we are not aware of any similar constraint on collecting copayments for the new Medicare drug benefit established by the MMA. We believe providers may deny a drug prescription to any beneficiary who does not make a copayment.

“Wrap-Around” Coverage Would Be Costly to Provide. As noted earlier, Medi-Cal provides a wide-ranging drug benefit. This drug coverage remains in place under state law and does not automatically change with the implementation of Medicare Part D. Thus, absent a change in current law, the state will provide what amounts to wrap-around coverage to dual eligibles beginning January 1, 2006. The result would be that beneficiaries could keep their same medications without disruption and without copayments. Our analysis indicates, however, that providing wrap-around coverage would probably prove to be costly to the state in the short term and even more costly over time. As noted earlier, of the \$3.3 billion total funds (net of rebates) the state currently spends on drugs, about 55 percent or about \$1.8 billion is for dual eligibles.

Effective January 2006, the state loses almost all federal matching funds for drugs provided to dual eligibles under the Medi-Cal Program. As a result, almost any wrap-around coverage that the state provides for dual eligibles would be paid for entirely with state General Fund resources.

While the initial cost could be significant—potentially in the low hundreds of millions of dollars annually—these costs to the state could grow rapidly. To the extent that the private providers scaled back the coverage provided under the Part D drug benefit, such as by enforcing stricter formularies, more drug coverage and costs would almost automatically shift to the state’s wrap-around coverage.

Over time, we believe these circumstances would take considerable pressure off of the federal government to provide a wide-ranging drug benefit to dual eligibles, since any dual eligible denied their preferred drug by

a PDP or a Medicare Advantage Plan could receive it from a state wrap-around program—at no cost to the federal government.

Medicare Part D Could Result in Some Offsetting State Savings

While the clawback and other provisions of Medicare Part D could prove costly to the state over time, some aspects of the MMA could result in some partially offsetting reductions in state costs.

Drug Costs Embedded in Some State Program Budgets. Certain state agencies and groups of medical providers who provide services to Medicare beneficiaries have historically built the costs of drug coverage into their operations. For example, the cost of providing prescription drugs is embedded in the rates that the state now pays to certain Medi-Cal managed care providers, and in funding for developmental centers operated by the Department of Developmental Services (DDS) and state hospitals operated by the Department of Mental Health (DMH).

The implementation of Medicare Part D means that the drug costs in these programs will decrease as drug costs for Medicare patients shifts to the new Part D program. However, our analysis indicates that the budgets for these other programs have not been adjusted in the Governor's budget plan to reflect these potential savings. Their rates and funding levels could be adjusted to reflect this anticipated decrease in their drug costs.

We estimate that fully recognizing these adjustments for the startup of Medicare Part D drug coverage could collectively result in significant General Fund savings of about \$100 million in 2005-06, and about \$200 million annually by 2006-07.

Enrolling More in Medicare Might Reduce State Costs. While it is relatively easy to enroll aged persons in Medicare, federal eligibility rules make the enrollment of disabled persons, such as the mentally ill, a potentially lengthy and difficult process. For example, federal rules generally require that someone who qualifies as being disabled wait two years before they receive Medicare benefits. These potential barriers to Medicare enrollment mean it is likely that some state-supported programs that serve persons with disabilities, such as county mental health systems, may not have taken all steps possible to enroll all eligible persons who need medications on a long-term basis into the Medicare Program.

Many such individuals have their medication costs—long-term costs that can be significant—covered under Medi-Cal. Our preliminary analysis indicates that it might be possible for the state to eventually reduce its Medi-Cal prescription drug costs by enrolling more such disabled persons in Medicare. The potential savings that could be achieved under this approach are unknown at this time.

New Medicare Benefits Could Reduce Other Program Costs. The MMA made a range of other changes in Medicare benefits, such as authorization for certain forms of preventative care. It is possible that some of these preventative medical services are now being paid for entirely under the Medi-Cal Program because they were not previously covered by Medicare. To the extent this is the case, it may be possible for the state to recognize Medi-Cal savings by shifting the cost for these services to Medicare. However, no such adjustments for coverage are now reflected in the Governor's budget plan for Medi-Cal.

Analyst's Recommendations

Tough Choices, Little State Control. The arrival of Medicare Part D drug coverage leaves the state in a difficult position. For the most part, the effects of the new federal law are beyond the control of California and any other state. Nevertheless, there may also be some limited actions and strategies the Legislature could adopt to help to partly offset the deficits that will probably result from the advent of Part D drug coverage. We discuss our recommended approach below.

Recognize Savings From MMA for Some Departments and Programs. We recommend that the budgets of DDS and DMH be adjusted to take into account the reduction in their drug costs that is likely to result from the implementation of Medicare Part D. The Department of Finance (DOF) should be directed to work in consultation with these departments to provide the Legislature at budget hearings with an estimate of these savings after the effects of recent federal regulations to implement Part D have been evaluated. The Legislature should then adjust the 2005-06 budgets of these departments accordingly to reduce General Fund expenditures. Similarly, we recommend that the rates paid by the state Medi-Cal Program to managed care providers be adjusted to reflect the shift of drug coverage costs for dual eligibles served by these programs to Medicare Part D. Such an adjustment could achieve General Fund savings of as much as \$100 million in 2005-06.

Avoid Commitment to Wrap-Around Coverage. In order to avoid a significant potential cost to the state, we recommend that the Legislature adopt the statutory language that the administration has proposed to eliminate wrap-around coverage. Our analysis indicates that providing wrap-around coverage would probably result in additional state expenditures in the low hundreds of millions of dollars annually—costs likely to increase significantly in the future. It is also premature to consider providing any form of wrap-around coverage for dual eligibles until the PDPs and Medicare Advantage Plans have been selected by the CMS and the specific formularies they will offer have been determined. If the state moves now to fill in any

gaps in Medicare Part D coverage, it may unintentionally take the pressure off of CMS and its network of providers to provide wide-ranging drug coverage that will meet the needs of dual eligibles.

Seek Modifications in the MMA. Last year, the Legislature approved Senate Joint Resolution 25 (Ortiz) which urged the U.S. Congress and the President to modify the MMA in ways that would make the new federal law less burdensome to states. We recommend that the state continue to appeal to the federal government to make the Medicare Part D drug benefit for dual eligibles as comparable as possible to the drug benefit now available under Medicaid. For example, a modification of Medicare copayment rules to conform to Medicaid standards would ensure that dual eligibles who were unable to make copayments would not be denied their access to drugs. The state should also continue to make its case for modifications to the clawback calculations so that California's clawback payments will accurately reflect the drug rebates the state collected for 2003 and thereby avoid overpayments of about \$91 million annually.

Examine How to Increase Enrollment in Medicare and Part D Coverage. In order to ensure a successful transition for dual eligibles from Medi-Cal drug benefits to Medicare Part D drug benefits, we recommend that the Legislature direct DHS to report at budget hearings on its outreach efforts to dual eligibles, whether federal funds are available to states to support such efforts, and what efforts are being made to obtain any available funds.

We also recommend that DMH be directed to assess and report to the Legislature at budget hearings regarding whether all disabled individuals in their community programs who have a significant long-term need for medications are being systematically enrolled in Medicare. If DMH were to determine that more of its clients could be enrolled in Medicare over time, the Legislature could then examine strategies to eventually shift them (after the required two-year waiting periods) from state-supported Medi-Cal drug coverage to the Medicare Part D program.

Defer Budget Adjustments for County Administration. At this time, we recommend against making any adjustments to the Medi-Cal budget for county eligibility administration. We recognize that counties could incur additional workload from the new federal mandate that they process applications for Part D assistance for low-income persons. In our view, however, it is the responsibility of the federal government to either provide financial assistance to counties to handle these tasks, or to permit counties, as DHS has suggested, to shift most of this workload to Social Security Administration offices. In any event, it is unclear at this time whether any significant increase in workload will be experienced at county welfare offices.

Defer Budget Adjustment for Medi-Cal Caseload. At this time, we recommend against making any caseload adjustments to account for the wood-

work effect. We recognize that there is the potential for increased caseload in the Medicare cost-sharing program. However, we do not believe that any increase in caseload that may occur would be significant and any necessary adjustment could be made at a later time.

Adjust Medi-Cal Costs for New Medicare Benefits. Finally, DOF and DHS should examine whether the inclusion of preventative benefits for Medicare services authorized in the MMA would have the effect of reducing any present costs to the Medi-Cal Program of providing these same services. They should be required to report their findings at budget hearings, and the Legislature should reduce the Medi-Cal budget accordingly to reflect the shift of any such costs to the Medicare Program.

DISEASE MANAGEMENT PILOT PROGRAM: FURTHER ACTIONS COULD HELP ENSURE SUCCESS

In enacting the 2003-04 Budget Act, the Legislature provided funds for a disease management pilot program which, if implemented properly, could significantly reduce costs for the medical services the state provides for aged, blind, and disabled persons covered by Medi-Cal. We recommend specific steps that the Legislature should take to ensure that the Department of Health Services follows through in a timely and effective manner on the implementation of the pilot program proposed to begin July 1, 2005.

Background

The administration has put forward a proposal to save state funds by “redesigning” Medi-Cal, in part by placing more of the aged, blind, and disabled in managed care. We believe that the changes proposed by the administration generally have merit and warrant consideration by the Legislature. We discuss the Governor’s initiative in more detail elsewhere in this *Analysis*. However, we believe it is also important to recognize that the Legislature has already adopted a disease management (DM) strategy which, if implemented properly, could significantly reduce state costs for the medical services now being provided to this high-cost population.

Disease management is a set of interventions, such as using patient education programs to promote preventative self-care, designed to improve the health of individuals with chronic conditions (lasting a year or longer) such as diabetes, chronic heart failure, and asthma. More than 30 other states have implemented various types of DM programs since at least 1995. Based on indications that the implementation of such programs can reduce patient utilization of high-cost services, such as emergency rooms and hospitals, the Legislature provided nearly \$100,000 General Fund for

three staff as part of the 2003-04 Budget Act. Related budget implementation legislation, Chapter 230, Statutes of 2003 (AB 1762, Committee on Budget), required DHS to apply for a federal waiver to initiate DM pilot projects within the Medi-Cal Program.

Our office recommended that the Legislature approve these expenditures and new positions because of the potential for achieving state Medi-Cal savings. As shown in Figure 12, we estimated, for illustrative purposes, the range of potential savings that could be achieved in Medi-Cal fee-for-service expenditures for several medical conditions that are commonly targeted for DM services. We estimate, for example, that a 1 percent reduction in costs for five chronic conditions often targeted for disease management services could result in annual savings of \$15 million (\$7 million General Fund). A 10 percent reduction in costs for these same five diseases could result in estimated savings of \$153 million (\$76 million General Fund).

Figure 12				
Expenditures and Potential Savings on Conditions Commonly Targeted by Disease Management Programs				
<i>Fiscal Year 2003 (In Millions)</i>				
Disease	Cost to Treat Condition	Potential Savings From Reductions in Costs		
		1 percent	5 percent	10 percent
Asthma/respiratory infections	\$510	\$5	\$26	\$51
Diabetes	458	5	23	46
Renal function failures	247	2	12	25
Chronic obstructive pulmonary disease	181	2	9	18
Depression	137	1	7	14
Totals	\$1,533	\$15	\$77	\$153

Budget Proposal. The Governor's proposed budget includes \$4 million in 2005-06 (\$2 million from the General Fund) for two contracts to establish disease management services. This funding is in addition to the three staff previously provided for implementation of the pilot project. The Governor's budget plan does not assume any Medi-Cal savings from the implementation of the pilot program in 2005-06. The DHS has indicated

that this is because it is not yet certain that the pilot projects will result in savings. Notably, some Medicaid programs in other states have encountered difficulties in trying to quantify the savings, if any, that have resulted from their DM programs.

Progress to Date of Medi-Cal Disease Management Projects

Population Targeted for Participation. The DHS has been working closely with an existing contractor to define the general categories of patients likely to benefit from DM services. This determination is based on the type and severity of a Medi-Cal beneficiary's disease and historical hospital utilization related to that disease. Based on this review, DHS has concluded that the population that best meets these criteria is aged persons as well as blind and disabled persons over 21 years of age who receive care from fee-for-service health care providers. The state's DM program will focus on Medi-Cal beneficiaries who are not also enrolled in the Medicare program, given that the federal government, rather than the state, now bears most of the costs for medical services for persons with dual enrollment in Medi-Cal and Medicare.

Developing Proposal to Identify Vendors. We are advised that DHS intends to release by March 2005 a request for proposal (RFP) to identify a vendor or two to provide medication management services, coordinated care management, risk assessments, and development of outcome measures necessary for the operation of a DM program. The RFP is to be structured to guarantee savings to the state, or at least to ensure that the program results in no additional costs to DHS. If a vendor does not achieve an agreed-upon level of savings, the state will not pay some or all of the fees owed to the vendor. The department has not announced a specific date for the award of the contract. However, the last estimated date of an award was May 2005.

Seeking Federal Waiver. The DHS is seeking a waiver from the federal government that will enable it to focus the provision of DM services on this specific population, and now assumes it will receive approval of the waiver by May 2005. The pilot project is expected to begin July 1, 2005 and to continue for three years.

Components for Successful Implementation

Our analysis indicates that, in general, DHS is addressing many of the critical components of a successful DM program. However, we have identified two key components—beneficiary and physician participation—that we believe deserve additional attention to help ensure the success of the pilot projects. We discuss these issues further below.

Beneficiary Participation. One critical component of a successful DM program is obtaining the full participation of the patients targeted for these services. Some studies of DM programs indicate that this can be accomplished by mandating participation. Other states have attracted participants through voluntary marketing strategies, such as encouraging DM contractors and medical services providers to promote to beneficiaries the advantages of participation in a DM program.

At this time, DHS intends to require eligible beneficiaries to enroll in the DM program, but allow individuals to opt out within 30 days or to voluntarily disenroll from DM services at the end of any month. While such an approach would be likely to encourage greater initial participation, it could undermine the goal of continued participation in the DM program.

Physician Participation. Physician involvement in the Medi-Cal DM program is also important in order for such a program to be successful. Research has found that programs failing to engage beneficiaries' physicians may have limited success. However, physicians may be resistant to participation if they do not believe such programs are effective. Physicians may also fear that they will not be compensated for supplemental services that they provide under DM, such as answering patient questions via e-mail or coordinating prescription drug utilization information with a patient's other physicians.

At least one state has recognized the importance of physician participation and intends to provide doctors that participate in such programs with a modest rate increase, dependent on such actions as their attendance at certain educational training sessions on such topics as managing chronic illnesses. Other states have stressed the importance of educating providers about DM and fostering the belief that DM can improve the quality of care through activities such as educational seminars. At this time, DHS has not proposed to increase payments to physicians or provide any other incentives that would encourage physicians to participate in the DM program.

Legislature Needs Information About Interaction With Medi-Cal Redesign

One component of the redesign of Medi-Cal proposed by the administration in the *2005-06 Governor's Budget* is to broaden the enrollment of aged, blind, and disabled Medi-Cal beneficiaries in managed care. Thus, the redesign could potentially affect some of the same fee-for-service beneficiaries that are being targeted for DM services. To the extent that managed care plans choose to offer DM services as a means to hold down medical costs, there exists in theory the possibility that the state could pay

twice for DM services for the same beneficiaries—once through payments to a managed care plan and again through payments to a DM services contractor who is participating in the state’s pilot projects.

For this reason, it will be important to coordinate the expansion of DM services and the expansion of managed care to ensure that no such overlap occurs. However, DHS has not yet provided the Legislature any information regarding the potential fiscal and programmatic interactions between the redesign of Medi-Cal and the DM pilot program. Absent such information, the Legislature does not have any way to assess whether such an overlap in services will be avoided.

Analyst’s Recommendations

As noted above, our analysis has identified some specific potential weaknesses in DHS’ developing proposal for a DM pilot program. Based on this we recommend that the Legislature take several actions that we believe would improve the odds of the program’s success.

Approve Budget Request. We recommend that the Legislature approve the \$4 million (\$2 million General Fund) requested by the administration in the 2005-06 budget proposal. This will enable DHS to continue with implementation of the pilot program.

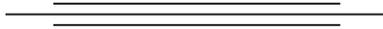
Encourage Beneficiary Participation. One potential problem, we have noted, is a possible fall off in participation by Medi-Cal beneficiaries in DM activities. The Legislature should consider, as an addition to DHS’ proposal to initially mandate participation by beneficiaries in the DM program, a design in which DM contractors and physicians would promote the advantages of DM services to Medi-Cal patients on an ongoing basis in order to encourage their continued participation. For example, the Legislature could direct DHS to require the DM contractors to strengthen their relationships with beneficiaries by (1) making contact with all participants within a set number of months after enrollment in the program to help increase Medi-Cal patients awareness of the services and benefits associated with continued participation and (2) following up with clients by phone or home visits at set intervals to promote continued participation in DM activities.

Encourage Physician Participation With Incentives. To help ensure strong participation by physicians in the DM pilot projects, the Legislature should direct DHS to conduct educational seminars for Medi-Cal providers that would explain the purpose of DM services and demonstrate their potential effectiveness. The DHS could encourage “buy-in” to the program by providing physicians with regular and ongoing feedback on how the

implementation of the DM pilot projects was affecting the quality of care of Medi-Cal patients.

The Legislature may also wish to eventually consider establishing financial incentives for Medi-Cal doctors to participate in the DM pilots. Such incentives as modest payments for the provision of DM services could be used to reward physicians for coordinating care with other physicians or providing other types of DM services. Our analysis suggests that the costs to pay for such financial incentives would probably be more than offset after several years by the savings the state would subsequently enjoy from the successful implementation of DM. We would note that there is likely a lag between when DM services are provided and when savings are realized. Thus, we believe it makes sense to phase in any financial incentives *after* savings are realized from the DM program.

Report at Budget Hearings. We further recommend that the Legislature direct DHS to report at budget hearings on the potential fiscal and programmatic interaction between the DM pilot project and the proposed Medi-Cal redesign. The department should explain how it will ensure that it does not pay twice for the same DM services for aged, blind, and disabled Medi-Cal beneficiaries who would be shifted into managed care.



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 \$3 billion (all funds) for public health programs in the budget year, a 1 percent (\$39 million) increase from the previous year. The budget proposes \$544 million from the General Fund in the budget year, a 7 percent (\$36 million) increase from the current year. This increase is largely due to caseload adjustments in the department's health insurance programs for special needs populations and the administration's proposals for an obesity prevention initiative and a pharmacy assistance program.

BUDGET PROPOSALS

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

- **California Rx Program.** The Governor's proposed budget includes \$3.9 million from the General Fund and 18.5 positions to establish a state pharmacy assistance program for low-income individuals who do not have a public or private prescription drug benefit. We more fully describe this new program and our analysis of the proposal in "Part V" of *The 2005-06 Budget: Perspectives and Issues*.
- **AIDS Drug Assistance Program (ADAP).** The ADAP provides drug subsidies for low-income persons with HIV who have no health insurance for prescription drugs. The budget proposes about \$264 million for this program (\$91 million from the General Fund) in 2005-06. This would provide an \$18.8 million increase in overall funding for the program (\$24.6 million more from the General

Fund, partly offset by decreases in other funding sources) and two additional staff positions to negotiate drug discounts from manufacturers. We discuss these proposals in this section of the *Analysis*.

- ***Obesity Prevention Initiative.*** The January budget plan proposes that approximately \$6 million be provided from the General Fund to establish an obesity prevention initiative, which would support various activities to promote physical activity and healthy eating habits. We provide more information regarding this proposal later in this section of the *Analysis*.
- ***California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP).*** The budget plan includes \$254 million (\$92 million from the General Fund) in funding for CCS and \$64 million (\$62 million General Fund) for GHPP. This funding would provide an \$18.3 million increase in overall funding for CCS and a \$6.1 million increase in overall (and General Fund) funding for GHPP due to caseload changes and increased utilization. These programs provide health care services to severely ill and medically fragile children and adults.
- ***Proposition 99 Funding Shifts.*** The Governor's proposed budget reflects a series of major shifts in the use of the tobacco tax revenues deposited into the Proposition 99 special fund, primarily due to the availability of funds that result from a proposal to draw down additional federal funds for prenatal services. Among other changes, the Governor proposes to augment Proposition 99 funding for the Breast Cancer Early Detection Program, state mental hospitals, certain clinics, and medical services for certain legal immigrants. Similar funding shifts would occur in the current fiscal year. We provide more information regarding this proposal later in this section of the *Analysis*. We further discuss the prenatal care services funding shift in the "Crosscutting Issues" section of this chapter of the *Analysis*.
- ***Child Health and Disability Prevention Program (CHDP) "Gateway."*** The Governor's budget proposes \$1.9 million (\$1.6 million General Fund) in total expenditures for CHDP, a health-screening program for low-income children. This is a 36 percent decrease in all funds and a 40 percent decrease in General Fund expenditures from the current year. This dramatic reduction is primarily due to the continued implementation of the CHDP gateway program, which connects eligible children to Healthy Families or Medi-Cal.
- ***Newborn Screening Program.*** The budget plan includes increased funding of \$15 million from the Genetic Disease Testing Fund and three new positions for the statewide expansion of the Newborn

Screening Program. Through this fee-supported expansion, the program will screen newborns for an additional 37 medical conditions which, once detected, can be more effectively prevented or ameliorated through early intervention.

- **Office of Binational Border Health.** The Governor's budget plan proposes to eliminate \$694,000 in General Fund support and contract positions at the University of California San Diego for the Office of Binational Border Health. Approximately \$200,000 in federal funds would remain to support this office.
- **Federally Funded Bioterrorism Efforts.** The Governor's budget plan proposes to provide \$8.2 million in federal funds and extend 94.8 existing positions that would otherwise expire for activities relating to bioterrorism preparedness.
- **County Medical Services Program (CMSP).** The CMSP provides health care to certain low-income adults who are not eligible for the state's Medi-Cal Program and reside in one of 34 participating small California counties. Consistent with prior years' actions, the Governor's budget proposes legislation to again suspend in 2005-06 the state's General Fund appropriation of \$20.2 million to CMSP.
- **Public Health-Related State Mandates.** The Governor's budget includes \$3.7 million in General Fund support to reimburse local governments for various public health mandates, including mandates pertaining to AIDS search warrants, Pacific beach safety, and perinatal services for alcohol and drug exposed infants.
- **Battered Women's Shelter Program: Restoration of Funding.** The budget plan restores \$1.1 million (\$515,000 from the General Fund) for the Battered Women's Shelter program to provide "culturally sensitive" services to unserved or underserved communities of color, teens, and disabled women.

PROPOSITION 99 FUND SHIFTS

We recommend that the Legislature approve the Governor's budget for Proposition 99 funded programs, which we believe presents a reasonable approach to maximize resources for health programs and achieve General Fund savings. We further recommend, however, that the Legislature begin this year to address the long-term issues posed by the present structure of Proposition 99 and seek the approval of the voters to reform the measure in a way that would enable the state to focus its funding more effectively as the funding derived from tobacco revenues continues to diminish.

Background

In November 1988, the voters approved Proposition 99, the Tobacco Tax and Health Protection Act, which established a surtax of 25 cents per pack on cigarette products. Generally, the revenues generated by the measure support various tobacco education and prevention efforts, tobacco-related disease research, environmental protection and recreational resource programs, and health care services for low-income uninsured Californians.

The proposition requires that the revenues from the surtax be distributed to six accounts within the Cigarette and Tobacco Products Surtax Fund, a special fund created by the measure, according to specified percentages, and further provides that expenditures from each account can be used for specific kinds of activities. Figure 1 identifies (1) the six accounts, (2) their specified purposes, and (3) the percentage of the tax revenues allocated under this measure.

Figure 1		
Distribution of Proposition 99 Funds		
Account Name	Purpose of Funding	Percentage of Funding
Health Education	For programs that prevent and reduce tobacco use, primarily among children, through school and community health education programs.	20%
Hospital Services	For payments to licensed public and private hospitals for uncompensated hospital care.	35
Physician Services	For payments to physicians for uncompensated medical care.	10
Research	For tobacco-related disease research.	5
Public Resources	For programs to protect, restore, enhance or maintain fish, waterfowl, and wildlife habitat (50 percent) and for programs to enhance state and local park and recreation resources (50 percent).	5
Unallocated	For any of the dedicated uses specified for the other accounts.	25

Under state law, amendments to the measure are permitted with the approval of four-fifths of the Legislature; however, those amendments must be consistent with the purposes of the measure described in Figure 1.

Governor's Proposal

The Governor's proposed budget projects that Proposition 99 revenues will decrease by \$9 million in the budget year. The budget proposes to

achieve General Fund and Proposition 99 savings through a series of funding shifts, to augment funding for certain activities, and to maintain Proposition 99 funding for various programs. The major changes in programs funded from Proposition 99 during the budget year are described below and summarized in Figure 2. (We note that the administration has proposed similar fund shifts for the current year and intends to sponsor urgency legislation that would enact the necessary changes in appropriation levels.)

Figure 2
2005-06 Governor's Budget
Proposition 99 Funding Shifts

(In Millions)

Program	Proposition 99	General Fund	Federal Funds
Access for Infants and Mothers	-\$78.4	\$27.5	\$51.0
Administration of tobacco control activities	1.1	—	—
Breast Cancer Early Detection Program	12.8	—	—
State mental hospitals	13.6	—	—
Expanded Access to Primary Care	10.0	-10.0	—
Medi-Cal coverage for recent immigrants	32.8	-32.8	—
Redirected to other Proposition 99 programs	-8.2	—	—
Total Impact^a	\$—	-\$15.3	\$51.0

^a Detail may not total due to rounding.

Fund Shift Frees Up Proposition 99 Funds. The administration proposes to “free up” \$78.4 million in Proposition 99 funds currently used to support prenatal services to low-income women in the Access for Infants and Mothers (AIM) program. It does this by replacing the Proposition 99 funds with \$27.5 million from the General Fund, which draws down \$51 million in federal State Children’s Health Insurance Program (SCHIP) funds.

The administration has proposed to substitute General Fund resources for Proposition 99 in AIM because Proposition 99 ordinarily cannot be used, under the terms of the initiative, to draw down federal funds. Through this fund shift, approximately \$78.4 million in Proposition 99 funding would be freed up in the budget year that could be used for other purposes. (We provide more information regarding this proposal in the Crosscutting Issues section of this chapter.)

Program Augmentations. The administration proposes that a portion of the Proposition 99 funds freed up by the fund shift be used to augment funding for three programs currently supported by Proposition 99.

First, the Governor proposes that \$1.1 million be used to restore funding for the administration of tobacco control activities that had been inadvertently reduced by budget actions taken in 2003-04.

The administration also proposes a \$12.8 million augmentation for the Breast Cancer Early Detection Program (BCEDP), also referred to as the "Every Woman Counts" program. This program provides breast cancer screening to low-income women ages 40 and older who are uninsured or underinsured. The demand for services through this program has steadily increased over the years, with the number of women served increasing by 50 percent between 1999-00 and 2003-04.

Lastly, the administration proposes to augment funding for the Department of Mental Health by \$13.6 million to provide care for additional patients in state mental hospitals.

Additional Fund Shifts. The administration further proposes to replace General Fund support for certain health programs with a portion of the freed up Proposition 99 funds. Specifically, the budget plan proposes that \$10 million in Proposition 99 funds be used in lieu of General Fund resources to support the Expanded Access to Primary Care (EAPC) program, which reimburses certain primary care clinics for uncompensated medical care. The overall level of state funding for EAPC would be maintained at the current-year level, but a larger portion of the program's funding would come from Proposition 99.

Finally, the Governor's budget plan proposes to substitute \$33 million in Proposition 99 funds for General Fund resources to offset the cost of nonemergency services provided under the Medi-Cal Program to recent legal immigrants. Under federal rules, the state can receive federal Medicaid funds to pay for the medical costs of emergency services for legal immigrants who have been in the country for less than five years. However, the federal government will not pay the costs of nonemergency services provided to these individuals. Since, under state law, these individuals are eligible for the same services as citizens, the state bears the full cost of the additional services provided to this group of immigrants under Medi-Cal. Part (but not all) of these costs would now be paid for using Proposition 99 funds.

Funding Held Steady for Remaining Programs and Reserve. The Governor's budget would use the remaining Proposition 99 resources (\$8.2 million) freed up from the AIM fund shift to maintain various programs and services now supported by Proposition 99 at their current year

funding level. The Proposition 99 reserve in the budget year would also remain generally at the same level as the current year.

Assessing the Governor's Proposal

Budget Proposal Is Reasonable. In light of the statutory restrictions that exist on the use of Proposition 99 funds, we believe that the Governor's budget proposal provides a reasonable approach for the use of these revenues in a way that both maximizes the total resources available for health programs and achieves some General Fund savings in the budget year.

The administration proposal, it should be noted, "works" in totality only if the Legislature concurs with the significant shift in the source of support for prenatal services that frees up a considerable amount of Proposition 99 resources for other programs. In our view, this administration proposal has merit in that it would maximize the amount of federal support available for the AIM (and Medi-Cal) programs that could be leveraged with state funds with no programmatic effect on program beneficiaries. We note, however, that part of the program shifts could be accomplished on a onetime basis using excess Major Risk Medical Insurance Program (MRMIP) reserve funds, a potential option we discuss below.

Although the Governor's proposal presents a reasonable approach to utilize the Proposition 99 funds in the short-term, the Legislature should also begin to consider how it can and will use these funds in the future. We discuss several aspects of this issue below.

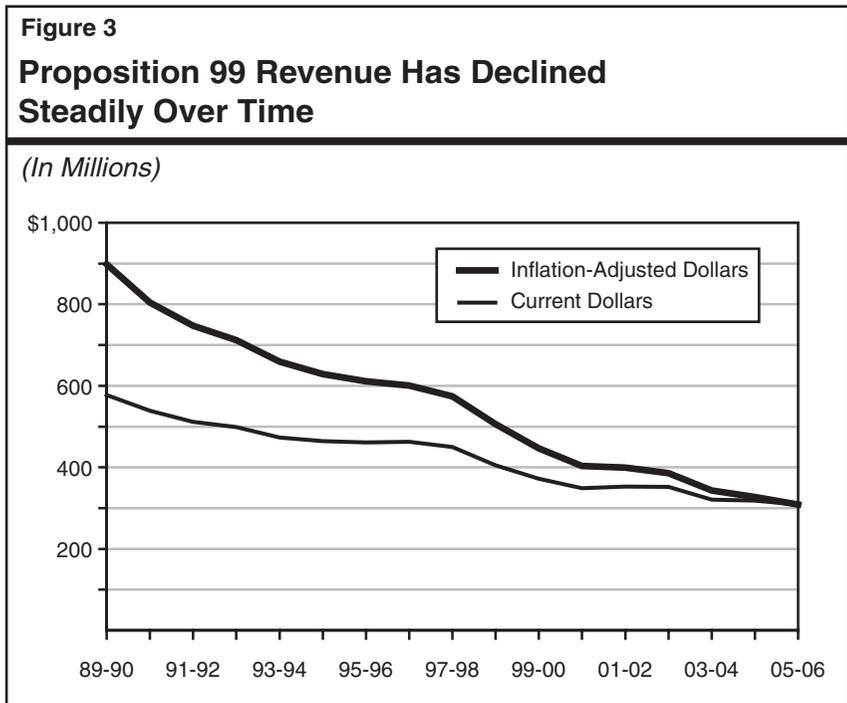
Proposition 99 After 16 Years: Steadily Declining Revenues, Too Many Programs

Proposition 99 Funds Have Declined Steadily. The tobacco-tax revenues generated under Proposition 99 have steadily declined since the measure's inception. As seen in Figure 3 (see next page), the success of efforts to reduce smoking, and the imposition of further tax increases on cigarette products, have resulted in a 46 percent decline in Proposition 99 revenues—from the \$573 million received in 1989-90 to an estimated \$309 million in 2005-06. The impact of this decline is even more apparent when the value of the initial revenue generated by this measure is adjusted for the effects of inflation. As seen in Figure 3, Proposition 99 revenues, as adjusted for inflation, have dropped by 66 percent since 1989-90.

Events Have Contributed to Decline in Proposition 99 Resources. Since the approval of Proposition 99, two additional measures have been enacted that increased the tax on tobacco products. These were Proposition 10, enacted by the voters in 1998, and the Breast Cancer Act of 1993 (Chapter 60, Statutes of 1993 [AB 478, Friedman]), enacted by the Legislature. In

addition, in 1998, the tobacco industry reached a master settlement agreement with a number of states, including California, that committed them to making ongoing cash payments to state and local governments.

All of these events have indirectly contributed to a further decline in Proposition 99 revenues. For example, the tobacco industry increased prices on tobacco products in response to the legal settlements, which had the effect of further reducing the consumption of tobacco products and Proposition 99 revenues. Proposition 10, which increased the tobacco tax by 50 cents per pack of cigarettes to generate revenue for various early childhood development programs, and the Breast Cancer Act which increased the same taxes by 2 cents for cancer research and breast cancer detection, had the same effect.



Proposition 10 did provide that some of its revenues would be used to “backfill” a portion of the revenues lost to Proposition 99 and breast cancer research and detection activities. (About \$16 million in backfill funding is provided in Proposition 99 for this purpose in the Governor’s budget plan.) However, the Proposition 10 backfill only goes to replace revenues lost to the health education and research accounts—and not the

other four Proposition 99 accounts. No backfill at all was provided for in the other legislation.

Too Many Programs Supported by Too Few Dollars. Pursuant to the terms of the initiative, the revenues generated by Proposition 99 are dedicated to a wide array of purposes—tobacco education and prevention, research, resources programs, and health care services for low-income uninsured Californians. Currently, these funds are used to support dozens of separate state programs and services administered by 12 separate state departments.

While the specific programs and activities supported with these revenues have fluctuated from year to year, the breadth of programs and services supported from the Proposition 99 special fund has not changed over time. Coupled with the steady decline in revenues, allocations of Proposition 99 funding are getting smaller each year, in general, program by program. Given estimates that Proposition 99 revenues will continue to drop, in both real and inflation-adjusted terms, the Legislature will inevitably face the question of whether the use of these monies is so fragmented that they are not being used as effectively as possible.

Diminishing Fund Source Ill-Suited for Growing Programs. The continual decline of Proposition 99 revenues means that this fund source cannot keep pace with programs that regularly experience growth in their budgets due to increases in caseloads or costs. Nevertheless, Proposition 99 revenues are now being used to support several programs with growing caseloads, such as AIM, the state mental hospitals, and BCEDP.

The Governor’s budget proposal would shift one of these caseload-driven programs (AIM) to the General Fund. But the administration proposal effectively replaces AIM in the Proposition 99 “line-up” with Medical services for recent immigrants—another activity likely to experience significant growth in caseloads and costs.

Inevitably, this approach of using this declining revenue source to support growing programs will force difficult choices upon the Legislature. If it wishes to maintain support for these programs using Proposition 99 revenues, it will have to come at the expense of the other programs funded from Proposition 99 or through the use of alternative funding sources.

Restrictions Limit Budgeting Flexibility. Proposition 99 contains a number of restrictions that give the Legislature little flexibility in the expenditure of these tobacco tax revenues. The requirement for six separate accounts, each with its own distinct funding purposes, and predetermined percentages of funding for each purpose, may or may not align with current legislative priorities. For instance, if the Legislature wished to shift the

health services funds to health education programs, or vice versa, these changes would not be permitted under the measure.

Furthermore, under the terms of the initiative, the state is generally prevented from using Proposition 99 funding to leverage federal resources for health care services funded under the Hospitals Services or Physician Services accounts. We are advised that this provision was drafted mainly to prevent Proposition 99 funds from being diverted to support caseload-driven health care programs supported by federal funds (for example, Medical). The drafters intended that the resources be used instead to expand the identified programs and services.

However, there is a significant downside to this constraint, in that this language potentially limits the state's opportunities to leverage state funds to draw down additional federal resources. For example, the state would generally be prohibited from using Proposition 99 resources to expand the Healthy Families Program (HFP) to poor adults (as the Legislature had previously declared its intent in Chapter 946, Statutes of 2000 [AB 1015, Gallegos]), even though the state would be able to draw down a two-to-one federal-state match for an expansion of health coverage that is a high legislative priority.

Separate Reserves Tie Up Proposition 99 Funding. Prior to this year, the state had maintained separate reserves of Proposition 99 revenue for AIM and MRMIP to address unanticipated increases in expenditures in those programs. (The MRMIP provides health coverage to individuals who are unable to obtain coverage on their own due to pre-existing medical conditions.) In 2004-05, the Legislature eliminated the separate AIM reserve. However, the Governor's proposed budget would keep in place a separate reserve for MRMIP of \$20.2 million in Proposition 99 revenues.

One effect of holding these funds in a reserve is to diminish the amount of Proposition 99 resources that could otherwise be used to support other Proposition 99-funded programs. (We provide more information regarding the Governor's proposed budget for MRMIP and the reserve issue later in this chapter of the *Analysis*.)

Changes in Funding Allocations or Uses Requires Voter Approval. As noted earlier, the measure contains a provision that authorizes amendments to Proposition 99 that are both consistent with the purposes specified in the measure and have the support of four-fifths of the Legislature. However, a 1994 court case concluded that this provision does not give the Legislature the authority to reallocate funding in keeping with state budget priorities.

Specifically, the state attempted to amend Proposition 99 in 1994 to permit a shift of funds from antismoking programs to other types of health

programs. A Superior Court judge subsequently struck down this legislative change and ruled that it was inconsistent with the intent of the voters in the enactment of the initiative. This ruling suggests that future attempts to change the existing allocations of funding in Proposition 99 would require voter approval.

Analyst's Recommendations

We recommend that the Legislature approve the Governor's budget for Proposition 99-funded programs, which we believe presents a reasonable interim approach to maximize resources for health programs and achieve General Fund savings. We believe this approach is interim because it involves the use of declining resources to support caseload-driven programs. A long-term solution is needed to appropriately match state programs with Proposition 99 resources.

Accordingly, we further recommend that the Legislature begin this year to address the long-term issues posed by the present structure of Proposition 99. We propose that the Legislature seek the approval of the voters to reform Proposition 99 in a way that would enable the state to focus its funding more effectively as the funding derived from tobacco revenues continues to diminish. Our proposed approach would seek the consent of voters to allow the Legislature more flexibility to change the way Proposition 99 funds are used to meet the state's ever-changing priorities and needs.

Such a measure could have these specific provisions:

- A consolidation of at least several of the six separate accounts into fewer and more flexible accounts. (For instance, the Legislature could pursue a consolidation of the health-related accounts.)
- Elimination of some of the Proposition 99 purposes to scale back the breadth of programs supported by the measure.
- Elimination of the restriction on the use of Proposition 99 funds to access federal funds for health services.

We note that there may be other issues the Legislature may also want to consider for restructuring Proposition 99. The Legislature may wish to examine the allocations required under Propositions 10 and the Breast Cancer Act to consider whether the voters should also be asked to backfill or consolidate any share of these resources into the new structure of Proposition 99 accounts that we identify. Alternatively, all restrictions on these funds could be removed—thus, helping to unlock the budget—so that they were available to meet the state's highest priorities on an annual basis.

Lastly, as we discuss in our analysis of the MRMIP budget, we recommend that the Legislature eliminate the separate reserve maintained in the

Governor’s budget for the MRMIP program thereby freeing up as much as \$20.2 million in Proposition 99 on a onetime basis for other purposes.

GOVERNOR’S ANTI-OBESITY INITIATIVE

While additional state public health efforts to combat the spread of obesity are warranted, the Governor’s proposal launches new anti-obesity projects before an assessment of existing Department of Health Services (DHS) efforts in this area is complete and does not sufficiently take advantage of alternative funding sources available to DHS. (Reduce Item 4260-001-0001 by \$2,803,623 and Item 4260-111-0001 by \$3,050,000).

Background

The prevalence of overweight Californians has increased from 38 percent in 1984 to 57 percent in 2003. This excess weight is a major contributor to disease, disability, premature death, and to the burden of increasing health care costs. In response to concerns about this growing public health problem, the Governor’s budget includes approximately \$6 million in General Fund resources to implement a variety of proposals to promote healthy nutrition, increased physical activity, and obesity prevention. The Governor’s initiative has several major components, which are summarized in Figure 4.

Figure 4
Proposed Components of
Anti-Obesity Initiative

(Dollars in Thousands)

	DHS Positions	General Fund
DHS coordinating office	1	\$371
Community action grants	1	3,029
Training and technical assistance	—	500
Enhanced health services for Medi-Cal children	—	1,408
Surveillance, evaluation, and research	—	500
Public relations	—	150
Miscellaneous OE&E expenses	—	76
Totals	2	\$6,034

New DHS Office. The administration has requested approximately \$371,000 and one new staff position to establish a new and separate office within DHS to coordinate the department's existing programs that promote nutrition and physical activity. According to DHS, the office is to (1) serve as the single point of contact for information regarding the development of public policies and scientific information related to obesity; (2) foster partnerships among programs within the department that have functions related to combating obesity; (3) coordinate the department's public health surveillance, training, and evaluation of obesity prevention efforts; and (4) carry out various other coordinating activities.

This new office would be directed by a new medical officer who would report directly to the State Public Health Officer. Part of the funding would also be used to implement a "worksite wellness" initiative by which DHS employees would themselves be encouraged through various strategies to lose or maintain a healthy weight.

Grants to Community Organizations. The Governor's proposal includes approximately \$3 million for grants to community organizations to implement projects involving schools and other local agencies and organizations to address various aspects of obesity prevention. For example, a grant might be used to support a project to encourage the layout of new housing developments in designs that encouraged new residents to walk to stores and schools instead of driving to them. The department estimates that 15 such projects would be funded through a competitive process with the funding that the administration is requesting. The administration is additionally requesting \$500,000 for technical assistance and training for these regional and local obesity prevention efforts.

Enhanced Health Services for Medi-Cal Children. About \$1.4 million would be provided to develop an initial demonstration project targeted at improving the quality of health care provided to Medi-Cal children to prevent or address obesity problems. This project would consist of three main activities: (1) the promotion of breastfeeding and the exclusion of other methods for feeding infants, (2) increased screening and counseling of children for obesity problems by primary care providers, and (3) improved referral and treatment services for children who are overweight or at risk of becoming overweight. This project would be implemented in up to six collaboratives made up of hospitals, clinics, and other medical service providers that serve significant numbers of Medi-Cal beneficiaries.

Other Components. The initiative includes \$500,000 for public health surveillance activities, program evaluation, and research into the design and development of effective public health initiatives to stem the rise in obesity. Lastly, the initiative includes approximately \$150,000 for public

relations materials and events intended to encourage the public to live healthier lifestyles and not be overweight.

Assessing the Governor's Proposal

Given the mounting medical evidence of the costly health problems that can result from obesity, the administration's increased focus on improving the state's efforts to help curb the rise of this serious public health problem is warranted. However, our analysis indicates that there are several problems with the administration's approach, as discussed below.

New Programs First, Assessment Later. Currently, DHS spends about \$1.2 billion annually from federal and private sources for a variety of programs that are intended to promote good nutrition and increased physical activity as a means to improve public health. (Of this amount, approximately 75 percent of the funding is for nutritious food provided to low-income families through the Women, Infants, and Children (WIC) program.) This figure does not include the expenditures in other state departments for anti-obesity activities.

Among other activities, the department's obesity prevention programs provide nutrition education to low-income women and young children, promote physical activity and healthy eating behaviors through public media campaigns, help develop school nutrition policy, and provide technical assistance and training to other entities engaged in obesity prevention efforts. The DHS has indicated that one of the functions of the proposed new state office is to assess how these existing programs could be better managed and focused on reducing obesity.

Nevertheless, the administration proposal immediately seeks additional General Fund resources for new obesity prevention efforts before such an assessment has been completed. This assessment is critical to avoid any duplication of effort and to understand (and eventually maximize) the full potential of our existing programs.

Some overlap with existing activities appears evident. For example, the Epidemiology and Health Promotion section of the Chronic Disease Control Branch of DHS already operates a "California Obesity Prevention Initiative." This initiative, with an annual budget of \$275,000 in federal funds, embarks upon many activities, which appear to be similar to those described in the Governor's new budget request. For instance, the initiative is involved in strategic planning, the identification and improvement of data collection and public health surveillance activities, the development of a pilot program to increase student physical fitness activity before and after school, and the provision of training and technical assistance to others both inside and outside the department. The new DHS office pro-

posed to centralize anti-obesity efforts appears to duplicate many functions already being performed within the department.

Alternative Funding Sources Available for Some Components. In its funding request, DHS has asserted that almost all of its existing programs to encourage good nutrition and greater physical activity target high-risk, low-income communities, largely because that focus is required as a condition of receiving federal funds to support them. According to DHS, General Fund support for new anti-obesity activities is necessary because no other funding source is available for its proposed projects, which are intended to improve the public health of a broader segment of the California population.

However, our analysis indicates that alternative funding sources are available in lieu of the General Fund for certain components of this proposal. For example, federal authorities have indicated that states can seek federal approval to establish a so-called “public health initiative” to address targeted health needs of children or carry out supplemental health care-related services not otherwise available through certain other federally supported programs. Every state dollar allocated for such a demonstration project could be used to draw down \$2 in federal funds under the SCHIP for certain anti-obesity activities. For example, subject to federal approval, we believe it is likely that SCHIP funds could be available for the component of the administration’s proposal to improve screening for obesity problems and other medical services for Medi-Cal children.

Another potential alternative funding source is the Health Information Data Statistics Fund, which consists of revenues derived from fees charged for document (such as marriage and birth certificate) searches and services provided to certain state and federal programs. State law allows this fund to be used to support the conduct of special health studies and to prepare statistical reports concerning the health status of Californians. Our analysis suggests that some of these same activities in the new state anti-obesity office could be supported from this special fund in lieu of the General Fund spending proposed by the administration. We also believe grant funding available from the National Institutes of Health and the Centers for Disease Control—resources not currently accessed by DHS—could also be explored.

Analyst’s Recommendations

Slimmer Budget Warranted. In light of the concerns we have identified with the administration’s anti-obesity initiative, we recommend that the Legislature reduce the funding request by \$5.9 million. We recommend that the Legislature approve only the request for \$180,000 from the General Fund for the medical officer position (and related operational costs) to direct the department’s coordinating activities. Additionally, the Legisla-

ture should redirect existing DHS funding and staff resources from the existing obesity prevention initiative in the Chronic Disease Control Branch to create the new centralized anti-obesity program.

This new DHS office should be directed to complete its assessment of the department's existing programs and to exhaust all available opportunities for obtaining alternative sources of funding in lieu of General Fund support for any new activities that do not duplicate existing DHS programs and functions. Once that has occurred, the administration could return to the Legislature next year with a revised budget request for any additional General Fund resources that are needed to advance efforts against obesity.

We also note that we view the worksite wellness initiative as a lower priority compared to direct services provided by this or other departments and recommend that this component of the proposal be rejected or implemented through a redirection of existing administrative resources.

Should the Legislature determine that it wished to move forward now with certain components of this initiative and not wait for an assessment of existing resources, we recommend it restructure the proposal to maximize the alternative fund sources that we have identified above.

OTHER PUBLIC HEALTH PROGRAM ISSUES

GHPP Accounting Adjustment Would Provide Savings and Consistency

We recommend that the department report at budget hearings on its estimate of the fiscal effect of shifting the Genetically Handicapped Persons Program from an accrual to cash basis of accounting. This change would bring the program in line with other Department of Health Services programs operating under a similar basis of accounting and could achieve net onetime program savings of several millions of dollars in the General Fund.

Background. In recent years, the Legislature has approved various program accounting changes in order to achieve onetime state savings. The 2003-04 Budget Act and related legislation shifted the Medi-Cal Program from an accrual to a cash basis of accounting. The 2004-05 Budget Act adjusted the spending level for the mental health services component of the Early and Periodic Screening, Diagnosis and Treatment Program to reflect the use of the same accounting basis as the rest of Medi-Cal. These technical changes had the effect, on a onetime basis, of shifting a portion of the programs' budget for a particular year to the next fiscal year.

The Governor's budget proposes a similar accounting change for the CHDP program, a change that is estimated to achieve onetime General Fund savings of approximately \$500,000 in 2005-06. The department indicates that such a change is warranted because of CHDP's financial support for the gateway, a program that screens for and connects children who are otherwise eligible for or currently enrolled in HFP or Medi-Cal to those programs. Most gateway funding comes from Medi-Cal, which, as noted earlier, is on a cash basis. It is also our understanding that the CCS program (a program that provides health care services to severely ill and medically fragile children) is already budgeted on a cash basis in part because of that program's close financial relationship with Medi-Cal. Notably, the Genetically Handicapped Persons Program (GHPP) (a program that provides comprehensive health care services to severely ill adults) is now budgeted on an accrual basis, which potentially complicates coordination of its "state only" component with Medi-Cal. The department has indicated that it might be possible to move this program to a cash accounting basis.

Analyst's Recommendation. We recommend that DHS report at budget hearings on its estimate of the fiscal effect of a shift of GHPP to a cash basis of accounting in order to make the program consistent with other DHS programs. We estimate that such a shift would result in potentially several millions of dollars in General Fund savings on a onetime basis.

Information Pending on ADAP Federal Allocation and Drug Rebates

We withhold recommendation on the AIDS Drug Assistance Program (ADAP) budget for local assistance funding given the uncertainty about how much money this program will receive from its federal funding allocation and supplemental rebates from drug manufacturers. In order to reduce the future reliance of ADAP on the state General Fund, we recommend that the Legislature approve two additional staff positions requested for the negotiation of better price discounts with drug manufacturers.

Program Description and Budget Proposal. The ADAP is a prescription drug assistance 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. The budget proposes \$264 million from all fund sources for ADAP in 2005-06, an increase of \$18.8 million over the revised current-year budget for the program. Of the amount requested, approximately 35 percent would originate from the General Fund, 38 percent from federal funds, and 27 percent from rebates paid to the state from drug manufacturers (which are deposited into the ADAP Rebate Fund). The Governor's budget also proposes to appropriate \$230,000 from the

ADAP Rebate Fund for two new staff positions and their associated operational costs to negotiate drug rebates with manufacturers.

Federal Funding Allocation and Supplemental Rebate Negotiations are Pending. The ADAP receives its federal funding under Title II of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, which is administered by the Health Resources and Services Administration in the U.S. Department of Health and Human Services. Final confirmation of California's share of the next annual grant is expected to be received in April 2005.

Currently, the department receives supplemental rebates from manufacturers for certain HIV and HIV-related drugs. The supplemental rebates are in addition to those rebates required under federal law. Most of these rebates are scheduled to expire on March 31, 2005. At present, the department is participating in negotiations conducted by a nationwide task force of AIDS programs to obtain new supplemental rebate agreements. The outcome of these negotiations could significantly affect the level of rebates received by California, as well as the other participating states, in the budget year.

No Staff Resources Dedicated to Rebate Negotiations. Currently, ADAP does not have any staff dedicated solely to negotiating ADAP supplemental rebates. Currently, this responsibility is shared between a DHS program chief and a program specialist. According to the department, the two additional positions it is requesting in ADAP would increase its capabilities for negotiating bigger rebates on the state's drug costs and help to ensure that the state receives the maximum allowable rebates from drug manufacturers.

In addition, DHS indicates that without these positions it would have limited staff time to participate and intervene in California's behalf to secure continued federal funding for California's program. The Ryan White CARE Act is scheduled to expire in September 2005 and must be reauthorized by Congress if federal funds are to continue for ADAP and comparable programs in other states. The federal reauthorization process provides not only an opportunity for Congress to evaluate the impact of the Ryan White CARE Act funds, but also to implement changes to current funding allocation methodologies and priorities that may affect California.

Our analysis indicates that the savings or cost avoidances to the General Fund that could result from adding these two staff members are likely to outweigh the personnel and operating costs of two positions.

Analyst's Recommendation. We withhold recommendation on the Governor's proposed local assistance budget for the ADAP program pending the receipt of additional information regarding the state's federal ADAP allocation and the outcome of the supplemental negotiations for discounts

with drug manufacturers. Also, we recommend that the Legislature approve the two staff positions requested for ADAP in order to bolster the pharmaceutical expertise in the program for the purpose of obtaining additional drug discounts from manufacturers.

Evaluating the Governor's California Rx Proposal

The Governor's 2005-06 budget plan includes a funding request and related legislation for a new state program to help low- and moderate-income Californians purchase prescription drugs at discounted prices. Our analysis indicates that the Governor's California Rx plan provides a reasonable starting point for the development of such a program, but we recommend modifications to the proposal that we believe will result in a more effective program that will protect the interests of California taxpayers and consumers. We propose, among other changes, that in the event that drug makers fail to make good on their promises for significant price concessions, an automatic trigger would phase out the proposed voluntary approach to obtaining rebates from drug manufacturers, and be replaced by an alternative strategy likely to result in greater discounts on more drugs for consumers.

We discuss the Governor's California Rx pharmacy proposal, including our recommendations for reducing the number of staff positions and funding requested for this policy initiative in the 2005-06 budget, in "Part V" of *The 2005-06 Budget: Perspectives and Issues*.

State Lacks a Unified Approach on Homeland Security

California has received almost \$900 million in federal homeland security funds, including bioterrorism preparedness grant activities coordinated by the state Department of Health Services, which has helped the state start addressing homeland security needs. The state, however, lacks a unified strategic approach to homeland security. In addition, only 31 percent of the state's homeland security funds have been spent to date. We make a number of recommendations on how to address these problems in the state's homeland security approach.

We discuss our recommendations on the state's use of homeland security funds, including DHS bioterrorism preparedness grant activities in the "Crosscutting Issues" section of the General Government Chapter.



HEALTH SERVICES—STATE OPERATIONS

The Department of Health Services (DHS) administers a broad range of programs for primary care and family health, public health, environmental health, and county health services. It also administers the Medi-Cal Program, which provides health care services to welfare recipients and other qualified low-income persons (primarily families with children and the aged, blind, or disabled). The DHS operates certification and licensing programs for certain types of medical providers, including nursing homes and hospitals.

The Governor's budget for DHS state operations proposes \$264 million from the General Fund (\$987 million from all fund sources) for 2005-06. The proposed budget would provide an increase of about \$3.6 million in General Fund resources, or about 1.4 percent, compared with the revised current-year level of expenditures for DHS state operations. These resources would be used to support almost 5,700 staff and offset other program expenses.

Information Technology Projects Violate State Rules

We withhold recommendations on several proposals to modify or develop information technology systems pending receipt and review of Feasibility Study Reports to support the requests.

The budget proposes \$13.8 million (all funds) and nine positions for a number of new or modified information technology (IT) systems for DHS. Figure 1 describes the requests and their proposed costs and positions. In "Part V" of *The 2005-06 Budget: Perspectives and Issues*, we provide specific recommendations on the proposed IT system for the California Rx program. We discuss the remaining proposals below.

Feasibility Study Reports (FSRs) Needed to Justify IT Proposals. Current state policy requires departments to prepare FSRs for any IT proposal that is included in the budget. The FSR must include (1) a description of the program problems that the department is attempting to solve, (2) the costs to develop and maintain the new or modified system, and (3) implementation schedules describing the tasks and timeframes to complete the IT proposal. In addition, according to state policy, IT projects that are included in

the budget must be submitted to the Legislature and receive approval from the Department of Finance (DOF). At the time this analysis was prepared, the department had not provided FSRs or detailed information to support any of the proposals. In addition, it is not clear why DOF approved these requests even though FSRs have not been prepared.

Figure 1
Department of Health Services
Information Technology Proposals
2005-06

(Dollars in Thousands)

Description	Costs	Positions
Medi-Cal eligibility information— Modify existing IT systems.	\$5,130	—
Medi-Cal beneficiary cost sharing— Develop new payment and reconciliation IT system.	2,000	—
Dental providers— Modify existing IT system.	2,000	1.5
Estate recovery and personal injury cases— Develop new case management system.	1,400	4.0
Medi-Cal managed care— Modify existing IT system.	1,215	2.0
California Rx program— Develop new IT system.	1,000	1.0
County caseload trends— Create reports.	743	—
Hospital financing— Modify existing IT system.	270	—
Totals	\$13,758	8.5

Withhold Recommendations on IT Proposals. Since FSRs have not been provided for these proposals, it is not clear what specific business problems the department is attempting to address, how much the new or modified systems would cost to maintain and operate, and how long it will take to implement or change the systems. For these reasons, we withhold recommendations on the proposals pending the receipt and review of FSRs to support the requests.

MANAGED RISK MEDICAL INSURANCE BOARD (4280)

The Managed Risk Medical Insurance Board (MRMIB) administers several programs designed to provide health care coverage to adults and children. The Major Risk Medical Insurance Program (MRMIP) provides health insurance to California residents unable to obtain it for themselves or their families because of 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 and, beginning this year, provides health coverage for certain uninsured infants born to AIM mothers.

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

Budget Proposal. The budget proposes \$1 billion from all fund sources (\$356 million from the General Fund) for support of MRMIB programs in 2005-06, which is an increase of \$66 million from all fund sources (\$30 million from the General Fund) or about 7 percent over estimated current-year expenditures. This increase is due primarily to projected caseload growth in the Healthy Families Program, in part resulting from the shift of certain AIM infants to the Healthy Families Program, and the administration's proposals to enhance education and outreach activities in the Healthy Families Program and Medi-Cal.

The Governor's budget plan includes the following significant changes to MRMIB programs:

- ***Enhanced Contractor Oversight and Customer Service.*** The Governor's budget includes \$2.2 million from all sources (\$775,000 from the General Fund) and an additional 24.5 positions to improve the oversight of the Healthy Families Program contractor and services to program participants. We more fully describe this request and our analysis of the proposal later in this section.
- ***Enhanced Outreach and Education Activities.*** The budget plan includes \$14.4 million in funding (\$5.9 million from the General Fund) to improve Healthy Families and Medi-Cal education and outreach activities. This funding would be used to (1) reinstate a program that had been discontinued by which the state pays fees to certified application assistants who help low-income families enroll in health coverage, (2) establish three additional staff positions to administer the fees and related outreach activities, and (3) fund the increase in Healthy Families enrollment that is expected to result from these actions.
- ***Increased Premiums for Children in Higher-Income Families.*** Budget-related legislation adopted last year to implement the *2004-05 Budget Act* authorized a \$6 increase per month in Healthy Families premiums for children in families earning incomes over 200 percent of the FPL beginning in 2005-06. The Governor's budget includes the additional revenues from the implementation of this increased premium for these children.
- ***Shift of AIM Infants to Healthy Families Program.*** The budget further reflects the continued efforts to shift infants born to AIM mothers into the Healthy Families Program at birth. Health coverage for the infant's mother continues to be provided through AIM.
- ***Funding Shift for AIM Mothers.*** The administration proposes to substitute General Fund resources for Proposition 99 funds to help pay for prenatal services provided to mothers enrolled in AIM. The General Fund resources then would be used to draw down a two-to-one federal match to cover the remaining costs of prenatal services provided through this program. The administration estimates that this proposal will free up approximately \$78 million in Proposition 99 funds and result in a net savings in state funds of approximately \$51 million in the budget year in the AIM program. We discuss this proposal in more detail within the "Crosscutting Issues" section of this chapter.

- **Leverage of Federal Funds for County Health Initiatives.** The Governor's budget plan includes \$140,000 in the current year (\$261,000 in the budget year) in foundation and federal funding and three additional staff positions to provide technical assistance to counties that are developing or expanding their local health insurance initiatives and to improve access to CHIM. These positions will also work to develop an option for counties to purchase state coverage for children who are not eligible for the Healthy Families Program. This option would benefit counties that do not have the funds or capability to create their own separate health insurance programs for children.

HEALTHY FAMILIES PROGRAM

Background

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

California utilizes its SCHIP funding to support the Healthy Families Program. Through this program, children in families earning up to 250 percent (and in select cases up to 300 percent) of the FPL receive comprehensive health care coverage that includes dental, vision, and basic mental health care benefits. Families pay a relatively low monthly premium and can choose from a selection of managed care plans for their children. This program is administered by MRMIB. (We provide more information regarding this program in our *Analysis of the 2004-05 Budget Bill*, page C-145.)

The Budget Proposal. As shown in Figure 1, the January budget proposes \$903 million (all funds) in Healthy Families Program expenditures in the budget year. This is an increase of about 11 percent over estimated current-year expenditures. The budget proposes \$328 million in General Fund support for the Healthy Families Program, a \$34 million increase above the current-year level. The increase in General Fund expenditures is primarily due to growth in caseload, staff augmentations, and the administration's proposals to restore outreach and education efforts in the program.

Figure 1**Managed Risk Medical Insurance Board
Healthy Families Program Expenditures***(Dollars in Millions)*

	2004-05		2005-06	
	Budget Act	Revised	January Budget	Percentage Change From Revised
Local assistance	\$871.5	\$806.8	\$894.9	11%
State operations	5.2	5.6	8.2	46
Totals^a	\$876.7	\$812.3	\$903.2	11%
General Fund	\$320.6	\$293.5	\$327.7	12%
Proposition 99	1.0	1.0	1.0	—
Federal funds	547.3	510.2	564.5	11
Reimbursements	7.8	7.6	9.9	30

^a Detail may not total due to rounding.

ACCESS FOR INFANTS AND MOTHERS

Background

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

In accordance with statutory budget language adopted in the 2003-04 *Budget Act*, infants born to AIM mothers who enroll in the program after July 1, 2004 are now enrolled in the Healthy Families Program at birth, while the mothers will remain covered through the AIM program. Over time, this shift of new AIM infants into the Healthy Families Program will

result in an AIM program consisting only of mothers. (We provide more information regarding the program in our *2004-05 Analysis*, page C-158)

Governor's Proposal

Significant Fund Shifts and Decrease in Spending. As summarized in Figure 2, the Governor's budget proposes about \$101 million from all funds (including approximately \$29 million from the General Fund and \$19 million in Proposition 99 funds) for the AIM program. This is a significant decrease in total spending of \$23.4 million (or 19 percent) from 2004-05 due primarily to the redirection of infants to the Healthy Families Program. Under the Governor's budget proposal, the AIM program would be more heavily financed with state General Fund and federal resources in the current and budget years. (We provide more information regarding these fund shifts in the "Crosscutting Issues" section of this chapter.)

Figure 2

Access for Infants and Mothers Program Budget Summary

(Dollars in Millions)

	2003-04	2004-05	2005-06	Percentage Change
Perinatal Insurance Fund (Proposition 99)	\$90.7	\$30.4	\$19.2	-37%
General Fund	7.1	32.8	28.5	-13
Federal funds	13.2	60.9	52.9	-13
Totals	\$111.1	\$124.1	\$100.6	-19%

Detail may not total due to rounding.

Caseload Shifts. In accordance with the recent changes in statute, the Governor's budget reflects the discontinuation of AIM coverage of infants who are redirected to coverage under the Healthy Families Program. Figure 3 summarizes the impact this new law is projected to have on AIM caseloads in the budget year.

While caseloads for women are expected to increase by 10 percent in 2005-06, the number of infants in their first year of AIM coverage is projected to decline by 87 percent. This dramatic decline is due to the shift of newborns from coverage in AIM to the Healthy Families Program. Infants of mothers who were enrolled before the change took effect will remain in

AIM as long as they are eligible. However, as Figure 3 also shows, the number of these infants is also declining. The MRMIB indicates that the infant caseload in the AIM program will be gone by the end of December 2006, as the children reach age two and are automatically disenrolled from the AIM program.

Figure 3
Access for Infants and Mothers
Caseload Summary

Projected Total Enrollment	2004-05	2005-06	Percentage Change
Women	8,491	9,340	10%
First-year infants	71,160	8,946	-87
Second-year infants	80,114	72,607	-9
Totals	159,765	90,893	-43%

MRMIB—STATE OPERATIONS

Mixed Signals From Administration, Staff Requests Must Be Clarified

The administration is sending mixed signals with regard to its requests for administrative support for the Managed Risk Medical Insurance Board that should be clarified before the Legislature considers its request for additional staff. Pending that clarification, we recommend the Legislature reject this proposal. (Reduce Item 4280-0001-0001 by \$775,000 and Item 4280-001-0890 by \$1,440,000.)

Governor’s Proposal. The Governor’s budget includes a request for an additional 24.5 positions and \$2.2 million in funding (\$775,000 from the General Fund) to enable MRMIB to enhance its oversight of the administrative contractor for the Healthy Families Program and AIM, to improve the customer services provided under its health insurance programs and provide general administration support of MRMIB. These additional support resources, we are advised, would be used for four distinct types of activities: (1) contract and fiscal management of program expenditures, (2) application and enrollee complaints and appeals, (3) onsite coordination and monitoring of the administrative vendor contract, and (4) executive management activities. In general, this proposal would restore positions that had been reduced from the MRMIB in recent fiscal years as part of state-

wide efforts to reduce the cost of state operations, as well as provide additional department staff to enhance its operations.

In addition to this and other program augmentations, the budget plan also proposes an unallocated reduction in MRMIB's state operations budget of \$937,000 (all funds).

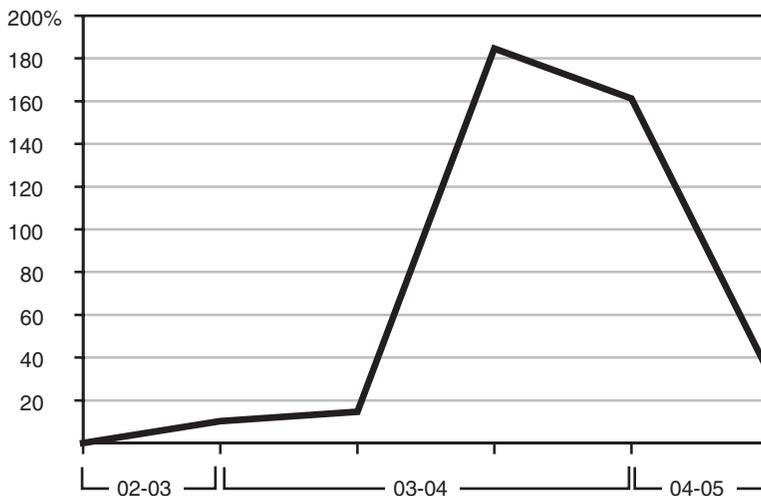
Assessing the Governor's Proposal. During the current year, the board experienced a number of budget and administrative changes, which have led to increased workload and turnover among staff at the board. For example, the board encountered a number of problems during its transition to its new administrative vendor that handles the eligibility and enrollment functions for the AIM and Healthy Families programs. Previous budget actions had eliminated funding for application assistance. This, in turn, had the effect of increasing the number of denied applications and appeals of such denials that are handled by MRMIB staff. The administration's lifting of a statewide hiring freeze resulted in the departure of a number of MRMIB staff to other state departments.

However, some of this increase in workload appears to be temporary. For example, our analysis indicates that the upswing in appeals is beginning to level off. As seen in Figure 4, the percentage increase in appeal requests spiked during two quarters of the current year, but now appears to be in line with previous trends.

The MRMIB has indicated that the unallocated reduction proposed for 2005-06 represents the equivalent of eliminating 13 staff positions. At the time this analysis was prepared, MRMIB was unable to identify exactly how it would achieve this reduction but indicated that the unallocated reductions would likely come out of its proposed staffing.

Analyst's Recommendations. While we acknowledge that the department has experienced an increase in workload as a result of recent budget and administrative changes, the administration is sending mixed signals with regard to its staffing requirements that should be clarified before the Legislature considers its staffing proposal. The administration has requested legislative approval for 24.5 positions, but at the same time has indicated that if the Governor's budget plan was approved it would reduce this request—in some unknown way—later in the fiscal year.

In our view, it is not appropriate for the administration to request position authority and funding for management positions it indicates that it may not fill. Coupled with the proposal for an unallocated reduction, this proposed approach to budgeting undermines legislative oversight. Once the Legislature granted the MRMIB augmentation, the administration would later determine, at its own discretion, which additional positions and funding would be deleted. For these reasons, we recommend the Legislature reject this request for a staffing augmentation.

Figure 4**Growth in MRMIB Appeals Has Dropped***Percent Change in Requests By Quarter*

MAJOR RISK MEDICAL INSURANCE PROGRAM

Background

The MRMIP provides comprehensive health coverage for Californians who are generally unable to obtain coverage in the individual insurance market or are able to obtain insurance only at a high cost. Typically, these individuals are considered by insurers to be high-risk since they have so-called “pre-existing medical conditions”—that is, conditions that were treated or diagnosed by a doctor prior to the individual’s enrollment in health insurance. While other state programs directly purchase health insurance coverage for individuals, MRMIP reimburses insurers when individuals incur high medical costs that exceed the regular health coverage provided to them by that insurer.

Limited Spending Led to Waiting Lists. Historically, the state has provided a set appropriation of \$40 million each year from Proposition 99 tobacco tax revenues to fund health care coverage for this particular population. The Proposition 99 funds are transferred to the Major Risk Medical Insurance Fund, the source of support for the state’s high-risk insurance program.

Given the state's practice of budgeting a fixed amount of funding each year, the number of individuals enrolled in the program at any given time has been capped in order to remain within the available appropriation. Historically, MRMIP has experienced lengthy waiting lists.

In 2002, the state enacted Chapter 794, Statutes of 2002 (AB 1401, Thomson), which, among other changes, limited the length of time individuals could be enrolled in MRMIP to 36 months. Chapter 794 also required private health plans and insurers to offer guaranteed coverage in the private market to individuals after they reached this time limit. These changes were implemented on a pilot basis and are in effect until September 2007. As a result of these changes, the department now uses its \$40 million appropriation both to subsidize health care coverage for individuals enrolled in MRMIP and those enrolled in the guaranteed private coverage. These policy changes enabled everyone on the waiting list to enroll in the program (after fulfilling a standard three-month waiting period).

Governor's Budget Proposal. The Governor's 2005-06 budget plan includes the customary \$40 million in Proposition 99 funding through the Major Risk Medical Insurance Fund for MRMIP. The budget plan also sets aside a reserve in the Major Risk Medical Insurance Fund to ensure the program has sufficient revenues to cover any unanticipated operating expenses. Under the 2005-06 budget plan, the reserve would total \$20.2 million, an amount roughly equal to 50 percent of the program expenditures annually supported by the fund.

Cost Uncertainties in MRMIP

In light of uncertainties surrounding program expenditures in the Major Risk Medical Insurance Program, we recommend the Legislature direct the Managed Risk Medical Insurance Board (MRMIB) to provide updated caseload and expenditure estimates for the current and budget years in May. Additionally, given the recent significant changes to the program, we recommend MRMIB be directed by statute to submit a detailed estimate of caseload and program spending to the Legislature in January and May of each year.

Caseload Lower Than Anticipated in the Current Year. Based on our review of caseload data through October 2004, we estimate that the average number of individuals enrolled in MRMIP in the current year will total 9,779—about 940 below the department's estimate. Moreover, the number of individuals enrolling in private coverage after they "timed out" of public coverage is also lower than anticipated. Overall, the department is subsidizing fewer persons than expected in the current year. Caseload trends do suggest that the program will reach its enrollment cap early in the bud-

get year, and thus the entire \$40 million proposed in the budget plan for continuation of the program will probably be needed.

Data Limitations Prevent Analysis of Actual Program Expenditures. In April 2004, the department encountered data issues, partially caused by significant caseload changes resulting from Chapter 794, which limited its ability to project MRMIP expenditures. The department has indicated that it expects to resolve these issues by this spring.

Analyst's Recommendation. Although current caseload trends indicate that the department is serving fewer high-risk individuals than originally anticipated, data limitations prevent us from definitively calculating the estimated savings at this time. Accordingly, we recommend the Legislature direct the department to provide updated caseload and expenditure estimates for the current and budget years at the time of the May Revision.

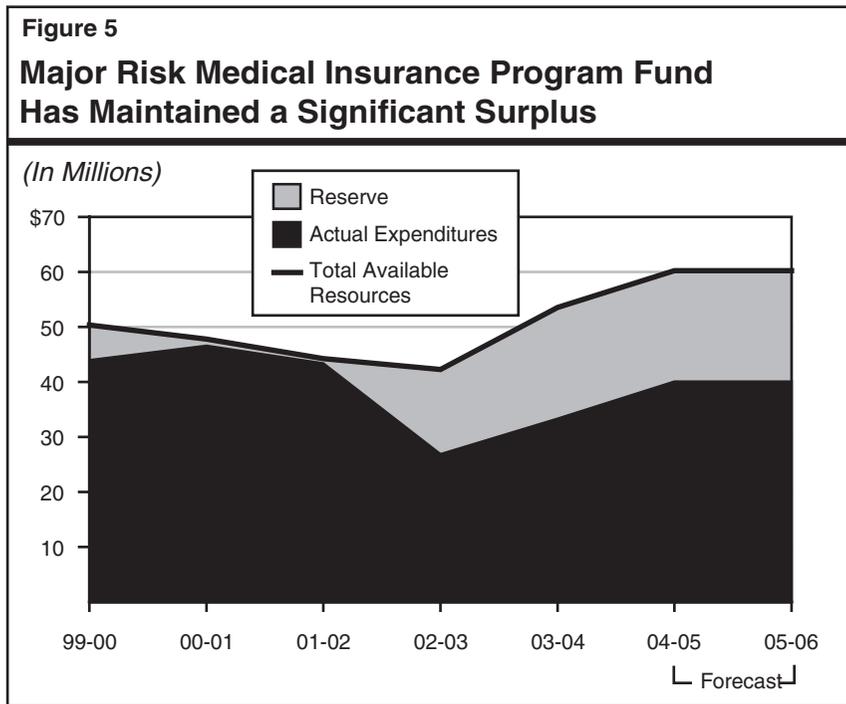
Furthermore, the recent significant programmatic changes that are occurring in the program warrant a closer and regular review by the Legislature of fluctuations in caseload and program spending. For this reason, we recommend MRMIB be directed by statute to submit to the Legislature a detailed estimate of caseload and program expenditures each January, as part of the department's budget plan, and again at the time of the May Revision. It is our understanding that this information is already compiled twice per year by the department and easily could be incorporated into the budget information MRMIB currently provides to the Legislature regarding its other programs.

Reserve Requirement Unnecessary

We recommend the Legislature repeal the statutory requirement that the Managed Risk Medical Insurance Board maintain a separate state reserve fund for the state's program to help persons who have trouble obtaining private health insurance coverage. It should also repeal a state law that authorizes unspent funds be carried forward to the succeeding fiscal year. We further recommend the Legislature redirect the \$18.2 million in Proposition 99 funding made available through these actions to other Proposition 99 programs in a way that would result in an equivalent amount of savings to the state General Fund and increase the Proposition 99 reserve by \$2 million.

State Law Mandates a Reserve and Authorizes Unspent Funds to be Carried Forward. State law requires MRMIB to maintain a reserve in the Major Risk Medical Insurance Fund (which consists of Proposition 99 revenues) that is sufficient to "prudently operate" MRMIP. However, the level of this reserve is not specified by law. Additionally, state law specifies that unspent monies in the fund may be carried into the next fiscal year.

Historically, the Major Risk Medical Insurance Fund has maintained a fund balance ranging between 0.2 percent and 61 percent of program expenditures supported by the fund. Generally, this reserve consists of unspent funds rolled over from prior years. Our analysis indicates that this reserve has not been tapped to help support the program since 2000-01. As seen in Figure 5, the total resources available for the support of MRMIP (the top line in the chart) have exceeded the program's expenditures for the past five years, resulting in a significant ongoing reserve due in part to the policy changes made pursuant to Chapter 794.



The administration has indicated that the reserve is needed because of the uncertainties associated with the recent implementation of Chapter 794 and the possibility of programmatic changes after the pilot expires in 2007. However, our analysis indicates that there is currently no need for a separate and special reserve fund for MRMIP. In the event that MRMIP program expenditures exceeded the 2005-06 budgeted amount, an alternative source of funding is available to fund unanticipated expenses. Specifically, a separate reserve is maintained for state programs funded through Proposition 99. The Governor's 2005-06 budget plan proposes to set aside \$16.7 million for the Proposition 99 reserve.

Analyst's Recommendation. In light of the state's fiscal difficulties, and the availability of the Proposition 99 reserve for any deficiencies for the support of MRMIP, we recommend the Legislature repeal the state law requiring a separate Major Risk Medical Insurance Fund reserve, as well as the state law that authorizes unspent funds to carry forward to the succeeding fiscal year. This action would free up as much as \$20.2 million in Proposition 99 savings on a one-time basis.

We would also recommend that the Legislature redirect part of the savings from the elimination of the separate MRMIP reserve fund to augment the Proposition 99 reserve to reflect the additional potential risk of a MRMIP deficiency. The department has indicated that it had customarily set aside a prudent reserve of 2 percent of program expenditures. In light of the uncertainties surrounding the recent implementation of Chapter 794, we believe augmenting the Proposition 99 reserve by 5 percent, or \$2 million, would provide a prudent reserve for the budget year. This would leave \$18 million in Proposition 99 savings that could be used in coordination with other state health programs to achieve General Fund savings. For instance, the Legislature could consider utilizing Proposition 99 funds in lieu of General Fund resources for particular activities that are consistent with the specified uses of Proposition 99.



DEVELOPMENTAL SERVICES (4300)

A developmental disability is defined as a severe and chronic disability, attributable to a mental or physical impairment that originates before a person's 18th birthday, and is expected to continue indefinitely. Developmental disabilities include, but are not limited to, mental retardation, cerebral palsy, epilepsy, autism, and disabling conditions closely related to mental retardation. The Lanterman Developmental Disabilities Services Act of 1969 forms the basis of the state's commitment to provide developmentally disabled individuals with a variety of services, which are overseen by the state Department of Developmental Services (DDS). Unlike most other public social services or medical services programs, services are generally provided to the developmentally disabled at state expense without any requirements that recipients demonstrate that they do not have the financial means to pay.

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

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

agencies. The RCs also purchase services, such as transportation, health care, respite, day programs, and residential care provided by community care facilities. The department contracts with the RCs to provide services to almost 200,000 clients each year.

Developmental Centers (DC) Program. The department operates five DCs, and two smaller leased facilities, which provide 24-hour care and supervision to approximately 3,300 clients. All the facilities provide residential and day programs as well as health care and assistance with daily activities, training, education, and employment. More than 8,300 permanent and temporary staff serve the current population of 3,300 at all seven facilities.

Budget Proposal. The budget proposes \$3.7 billion (all funds) for support of DDS programs in 2005-06, which is a 4.7 percent increase over estimated current-year expenditures. General Fund expenditures for 2005-06 are proposed at \$2.3 billion, an increase of \$130 million, or 5.9 percent, above the revised estimate of current-year expenditures.

The budget proposes \$3 billion from all funds (\$1.9 billion from the General Fund) for support of the Community Services Program in 2005-06. This represents a \$143 million General Fund net increase, or 7.9 percent, over the revised estimate of current-year spending primarily as a result of caseload growth, higher utilization rates for services, and other program changes. The increases would be partly offset by proposed reductions in the budget including policy initiatives to impose long-term cost containment measures on RC purchase of services and expand a self-directed services program commonly referred to as self-determination. Another policy initiative would implement a statewide Quality Management System (QMS) the administration believes is necessary to maintain and increase federal funding. The 2005-06 Community Services Program also includes a net reduction of \$60 million in General Fund and an equivalent increase in federal funds due to the proposed transfer of federal Title XX Block Grant funds from the Department of Social Services.

The budget proposes \$699 million from all funds (\$373 million from the General Fund) for the support of the DCs in 2005-06. This represents a net decrease of \$14 million General Fund, or 4 percent, over the revised estimate of current-year expenditures. The decrease in General Fund resources is mainly due to the continuing decline in the DC population.

The budget proposes \$37 million from all funds (\$24 million from General Fund) for support of headquarters. About 60 percent of headquarters funding is for support of the community services program with the remainder for support of the DC program.

THE REGIONAL CENTER SYSTEM: GROWTH TRENDS CONTINUE

The 2005-06 budget proposal for community services reflects the increasing costs to the state for the services and supports provided by regional centers (RCs) for persons with developmental disabilities. While the growth trend remains strong overall, the budget plan does not correct for recent trends indicating that caseloads are lagging somewhat below the level budgeted for 2004-05. We recommend that the Legislature reduce RC expenditures by \$9 million General Fund (\$12 million all funds) to correct for overbudgeting of expenditures in both the current and the budget year.

Background

The Regional Center System

Fund Sources. General Fund support has typically accounted for about 65 percent of the RC budget in recent years, while federal reimbursements resulting from the state's participation in a Medicaid waiver program for certain clients are the source of about 21 percent of RC support. Other major sources of RC funding include: (1) federal Title XX Social Services Block Grant funds; (2) federal Targeted Case Management funds; and (3) other federal funds, mainly related to Early Start services for infants.

Two Types of Expenditures. The RC budget is mainly comprised of two major types of expenditures—*purchase of services* and *RC operations*.

The Governor's budget proposes \$2.5 billion for RC purchase of services in 2005-06. The total purchase of services budget consists of ten basic service categories plus adjustments to reflect various funding or program changes, such as unallocated reductions, and changes in eligibility. Figure 1 shows the Governor's revised and proposed expenditures for 2004-05 and 2005-06 for each of these categories. The ten purchase-of-service categories are as follows:

- **Day Programs.** These programs are designed to develop a variety of skills including but not limited to: self-help and self-care; the ability to interact with others; self advocacy and employment skills; and community integration skills.
- **Community Care Facilities.** These facilities provide 24-hour non-medical residential care to children and adults with developmental disabilities who need personal services, supervision, and assistance in daily living activities.

Figure 1
Regional Center Purchase of Services
By Service Category

All Funds (Dollars in Thousands)

Service Category	2004-05	2005-06	Change	
			Amount	Percent
Day Programs	\$619,718	\$668,836	\$49,118	7.9%
Community Care Facilities	599,139	662,193	63,054	10.5
Support Services	384,648	415,928	31,280	8.1
Transportation	172,928	181,422	8,494	4.9
In-Home Respite	161,410	175,465	14,055	8.7
Habilitation Services	123,453	124,485	1,032	0.8
Health Care	64,519	64,044	-475	-0.7
Out-of-Home Respite	38,355	46,830	8,475	22.1
Medical Facilities	17,658	20,746	3,088	17.5
Miscellaneous Services	148,170	135,846	-12,324	-8.3
Adjustments	-22,559	-23,855	-1,296	5.7
Totals	\$2,307,439	\$2,471,940	\$164,501	7.1%

- **Support Services.** These include the independent living program, supported living program, and a broad range of support for adults who choose to live on their own in homes that they own or lease in the community.
- **Transportation.** Transportation services are intended to help RC clients participate in programs and activities and receive medical care, and can include public transit, specialized transportation companies, or assistance to clients while boarding and exiting a vehicle and monitoring while the client is being transported.
- **In-Home Respite.** This service includes intermittent or regularly scheduled temporary nonmedical care and supervision of a RC client provided in the client's home in order to provide the client's family or regular caregiver relief from the ongoing demands of caring for the client.
- **Habilitation Services Program.** This program provides opportunities for RC clients to develop job skills and to be employed under the Work Activity Program and Supported Employment Program.

- **Health Care.** This includes medical and other health-care-related services, such as doctor visits and dental care, necessary to maintain the health of RC clients.
- **Out-of-Home Respite.** This service includes supervision of a client in residential and day-care facilities and camping facilities in order to provide the client's family or regular caregiver relief from the ongoing demands of caring for the client.
- **Medical Facilities.** These 24-hour health facilities, commonly referred to as Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs), provide medical residential care to children and adults with developmental disabilities who need personal services, supervision, and assistance in daily living activities and varying levels of medical care.
- **Miscellaneous Services.** This category is comprised of the wide variety of goods and services provided by RCs which do not fit into the categories listed above. Miscellaneous services include, but are not limited to, translator services, and Special Olympics.

The other major category of RC expenditures consists of RC *operations*, which includes eligibility determinations and client assessment, the development of individual program plans for clients, service coordination (also known as case management), as well as associated administrative and personnel management activities. The Governor's budget proposes \$462 million for RC operations, including \$26 million in so-called "pass-throughs" of funding for various contracts, programs, and projects that are not directly controlled by RCs.

Regional Center Caseload Trends

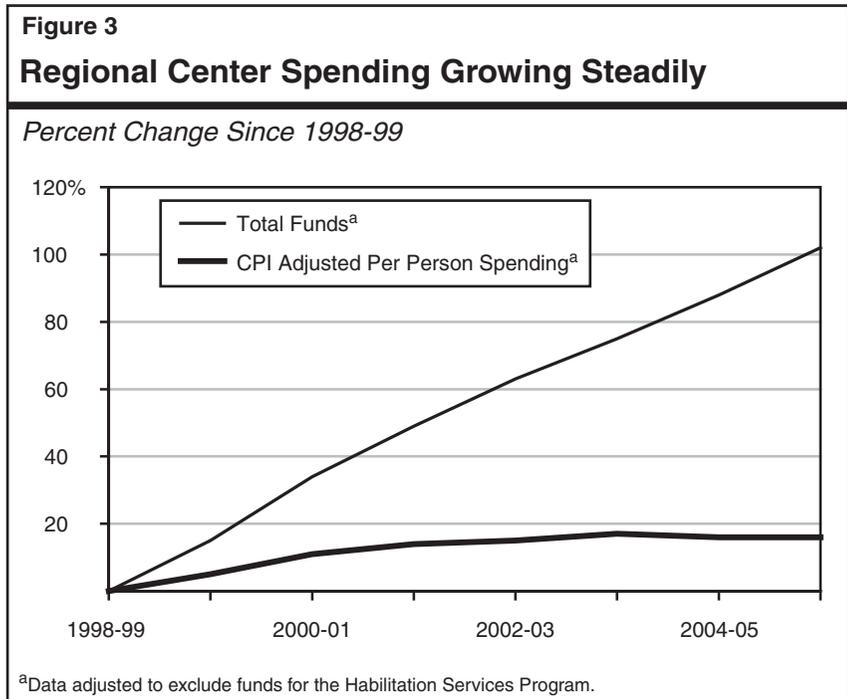
Growth Trend Continues. Between 2000-01 and 2005-06, the RC caseload is projected to grow from about 164,000 to more than 208,000, an average annual growth rate of about 5 percent. The caseload trend is shown in Figure 2.

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

Figure 2			
Regional Center Caseload Growth			
Fiscal Year	Caseload	Increase From Prior Year	
		Amount	Percent
2000-01	163,613	8,651	5.6%
2001-02	172,505	8,892	5.4
2002-03	182,175	9,670	5.6
2003-04	190,030	7,855	4.3
2004-05	199,255	9,225	4.9
2005-06	208,020	8,765	4.4

Program Expenditure Trends

Overall Spending and Cost Per Client. As shown in Figure 3, between 1998-99 and 2005-06, total spending increased by 102 percent (after adjusting for a program shift to DDS) while spending per person after adjusting for inflation has gone up 16 percent.



Why Spending Is Escalating. Several factors help to explain why per-person spending is increasing. One factor is an aging RC population which requires more intensive and more costly services and supports. Another probable factor pushing costs upwards is the increase in diagnosed autism caseloads and the comparatively higher costs of treating autistic individuals. Also, as new medical treatments, equipment, and technology become available, the scope of services that DDS is able to provide to developmentally disabled individuals is broadening. In addition, increased spending is, to some extent, a result of rate increases provided for some classes of vendors. We discuss rates and their impact on RC expenditures in more detail below.

Governor's Budget Proposal

Caseload Estimate Lagging. The 2005-06 budget plan includes DDS' updated caseload projections for RCs for the current fiscal year and the budget year. The budget plan estimates current-year caseload to be 199,255. However, based on the most recent caseload data, the current-year RC caseload is 940 below that number. The budget plan further estimates that the RC population will grow from 199,255 in 2004-05 to 208,020 in 2005-06, a year-to-year increase of 8,765 or 4.4 percent.

No Fiscal Adjustments Proposed. The budget plan does not propose any reductions in current-year spending as a result of the lower-than-expected caseload. Nor does it adjust the 2005-06 budget request for the lag in caseload growth. The DDS has indicated that it will update its caseload estimates and propose any fiscal adjustments at the time of the May Revision. If this RC caseload trend were to continue, we estimate that RC purchase of services may be overbudgeted by as much as \$9 million General Fund (\$12 million all funds) in the current fiscal year and \$9 million General Fund (\$12 million all funds) in the budget year.

Analyst's Recommendation. Based upon the caseload trend information available to the Legislature at this time, DDS expenditures for purchase of services are overbudgeted in both the current and the budget year. Accordingly, we recommend that the Legislature reduce RC expenditures in both 2004-05 and 2005-06 by \$9 million General Fund (\$12 million all funds) to limit expenditures to the level justified by the department's own experience.

The administration has indicated that it will provide updated caseload estimates at the time of the May Revision. We will continue to monitor caseload trends and will recommend appropriate adjustments in May when DDS' updated caseload estimates are available.

TOWARDS A MORE SYSTEMATIC RATE-SETTING MODEL

The Department of Developmental Services (DDS) and its system of regional centers provide a wide array of services and supports for the developmentally disabled. Our analysis indicates that the way that DDS and the RCs set rates for the vendors who provide these services also varies widely—and as a whole lacks a rational and consistent approach. In this analysis, we review how rates are set for these services and offer an improved and systematic approach to rate-setting that could ensure that the state does not overpay for services.

Background

Who Sets the Rates for RC Services?

Rate-Setting a Split Responsibility. The rates paid to vendors who provide the wide array of services available for persons with developmental disabilities are established by DDS on a statewide basis for some services, and others are determined at the RC level using guidelines established by DDS.

The DDS directly sets rates for community care facilities (CCFs), day programs, in-home respite, and the work activity program. Thus, DDS now directly sets the rates on a statewide basis for about \$1.6 billion of community services provided by RCs, roughly 63 percent of the total \$2.5 billion in purchase of services projected for 2005-06.

Although DDS has overall responsibility and statutory authority for the provision of community services, it has delegated some of that authority to the RCs. Specifically, it has provided the RCs with guidelines for determining how rates are set for about \$900 million or 37 percent of the total \$2.5 billion in purchase of services projected for 2005-06. We describe these rate-setting guidelines in more detail later in this analysis.

Some Vendor Rates Have Been Frozen

Rates a Key Fiscal Control. Three key factors drive spending for RC services: caseload levels, trends in the utilization of services, and rates. In order to slow growth in state costs for RCs, the Legislature has taken some steps in recent years to slow caseload growth and to decrease spending on services. In 2003-04 and 2004-05, it also acted to control costs by adopting legislation imposing rate freezes on selected community services. The Governor's budget proposes legislation to continue the rate freezes now in effect.

The programs and services affected by these rate freezes include: (1) day programs and in-home respite agencies; (2) vendors with whom the

RCs contract for services; and (3) work activity programs. We discuss the effect and ramifications of these rate freezes later in this analysis.

Department Currently Studying Rate Reform

Reform Process Could Take Years. Last year, the administration proposed that several areas of the RC system be reformed as part of an effort at containing state costs, including a review of the rate-setting system for community services. In the *2004-05 Budget Act*, the Legislature approved four permanent staff positions and \$500,000 in one-time funding for contract resources to enable DDS headquarters to develop standardized rates for certain types of RC vendors. We are advised by DDS that the contractor will be required to: (1) conduct research and make recommendations regarding cost differences among different geographic areas in the state for certain community services; (2) develop and maintain a Web site that will allow vendors providing these services to submit cost statements electronically; (3) create and maintain a database and associated software for managing the cost information that is collected; and (4) develop software to help calculate the rates that should be established for these services.

The DDS indicates that this system-wide rate reform effort will require several years to complete. This process is expected to include a review with stakeholders of the existing rate-setting methodology applicable to their programs, identification of any drawbacks or inadequacies in the way rates are set, identification and development of any statutory and regulatory changes found to be necessary to address these problems, and implementation and monitoring of the revised rate-setting methodology. The DDS has emphasized that the rates that ultimately result from this process must be simple to administer, easy to understand, cost-effective, and flexible enough to allow for differences in costs between geographic regions.

Review Will Start With Selected Services. The DDS intends to focus some of its initial rate reform efforts on selected services for which it currently sets rates on a statewide basis. These include day programs, in-home respite agencies, and the work activity programs. The DDS also intends to focus some of its initial rate reform efforts on selected services, such as supported living, that previously have not had their rates set by the department on a statewide basis and for which per-person expenditures have varied greatly from RC to RC.

The DDS's rate reform effort will involve a survey to gather data about the rates paid for selected services. The survey instrument is designed to determine minimum levels of education, training, experience, and licensing required for the vendor staff who provide a service, as well as the rate that is paid to the vendor for that service. The survey instrument will also collect information on the highest and lowest rates being paid by a RC for

a particular service, any special circumstances that significantly affect the rate, and how often that rate is adjusted by the RC.

The department intends to survey about six services every six months. Once the data have been analyzed, DDS will have follow-up meetings with RCs and stakeholders to clarify any further issues prior to proposing a revised or new rate methodology for a specific service. Once the new methodology is proposed, any statutory or regulatory changes necessary prior to implementation must be approved. Thus, establishment of a new rate or revision of an existing rate will likely take one year or more to accomplish, and the entire task of examining rate-setting for various RC services could take several years to accomplish. Based on our discussions with DDS, we do not believe that there is any plan in place to integrate data from the rate survey with data from the proposed quality management system that we discuss next.

Quality Management System (QMS) Proposal. For 2005-06, the DDS is requesting \$522,000 (all funds) and four positions to implement a state-wide QMS. According to DDS, implementation of a statewide QMS is necessary for maintaining and increasing federal financial participation. Currently, the quality assurance programs maintained by the 21 RCs differ among RCs in terms of their structure and their level of effectiveness. We will discuss the proposed QMS, and its potential relationship with RC rates, later in our analysis.

A Flawed, Complex, and Inconsistent System for Setting Rates

No Rational Basis for Some Rates. Four years ago, our office conducted a review of the way the rates paid to different types of physicians participating in the Medi-Cal Program were set. We determined that rates for different medical specialties, as well as rates overall, were largely established on an *ad hoc* basis, in response to improvement or deterioration of the state's financial condition, without regard to the state's goals as a purchaser of medical services. Specifically, we found that the state did not set rates on the basis of two critical factors—first, the potential effect of those rates on the access to care available to Medi-Cal patients, and second, the effect of those rates on the quality of care received by those patients.

Our analysis indicates that there is, similarly, no rational basis for the way rates are often set for community services for the developmentally disabled. The current rate-setting mechanisms do not sufficiently take into account cost-effectiveness, whether the quality of the services being purchased is adequate to meet federal, state, and local requirements or exceeds them, and individual RC client access to specific services. Also, the rate-

setting process established for services for persons with developmental disabilities varies from service to service, from RC to RC, and even in some instances from vendor to vendor providing the very same service within an RC catchment area.

As we described above, DDS has begun a rate reform initiative to address problems with the current rate-setting system. This flawed and needlessly complex rate-setting system often does not serve the needs of RCs, vendors, and program beneficiaries, and our analysis further indicates that it results in some cases in unduly high costs to the state for its purchase of services. We discuss our findings in more detail below.

Great Variation in Rate-Setting

Rate Systems Used. As noted earlier, both DDS and the RCs all play a role in setting rates for community services for persons with developmental disabilities. Our analysis indicates that there is significant variation in the way rates are set from service to service. Some rates are set competitively while others are not. Some rates are based on historical cost data while others are tied to what other similar vendors are paid, or the rates paid under the state's Medi-Cal health program for the poor, or what the public would pay for the same services.

The more common rate-setting techniques used by RCs to set payment rates for RC services are discussed below.

- *Schedules of Maximum Allowances (SMA).* The SMA establishes a maximum amount that can be paid for medical goods and services comparable to those provided for Medi-Cal patients. For example, when RC clients require placement in an ICF/DD, the RC is not permitted to pay a higher rate than the SMA established by the Department of Health Services for that same service for the Medi-Cal Program.
- *"Usual and Customary" Rates.* A vendor's usual and customary rate is the rate the vendor charges to members of the general public for comparable services. It generally applies to vendors who serve both the general public and RC clients, and for whom there is not an established SMA. A vendor may be paid the usual and customary rate if 30 percent or more of the individuals the vendor serves are *not* RC clients. If that is not the case, the rate of reimbursement is negotiated between the RC and the vendor.
- *Negotiated Rates.* The RCs may negotiate rates for some services with vendors where an SMA or a usual and customary rate does not apply. The rates negotiated with one vendor may not be in line with those paid to another vendor for the same service. The out-

come of those negotiations can be affected by the RC's size and sophistication at negotiations as well as the size and bargaining ability of the vendor.

- **Competitive Bidding.** The RCs are authorized by regulation to utilize a formal competitive bidding process only for transportation services.
- **Noncompetitive Procurement.** The RCs also are permitted to use so-called "noncompetitive procurement methods" to pay for transportation services.

The use of several different methodologies, described above, to set rates for RC services has resulted in a system in which DDS has considerable control over the rates paid for some services, but very little control over the rates paid for others—particularly those for which the RCs negotiate the rate. Utilization of a variety of rate-setting methodologies, some of which delegate the responsibility for setting rates to the RCs, limits DDS's ability to control costs and ensure that services are provided in the most cost-effective manner.

Quality and Access Concerns Not Integrated With Rate-Setting

The Lanterman Act requires that the services provided to RC clients reflect a cost-effective use of public resources. In order to achieve this, in our view, the rate for a service should be set at the level necessary to ensure that individual RC clients have access to that specific service. Rates should also be set at the level necessary to ensure that the quality of that service meets federal requirements and any other applicable state or local government requirements.

If the state sets a rate too low and federal quality standards for that service are violated, it would risk the loss of federal funds received under the Home and Community-Based Waiver. That, in turn, would create a risk that additional General Fund resources would be needed to make up for such a loss. Conversely, if the state set a rate at a level that was higher than necessary to meet federal standards, it would risk paying more than it needed to for that service. If there is sufficient capacity of quality services at a given rate, then there is no reason, from the state's perspective, to adjust the rates.

Our analysis indicates that DDS is not now systematically measuring the quality level and access to the services being provided to RC clients, or using such information to set rates for community services. One such example is the way rates are set for CCFs.

The ARM Example. The DDS establishes rates for CCFs using a rate-setting method known as the Alternative Residential Model (ARM) that was developed through a contract with a consultant. The consultant based its rate recommendation on an analysis of CCF cost data, the levels of service being provided by the facilities, and each facility's staff-to-client ratios. While the ARM may ensure that CCF providers are reimbursed based on the costs that they incurred, such a rate-setting approach does not necessarily serve the interests of the state or RC clients. In general, as we have indicated above, the interests of the state are best served when it pays the lowest rates sufficient to (1) obtain services of adequate quality to meet federal, state, and local government requirements and (2) ensure sufficient individual access to specific services for RC clients. In the case of ARM, the state's consultant did not conduct any assessment of the quality of services provided by CCFs. Moreover, the consultant provided no information that indicated whether or how differences in service quality or access to services for RC clients might relate to the variations in costs they identified and used as a basis for rate-setting purposes.

Day Programs and Respite Care Agencies. The rates for day programs and in-home respite service agencies are similarly established using formulas developed in the late 1980s that were based on measurement of the actual costs of like programs throughout the state. Again, quality of care or individual access to specific services are not systematically measured or used to set rates for these services. As a result, the state is at risk of both paying more than it may need to for these services without assurance that the services provided will be of adequate quality and will be accessible to RC clients who need them.

The rate-setting approach we have described is also potentially inequitable to these RC providers. For example, a provider who has recently contracted with an RC to provide day program services may receive a significantly higher reimbursement rate than another vendor who is providing the identical service, but who began providing the service at an earlier date. This is due to the way the rate-setting formula is structured.

Quality and Access Measurements Could Be Integrated Into Rate-Setting. As discussed above, our analysis indicates that DDS does not sufficiently incorporate quality measurements into the rate-setting methodologies that it uses, nor could it easily do so at this time. At present, DDS does not have the tools needed to make systematic, quantifiable measurements of service provider quality or of individual client access to specific services. Current efforts to integrate these measures with vendor rate-setting rely on the fragmented and inconsistent quality assurance programs operated by the RCs.

This situation could be changing. The 2005-06 Governor's Budget requests resources for DDS to support the development of a statewide QMS. We believe development of the QMS is necessary in order to meet federal requirements under the Home- and Community-Based Services Waiver and to continue to receive these federal funds.

The department also plans to complete the implementation of the California Developmental Disabilities Information System (CADDIS) by the end of June 2006. The CADDIS is designed to provide the RCs with an integrated case management and fiscal system that is intended to improve their efficiency in delivering services to clients. Together, QMS and CADDIS would provide DDS with an improved capability to incorporate quality and access measurements into rate-setting mechanisms in a systematic and ongoing process.

Rate Freezes Appear Effective in Short Term, But Problematic in Long Term

Cost-Per-Person Grew More Slowly. The rate freezes adopted by the Legislature in recent years appear to have been effective in slowing spending growth for the services that were affected by this budget strategy. For example, the average year-to-year growth in the cost per person for independent living specialists in 2002-03 was 12 percent. Growth dropped to 0.5 percent in 2003-04 when the freeze was in effect. While the freezes probably were the primary contributor to this trend, it is also possible that some of the slowdown in growth was due to decreased utilization of services by RC clients. We would note, however, that while the evidence suggests that rate freezes can be an effective way to control spending for RC services in the short term, both the legislature and the administration have viewed them as temporary measures.

DDS Rate Reform Initiative Generally on Target

Efforts Could Move State Toward More Rational System. Our analysis indicates that the rate reform initiative undertaken by DDS has the potential to result in long-term savings to the state and help to establish a more rational basis for setting rates. We find that the rate reform initiative is staffed at a reasonable level and that DDS is generally focusing its rate-reform efforts on the right services. Specifically, it is appropriately focusing its efforts on those services that are growing rapidly in cost and demonstrate great variation in payment rates and that thus offer the greatest potential for slowing future spending growth for services for persons with developmental disabilities.

Interim Rate-Setting Actions Possible to Hold Down Program Costs

Upper Payment Limits Possible. As already noted, the DDS rate-reform initiative is an ongoing effort that will take years to complete. While DDS moves forward in a deliberate fashion with this effort, an interim cost-control measure is available to the Legislature to ensure that the RCs do not pay excessive rates for RC services. The state could impose interim upper payment limits on services, identified by DDS through its rate-reform efforts, that have a wide variation between RCs in their average cost per unit of service.

Under this approach, DDS would calculate the average statewide cost for a particular service and then set an upper limit on vendor reimbursements based upon that statewide average. For example, if the statewide average cost of a service is determined to be \$10 per hour, DDS could set an upper spending limit of 150 percent of that statewide average cost, or \$15 per hour.

An upper payment limit could be applied to a service on a prospective basis. Service provider contracts already in effect would not fall under the upper payment limit until the contract came up for renewal. These contracts are generally renewed on an annual basis. The RCs could retain their current authority to negotiate rates with vendors for certain services, as long as those negotiated rates did not exceed the upper payment limits established for that service. In this way, RCs could still try to lower their costs. Exceptions to the limits could be granted by the department in any individual case where such an action was necessary to protect the health and safety of a RC client. Since DDS anticipates having finalized its analysis of its initial wave of rate surveys early in the 2005-06 fiscal year, we believe that there may be an opportunity to apply upper payment limits and achieve some savings in 2005-06. Such upper payment limits would be temporary in nature and could be removed upon DDS's implementation of a permanent new rate-setting mechanism for that service.

We believe that upper payment limits could be successfully applied to those services which are fairly standardized in nature and are generally purchased on an hourly or daily basis. Some services purchased to meet unique individual needs of a specific RC client are too disparate and unique in nature to have upper payment limits applied to them.

The exact fiscal effect of upper payment limits is unknown, and would depend upon the number of services to which limits were applied and the maximum rate levels actually established by DDS. We believe it is possible that, using such a mechanism, the state could begin to achieve some savings in 2005-06 and could also eventually avoid significant cost increases by millions to low tens of millions of dollars annually in the future.

Creating a Systematic and Rational Rate-Setting Process

We recommend that the Legislature consider taking a series of steps to ensure that rate reform proceeds on schedule and results in meaningful changes to existing rate-setting methodologies. These steps could move the state closer to having a systematic and rational process for setting vendor rates.

We recommend shifting the state toward a more systematic and rational approach to rate-setting for community services for the developmentally disabled based on (1) cost-effectiveness as required under the Lanterman Act; (2) measurement of individual access to specific services; and (3) the quality of the services provided based on federal, state, and local requirements.

We acknowledge that, in the short term, applying these criteria in a systematic way might result in rate increases that would increase state costs for some specific community services. Our analysis indicates, however, that our proposed approach would generally have the effect of ensuring that the state does not overpay for specific services. This is primarily because rates would no longer be driven upward by the present cost-based system, which rewards providers over time with higher rates with little regard to efficiency and quality of the service delivered. Under our revised approach, the state would be able to base rate-setting on the resources needed to compensate cost-effective providers of services. The state would pay only what was required to ensure individual access to specific services which meet quality requirements.

Accordingly, we recommend that the Legislature consider the following series of actions:

Continue Funding for the DDS Rate Reform Initiative. We recommend that the Legislature approve the funding and staffing levels proposed in DDS' 2005-06 budget request to move forward with its rate-reform initiative. Implementation of meaningful rate reform should result in savings or cost avoidances for the state, improved service quality and access to services, and reduce inequitable inconsistencies in the way that vendors are reimbursed for their services to clients.

Maintain Rate Freezes Currently in Effect. We recommend that the Legislature maintain, through 2005-06, the rate freezes now in effect as proposed in the Governor's budget. This action would continue to temporarily slow expenditure growth in the affected services until permanent rate reform can be implemented.

Incorporate Quality and Access Measurements Into Rate-Setting Methodologies. We recommend the enactment of legislation requiring DDS to incorporate measurements of quality and individual access to specific services into the rate-setting methodologies that it develops for RC services.

The incorporation of quality and access measurements into rate-setting methodologies will be feasible as soon as the proposed QMS and CADDIS come on line within the next two years. We further recommend that the Legislature require DDS to submit a report after these new systems have been fully implemented, in January 2007, on how quality and access measurements will be incorporated into the rate-setting methodologies.

Control Costs Through Upper Payment Limits. We recommend that the Legislature provide DDS with statutory authority to promulgate emergency regulations to impose upper payment limits on the rates paid for certain RC services as an interim cost-control measure. The legislation would authorize the department to take immediate action to control costs by these means whenever it determines that the rates some RCs are paying for a service are higher than is generally justified by the data collected under the rate-reform initiative.

DEVELOPMENTAL CENTERS PROGRAM

Agnews Developmental Center Closure Plan

The Department of Developmental Services (DDS) has released its plan for the closure of the Agnews Developmental Center. Our preliminary analysis indicates that the plan, which would extend the closure process by an additional year to June 2007, raises a number of significant fiscal and policy issues that the Legislature may wish to consider as it evaluates the administration's proposal. At the time of this analysis, we were advised that this plan would be updated in the near future. We will provide a more detailed analysis of these issues and the Agnews closure plan at budget hearings.

Agnews DC Closure Plan Released. In January 2004, the administration announced its intention to close Agnews DC as part of an overall policy to enhance community-based resources to a level where large, state-operated facilities such as Agnews would no longer be necessary. The administration plan is to focus on having as many developmentally disabled individuals as is appropriate live in their communities instead of institutions.

As justification for its policy, the administration cited the need for the state to comply with the 1999 United States Supreme Court decision, *L.C. & E.W. v. Olmstead* ("Olmstead"), in which the court ruled that keeping persons in institutions who could transition to a community setting constituted discrimination under the Americans with Disabilities Act. The administration also cited as reasons to close Agnews the high capital improvement costs that would have to be incurred if the facility were left open, and the relatively high costs of providing institutional care at Agnews

specifically as compared to community-based care. In our *Analysis of the 2003-04 Budget Bill*, we noted that the cost of care at DCs on a per-resident basis had grown significantly, and we recommended that the Legislature initiate a process to close two DCs, including Agnews.

In January 2005, the administration, in keeping with statutory requirements for DC closures, released a plan to close Agnews by July 2007, a closure date that is one year later than it had previously proposed.

Agnews Closure Plan Emphasizes Community Placements. The closure plan emphasizes DDS's commitment to placing Agnews DC residents in the community as facility operations are phased out. In this way, the plan differs significantly from the two most recent closures of DCs in California—Stockton DC in 1996 and Camarillo State Hospital and DC in 1997—both of which resulted in the transfer of large numbers of individuals to other state-operated facilities. In contrast, the closure plan for Agnews DC emphasizes development of an improved community service delivery system in the Bay Area that will allow Agnews DC residents to remain in their home communities. According to DDS this will be achieved by:

- Establishing a permanent stock of housing dedicated to serving individuals with developmental disabilities.
- Establishing new residential service models for the care of developmentally disabled adults.
- Providing community services—currently community services are not directly provided by the state—by employing 200 current Agnews employees, at state expense, for two years after Agnews' closure in 2007. The 200 Agnews DC staff have specialized knowledge of Agnews residents with significant medical and behavioral issues and their services would be retained to ensure client health and safety during the transition period.
- Implementing a QMS that focuses on assuring that quality services and supports are available in the community.

Closure Plan Raises Several Policy and Fiscal Issues. We discussed in detail the policy and fiscal implications of closing Agnews DC in the "Department of Developmental Services" section of the Health and Social Services chapter of the *Analysis of the 2003-04 Budget Bill*. Based upon our initial review of the Agnews closure plan, we have identified several additional fiscal and policy issues that the Legislature may wish to address in its deliberations over Agnews DC closure. Among these issues:

- Whether the funds estimated for Agnews closure are sufficient to successfully implement the closure plan that has been presented.

- Whether the state should continue to employ 200 Agnews personnel after the facility has been closed for as long as two years.
- Whether the regional centers should purchase additional medical insurance, as has been proposed in the closure plan, for Medi-Cal-eligible Agnews residents who are placed in the community.

At this time, we are continuing to examine these and other policy issues related to the closure. Because we are advised at the time of this analysis that the Agnews closure plan will be updated in the near future, we will provide the Legislature with an updated analysis of the plan at budget hearings.

Developmental Centers Overbudgeted

We recommend the Legislature reduce Developmental Center expenditures by \$4 million General Fund to correct for caseload overbudgeting in the budget year. In addition, we recommend that the Legislature recognize a like amount of savings in the current year due to caseload overbudgeting. (Reduce Item 4300-003-0001 by \$4,000,000.)

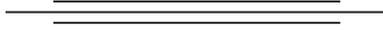
DC Caseload Below Budget Levels. The 2005-06 budget plan includes DDS' updated caseload projections for DCs in the current fiscal year and the budget year. The Governor's budget plan assumes that the DC population will average 3,307 clients in 2004-05, and 3,101 in 2005-06, and will continue on the present long-term trend and decrease through the remainder of the current and the budget year.

Based on our analysis, the most recent caseload data for the months of November and December of 2004 show that the average population actually present at any given time in the DCs was about 3,220. (Our estimate was adjusted to take into account the greater-than-average number of DC clients that are on leave from the DCs during the holiday season.) Thus, the actual average DC population falls 87 clients below the caseload level of 3,307 that the Governor's current-year budget plan proposes to fund.

No Caseload Adjustments in Governor's Budget Plan. The Governor's budget does not adjust funding for the DCs to account for recent trends indicating that the DC population is dropping faster than expected and is thus below DDS projections. The DDS has indicated that it intends to update its DC caseload projections and the associated funding at the time of the May Revision.

We estimate that the DCs are currently overbudgeted by about \$4 million General Fund in the current fiscal year and an additional \$4 million General Fund in the budget year.

Analyst's Recommendation. We recommend that the Legislature reduce the DC budget by \$4 million General Fund (\$8 million all funds) both in the current year and the budget year to adjust for lower-than-projected DC caseload. We will continue to monitor DC caseload and recommend any appropriate budget adjustments at the time of the May Revision.



DEPARTMENT OF MENTAL HEALTH (4440)

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

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

Budget Proposal Increases DMH Budget Overall. The budget proposes \$2.7 billion from all funds for support of DMH programs in 2005-06, which is an increase of about \$172 million and 6.7 percent above estimated current-year expenditures. As discussed later in this analysis, these budget totals do not include hundreds of millions of dollars in additional anticipated expenditures from a new special fund created by voter-approved Proposition 63, also known as the Mental Health Services Act.

The budget proposes about \$1 billion from the General Fund, which is an increase of about \$78 million, or 8.2 percent, above the Governor's revised budget plan for the current year. Reimbursements that would be received by DMH—largely Medi-Cal funding passed through to community mental health programs—would amount to about \$1.6 billion, an increase of \$90 million or 5.9 percent.

The overall proposed increase in DMH expenditures is mainly due to higher costs for state hospital operations. The budget plan provides about \$74 million (\$66 million from the General Fund) to begin to activate the

new Coalinga State Hospital in September 2005. The spending plan provides additional resources to expand the number of treatment beds available for CDC inmates at state hospitals and the DMH treatment facility at the Vacaville state prison, and to intensify staffing levels for certain youth and skilled nursing units. The budget plan also makes adjustments in both the current and budget years for increases in the patient caseload that are occurring across most of the state hospital system.

In regard to community programs, the budget plan reflects the continued expansion of the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) for children with emotional problems. The EPSDT funding level would be adjusted downward in the current year by \$29 million (with a \$16 million decrease in General Fund costs). However, budget-year expenditures for EPSDT would grow by \$77 million (\$43 million from the General Fund) compared to the revised level of expenditures for 2004-05. The spending plan also provides additional resources for mental health managed care programs administered by counties and the restoration of some state-mandated mental health programs. The budget also provides about \$12.5 million from the General Fund to reimburse counties for some state-mandated programs, such as commitment proceedings for offenders known as Sexually Violent Predators (SVPs). (As discussed below, certain other state mandates would not be funded and thereby suspended.)

Budget Proposal Includes Some Reductions. Although the budget plan provides for an overall net increase in General Fund resources, it does include some significant actions to reduce or avoid paying for the costs of mental health programs. Among these proposals:

- ***State Mandate Actions.*** While the state, as noted earlier, would resume payment of claims for certain state-mandated mental health programs, it would continue to postpone the payment of more than \$514 million in past county claims for such mandates that have accumulated as of November 2004. Among the most significant programs affected by this postponement are the "AB 3632" (Brown) services for special education children and a separate mandate for out-of-state residential services for seriously emotionally disturbed pupils. In addition, the Governor's budget proposal would suspend these two mandates by budgeting nothing for them in 2005-06, thereby freeing counties of any further legal obligation to pay for these services.
- ***State Hospital Changes.*** The budget plan would reduce the General Fund cost of operating the state hospital system by (1) shifting some individuals who are being considered for commitment to state hospitals as SVPs to local jails while they await their commitment proceedings, (2) reduce staffing and treatment services for

individuals who have been committed as SVPs but are unwilling to participate in treatment, and (3) shifting additional support costs from the General Fund to Proposition 99 tobacco tax revenues.

- **Community Program Reductions.** The budget plan reduces funding for the Early Mental Health Initiative (supported with Proposition 98 General Fund) by \$5 million and does not include a cost-of-living increase for the managed care program.

We discuss some of these specific proposals later in this section of the analysis. The mandate suspension proposals are examined in more detail in the “Education” chapter.

COMMUNITY PROGRAM ISSUES

Proposition 63 Language Requires Clarification

In November, California voters approved Proposition 63, the Mental Health Services Act, a measure imposing a new state income tax surcharge to finance an expansion of community mental health services. We recommend the Legislature consider the enactment of legislation that would clarify the meaning of some key but ambiguous provisions of the measure in order to ensure its smooth and effective implementation and avoid future state budget problems.

New Funding for Community Mental Health Services

Funds Raised Through Income Tax Surcharge. Proposition 63, approved by voters in November 2004, enacted a state personal income tax surcharge of 1 percent that applies to taxpayers with annual taxable incomes of more than \$1 million. The proceeds of the tax surcharge are earmarked to finance an expansion of community mental health programs. Under this measure, also known as the Mental Health Services Act, the State Controller is to transfer specified amounts of state funding each year on a monthly basis beginning in 2004-05 into a new state special fund, named the Mental Health Services Fund. The amounts transferred are to be based on an estimate of surcharge revenues. The amounts deposited into the fund are to be adjusted later to reflect the revenues actually received from the tax surcharge.

How This Funding Would Be Spent. Beginning in 2004-05, revenues deposited in the Mental Health Services Fund are to be used to create new community mental health programs and to expand some existing programs. Specifically, the funds are to be used for the activities summarized in Figure 1.

Figure 1**Programs Supported With Proposition 63 Funds**

- **Children’s System of Care.** Expansion of existing system of care services for children who lack other public or private health coverage to pay for mental health treatment.
- **Adult System of Care.** Expansion of existing system of care services for adults with serious mental disorders or who are at serious risk of such disorders if they do not receive treatment.
- **Prevention and Early Intervention.** New county prevention and early intervention programs to get persons showing early signs of a mental illness into treatment quickly before their illness becomes more severe.
- **“Wraparound” Services for Families.** A new program to provide state assistance to counties, where feasible, to establish wraparound services providing various types of medical and social services for families (for example, family counseling) where the children are at risk of being placed in group homes.
- **“Innovation” Programs.** New county programs to experiment with ways to improve access to mental health services, including for underserved groups, to improve program quality, or to promote interagency collaboration in the delivery of services to clients.
- **Mental Health Workforce Education and Training.** Stipends, loan forgiveness, scholarship programs, and other steps to (1) address existing shortages of mental health staffing in community programs and (2) help provide the additional staffing that would be needed to carry out the program expansions proposed in this measure.
- **Capital Facilities and Technology.** A new program to allocate funding to counties for technology improvements and capital facilities for the provision of mental health services.

Oversight and Administration. The DMH, in coordination with certain other state agencies, has the lead role in implementing most of the programs specified in the measure through contracts with counties. A new Mental Health Services Oversight and Accountability Commission is to be established to implement this measure, and would have the role of reviewing and approving certain county expenditures authorized by the proposition. Each county would be directed to draft and submit for state review and approval a three-year plan for the delivery of mental health services within their jurisdiction. Counties would also be obligated to prepare annual updates and expenditure plans for the provision of mental health services.

The measure permits up to 5 percent of the funding allocated annually from the Mental Health Services Fund to be used to offset state costs for implementation of the measure. Up to an additional 5 percent could be used annually for county planning and other administrative activities.

Legislative Role in Proposition Limited

Continuous Appropriation. The funding provided through Proposition 63 is “continuously appropriated.” This means that, unlike some other mental health programs, DMH is authorized under Proposition 63 to allocate funds for its various purposes without appropriation by the Legislature in the annual budget act. The measure specifically authorizes DMH to “immediately make any necessary expenditures and to hire staff for that purpose” as well as to adopt regulations to carry out its provisions. The administration has indicated that it intends to take administrative actions to bring on staff to implement the measure, but will submit requests to the Legislature for permanent new DMH staff position authority as part of the 2005-06 budget process during the spring.

Proposition 63 does give the Legislature some limited authority to assist in its implementation. The measure specifies that it can be amended by the Legislature by a two-thirds vote so long as any amendments are “consistent with and further the intent” of the act. The measure does provide an exception to the two-thirds vote rule, allowing the Legislature to add provisions by majority vote “to clarify procedures and terms” of the measure.

Limitations on Use of Proposition 63 Resources

“Maintenance of Effort” Required. Proposition 63 contains maintenance of effort (MOE) language specifying that the state and counties are prohibited from redirecting funds now used for mental health services to other purposes. It also contains various provisions relating to whether or how Proposition 63 funds can be used to provide mental health services for children or adults eligible for so-called “entitlement” programs, such as Medi-Cal. The language of several such provisions is presented in Figure 2. The policy implications of these provisions are discussed later in this analysis.

Implementation Actions to Date

In light of the timetable set forth in Proposition 63 for the first allocation of funding within the current year, DMH has moved fairly quickly to begin implementing the measure. It has convened meetings of “stakeholder” groups and governmental officials involved in the state’s mental health system, drafted and submitted for public review a “vision statement” outlining its intended approach to expanding systems of care, and begun

working out the rules for allocating planning grants to counties to assist them in drafting their required county mental health plans. It is also developing guidelines for counties to follow in drafting their Proposition 63 implementation plans.

Figure 2

Several Key Provisions of Proposition 63 Regarding Maintenance of Effort Rules and Entitlement Programs

(Ellipses indicate where language has been omitted for brevity. All sections are the Welfare and Institutions Code.)

Section 5878.3. (a) Subject to the availability of funds . . . county mental health programs shall offer services to severely mentally ill children for whom services under any other public or private insurance or other mental health or entitlement program is inadequate or unavailable. Other entitlement programs include but are not limited to mental health services available pursuant to Medi-Cal, child welfare, and special education programs. The funding shall cover only those portions of care that cannot be paid for with public or private insurance, other mental health funds or other entitlement programs

Section 5813.5 . . . Services shall be available to adults and seniors with severe illnesses . . . (b) The funding shall only cover the portions of those costs of services that cannot be paid for with other funds including other mental health funds, public and private insurance, and other local, state and federal funds

Section 5891. The funding established pursuant to this act shall be utilized to expand mental health services. These funds shall not be used to supplant existing state or county funds utilized to provide mental health services. The state shall continue to provide financial support for mental health programs with not less than the same entitlements, amounts of allocations from the General Fund and formula distributions of dedicated funds as provided in the last fiscal year which ended prior to the effective date of this act. The state shall not make any change to the structure of financing mental health services, which increases a county's share of costs or financial risk for mental health services unless the state includes adequate funding to fully compensate for such increased costs or financial risk

Important fiscal details of DMH's Proposition 63 implementation plan have not yet been worked out, however. The DMH's 2005-06 budget plan does not yet include any expenditures from the Mental Health Services Act, although the documents do display preliminary administration estimates that \$254 million in Proposition 63 revenues will be received for

2004-05 with an additional \$683 million available in 2005-06. The administration has indicated that it intends to formally incorporate Proposition 63 funding into its spending plan at the time of the May Revision.

Some Key Aspects of Language Are Ambiguous

Our analysis indicates that some key aspects of the language in Proposition 63 are ambiguous. The varying interpretations that could arise from these provisions could potentially make it more difficult for policymakers to implement the initiative in a timely and effective manner, lead to legal and other types of conflicts over the meaning of its provisions, and create future budgetary issues for the state.

The MOE provisions and the language relating to the relationship between Proposition 63 and existing entitlement programs raise a number of issues, including:

- Which particular mental health programs are subject to MOE rules? The language does not specify whether only community mental health services administered by counties are subject to MOE or whether its language should be interpreted more broadly to apply to expenditures for state mental hospitals, state supervision of persons released from hospitals into the Community Release Program (CONREP), community mental health services provided by CDC, services in county jails, or state-mandated programs for special education students.
- Whether 2004-05 spending levels are subject to the MOE rules or whether the measure's provisions apply only prospectively to the 2005-06 fiscal year and beyond.
- Whether the MOE requirement applies to state General Fund spending in the aggregate, or whether each separate state mental health program that has been receiving support from the General Fund has its own separate MOE requirement.
- Whether the language preventing the shifting of risks and costs from the state to counties protects each individual county or applies on a statewide basis.
- Whether Proposition 63 funds can be used to expand or supplement mental health services which now receive support from existing entitlement programs, such as Medi-Cal.

Fiscal Ramifications Are Great. Ambiguities such as these in the language of the measure could have important operational and fiscal ramifications. The uncertainty over how the measure affects the required fund-

ing level of the Children's System of Care program serves as an example of the complications that could arise.

The sponsors of the initiative have generally interpreted the MOE language of Proposition 63 as requiring funding for each distinctive community mental health program now operated by the state at the level it was budgeted in 2003-04. In the case of the Children's System of Care program, this would amount to a funding level of \$20 million from the General Fund. Most of this funding was vetoed from the *2004-05 Budget Act*, but presumably would have to be restored in the future because of the passage of Proposition 63.

However, the administration is relying on its own and differing interpretation of the new law that the MOE requirements apply only to the aggregate level of state spending for mental health programs. On this basis, the administration's 2005-06 budget proposal does not restore any funding for the Children's System of Care program. These differences in interpretation could lead to future county-state conflicts over the funding level of this program.

Ambiguity over how Proposition 63 applies to the two state-mandated programs for mental health services for special education students has potentially even bigger financial consequences. The administration has proposed to suspend these mandates in a step that could allow the state to avoid paying more than \$140 million per year in future claims for county reimbursements for these services. If the Legislature were to approve the administration's budget proposal without restoring this mandate funding and the courts were to subsequently order this funding restored, the state could face large and unbudgeted expenditures for these services.

Analyst's Recommendations

Alternative Approaches Available. Our analysis has identified a number of ambiguities that can be found in the language of Proposition 63. Several approaches are available to the Legislature to sort through and clarify the language in some key provisions of the measure. As a first step, the Legislature may wish to request that DMH consult with stakeholders in the mental health community, including the sponsors of the initiative, to help identify in advance the major potential points of dispute over the interpretation of the measure. The Legislature could also seek formal legal opinions from the Office of Legislative Counsel and the Attorney General to clarify some aspects of the measure and to guide its actions. The Legislature could also rely upon DMH itself to resolve some of these issues through the regulatory authority granted to the department within the language of Proposition 63.

Given the potentially serious fiscal consequences for the state down the line if Proposition 63 were to be interpreted after-the-fact by the courts as requiring large and unbudgeted General Fund expenditures, we believe clarifying action is needed. Specifically, we recommend that the Legislature enact legislation to add new provisions to the Mental Health Service Act that would clarify the major ambiguities in the law. Notably, Proposition 63 explicitly authorizes the Legislature to take exactly such actions, and allows such clarifying legislation of procedures and terms to be approved by a majority vote.

Community Program Issues

We recommend the Legislature eliminate two state-mandated programs within the Department of Mental Health budget for mental health services for special education students. We further recommend the Legislature provide a total of \$143 million in state and federal funds to support the costs of Special Education Local Plan Areas for providing these mental health services.

We discuss the Governor's proposal in DMH's 2005-06 budget plan to suspend two state-mandated programs for special education, including the AB 3632 mandate, as well as our own recommendations in regard to this issue, in our analysis of special education programs in the "Education" chapter of this *Analysis*.

STATE HOSPITAL ISSUES

Population Growth and New Facility Costs Increasing Expenditures of Hospital System

The budget proposal increases General Fund spending for the state hospital system by more than \$86 million compared to the amount provided for these purposes in the 2004-05 Budget Act, including the resources to complete the planned activation of a new state hospital in Coalinga. We believe these proposals are generally justified and warrant legislative approval. However, we withhold recommendation on two policy proposals to reduce costs for Sexually Violent Predators pending receipt of the proposed legislation to implement these changes.

Governor's Proposal

The Governor's spending plan proposes to provide additional funding for DMH in both the current and the budget years primarily to accom-

moderate population increases that the department projects will occur in state hospitals and in hospital facilities that DMH operates on the grounds of two state prisons. The proposal is summarized in Figure 3 below.

Figure 3				
Major State Hospital Budget Changes				
2005-06 Proposed Budget^a				
<i>(In Millions)</i>				
	2004-05		2005-06	
	General Fund	All Funds	General Fund	All Funds
Activation of Coalinga state hospital	—	—	\$65.7	\$74.2
State hospital population adjustments ^b	\$11.8	\$20.2	-4.3	0.1
Adjustment for full-year cost of prior year's population growth	—	—	34.9	32.9
Transfer "precommitment SVPs" to counties	—	—	-9.2	-9.2
Restructure SVP treatment program	—	—	-6.0	-6.0
Employee compensation and other miscellaneous adjustments	10.4	13.8	5.2	15.8
Net Change in Funding	\$22.2	\$34.0	\$86.3	\$107.7

^a Dollar amounts represent changes relative to *2004-05 Budget Act*.

^b Includes shift of support from General Fund to Proposition 99.

Current Year. For the current year, the administration has proposed an increase of about \$22 million in General Fund support relative to the funding previously authorized in the *2004-05 Budget Act*. The administration proposes to increase the amount of Proposition 99 revenues, which are generated from taxes on tobacco products, by about \$9.8 million to offset the costs of hospital caseload increases. Adjustments are also proposed in the level of reimbursements paid by counties. Spending from all fund sources would increase by \$34 million.

These and other adjustments are proposed partly due to a net increase in the population of certain groups of patients. The number of Incompetent to Stand Trial (IST) and Mentally Disorder Offender (MDO) patients is greater than initially budgeted, although this increase is partly offset by a reduction in the estimated population of SVPs. The budget proposal reflects the activation of 61 additional DMH beds for an intermediate care and day

treatment program for inmates at the state prison in Vacaville, the California Medical Facility. Adjustments for employee compensation and health benefits and other factors are also assumed in the budget proposal.

Budget Year. In the budget year, the spending plan requests a net increase of General Fund spending of \$86 million above the 2004-05 *Budget Act* level. Support from Proposition 99 would increase by \$13.6 million, as support from all fund sources would go up by almost \$108 million. As we will discuss later in this analysis, this increase in spending for the state hospitals does not reflect an estimated additional \$27 million in General Fund costs for repayment of the lease-revenue bonds used to build the new state hospital at Coalinga.

The proposed increase in hospital spending levels primarily reflects an assumption of continued growth in most patient groups as well as a number of other technical budget adjustments, such as for one-time expenditures on equipment for Coalinga in the current year that will not require continuation of funding in the budget year. Two groups are assumed to decline in number: persons committed to the hospitals by counties under the Lanterman-Petris-Short Act (LPS patients) and SVPs.

The drop in LPS patients reflects a continued trend by which counties are relying less on the state hospital system to provide services for patients with acute psychiatric needs. The reduction in SVPs also reflects an assumption that the Legislature will adopt two proposed policy changes: (1) statutory changes allowing a shift of so-called "precommitment SVPs" from state hospitals to counties, and (2) further statutory changes allowing DMH to create a new and less costly licensing category of beds for SVPs who decline to participate actively in treatment.

The single largest component of the proposed budget-year increase is the proposal for the activation of the new Coalinga facility in September 2005, in keeping with the timetable accepted by the Legislature last year. The proposal assumes that the state would phase in 683 beds at Coalinga during 2005-06, including a new 50-bed intermediate care and day treatment facility for CDC inmates. (The number would be 583 beds if the Legislature approves a separate proposal to allow a net shift of 100 SVPs to the counties.) The Coalinga facility is designed to eventually hold 1,500 patients in all. The budget plan reflects a reduction in the patient population, and DMH staffing at Atascadero State Hospital, as SVPs from that facility are transferred to Coalinga.

LAO Assessment of the Governor's Budget Requests

Population Estimates Generally in Line With Budget Request. Our analysis indicates that the patient population growth assumed in the Governor's

budget plan is reasonable and generally in line with recent population reports that we have reviewed. Our review of the data indicates that the populations of Not Guilty by reason of Insanity, SVPs, CDC inmate commitments, and LPS patients committed by counties are tracking below the projection trend assumed by the administration. However, the number of ISTs and MDOs are coming in significantly above projections. So, on balance, we believe that the overall caseload projection is reasonable.

We note that DMH is expected to update its budget requests related to the patient population at the time of the May Revision to reflect any changes that occur in caseload trends.

Shift of Proposition 99 Funds. The additional Proposition 99 resources that the administration proposes to use for the support of the state hospital system in the current and budget years are part of a larger and complex set of Proposition 99 funding shifts. We believe the use of funding from the Proposition 99 account for support of the state hospitals, which is in keeping with prior legislative actions, constitutes a reasonable use of these monies. We discuss the broader budget and policy implications of this and other Proposition 99 funding shifts in our discussion of public health programs in this chapter of the *Analysis*.

Coalinga Nearly Ready for Activation. The continued growth in the overall state hospital population, driven mainly by increases in IST, MDO, and SVP patients, prompted the Legislature last year to approve an additional round of staffing and funding to prepare for the opening of the new Coalinga hospital facility. The Governor's 2005-06 budget request would provide the funds for more staffing and equipment to activate the facility beginning in September 2005. We are advised that the construction, licensing, and hiring for the facility are generally on track with the timetable for activation of the facility presented by the administration and approved by the Legislature last year.

Administration Proposals Could Reduce SVP Costs. As noted earlier, the budget plan assumes adoption by the Legislature of two significant policy changes relating to the SVP program.

First, in order to achieve estimated savings of about \$9.2 million General Fund in the state hospital budget, the administration is proposing statutory changes that would allow a shift of precommitment SVPs from state hospitals to counties. Precommitment SVPs are individuals who are awaiting court proceedings for an SVP commitment and who are being held in state hospitals while their cases proceed. Some additional individuals are being held in state prisons as these proceedings occur, while still others who have been released from prison are held in county jails.

We examined a similar proposal last year in our *Analysis of the 2004-05 Budget Bill* (please see page C-198) and determined that such a change was feasible and could result in some savings in excess of the amount projected by the administration at that time. Our preliminary analysis of the new administration proposal suggests that this is again the case—that several million dollars in state savings beyond those estimated by the administration are possible. One reason is that the actual number of precommitment SVPs held by the state hospitals was 174 as of December 2004. The administration's budget proposal assumes, in effect, that after all 174 of these SVPs are transferred to counties, counties complete the court commitment process for 74 of them, resulting in a net savings equivalent to 100 SVPs. Given the slow pace at which these cases have been resolved in the past, there is a strong likelihood that some of those adjudicated in the courts will not receive an SVP commitment (and therefore will not be returning to state custody). As a result, it is possible that the number of SVPs in the state hospital system in 2005-06 will be fewer than assumed in the Governor's budget.

Other technical adjustments that we believe are warranted to the Governor's proposal would also result in a further net increase in the projected savings. Taken altogether, these factors could mean that the savings from this proposal to the General Fund could be as much as \$5 million greater than assumed.

The 2005-06 budget plan further assumes General Fund savings of about \$6 million as a result of statutory changes allowing DMH to create a new and less costly licensing category of beds for SVPs who decline to participate actively in treatment. The General Fund savings from these changes are anticipated to grow to \$11 million annually by 2006-07.

Our analysis indicates that there is some risk that the level of savings estimated to result from this change in the budget year could be overstated because the implementation of the new licensing categories is assumed to occur by January 2006. It is possible that the regulatory and other administrative changes necessary to create new licensing categories and implement them could take longer than the period assumed by the administration.

In summary, we believe that both of these proposals have merit in concept, in that they would achieve significant state savings over time and prioritize the use of expensive state hospital treatment resources for patients who are ready and willing to accept treatment for their mental illness. However, at the time this analysis was prepared, the administration had released only narrative summaries of its proposals and had not yet released the proposed statutory language to implement either of these changes. The Legislature will not be in a position to fully understand and assess the proposals until the statutory language for them has been made

available. For example, the language will enable the Legislature to clarify whether the savings are likely to be greater or less than the amounts assumed in the Governor's budget.

We are advised that the administration intends to send these proposals to legislative policy committees for their consideration. Given the important potential legal and policy ramifications of these proposed changes in the SVP statutes, we believe that it is a reasonable and appropriate approach. We would note, however, that should the Legislature decide to reject the administration's two SVP proposals, it would mean that the state hospital budget would be out of balance by \$15.2 million from the General Fund.

Analyst's Recommendations

In general, we recommend approval of the administration's funding requests related to the state hospital population and the activation of the Coalinga hospital, including the shift of Proposition 99 revenues to achieve General Fund savings.

However, we withhold recommendation at this time on the two proposals for policy changes to reduce SVP program costs. While we believe that both proposals for achieving savings have merit in concept, our full analysis of them cannot be completed until the proposed statutory language to implement them is available for review by the Legislature.

State Operations Issues

Technical Budget Adjustments Warranted

Our analysis has identified a series of largely technical issues relating to state operations of the Department of Mental Health. A number of these matters warrant legislative action either at budget hearings or at the time of the May Revision.

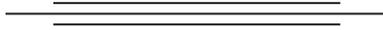
In our review of various DMH budget requests, we identified a number of largely technical budgeting issues, some of which warrant consideration by the Legislature in the 2005-06 budget process. These issues relate to: (1) lease-payment debt service for the new Coalinga State Hospital, (2) a proposal to intensify staffing of certain hospital units at Napa and Metropolitan, (3) the way the state bills for prescription drugs under Medicaid, (4) the fiscal impact of the new Medicare drug benefit on the state hospital system, (5) the "Strategic Sourcing Initiative," (6) a study commissioned by the Legislature regarding how the state could obtain greater federal funds for the support of DMH programs, and (7) the caseload for the CONREP program.

We summarize these technical issues below:

- ***Coalinga Debt Service.*** The DMH budget item does not yet incorporate the General Fund costs for repayment of lease-payment bonds issued to build the new Coalinga state hospital. These costs, currently estimated to be about \$27 million in 2005-06, upon activation of the new facility. These costs are currently included, but are not separately identified, in the Governor's budget document within an aggregate amount for lease-payment debt service. We are advised that, at the time of the May Revision, the administration will update the Coalinga debt-service costs and propose to shift this updated amount from the aggregate item to the DMH budget item.
- ***Staffing at Napa and Metropolitan Hospitals.*** The budget requests \$3.6 million in reimbursements paid by counties for staffing increases for certain youth and skilled nursing facility units at the state hospitals at Metropolitan and Napa. The proposed request relates to concerns that, although the overall number of patients being committed by the counties to the state hospitals has decreased, the medical needs of the patients are typically much more intense and therefore more clinical staff are required to care for them. However, the budget request is based in part on a count of 85 youth at Metropolitan when the current population is actually about 50. We recommend approval of the proposal with a reduction of about \$560,000 and eight positions to correct for the overstatement of the youth population. We further recommend the Legislature direct DMH to update and adjust its funding request at the time of the May Revision to reflect an accurate projection of the patients who will actually be in the affected units during 2005-06.
- ***Drug Procurement Savings.*** In "Part V" of *The 2005-06 Budget: Perspectives and Issues*, we discuss a number of steps the state could take to reduce expenditures for the procurement of pharmaceuticals for various state agencies and programs, including DMH's state hospital system. In regard to DMH, we specifically propose that its Medi-Cal reimbursement procedures be modified so that drug purchases for Medi-Cal patients in the state hospitals are accounted for separately and the state gets deeper discounts on prices available under federal law. We recommend that the Legislature direct DMH (in consultation with the Department of Developmental Services, which handles Medi-Cal billing for DMH) to estimate the state savings that could be achieved in the budget year from such a change.

- ***Adjustment for Medicare Part D Drug Benefit.*** In our analysis of the Medi-Cal Program, we recommend that the Legislature recognize savings that are likely to accrue to certain state agencies as a result of the new federal law. We estimate that the costs to the state hospital system for prescription drugs will decrease by about \$3.6 million (all funds) if all 590 patients enrolled in Medicare henceforth receive their drug benefit under Medicare instead of under state programs. Now that federal authorities have released final regulations to implement Part D, we recommend that DMH, in consultation with the Department of Health Services, present the Legislature with an appropriate budget adjustment relating to the Part D benefit at the time of the May Revision.
- ***Strategic Sourcing Initiative.*** The DMH spending plan assumes that the department will achieve about \$2.4 million in General Fund savings in the current year and a further \$2.4 million in General Fund savings in the budget year, as a result of the Strategic Sourcing Initiative, an effort to improve state procurement efforts. However, the budget plan does not identify specifically how the assumed savings will actually be obtained, and it appears likely that little if any of the savings will be achieved in the current fiscal year. We examine several issues related to the Strategic Sourcing Initiative in our discussion of Control Section 33.5 in the "General Government" chapter of the *Analysis*.
- ***Report on Federal Funds Pending.*** The *2004-05 Budget Act* provided DMH with \$472,000 for staffing and contract services to identify and evaluate approaches for increasing federal funding and reducing state costs for community mental health services and the state hospital system. Provision 3 of Item 4440-001-0001 in the budget act directed DMH to provide the Legislature by January 10, 2005, with a status report on its work and any findings and recommendations stemming from that study. At the time this analysis was prepared, the status report had not yet been presented to the Legislature. The DMH indicated that a written report on this subject was pending and being reviewed by the administration prior to its release.
- ***CONREP Program Caseload.*** The Governor's budget plan proposes various caseload adjustments for CONREP, which provides supervision and treatment for certain mental health patients after they are released from state hospitals into the community. The *2004-05 Budget Act* assumed that the program would provide community care for 753 patients by July 2005. However, the CONREP population estimate for July 2005 has been revised downward by

23 to 730. The Governor's budget plan proposes to reduce CONREP funding by \$485,000 in the budget year to reflect the lower-than-anticipated caseload. However, it proposes to make no adjustment in the current year for this change. We believe such a change is appropriate because the program has been overbudgeted also in the current year. Accordingly, we recommend that the Legislature direct DMH to provide an updated estimate of the current-year CONREP caseload and the appropriate budget adjustments for both the current and budget years at the time of the May Revision.



DEPARTMENT OF CHILD SUPPORT SERVICES (5175)

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

The Governor's budget proposes expenditures totaling \$1.2 billion from all funds for support of DCSS in the budget year. This is an increase of 28 percent over 2004-05. The budget proposes \$471 million from the General Fund for 2005-06, which is an increase of \$204 million, or 77 percent, compared to 2004-05. The increase is attributable to deferring payment of the federal child support penalty from 2004-05 to 2005-06, partially offset by a decrease in automation funding.

Administrative Expenditures Excessive

Many county child support agencies are spending large portions of their budgets on administrative expenditures rather than on core program services. We recommend enactment of legislation prospectively phasing in a 20 percent cap on administrative expenditures. We further recommend that for 2005-06, county administrative funding not exceed 25 percent. Adopting this recommendation would result in over \$6 million in state General Fund savings. (Reduce Item 5175-101-0001 by \$6,200,000.)

Current Administrative Spending. Administrative spending for this program, like most other programs, includes such things as the cost of clerical support staff, rent and utilities, office supplies, postage and printing, staff for payroll, and other human resources activities. These expenditures do not include salaries for the staff providing direct services such as attorneys, caseworkers, and investigators. Under current law, there is no

cap on the amount a local child support agency is allowed to expend for these activities

An administrative cost ratio analysis conducted by DCSS revealed that, on average, California's 58 local child support agencies spent over 26 percent of their program allocations on administrative overhead costs in 2003-04 (the most recent data available). Expenditures ranged from a high of over 40 percent in San Francisco County to just over 16 percent in Stanislaus County. Thirteen local child support agencies are spending over 30 percent of their funding on administration.

While one might assume that a higher administrative ratio might be necessary in high-cost Bay Area counties, a review of the expenditures does not reveal any of those patterns. For example, while San Francisco is the highest of the counties, nearby Contra Costa ranks among the lowest with administrative expenditures coming in under 19 percent.

Administrative Spending in Other Social Services Programs. An average administrative cost ratio of 26 percent is high when compared to other social services and health programs. Child Welfare Services (CWS) is similar to child support in that it provides client services rather than a cash grant. For CWS, counties spend an average of 17 percent of their funding on administrative activities. In-Home Supportive Services also has no grant payment and has estimated administrative costs of approximately 12 percent in 2005-06. Administrative funding for the state's Medi-Cal program constitutes less than 7 percent of the total program funding. Clearly, spending on administration for local child support agencies exceeds that of similar programs.

Administrative Caps on Federal Funds. Excessive administrative spending has traditionally been a concern of the federal government. In an attempt to ensure that federal funds are used to provide services, the federal government has regularly established administrative funding caps. For example, administrative expenditures for federal Promoting Safe and Stable Families funding and Independent Living Program funding are limited to 20 percent. Likewise, administrative expenditures for Temporary Assistance for Needy Families funds are limited to 15 percent.

Why Other State Programs May Not Need Administrative Caps. Despite the existence of federal caps, California generally has not established administrative caps for its social services programs. However, most of those programs contain a significant county share of costs, which provides an incentive for counties to limit the amount they spend on administration. Child support is unique in that regard because it does not contain a county share of costs and thus does not have the same cost control incentive. An administrative cap would create this type of incentive in this program.

Analyst's Recommendation. In trying to determine our recommended level for administration funding, we relied primarily upon the 17 percent administrative funding ratio for CWS. Of the social services programs we reviewed, CWS and child support are the most comparable. Neither program distributes cash grants or other benefits to its participants. Both primarily provide caseworker services to families. Therefore, we recommend capping the local child support agencies' administrative expenditures at 20 percent. Further, we recommend phasing in this cap over the next two fiscal years. For 2005-06, county administrative allocations would be limited to 25 percent. Based on our estimates using available 2003-04 data, the allocations of 27 counties would be reduced, resulting in a savings of \$6 million General Fund (\$18 million total funds). Our recommendation exempts six small local child support agencies with allocations under \$1 million from the administrative funding cap, because their small size limits their ability to achieve economies of scale.

We believe that phasing in the reduction would allow counties one year to make adjustments to their claims to the extent that they have been inadvertently claiming direct program costs as administrative costs. We also recommend that the department report to the Legislature on whether or not local child support agencies shifted large portions of their former administrative expenditures to direct services. To the extent that shifts take place, the department should verify their validity. Beginning with the 2006-07 budget, all administrative expenditures would need to fall under the 20 percent cap.

Under our approach, total funding per case would be \$582. This is nearly double the average of the next ten largest states (\$293). Even in the relatively high-cost state of New York, funding per case is \$324 (significantly below California), and New York generally outperforms California on child support collection.

California Child Support Automation System Project

We withhold recommendation on the proposed transfer of \$79 million to the Franchise Tax Board for the continued development of the California Child Support Automation System pending (1) renegotiation of a recent contract amendment to be consistent with prior legislative approvals and (2) the review of a cost/benefit analysis supporting early system certification.

The budget proposes to transfer \$79 million (\$27 million General Fund) from DCSS to the Franchise Tax Board (FTB) for the continued development of the Child Support Enforcement (CSE) component of the California Child Support Automation System (CCSAS) project. Chapter 479, Statutes of 1999 (AB 150, Aroner), requires FTB to act as DCSS' agent for the procurement, development, and maintenance of the CCSAS project.

Background. The CCSAS project consists of two major components—CSE and the State Disbursement Unit (SDU). The CCSAS CSE project cost is projected to be \$1.3 billion (\$876 federal funds and \$465 million General Fund) over the next ten years. This amount includes \$815 million for the primary contract, and \$500 million in state staff and other contract costs. The CSE includes two phases: (1) phase I, which will provide a centralized database and reporting system and (2) phase II, which will provide a statewide CSE system. The FTB is currently developing both CSE phases. In addition, FTB is also working with another contractor to develop and implement the SDU, which is required by the federal government for state child support systems. The SDU would collect child support payments from noncustodial parents and their employers and then issue payments to custodial parents. Upon implementation of CSE phase I and the SDU in September 2006, the administration intends to request federal certification for an alternative statewide CSE system. The primary purpose of the early certification is to seek some relief starting in 2006-07 from federal penalties imposed on the state for failure to implement a statewide child support system.

Recent Contract Amendment. In December 2004, FTB signed a contract amendment which would increase costs of the primary CSE contract by \$14 million. Specifically, the contract amendment consists of: (1) \$7 million for additional contractor staff and data center operations for a revised schedule and (2) \$7 million to enhance CCSAS training, expand the help desk, and provide additional maintenance and operations to support the revised schedule. The five additional months would allow for further testing and support for implementation of the SDU component.

Proposal. In the 2005-06 budget, DCSS is proposing to provide FTB with:

- \$1.5 million to hire 16 additional staff for various system development activities and expand the CCSAS project network.
- \$63.5 million for previously approved CSE contract payments.
- \$14 million for the recent CSE contract amendment.

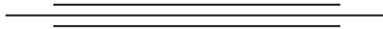
We have two concerns with the proposal that we discuss below.

Amendment Payment Inconsistent With Previous Legislative Approvals. In establishing parameters for the CCSAS project, Chapter 479 directs the state to use the same performance-based procurement and contract practices used in previous FTB tax automation projects. Under a performance-based contract, the vendor receives payments after a system is operating and achieving benefits. Based on previous legislative approvals, the CCSAS prime contract provides both performance and deliverable-based payments (deliverables include providing specific products). The recent contract amendment, however, provides a \$7 million payment to the ven-

dor for neither meeting a performance objective nor providing a deliverable. Under the amendment, the contractor would be paid for simply providing additional staff and beginning operation of its data center. This payment is inconsistent with both the legislative direction of Chapter 479 and the Legislature's approval of the contract's previous payment arrangements. According to FTB and DCSS, the state is currently renegotiating this payment to be consistent with prior legislative contract approvals.

Cost/Benefit Analysis Not Completed. If the state receives federal certification for an alternative system before implementation of CSE phase II, the federal government could limit its funding of all remaining CSE phase II development and maintenance and operation activities. This is because the federal government would not pay for development costs on certified systems. If this were to happen, the state would be required to complete the project exclusively with General Fund dollars. To better understand the early certification funding implications, the Department of Finance directed FTB and DCSS in June 2003 to conduct a cost/benefit analysis of the alternative certification schedule. According to FTB and DCSS, this cost/benefit analysis will be provided to the Legislature in March 2005. In our view, prior to making funding decisions regarding early certification, the cost/benefit analysis should be reviewed so the Legislature can better understand the full funding needs and potential risks of early certification.

Withhold Recommendation. Since the CSE contract amendment payment is currently being renegotiated and the cost/benefit analysis of the early system certification will not be available until March 2005, we withhold our recommendation on the proposed transfer of \$79 million to FTB.



CALIFORNIA WORK OPPORTUNITY AND RESPONSIBILITY TO KIDS (5180)

In response to federal welfare reform legislation, the Legislature created the California Work Opportunity and Responsibility to Kids (CalWORKs) program, enacted by Chapter 270, Statutes of 1997 (AB 1542, Ducheny, Ashburn, Thompson, and Maddy). Like its predecessor, Aid to Families with Dependent Children (AFDC), 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 (\$1.9 billion General Fund, \$153 million county funds, \$40 million from the Employment Training Fund, and \$2.9 billion federal funds), to the Department of Social Services (DSS) for the CalWORKs program in 2005-06. In total funds, this is a decrease of \$521 million, or 11 percent, compared to estimated spending of \$5.6 billion in 2004-05. This decrease is primarily attributable to savings from (1) a proposed 6.5 percent maximum grant reduction, (2) a proposed reduction in the amount of income which may be disregarded for purposes of determining a working family's grant, (3) savings from adults reaching their 60 month CalWORKS time limit, and (4) savings from proposed child care reforms.

We note that Congress extended funding for the Temporary Assistance for Needy Families (TANF) block grant through March 31, 2005. The Governor's budget assumes TANF funding will eventually be extended or reauthorized at current funding levels (\$3.7 billion annually for California) at least through 2005-06.

MAINTENANCE-OF-EFFORT AND TRANSFERS OUTSIDE OF CALWORKS

The proposed budget achieves General Fund savings of \$443 million by recognizing additional countable maintenance-of-effort (MOE) spending on State Department of Education (SDE) Child Care and by increasing the amount of Temporary Assistance for Needy Families (TANF) federal funds used to offset General Fund costs in other programs. We review the recent history of CalWORKs MOE expenditures and TANF expenditures for other programs and comment on the Governor's proposals.

TANF MOE Requirement. To receive the federal TANF block grant, states must meet an MOE requirement that state spending on assistance for needy families be at least 75 percent of the federal fiscal year (FFY) 1994 level, which is \$2.7 billion for California. (The requirement increases to 80 percent if the state fails to comply with federal work participation requirements.) Countable MOE expenditures include those made on behalf of CalWORKs recipients as well as for families who are *eligible* for CalWORKs but are not receiving cash assistance. Although the MOE requirement is primarily met through state and county spending on CalWORKs and other programs administered by DSS, state spending in other departments is also counted toward satisfying the requirement. The *2004-05 Budget Act* includes \$321 million in countable MOE expenditures outside of the CalWORKs program (\$28 million from other DSS programs and \$293 million from other departments).

The recognition of additional state-countable expenditures outside of CalWORKs toward the MOE has two impacts. First, it reduces the total amount of state funding that needs to be spent specifically on CalWORKs to meet the MOE requirement. Second, it enables the state to achieve General Fund savings while maintaining compliance with the federal MOE requirements by reducing the General Fund appropriation to DSS for CalWORKs. However, to obtain the General Fund savings, program reductions in CalWORKs are necessary unless there are sufficient federal TANF funds available to cover CalWORKs program costs pursuant to current law.

TANF Expenditures Offsetting General Funds Costs. Federal law permits the expenditure of TANF funds on a variety of programs and activities. It may be expended on any program designed to (1) provide assistance to needy families and children; (2) end the dependence of needy parents on government benefits by promoting job preparation, work, and marriage; (3) prevent and reduce the incidence of out-of-wedlock pregnancies; and (4) encourage the formation and maintenance of two-parent families. Moreover, TANF funds can be spent for any purpose permitted under the AFDC

program (the predecessor of TANF) or under AFDC Emergency Assistance (EA). (For example, AFDC-EA could be used for juvenile probation.) Finally, up to 10 percent of TANF funds may be transferred to the Title XX Social Services Block Grant and then expended in accordance with the federal rules pertaining to Title XX.

The *2004-05 Budget Act* includes TANF appropriations of \$138 million for Child Welfare Services, \$51 million for emergency assistance Foster Care, \$67 million for youth probation, and \$315 million to fund Stage 2 child care costs at SDE. In addition, the act transfers \$63 million into the Title XX Social Services Block Grant to fund child welfare services and child care.

Historical Fiscal Policy. In the late 1990s, California had relatively large TANF fund balances in comparison to CalWORKs program costs. This was due to CalWORKs caseload decline (which reduced grant costs) and the relatively slow ramp-up of the costs for CalWORKs welfare-to-work activities and associated child care. Accordingly, budgets enacted during this period attempted to use TANF to offset costs in other programs and to maximize countable MOE expenditures in other departments. This provided substantial General Fund savings while allowing CalWORKs to be fully funded. More recently, the end of the caseload decline, increased costs for employment services and child care, and statutory cost-of-living adjustments (COLAs) have put pressure on TANF and MOE funds. In order for the state to remain at the MOE floor (while continuing to maximize both the counting of MOE funds in other departments and the use of TANF funds to generate savings in other programs) reductions in CalWORKs were necessary. For example, COLAs were delayed and a county incentive program was terminated.

The 2004-05 CalWORKs Budget. The budget act contained two significant changes. First, the Legislature adopted budget control language which limited the amount of SDE child care expenditures that would be counted toward the MOE. Specifically, the language limited countable SDE child care to those expenditures on behalf of families *receiving* CalWORKs, rather than families who may be *eligible* for CalWORKs but were not receiving cash assistance. This language reduced the amount of countable MOE expenditures by \$153 million. Second, with the sunset of the state Comprehensive Youth Services Act on November 1, 2004, the budget replaced \$134 million in TANF funding for local youth probation programs with support from the General Fund in the Board of Corrections. Previously, the state had provided \$201 million in TANF funding for youth probation on a full-year basis. These two actions freed up \$287 million in TANF (\$124 million) and MOE (\$153 million) funds to be used for CalWORKs recipients. The actions also resulted in General Fund costs of an identical \$287 million.

Governor's Proposal. For 2005-06, the Governor proposes to reverse the decisions made in 2004-05. Specifically, the budget proposes to increase the amount of countable SDE child care expenditures and to fund local youth probation programs with TANF federal funds. In addition, the budget proposes new and expanded TANF transfers to offset General Fund costs in other programs. Figure 1 lists \$443 million in new or expanded proposals for creating General Fund savings from the CalWORKs program. In order to free up the TANF funds needed for the proposed transfers shown in Figure 1, the budget proposes grant reductions and other changes discussed later in this chapter. We note that the Legislature rejected similar proposals to transfer TANF funds to Title XX to offset costs in Foster Care and Developmental Services last year.

Figure 1

New or Expanded Proposals for General Fund Savings From TANF^a Expenditures and MOE^b Accounting

2005-06
(In Millions)

Proposal	Amount
Replace General Fund in DSS^c With MOE From Other Departments	
Recognize increased countable MOE child care expenditures in SDE ^d	\$57.1
Replace General Fund in Other Programs With TANF Expenditures	
Board of Corrections—juvenile probation	\$201.4
SDE—Stage 2 child care	69.0
Replace General Fund in Other Programs With TANF Transfers to Title XX	
Developmental Services—Community Services Program	\$60.0
DSS—Foster Care	55.1
Total Savings	\$442.6

^a Temporary Assistance for Needy Families federal block grant funds.
^b Maintenance-of-effort.
^c Department of Social Services.
^d State Department of Education.

Legislature Has Flexibility. The proposed TANF transfers in Figure 1 appear feasible, but some require state law changes. Similarly, the proposal to recognize additional SDE child care expenditures to meet the MOE requirement is workable under federal law. In fact, the Legislature could elect to count additional SDE child care expenditures toward the MOE, beyond what the Governor proposes. The proposed budget counts toward the MOE \$431 million in SDE child care expenditures on CalWORKs recipients and *some* CalWORKs eligibles. If the Legislature elected to count *all* SDE child care spending on CalWORKs eligibles, then total countable SDE MOE spending would be \$509 million, an increase of \$78 million. However, to obtain \$78 million in General Fund savings, additional CalWORKs program reductions would be necessary.

Conclusion. The amount of General Fund support for CalWORKs and the use of TANF funds to offset General Fund costs in other programs are fiscal and policy decisions for the Legislature. Specific decisions regarding countable MOE spending and the amount of TANF transfers are set through the budget act. The Governor has set a goal of \$443 million in additional savings from CalWORKs. Based on its overall spending priorities, the Legislature must decide whether it concurs with the \$443 million target. The Legislature could seek more or less General Fund savings from the CalWORKs program. After the Legislature sets its goal, the CalWORKs MOE accounting and TANF support for other programs can be adjusted accordingly to fit that target.

In other words, the amount of General Fund support and TANF support for CalWORKs and other eligible programs should be based on the fiscal and policy priorities of the Legislature, not an assumed constraint of remaining below the MOE.

CASELOAD AND GRANTS

Overestimate of CalWORKs Caseload

We recommend that proposed spending for CalWORKs grants be reduced by \$17.4 million in 2005-06 because the caseload is overstated. (Reduce Item 5180-101-0890 by \$17,400,000.)

CalWORKs Caseload Trends. In 1994-95, the average monthly CalWORKs caseload (families) was about 921,000. Since then, the caseload has declined every year, eventually dropping to about 481,000 in 2003-04. Most of the decline occurred by 2001-02. Since October 2002, the caseload has been essentially flat.

Governor's Budget Forecast. For 2004-05, the Governor's budget forecasts a slight increase in the caseload to 495,000 since 2003-04. The in-

crease is primarily attributable to onetime factors including the recent migration of certain refugees and the end of extended unemployment benefits. Absent policy changes, the budget forecasts a modest caseload decline to 486,000 cases in the budget year.

The Governor's budget proposes to reduce grants by 6.5 percent and to reduce the earned income disregard. Both of these proposals have the effect of lowering the income threshold at which working families become ineligible for cash assistance. If these are adopted, the average monthly caseload will drop by an additional 14,000 cases during 2005-06.

LAO Caseload Forecast. The most recent actual caseload data from the first quarter of 2004-05 indicate that the Governor's budget has overstated the number of cases (families) by about 0.6 percent. Moreover, the budget has overstated the number of persons (adults and children in the family comprising the case) by 2.8 percent. We note that there is significant uncertainty regarding the number of persons per case, especially the number of adults who have reached their time limit and are removed from the assistance unit (the children continue to receive their grant). Although total persons is usually the best indicator of grant costs, given the uncertainty, we are basing our estimate of caseload savings on the difference between the budgeted number of cases in comparison to the actual number of cases. Based on the 0.6 percent difference identified above, the budget for CalWORKs grants is overstated by \$17.4 million. Accordingly, we recommend reducing the budget for cash assistance for by \$17.4 million.

Budget Deletes Statutory COLAs and Reduces Grant Payments

The Governor proposes to reduce grant payments by 6.5 percent and permanently eliminate the statutory cost-of-living adjustments (COLAs) currently required each year. These proposals result in state savings of \$355 million in comparison to the requirements of current law. In addition, the Governor proposes trailer bill language to delete the October 2003 COLA in the event that the state loses its appeal of the Guillen court case requiring such payment.

Repealing the State COLA. Current law requires that CalWORKs recipients receive a COLA equal to the percent change in the California Necessities Index (CNI) each July. The Governor proposes trailer bill language to eliminate this requirement. The January budget assumed that the CNI would be 4.6 percent and that deleting the CalWORKs COLA would result in savings of \$164 million. Based on final data, the CNI will actually be 4.07 percent. Accordingly, the savings from deleting the COLA are reduced to \$143 million, based on the actual CNI.

Grant Reduction. The Governor proposes to reduce grants by 6.5 percent. This results in state savings of \$212 million. Lowering the maximum grant payment level has the effect of lowering the income threshold at which working families become income-ineligible for cash assistance. As a result, about 7,000 families currently receiving relatively small grants would no longer be eligible for CalWORKs under this proposal.

October 2003 COLA Litigation. As discussed in our *Analysis of the 2004-05 Budget Bill* (page C-223), the state has not provided the October 2003 COLA. In the *Guillen* court case, advocates for the state's CalWORKs recipients successfully argued in superior court that the state should provide the October COLA. Currently, the administration is appealing this ruling and an appellate court decision is expected sometime during the second half of 2005. The administration is proposing a trailer bill to delete the October 2003 COLA in the event that the state loses its appeal. This trailer bill would result in avoided costs of \$131 million in 2005-06. In the event that *Guillen* is affirmed by the appeals court, the state faces a budget risk of \$222 million in retroactive payment to CalWORKs recipients.

Impact on Recipients. 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 reduction proposals. In general, food stamps increases offset about 45 percent of the proposed grant reductions. As the figure shows, under the Governor's proposals, in 2005-06 the maximum monthly CalWORKs grant for a family of three in a high-cost county would be \$676, compared to \$778 under current law. The maximum monthly CalWORKs grant for a family of three in a low-cost county would be \$644 under the Governor's proposals, compared to \$742 under current law. (For purposes of discussion, Figure 2 assumes that restoration of the October 2003 COLA is part of current law.)

As a point of reference, the federal poverty guideline for 2004 (the latest reported figure) for a family of three is \$1,306 per month. (Federal poverty guidelines are adjusted annually for inflation.) Under current law, the combined maximum CalWORKs grant and food stamps benefits in high-cost counties would be \$1,057 per month (81 percent of the poverty guideline). Under the Governor's proposals, combined benefits in high-cost counties would instead be \$1,001 per month (77 percent of the poverty guideline). Combined benefits in low-cost counties would be \$1,037 per month (79 percent of the poverty guideline) under current law, compared to \$983 (75 percent of the poverty guideline) under the Governor's proposals.

Figure 2**CalWORKs Maximum Monthly Grant and Food Stamps***Family of Three
2005-06*

	CalWORKs Grant	Food Stamps	Total
High-Cost Counties			
Current grant	\$723	\$303	\$1,026
With July 2005 COLA	752	290	1,042
Current law: plus Oct. 2003 COLA restoration ^a	778	279	1,057
Governor's proposal: reduces grants by 6.5 percent and deletes Oct. 2003 and July 2005 COLAs	676	325	1,001
Change From Current Law	-\$102	\$46	-\$56
Low-Cost Counties			
Current grant	\$689	\$319	\$1,008
With July 2005 COLA	717	306	1,023
Current law: plus Oct. 2003 COLA restoration ^a	742	295	1,037
Governor's proposal: reduces grants by 6.5 percent and deletes Oct. 2003 and July 2005 COLAs	644	339	983
Change From Current Law	-\$98	\$44	-\$54

^a The state has never paid the October 2003 COLA and has appealed the *Guillen* court case requiring its payment.

OTHER BUDGET ISSUES***Unspent TANF Funds Identified***

The Governor's budget has identified \$407 million in additional unspent Temporary Assistance to Needy Families (TANF) funds from past years in comparison to the May 2004 estimate. We review the sources of these additional TANF carry-over funds. To reduce future overbudgeting, we recommend eliminating the child care "hold back" and midyear supplemental allocations to counties.

Background. Each year California receives from the federal government its \$3.7 billion annual TANF block grant. Any unspent TANF funds

are carried forward on California's books for expenditure in future years. The 2004-05 Budget Act assumed that \$115 million in federal TANF funds would be carried forward from 2003-04 and be available for expenditure in 2004-05.

Additional Carry-Forward TANF Funds Identified for 2004-05. The Governor's budget has identified \$407 million in additional TANF carry-forward funds as compared to the May 2004 estimate. Figure 3 shows the sources for these additional funds. Specifically, about \$182 million is from an accounting error pertaining to 2001, and \$202 million is from unspent county allocations from 2002-03 and 2003-04. (Under current law counties receive one block grant to cover the estimated costs of administration, welfare-to-work services [including case management], and child care.) This block grant is known as the single allocation, and counties are free to move funds among the different program components funded in the block grant. Under current practice, DSS increases block grants midyear if it identifies additional costs pertaining to caseload, workload, or court cases.

Figure 3	
Additional TANF Carry-Forward Funds	
2004-05	
<i>(In Millions)</i>	
Source	Amount
Unspent county block grant funds	
From 2002-03	\$59.0
From 2003-04	143.4
Subtotal	(\$202.4)
Accounting error	\$181.5
Reduced automation costs for 2003-04	14.4
Reduced Emergency Assistance and Foster Care costs	6.7
Other	2.0
Total	\$407.0

History of Finding Additional Carry-Forward Funds. The identification of additional carry-forward funds following enactment of a budget is not an isolated incident (though the magnitude for this year is unprecedented). For the past four fiscal years, the January budget has identified an average of \$111 million in additional carry-forward TANF funds in comparison to budgets enacted about six months earlier.

What Causes Unspent Funds? As noted above, a major factor contributing to unexpended carry-over balances was the counties' inability to expend their single allocation block grant funds. This amounted to \$143 million in overbudgeting for 2003-04. We believe that most of the unspent funds are related to uncertainty regarding the amount of the single allocation, and cautious budgeting practices by counties which limit expenditures until final allocations are known. Below we discuss three possible causes of uncertainty and unspent funds.

- **Counties Receive Midyear Increases Too Late to Enable Their Expenditure.** Counties receive notification of their initial planning allocation just before the start of the fiscal year. Soon after the state budget is enacted, a final allocation letter is sent to the counties. For 2003-04, the final allocation was sent in September 2003. At the time the Governor's budget is released each January, supplemental allocations are discussed with counties and a supplemental allocation letter (noting that additional funds are contingent on legislative approval) is sent to the counties within a few weeks of the release of the budget. During 2003-04, counties were notified of a supplemental allocation of \$48 million in February 2004. On April 22, counties received final notification that the February funds were approved. Finally, counties were notified of an additional \$9 million allocation on June 30, 2004, the last day of the fiscal year.
- **The Child Care Hold Back.** The state holds back approximately 5 percent of estimated costs for Stage 1 and Stage 2 CalWORKs child care in a reserve (about \$60 million). The reason for the hold back is that Stage 2 is controlled by SDE while Stage 1 is controlled by DSS, and there is some uncertainty as to how many families will move from Stage 1 to Stage 2 each year. Under this system, counties do not know how much of these hold back funds they will eventually receive until notified by the administration well into the fiscal year. Thus, counties may tend to reduce spending on program components they directly control such as eligibility administration and employment services, so that they can fund child care (which they do control because it is virtually an entitlement). This way, counties will be sure they have enough funds to cover program expenses, even if they do not receive the child care reserve funds they have requested.
- **General County Fiscal Concerns.** During 2003-04, there was substantial uncertainty about the payment of vehicle license fee subventions to the counties. As a result, many counties adopted county-wide hiring freezes. Since most single allocation funds are for county staff, these freezes could have contributed to unspent funds.

Issues for Legislative Consideration. Overbudgeting means that TANF funds are held at the county level and are not available for other program needs such as grant costs, or for transfer to other programs for the purpose of creating General Fund savings. To avoid future overbudgeting, we discuss some advantages and disadvantages of two possible changes.

- **Eliminate the Child Care Holdback.** Under this option, all estimated child care funds would be allocated to Stage 1 and Stage 2 with no holdback, thereby reducing uncertainty. In the event the allocation between Stage 1 and Stage 2 is incorrect, both counties and SDE's alternative payment providers usually have unspent funds to cover deficiencies. Thus, recipients are not likely to be impacted by this change.
- **End Midyear County Block Grant Supplemental Allocations.** Under this approach, county allocations would not be increased mid-way through the current year for cost increases. However, the budget year proposed allocation would reflect any such costs pressures. This approach would free up TANF funds for expenditure by the Legislature in the budget year instead of maintaining them in county allocations which would not revert for another 15 months. This would give the Legislature more control over scarce TANF funds that could be used for priorities both inside and outside of the CalWORKs program. The downside of this approach is that supplemental allocations are made in order to address unanticipated costs, usually related to caseload. Without midyear supplements, some counties may have difficulty serving all clients with the necessary case management and employment services.

Analyst's Recommendation. In order to increase legislative authority over TANF funds, we recommend adopting the changes presented above. We also recommend working with stakeholders to develop a "county request" program, for counties who can demonstrate both midyear cost increases related to workload and the ability to expend the additional funds.

Current-Year Costs Overstated

Our review of actual caseload and expenditure data through October 2004 indicates that the Governor's budget overstates the CalWORKs costs for 2004-05 by \$118.5 million. We recommend that the Legislature recognize these savings and increase the Temporary Assistance to Needy Families carry-forward balance available for 2005-06 by \$118.5 million. (Increase Item 5180-101-0890 by \$118.5 million.)

Our review indicates that DSS has over-estimated program costs for 2004-05 for both cash grants and county single allocation expenditures. We discuss each overestimate below.

DSS Budgeting Process for Cash Grants. To estimate the budget for cash assistance payments in the current year, DSS determines the cost per person based on the actual trends from prior years and then applies the cost per person to its latest estimate of the future caseload. The department then adjusts the projected budget based on recently enacted policy changes that would not be captured in recent expenditure trends (for example, the estimated impact of the recently adopted welfare reform measures which were not implemented until December 2004). At the time DSS prepared the budget, it had access to expenditure and caseload trends through July of 2004.

More Recent Data Available. Subsequently, we reviewed caseload data through September 2004 and cash expenditure data through October 2004. We then applied the cost per case in September 2004, to the department's estimated caseload from November 2004 through June 2005 to arrive at a baseline budget for 2004-05 cash assistance. We then adjusted this baseline to reflect policy changes not captured in the trend through September. We conclude that DSS has overestimated grant costs for 2004-05 by \$96.5 million.

Budgeting Practice for County Block Grants. With respect to 2004-05 county block grant allocations for CalWORKs administration, welfare-to-work services, and Stage 1 child care, DSS assumes that counties will spend their entire allocation. In addition, DSS assumes that counties will also expend an additional \$22 million that will be allocated to them in a supplemental letter released in February 2005.

History of Unspent County Allocations. As discussed in the previous issue, counties have a history of not spending all of their block grant funds. One source of these unspent funds is late notification of additional county block grant funds. Based on past history, we conclude that, at a minimum, counties are not likely to expend the most recently allocated \$22 million in block grant funds. Thus, the budget overstates county expenditures by \$22 million and underestimates the likely TANF carry-forward by an identical amount.

Analyst's Recommendation. As discussed above, we estimate that cash grants and county block grant expenditures are overstated by a total of \$118.5 million. We recommend that the Legislature recognize these savings by increasing the TANF carry-forward balance for 2005-06 by \$118.5 million. These TANF funds are available for expenditure in the budget year or may be held in reserve for future years. We will monitor actual expenditure and caseload trends over the coming months and will advise the Legislature of any changes in our estimates for 2004-05.

Proposal to Reduce Earned Income Disregard

Under current law, the first \$225 of earned income and 50 percent of each additional dollar earned is disregarded (not counted) for purposes of determining a family's grant amount. The Governor proposes to reduce the disregard factors to \$200 and 40 percent. This proposal reduces the grants for all working recipients, results in savings of \$80 million and probably has minimal impact on the work incentive of CalWORKs recipients. We comment on the Governor's proposal and present alternative approaches which would likely increase the work incentive of CalWORKs recipients, but would result in lower budgetary savings.

Background. The maximum CalWORKs grant is the amount of money a family receives if it has no other income. If the family has income, the grant is reduced after a specified amount of income is not counted (referred to as the income disregard). In order to provide an incentive for CalWORKs recipients to work, current law disregards (does not count) the first \$225 in earned income and 50 percent of each additional dollar earned when determining a family's grant amount. In the nearby shaded box, we show how the disregard works in determining the grants for families with two different levels of income.

Exit Point for Cash Assistance. The maximum monthly grant, in combination with the disregard policy, creates the exit point for CalWORKs (the point at which a family is no longer financially eligible for the program). For a family of three in a high-cost county the current exit point is a monthly income of \$1,671 (128 percent of the 2004 poverty guideline). When food stamps and the earned income tax credit are added, the family's total income at the exit point is about \$1,939 (149 percent of the poverty guideline). Figure 4 (see page C-216) shows how grants decline as earned income rises. As the figure shows, the grant for a family of three reaches zero (the exit point) before \$1,700 per month.

Governor's Proposal. The governor proposes to reduce the earned income disregard factors to \$200 and 40 percent, effective October 1, 2005. This would reduce the grants for all working recipients. This is because reducing the earned income disregard has the practical effect of increasing the amount of income that is counted when determining a family's grant level. The DSS estimates that for cases with income, the average grant reduction will be about \$79 per month. Figure 5 (see page C-216) compares the combined earned income and CalWORKs grant for a family of three in a high-cost county under both current law and the Governor's proposal at four different income levels. As the figure shows, working families would have less income (combined earnings and grant) under the Governor's proposal as compared to current law. The greatest impact is on families

CalWORKs Earned Income Disregard

When determining a family's grant, California disregards the first \$225 in earned income and 50 percent of each additional dollar earned. Below we show the grant calculations for two families with difficult levels of earnings.

Family Earning \$225.

Currently, the maximum monthly CalWORKs grant for a family of three in a high-cost county is \$723. Under the current income disregard policy, a family of three who earned \$225 per month would have 100 percent of their earnings disregarded and

would receive the maximum grant of \$723 plus their earnings of \$225 for a total income of \$948 per month (excluding food stamps).

Family Earning \$1,025. The figure below shows the disregard and grant calculations for a family of three with \$1,025 in monthly earnings. The top portion of the figure shows that \$625 in earnings will be disregarded for purposes of determining the family's grant and that \$400 will be counted. The bottom portion of the figure calculates the family's grant by subtracting the \$400 in countable earnings from the maximum grant of \$723 resulting in a grant of \$323. The grant plus earnings would result in total income of \$1,348 per month (excluding food stamps) for this family.

CalWORKs Earned Income Disregard Family of Three, \$1,025 in Earnings	
Disregard Calculation	Amount
Earnings	\$1,025
Initial disregard of \$225	225
Remainder	\$800
Apply 50% disregard to remainder	50%
Additional Earnings Disregarded	\$400
Initial disregard from above	225
Total Earnings:	
Disregarded	\$625
Counted	\$400
Grant Calculation	
Maximum grant	\$723
Less countable earnings	400
Grant	\$323

with more income. A family working 40 hours per week at \$6.75 per hour would see their combined grant and income decline by \$109 per month, a reduction of almost 8 percent.

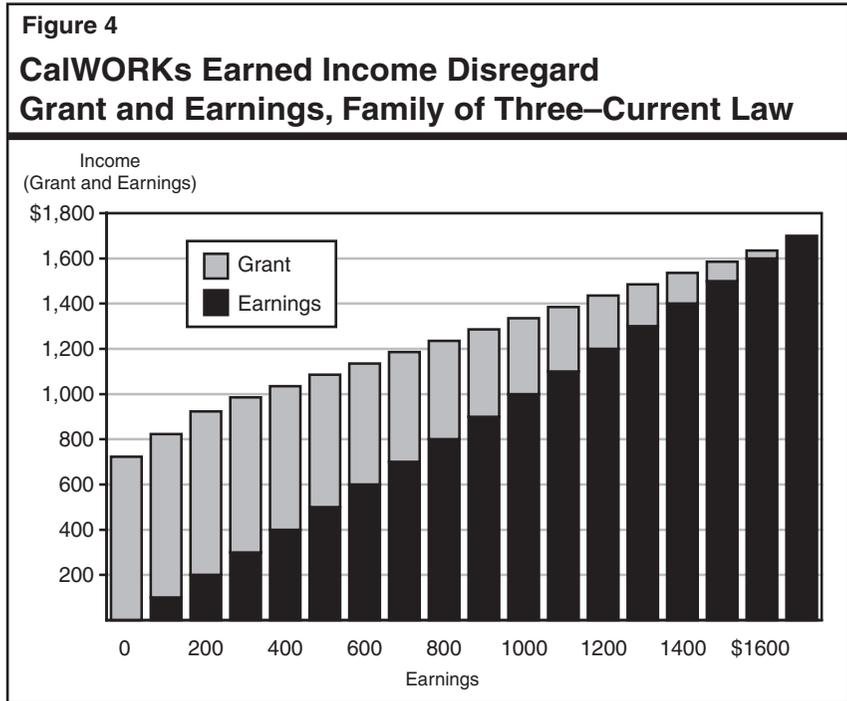


Figure 5
Impact of Governor’s Income Disregard
Family of Three
High-Cost Counties^a

Hours/Week, Hourly Wage	Monthly Earned Income	Grant Plus Earnings		Change From Current Law	
		Current Law	Governor's Proposal	Amount	Percent
10 hours, \$6.75	\$292	\$982	\$960	-\$22	-2.2%
20 hours, \$6.75	585	1,128	1,077	-51	-4.5
40 hours, \$6.75	1,169	1,420	1,311	-109	-7.7
40 hours, \$9.00	1,559	1,615	1,559	-56	-3.5

^a Assumes current \$723 maximum monthly grant.

Impact on Eligibility. Reducing the income disregard lowers the point at which families would no longer be eligible for a grant. As noted above, the exit point is currently \$1,671 per month for a family of three. Under the Governor's proposal, the exit point for a similar family would drop to \$1,405 per month (108 percent of poverty guideline). Reducing the exit point will mean that about 8,900 families will become ineligible for CalWORKs. Such exiting families, however, would remain eligible for food stamps, child care, and Medi-Cal, so long as their income remains below the eligibility thresholds for these programs.

Estimated Savings. The Governor's budget estimates that reducing the earned income disregard will result in grant savings of \$80.4 million, based on nine months of implementation starting in October 2005. In addition, the budget includes administrative savings of \$1.5 million due to the case exits noted above. The budget assumes automation costs of \$2.5 million for reprogramming welfare automation systems to reflect the new disregard. For 2005-06, net savings from the proposal would be \$79.4 million. In 2006-07, the savings would increase to about \$109 million, based on a full-year of operation. These savings assume no behavioral response by CalWORKs recipients. In other words, these estimates do not assume either an increase or decrease in the amount of work performed by CalWORKs families.

Impacts on the Work Incentive and Behavior. Reducing the disregard could have two impacts on the working behavior of recipients. On the one hand, it could result in a disincentive to work by reducing the amount of income retained from starting work or increasing one's hours of work. Thus, new entrants to CalWORKs who have no income along with currently aided families who are not working would be most affected by this disincentive. On the other hand, reducing the disregard could increase the incentive to work to the extent that families decide to work more hours in order to make up for the grant reduction pursuant to the revised disregard. Families with substantial earnings, but with incomes below the exit point would be most affected by this increase in the incentive. With more hours of work, such a family could make up for the lost income and possibly leave cash assistance. We would expect these two effects to in part offset each other.

Given the relatively small change in the disregard structure proposed by the Governor, we would expect minimal net change in the propensity of CalWORKs families to work. Accordingly, the Governor's savings estimates (which assume no change in the work behavior) are reasonable.

Alternatives to the Governor's Proposal

The earned income disregard is a key component of the CalWORKs program. It is a significant part of the work incentive for CalWORKs recipi-

ents and, in conjunction with the maximum grant, sets the exit point for the program. However, other factors such as the earned income tax credit and food stamps benefits also affect family income and the incentive to work. Before examining alternative approaches to the earned income disregard, we compare California's disregard to the disregard policies in ten other large states.

Comparison of Disregards to Other Large States. Figure 6 presents the earned income disregard and the exit point for cash assistance for the ten largest states in 2003 (the most recent available data). As the figure shows, California's disregard is among the most generous (only Ohio disregards more earned income), and California has the highest exit point for cash assistance. As a point of reference, Figure 6 also shows the exit point relative to the 2003 poverty guideline.

Figure 6
Earned Income Disregard and Exit Point
Ten Largest States, Family of Three
January 2003

State	Amount Disregarded at One Year on Aid ^a	Cash Aid Exit Point	Percent of Poverty
California	\$225 and 50 percent	\$1,563	123%
New York	\$90 and 46 percent	1,219	96
Illinois	67 percent	1,185	93
Ohio	\$250 and 50 percent	976	77
New Jersey	50 percent	848	67
Pennsylvania	50 percent	822	65
Michigan	\$200 and 20 percent	798	63
Florida	\$200 and 50 percent	786	62
Georgia	\$90	504	40
Texas	\$120	323	25

Sources: 2004 Green Book and Manpower Demonstration Research Corporation.
^a TX, GA, NJ disregard more income for the first few months on aid.

Comparison of Participation Rates to Other Large States. The earned income disregard is intended as an incentive that affects work participation. Figure 7 compares the disregard in each state to the percentage of families meeting federal work participation requirements through just employment, or through employment and other activities. The states are ranked in order of the percentage employed. In general, states with more generous

disregards have higher levels of employment among their caseloads. For example, of the five states with the more generous disregards, four (Illinois, New York, California, and Ohio) have the highest employment rates among their program participants. There are, however, important exceptions. Michigan and New York, which clearly have less generous disregards than California, also have higher participation than California. Texas, with the least generous disregard, still manages the sixth best participation rates among these states. Clearly, other factors besides the disregard affect the work behavior of recipients. These factors include local economic conditions, sanction policies, and the ability of recipients to meet participation through activities other than unsubsidized employment.

Figure 7

Comparison of Disregards to Work Participation Ten Largest States, 2002

State	Amount Disregarded At One Year on Aid	Percent Meeting Federal Hourly Participation Standards	
		Employment	Overall
Illinois	67 percent	37.7%	58.5%
Michigan	\$200 and 20 percent	25.9	28.8
New York	\$90 and 46 percent	23.8	38.7
California	\$225 and 50 percent	21.3	27.3
Ohio	\$250 and 50 percent	21.0	56.2
Texas	\$120	19.7	29.6
Florida	\$200 and 50 percent	14.0	32.0
New Jersey	50 percent	14.0	36.5
Pennsylvania	50 percent	9.1	10.4
Georgia	\$90	3.9	8.3

Because the Governor's proposal has minimal impact on the work incentive, we discuss two alternatives.

Disregard All Income at a Constant Percentage Rate. Given that Illinois had the highest level of work participation among the ten largest states (see Figure 7), we first examined their disregard. In Illinois, 67 percent of all income is disregarded; however, there is no minimum income amount which is disregarded at 100 percent. (For example, California disregards 100 percent of the first \$225 in earnings.) Assuming no change in work behavior, adopting a straight 67 percent disregard in California would

actually cost more than current law (at least \$40 million per year). It would also raise the exit point for CalWORKs by about \$170 for a family of three. A variant on this approach would be to set the disregard rate at 57 percent. This would keep California's exit point near where it is today and would result in annual savings of about \$65 million compared to current law. (When welfare reform was first debated in 1997, the Wilson administration initially proposed a 54 percent disregard.)

The main advantage of a constant disregard at a rate higher than the current 50 percent is that it creates a stronger incentive to increase earnings as seems to be illustrated by Illinois. For example, a family earning more than \$225 per month who increased their monthly earnings by \$100 would keep \$67 under the Illinois style disregard compared to just \$50 under California's current law. The main disadvantage is that families earning less than \$225 would have less of an incentive to work since they could only keep 67 percent of their earnings (instead of the entire amount under California's system). Consequently, such families would be worse off financially.

Disregard More Income at Higher Earnings. Under this approach the 50 percent disregard would apply to all families, but the 100 percent exclusion on the first \$225 earned would only be provided to families earning \$600 or more per month. Those earning less than \$600 (about 20 hours per week at the minimum wage), would receive a flat disregard of 50 percent, but they would not receive the base 100 percent disregard on their first \$225 in earnings.

The reason for selecting the \$600 amount is that it corresponds to roughly 20 hours of work per week at the minimum wage. Under current law, adult participants must meet a "core" participation hour requirement of 20 hours per week. Unsubsidized employment is one way to meet the core requirement.

This approach would result in annual savings of about \$48 million compared to current law. The advantage is that it would strongly encourage recipients to work at least 20 hours per week, because they would receive the benefit of the \$225 exclusion once their earnings reach \$600 per month. The disadvantage is that it would lower the grants for families with earnings below \$600 per month because until they earned \$600 they would not receive the 100 percent disregard on their first \$225 earned. It would also reduce the incentive for those not working to begin work at less than \$600. It would not change the exit point for CalWORKs in relation to current law.

Federal Welfare Reform Reauthorization Clouds This Issue. Under current federal law, states must have certain percentages of their families working or participating in program activities. These percentages are reduced

by the "Caseload Reduction Credit," which is the amount of caseload reduction that has occurred since the enactment of the federal 1996 welfare reform legislation. Some versions of welfare reform reauthorization continue or modify this caseload reduction credit. Other versions eliminate this credit. All versions increase the percentage requirements for participation. Because welfare reauthorization provisions are unknown, it is difficult to determine which type of disregard polices will be most advantageous to satisfying revised federal work participation rates.

Conclusion. Whether to change the earned income disregard is a policy decision for the Legislature. The Governor's proposal results in budgetary savings of \$80 million and would likely have minimal impact on the work incentive. The alternative approaches described above would probably increase the work incentive, especially the incentive to work more than half-time. On the other hand, they result in less budgetary savings and reduce grants for families with the lowest earnings.

County Performance Rewards and Sanctions

Effective in 2006-07, the Governor proposes to increase or decrease county block grant allocations by up to 5 percent based on county performance in meeting specified participation goals during 2005-06. In advance of this bonus/sanction system, the Governor's budget assumes that counties will increase the hours of employment for recipients resulting in grant savings of \$22 million during 2005-06. We review and comment on the Governor's proposal.

Governor's Proposal

The Governor proposes to establish two performance measures for counties: first, that counties increase the rate of employment among their recipients, and second that counties increase the percentage of their recipients meeting federal work participation requirements. (Federal law recognizes activities other than employment, such as vocational education, as counting towards the work participation rate.) Beginning in 2006-07, the Governor proposes to hold back 5 percent of each county's single allocation block grant (excluding child care). Based on county performance for each participation measure, counties could lose or gain up to 2.5 percent of their single allocation funds. It is our understanding that DSS will establish different improvement benchmarks for each county based on local economic conditions and existing performance. The budget assumes that counties will change their approach to welfare-to-work services so as to increase employment among recipients during 2005-06, in advance of the bonus/sanction system being implemented in 2006-07. Based on this in-

crease in employment, the budget estimates grant savings of \$22 million in 2005-06.

Previous Incentive Program

Prior to 2000-01, the state law provided that CalWORKs 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. Chapter 108, Statutes of 2000 (AB 2876, Aroner), changed the treatment of performance incentives in several important ways. Among these changes, it:

- Prohibited counties from earning new incentives beginning in 2000-01 until the estimated prior obligation owed to the counties had been paid by the state.
- Made future performance incentive payments subject to annual budget act appropriations, rather than being treated as an “entitlement.”

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 incentive funds. However, the state has paid the counties about \$900 million of these incentives, leaving a balance of about \$300 million.

Current County Performance Measure

Under current law, counties have only one performance measure for which they are financially accountable. Specifically, in the event that the state fails to meet federal work participation rates, counties would share proportionately in a federal penalty. Under federal law, states are subject to specified federal work participation rates. However, states may reduce the required work percentage rates by reducing their caseload through a mechanism called the caseload reduction credit. Because California (like all other states) has substantially reduced its caseload, its caseload reduction credit means that California’s required rate of work participation was 6.7 percent as of 2002. Given this very low performance standard, it may be time to consider adding new performance measures for counties.

Problems With Governor’s Proposal

Although consideration of how to improve state and county performance with respect to employment levels and federal participation rates is warranted, we have identified two problems with the Governor’s approach.

Performance Measures Reflect Federal Rather Than State Goals. The Governor's selected performance measures are more reflective of federal participation activities than state participation activities. Specifically, California allows recipients to participate in certain activities (such as mental health and substance abuse treatment) which are not countable toward the federal work participation rates. If the Legislature adopts new performance measure for counties, such measures should be consistent with state participation activities and priorities.

Holdback Would Be Disruptive. As discussed in a previous issue, counties have had substantial unspent block grant funds. One source of these funds is uncertainty related to the ultimate receipt of child care hold back funds. Holding back additional county funds, as the Governor proposes, would probably compound the problem. Even in counties that perform relatively well on participation and employment, the data needed to verify their performance will not be available until the latter half of the fiscal year. Thus, even higher performing counties would not know their final allocation and would probably need to reduce spending to allow for the possibility of not receiving the held back funds. Moreover, for counties that fail to meet the performance measures, taking resources away in the form of block grant reductions is likely to compound rather than help their performance problems. This is because it may be difficult for counties to achieve the same performance with less resources.

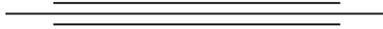
Alternative Approaches to Funding and Incenting County Performance

Funding County Incentives. As discussed above, counties have about \$300 million in earned, but unpaid performance incentives. If the Legislature decides to adopt new county performance measures, it could reward high performing counties by paying off the previous incentives. The payments could be limited to a certain amount each year, and could be subject to the identification of additional carryover funds from prior years. For example, counties could be offered payments of up to \$40 million in 2006-07 based on performance in 2005-06 subject to the condition that unexpended TANF carryover funds from 2004-05 are identified by 2006-07. This approach avoids the disruption associated with the Governor's proposed hold back of single allocation funds.

Improving County Performance. Another way of increasing the county incentive to move recipients into employment and self-sufficiency would be to increase the counties' share of grant costs. Currently counties pay just 2.5 percent of grant costs. The state pays the remainder with General Fund and TANF federal funds. If counties had a higher share of grants, for example 10 percent, then they would have a substantial incentive to move

recipients into employment so as to reduce the county costs for grants. In order to avoid creating a reimbursable state mandate, offsetting county savings may need to be provided. For example the county share for Adoptions Assistance payments could be reduced, a program over which counties have little policy control; so as to offset the increase in CalWORKs costs, a program over which counties have more control from the point of view of offering employment and education-related services.

Conclusion. Given the limited performance measure in current law, the Legislature should consider adding county performance measures. The Governor's proposed performance measures are reflective of federal priorities, not necessarily state priorities. The Legislature should ensure that any new performance measures are reflective of its policy priorities. The proposed hold back is likely to be disruptive, could compound the existing problem of unspent funds, and may leave low performing counties with insufficient funds to improve their performance.



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). In August 2004, the U.S. Department of Health and Human Services approved a Medicaid Section 1115 demonstration waiver that made virtually all IHSS recipients eligible for federal financial participation. Prior to the waiver, about 25 percent of the caseload were not eligible for federal funding and were served in the state-only “residual” program.

The budget proposes just over \$1 billion from the General Fund for support of the IHSS program in 2005-06, a decrease of \$160 million (14 percent) compared to estimated expenditures in the current year. Most of the decrease is attributable to the proposed reductions in state participation in provider wages and increased savings from full implementation of the quality assurance reforms enacted in 2004-05, partially offset by a caseload increase.

Reducing State Participation in Provider Wages

The budget proposes to limit state participation in provider wages to the minimum wage (\$6.75 currently), rather than the \$10.10 per hour currently authorized. This proposal results in General Fund savings of \$195 million in 2005-06, increasing to \$260 million in 2006-07. We review and comment on the Governor’s proposal.

Program Funding. The federal, state, and local governments share in the cost of the IHSS program. The federal government pays for 50 percent of program costs that are eligible for reimbursement through Medicaid. Under the recently approved Medicaid demonstration waiver, virtually all cases receive federal funding. (Prior to the waiver about 25 percent of cases were

not federally eligible and such cases were served in the state-only residual program.) The state pays 65 percent and the counties pay 35 percent of the nonfederal share of program costs. The sharing ratio for nonfederally funded administrative costs is 70 percent state and 30 percent county.

Background on State Participation in Wage Increases. Prior to 2000-01, the state participated in wages only up to the minimum wage. Accordingly, the federal government paid 50 percent of the hourly wage, with the nonfederal costs being shared by the state (65 percent) and local governments (35 percent). Chapter 108, Statutes of 2000 (AB 2876, Aroner), authorized 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 public authorities, on behalf of counties, negotiate wage increases with the representatives of IHSS providers. 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. Chapter 108 also authorizes state participation in health benefits worth up to 60 cents per hour worked.

State participation in wage increases after 2000-01 is contingent upon meeting a revenue "trigger" whereby General Fund revenues and transfers grow by at least 5 percent since the last time wages were increased. Pursuant to this revenue trigger, the state currently participates in wages of \$9.50 per hour plus 60 cents for health benefits, for a total of \$10.10 per hour. Based on our revenue estimate, additional state participation in wages would be triggered in 2005-06, raising the total state participation in wages to \$11.10 per hour.

Governor's Proposal. The budget has two separate proposals to reduce state participation in provider wages. First, effective July 1, 2005, the Governor proposes to roll back state participation in wages to the levels provided during 2003-04. This proposal impacts 12 counties that raised wages since June 30, 2004. If adopted, this would result in savings of \$43 million. Second, effective October 2005, the budget proposes to reduce state participation in provider wages to the minimum wage in all counties. This proposal results in savings of \$152 million in 2005-06, increasing to \$217 million in 2006-07, based on a full-year impact.

The Governor's proposal does not reduce the wages paid to IHSS providers; rather, it limits state participation to the minimum wage. Counties that elect to pay wages above the minimum wage would share such wage costs with the federal government (50 percent county and 50 percent federal). The state would continue to pay its 65 percent share of the nonfederal costs of wages up to the minimum wage. Below we discuss factors affecting the counties' ability to pay provider wages assuming the Governor's proposed reduction in state support.

County Waiver Savings. In August 2004, the federal government approved a Section 1115 Medicaid demonstration waiver that made virtually all IHSS recipients eligible for federal funding. This waiver resulted in state savings of \$211 million in 2004-05 and \$231 million in 2005-06. According to the Department of Finance, counties will realize savings of \$112 million in 2004-05 and \$93 million in 2005-06. The state and county savings come from federal participation in cases that were formerly supported with 100 percent state and county dollars. We note, however, that to date counties have received no savings because the federal government has not yet approved the state's financial claiming system pursuant to the federal waiver. Once this system is approved (probably before the end of 2004-05), counties should begin to receive the savings noted above. Finally, we note that the total annual county savings would not be sufficient for all counties to maintain wages at their current levels without using county funds.

Current Wages. Among California's 58 counties, 38 currently pay provider wages above the minimum wage (the remaining 20 counties pay the minimum wage). Of these 38 counties, 11 counties have increased wages since the end of 2003-04. Accordingly, these 11 counties would face reduction in state support on July 1, 2005 as a result of the Governor's proposal to reduce the state's share to the levels provided during 2003-04. On October 1, 2005, a total of 38 counties face reductions when state support would be limited to the minimum wage. Figure 1 (see next page) lists all counties currently paying providers more than the minimum wage. About 90 percent of providers are currently paid above the minimum wage.

County Flexibility. Many counties formed public authorities for the purpose of establishing an employer of record to negotiate collective bargaining agreements with providers and their unions. According to a survey conducted by the California Association of Public Authorities (CAPA) during January 2005, 22 counties have language in their current union agreements which give them some financial protection from potential reductions in state or federal support for the IHSS program. In some counties, the protection is absolute, meaning that county financial exposure is capped and any reduction in outside support results in automatic wage reductions. In other cases, the protection is more limited, such as requiring the union to discuss changes with the county. The CAPA survey indicates that six counties have no protection from reductions in state or federal financial support. No information was available from ten other counties currently paying above the minimum wage. Figure 1 (see next page) identifies those counties with some type of identified financial protection.

Figure 1**County IHSS Wages and Protection Clause Status**

County	Hourly Wages Plus Health Benefits	County Has Some Financial Protection	County	Hourly Wages Plus Health Benefits	County Has Some Financial Protection
Alameda	\$10.10	No	Riverside	\$9.10	Yes
Alpine	7.11	—	Sacramento	10.10	Yes
Amador	6.95	—	San Benito	9.50	Yes
Butte	7.11	—	San Bernardino	8.88	Yes
Contra Costa	10.95	No	San Diego	9.10	Yes
El Dorado	8.00	Yes	San Francisco	11.98	No
Fresno	8.35	Yes	San Joaquin	9.03	Yes
Glenn	7.11	—	San Luis Obispo	8.00	Yes
Los Angeles	8.46	Yes	San Mateo	10.38	Yes
Marin	10.35	Yes	Santa Barbara	8.60	Yes
Mendocino	8.50	No	Santa Clara	12.03	No
Merced	6.95	—	Santa Cruz	10.10	No
Mono	7.11	—	Sierra	7.71	—
Monterey	10.10	Yes	Solano	10.10	Yes
Napa	10.10	Yes	Sonoma	10.10	Yes
Nevada	7.71	—	Stanislaus	6.95	—
Orange	8.60	Yes	Ventura	8.60	Yes
Placer	8.60	Yes	Yolo	10.20	Yes
Plumas	7.71	—	Yuba	8.00	Yes

Bold = increased wages since June 30, 2004.
 — Indicates no information available.
 Source: California Association of Public Authorities.

As described above, some counties have bargaining agreements with no “out clause” in the event the state changes its level of participation in wages. For the time period that some counties may be unable to reduce wages (because of their agreements), the potential exists for a reimbursable mandate claim against the state, although this is not a settled legal issue.

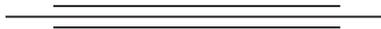
County Action Likely to Vary. County decisions about whether to reduce wages in response to the Governor’s proposed reduction will depend on many factors. These factors include (1) the nature of a county’s bargaining agreement with their union, (2) county fiscal health, and (3) the relative priority of IHSS in comparison to other county programs. Some counties already provide wages and benefits in excess of current state support. Given the range of circumstances, we would expect some counties to reduce wages

pursuant to their agreements, while others may elect to maintain higher wages despite the reduction in state support.

Impacts on Recipients and Providers. If counties reduce wages for providers, it will impact recipients and providers in several different ways. Compared to the currently authorized level of \$10.10 per hour, paying at the minimum wage of \$6.75 represents a reduction of 33 percent in wages. However, the average reduction for the 38 counties would be 24 percent because most of these counties are paying less than \$10.10 per hour. Below, we assess the potential impacts on recipients with relative and nonrelative providers.

- **Relative Providers.** According to a DSS report from October 2000, about 43 percent of IHSS providers are immediate family members. Reducing wages will reduce the income of the provider, and assuming the provider lives with the recipient, the household income for the recipient as well. Given the familial relationship, it is quite possible that many of these providers would continue to serve their family members despite the reduction in wages.
- **Nonrelative Providers.** For cases in which the provider is not a relative, a reduction in wages could reduce the supply of labor in terms of available providers, depending on the local labor markets. It is possible that some recipients may be unable to find providers and/or that their providers will be less skilled.

Conclusion. The Governor's proposal to reduce wages to the minimum wage results in substantial budgetary savings of \$195 million in 2005-06, growing to \$260 million in 2006-07. If counties respond to this reduction in state support by reducing wages to the minimum wage, it would represent a 33 percent reduction in wages for providers who are receiving the \$10.10 per hour currently authorized. The potential reduction in wages would reduce the household income for all providers and any recipients for which the provider is a relative living with the recipient. For some recipients, the reduction in wages could make it more difficult to find and retain providers. In deciding whether to adopt this proposal, the Legislature should weigh the budgetary savings against the potential for negative impacts on recipients and providers if counties elect to reduce wages.



SUPPLEMENTAL SECURITY INCOME/ STATE SUPPLEMENTARY PROGRAM

The Supplemental Security Income/State Supplementary Program (SSI/SSP) provides cash assistance to eligible aged, blind, and disabled persons. The budget proposes an appropriation of \$3.5 billion from the General Fund for the state's share of SSI/SSP in 2005-06. This is an increase of \$79 million, or 2.3 percent, above estimated current-year expenditures. This increase is primarily due to caseload growth of 2.4 percent, partially offset by savings due to not "passing through" the January 2006 federal cost-of-living adjustment (COLA).

In December 2004, there were 352,716 aged, 21,766 blind, and 813,158 disabled SSI/SSP recipients. In addition to these federally eligible recipients, the state-only Cash Assistance Program for Immigrants (CAPI) was estimated to provide benefits to about 8,600 legal immigrants in December 2004.

Budget Proposes COLA Suspensions

By suspending the January 2006 state cost-of-living adjustment (COLA) and capturing General Fund savings equal to the January 2006 federal COLA, the budget achieves combined savings of \$229 million in 2005-06 compared to current law.

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

Governor's Proposals Achieve \$229 Million in Savings. The Governor proposes to suspend the January 2006 state COLA (4.07 percent) which results in a six-month cost avoidance of \$144 million in 2005-06. In 2006-07,

the annual savings from this proposal would double to \$298 million. In addition, the Governor proposes to capture General Fund savings equal to the federal SSI COLA (2.3 percent). This is accomplished by reducing the state funded SSP portion of the grant by an amount equal to the federal COLA increase in the SSI portion of the grant scheduled for January 2006. For example, the maximum monthly SSP grant for an individual would be reduced by \$13 from the current level of \$233 to \$220, just enough to offset the estimated SSI increase of \$13 per month. This approach, sometimes referred to as “no pass through” of the federal SSI COLA, results in a six-month savings of \$85 million in 2005-06, rising to \$170 million in 2006-07.

Impact on Recipients. Figure 1 shows the SSI/SSP grants for January 2006 for individuals and couples under both current law and the Governor’s proposal. Although the total grant for individuals remains the same in January 2006, the SSP portion is \$33 (13 percent) less than what the grant would be under current law. For couples, the SSP grant is \$58 (9.6 percent) less than what is called for under current law. Figure 1 also compares the grants under current law and the Governor’s proposal to the 2004 federal poverty guidelines. Specifically, the maximum monthly grant for

Figure 1

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

Recipient Category	April 2005 ^a	January 2006		Change From Current Law	
		Current Law	Governor’s Budget	Amount	Percent
Individuals					
SSI	\$579	\$592	\$592	—	—
SSP	233	253	220	-\$33	-13.0%
Totals	\$812	\$845	\$812	-\$33	-3.9%
Percent of Poverty^b	105%	109%	105%		
Couples					
SSI	\$869	\$889	\$889	—	—
SSP	568	606	548	-\$58	-9.6%
Totals	\$1,437	\$1,495	\$1,437	-\$58	-3.9%
Percent of Poverty^b	138%	144%	138%		

^a The 2004-05 Budget Act delayed the January 2005 state COLA until April 2005.

^b 2004 U.S. Department of Health and Human Services Poverty Guidelines. The guidelines are adjusted annually for inflation.

individuals would be 109 percent of poverty under current law, but would fall to 105 percent under the Governor's proposal. Grants for couples would be 144 percent of poverty under current law, but would fall to 138 percent under the Governor's proposal. (We note that poverty guidelines are adjusted annually for inflation.)

About 1,200 Recipients Would Become Ineligible. Recipients who receive social security payments in excess of the federal SSI grant do not receive SSI but may receive SSP payments, and are known as "SSP-only" cases. The Governor's proposal to not pass through the federal COLA has the effect of reducing the maximum monthly SSP grant by \$13 for an individual and \$20 per couple compared to the current SSP grant. Under this proposal, individuals receiving \$13 or less in SSP benefits in December 2005 would have their benefits drop to zero and become ineligible for SSI/SSP in January 2006. (The corresponding figure for couples is \$20 per month.) In total, about 1,215 individuals and couple members would lose eligibility under this proposal. Becoming ineligible for SSI/SSP may result in a Medi-Cal share of cost for affected individuals.

Caseload Overestimated for Cash Assistance Program for Immigrants

We recommend that proposed General Fund spending for the Cash Assistance Program for Immigrants be reduced by \$2 million in 2004-05 and \$3.5 million in 2005-06 because the caseload is overstated. (Reduce Item 5180-111-0001 by \$3,497,000.)

The CAPI provides state-only funded SSI/SSP benefits to legal noncitizens who are ineligible for federal benefits. During 2003-04, the average monthly caseload for CAPI was just under 8,300 cases.

Department of Social Services Caseload Projection. The department projects that the CAPI caseload will increase by 4 percent during 2004-05 and 4.9 percent in 2005-06. The department based this projection on available data through June 2004.

LAO Caseload Projection. Our review of the actual data through November 2004 indicates that the caseload has been essentially flat since May 2004. However, given the caseload growth in the months prior to May 2004, we believe it is prudent to budget for some caseload increase in the future. Specifically, we calculated the growth rate from the most recent full year of data (November 2003 through November 2004). Based on that growth rate of 23 cases per month, we estimate that the CAPI caseload will increase by 1.4 percent in 2004-05 and 2.9 percent in 2005-06.

Savings Estimate. Based on our forecasted growth rate, the budget overstates the General Fund cost of CAPI by \$2 million in 2004-05 and \$3.5 million in 2005-06. Accordingly, we recommend that the Legislature reduce the budget for CAPI by \$3.5 million for 2005-06, and recognize additional savings of \$2 million in 2004-05.



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 2005-06 Governor's Budget proposes \$2.2 billion from all funds, including \$645 million from the General Fund, for CWS. This represents an increase of 4 percent from the General Fund over current-year expenditures. This increase is primarily due to a restoration of CWS augmentation funding (discussed further below), increased automation funds, and new program activities, partially offset by declining emergency shelter and direct services costs.

MEASURING PROGRESS IN WORKLOAD STANDARDS

In April 2000, a legislatively required workload study presented minimal and optimal child welfare services case carrying ratios for social workers. Although base funding for child welfare services remains well below these minimal standards, the current budget display overstates the severity of the standards "gap" because it ignores important funding sources and necessary caseload adjustments. Our review indicates that California has made significant progress toward meeting the minimum workload standards. In order to assist the Legislature in monitoring future progress toward meeting these standards, we recommend enactment of legislation requiring the Department of Social Services to provide an annual report to the Legislature which shows where each county, based on total funding and caseload, stands in relation to the workload standards.

Background

The Child Welfare Services program is responsible for providing intervention and services which address child abuse and neglect. The core of the program is made up of five components:

- **Emergency Response Assessment**—the initial reports of abuse made to county welfare departments that do not result in an investigation.
- **Emergency Response**—investigations of cases where there is sufficient evidence to suspect that a child is being abused or neglected.
- **Family Maintenance**—a child is allowed to remain in the home and social workers provide services to prevent or remedy abuse or neglect.
- **Family Reunification**—a child is placed in foster care and services are provided to the family with the goal of ultimately returning the child to the home.
- **Permanent Placement**—permanency services provided to a child that is placed in foster care and is unable to return home.

Child Welfare Services Projected Caseload. As Figure 1 shows, the Department of Social Services estimates that there will be, on average, over 167,000 cases involved in the CWS program each month during 2005-06. Most of those cases are either an emergency response investigation case or a permanent placement case.

Figure 1
Average Monthly CWS Caseload by Component
2005-06

	Cases	
	Number	Percent
Emergency Response Assessment	17,461	10%
Emergency Response	44,534	27
Family Maintenance	24,398	15
Family Reunification	22,690	14
Permanent Placement	58,305	35
Totals	167,388	100%

Detail may not total due to rounding.

Child Welfare Services Funding Streams. Funding for the CWS program comes from a variety of state, federal, and local sources. Federal funding is provided through Titles IV, XIX, and XX of the Social Security Act. The state also uses Temporary Assistance for Needy Families (TANF) funding for Emergency Assistance cases. In addition to federal funds, the state and counties provide support, with the state providing 70 percent and the counties providing 30 percent. The proposed budget for 2005-06 requests a total of \$2.2 billion (\$645 million state General Fund) for the child welfare services program.

Appropriate Level of Social Worker Caseloads. There has been an ongoing effort in the Child Welfare Services program to determine how many cases a social worker can carry and still effectively do his or her job. In 1984, the County Welfare Directors Association (CWDA) and the Department of Social Services established an agreed upon level of cases for each of the five child welfare components. In 2000, the Child Welfare Services Workload Study required by Chapter 785, Statutes of 1998 (SB 2030, Costa) determined that those caseload standards were too high and that social workers had too many cases to effectively ensure the safety and well-being of California's children. The SB 2030 Study, as it is commonly called, proposed revised minimum and optimum caseload standards for social workers. In the following section, we provide a detailed discussion of those findings.

Child Welfare Services Workload Study (SB 2030) Findings

In 1998, the Department of Social Services commissioned the SB 2030 study of counties' caseloads. At the time, the study concluded that for most categories the caseloads per-worker were twice the recommended levels. According to the study, it was difficult for social workers to provide services or maintain meaningful contact with children and their families because of the number of cases they were expected to carry.

The report also found that the 1984 standards used by the state were based on outdated workload factors, and did not reflect any additional responsibilities that had been placed on social workers by the state and federal governments. These findings and the minimal and optimal social worker standards proposed by the report (illustrated in Figure 2), have dominated budget discussions regarding staffing standards since the report's release. However, due to the state's budget shortfalls, the department has continued to use the 1984 workload standards, instead of the minimal and optimal standards, as the basis for allocating funds to counties for child welfare services staff.

Figure 2
Workload Standards
Cases Per Social Worker

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

The continued use of the 1984 workload standard to determine the CWS “base line” funding amount, however, does not mean that the state has not improved social worker caseload staffing ratios. As discussed in the following section, several funding policies, and one estimating error, have moved California considerably closer to the SB 2030 standards and that gap continues to shrink every year.

Child Welfare Services Budget Components

Several funding elements make up the total funding for core child welfare services. When these pieces are looked at in their entirety, California has made significant progress toward improving social worker staffing ratios.

Base Funding. The estimate for the basic funding for child welfare services includes funding for the projected cases at the agreed upon 1984 social worker ratios, any emergency shelter costs, and any other direct services that the county will be providing. Those direct services include activities such as counseling and drug testing. The 2005-06 proposed budget includes \$742 million in total funding (\$267 million General Fund) for the base funding.

Hold Harmless. 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, though DSS technically refers to this as the base funding adjustment.

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 dra-

matic reduction in the CWS caseload from the previously reported caseload. Because of uncertainty about the accuracy of the CWS/CMS data, DSS decided to use 1997-98 pre-CWS/CMS caseload data as its base and has not reduced the number of social workers since that time.

However, as of January 1999, DSS determined that the CWS/CMS data were "cleaned up" and reliable. Despite that determination and a steadily declining CWS caseload, DSS has retained the hold harmless methodology for its CWS estimate. In the 2005-06 proposed budget, DSS has included a total of \$240 million for the hold harmless adjustment, an increase of almost \$40 million over 2004-05. In other words, this budget policy provides counties with \$240 million more than needed to meet the 1984 standards.

CWS Augmentation. The Legislature has been concerned about the large caseloads carried by social workers in many counties. As a result, the Legislature established the CWS augmentation in 1998 and increased the amount available in 2000. These funds are targeted for services provided for Emergency Response, Family Maintenance, Family Reunification, and Permanent Placement cases. These funds cannot be used to supplant existing CWS funding. They must supplement the base funding. In addition, unlike the rest of the CWS funding, there is no county share of funds for the augmentation. It is entirely supported by federal funds and the state General Fund. For 2005-06, the Governor's budget proposes \$90.7 million in total funds for the augmentation (\$57 million General Fund). Like the hold harmless funds, these monies enable counties to hire more caseworkers and move toward the SB 2030 standards.

Caseload Error. The administration includes children living with non-related legal guardians (NRLG) in its CWS caseload and funding estimates. However, these children are not part of the CWS caseload and do not receive social worker visits. This effectively inflates the funding for the permanent placement caseload by approximately 9 percent, or \$17.4 million (\$4.7 million General Fund). (Please see the following writeup for our recommendation associated with this budgeting error.)

Total Proposed Funding. Figure 3 shows the proposed total social worker funding (including General Fund) for 2005-06. In total, counties would receive \$348 million more than what is necessary to achieve the 1984 standards.

Revised Social Worker Staffing Ratios

As noted above, when all funding sources are taken into account, the counties have approximately \$348 million in additional funding above what would be needed to support the 1984 social worker staffing levels. Based on this increase, we calculated what the revised staffing ratios would

be in 2005-06. Figure 4 compares projected staffing ratios in 2005-06 with the minimal standards assuming these funds are spent by program component in the same way as the basic funding.

Figure 3
Total Proposed Social Worker Funding by Component 2005-06

(In Millions)

	Total	General Fund
Base Funding	\$742.4	\$266.8
Additional Funding		
Hold Harmless	(\$239.5)	(\$86.2)
CWS Augmentation	(90.7)	(57.1)
NRLG Caseload	(17.4)	(4.7)
Total Additional Funding	\$347.6	\$148.0
Totals	\$1,090.0	\$414.8

Specifically, Figure 4 shows the number of cases each social worker would carry in 2005-06 compared to the SB 2030 minimal standards. When the caseload level supported by the proposed funding level for 2005-06 exceeds the minimal SB 2030 standards, we refer to the difference as a “gap.” For example, the 2005-06 budget proposal assumes that caseworkers will carry 23.1 family maintenance cases, while the minimal standard calls for a lower caseload of 14.2 cases per social worker. Thus, there is a gap of 8.9 cases between the funded level and the SB 2030 minimal standards.

Figure 4
Social Worker Caseloads
Current Gap in Standards, by Component

Staffing Ratios	Emergency Response Assessment	Emergency Response	Family Maintenance	Family Reunification	Permanent Placement
Minimal Standard	116.1	13.0	14.2	15.6	23.7
2005-06 Budget	232.2	10.2	23.1	17.5	32.6
Gap (-)/Surplus (+)	-116.1	2.8	-8.9	-1.9	-8.9

Due to the additional funding that has been dedicated to reducing social worker caseloads, CWS social workers are now handling significantly fewer cases than prescribed by the 1984 standards and are moving closer to meeting SB 2030 minimal standards. Figure 5 shows the difference (or gap) in the number of cases required to be carried under the 1984 standard and the SB 2030 minimal standard. For example, the gap between the number of cases required to be carried by a social worker under the 1984 standard and the SB 2030 minimal standard is 11.4 cases for family reunification. The figure also shows the reduction in this gap, in other words, the reduction in the number of cases carried by social workers based upon the proposed 2005-06 budget. For example, in 1984, social workers were asked to carry 11.4 more family reunification cases than the minimal standards established later by the SB 2030 study. Under the proposed budget, social workers will be carrying 9.5 fewer cases than in 1984. This caseload reduction eliminates 83 percent of the gap between the two standards. For Permanent Placement, the state has closed 71 percent of the gap. In Emergency Response Assessment and Family Maintenance, the state is clearly above the 1984 standards, but is well below the minimum staffing levels recommended by the SB 2030 study.

Figure 5
Reduction in Social Worker Caseload
Compared to 1984 Standards, by Component
2005-06

	Emergency Response Assessment	Emergency Response	Family Maintenance	Family Reunification	Permanent Placement
1984 Standard Gap ^a	206.4	2.8	20.8	11.4	30.3
Reduction in Caseload ^b	90.3	5.4	11.9	9.5	21.5
Percentage of Gap Closed	44%	195%	57%	83%	71%

^a Difference in number of cases required to be carried under the 1984 Standard and the SB 2030 minimal standard.
^b Reduction based on proposed 2005-06 funding level.

Caseload Impact. Over the past several years, caseloads in CWS have steadily declined. If that decline continues, more funds will shift to the hold harmless adjustment. Such additional hold harmless funds will enable the counties to continue making progress toward the SB 2030 standards. However, should this trend change and caseloads begin to grow, the state will reverse direction and move closer to the 1984 workload standards.

County Variance. It is important to note that counties are not required to spend their hold harmless or augmentation funding using the same ratio as the base funding. Therefore, counties may be targeting their funds on specific components and have different social worker to case ratios than shown in Figures 4 and 5. In addition, because caseloads are declining in some counties and not others, the amount of hold harmless funding for each county will vary. Therefore, the statewide caseload ratios presented represent an average and will not be the same for every county.

LAO Recommendation

We believe that the Legislature should be informed of the progress that is being made toward reducing social worker caseloads and the steady movement toward the SB 2030 recommendations. Toward this end, we recommend enactment of legislation that requires DSS to submit a county specific social worker staffing ratio report annually no later than January 31. This report should provide for each county the social worker staffing ratios compared to the Child Welfare Services Workload Study's (SB 2030) minimum and optimum caseload standards and the agreed upon 1984 standards. The methodology for measuring the individual county staffing ratios should take into account funding from the CWS augmentation, hold harmless funding, and any other funding that is used for social worker staffing. We note that the additional workload generated by this requirement would be minimal because the current budget is built individually for each of the 58 counties. Therefore, there should not be any state staffing increases needed to produce this report.

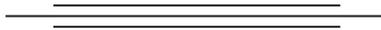
CHILD WELFARE SERVICES OVERBUDGETED

We recommend that the proposed expenditures for Child Welfare Services (CWS) be reduced by \$4.8 million from the General Fund because the department has included funding in the CWS program for approximately 5,000 children who are not receiving services. (Reduce Item 5180-151-0001 by \$4,786,000.)

The data used for projecting the permanent placement caseload for the CWS budget estimate includes approximately 5,000 children who have been placed with non-related legal guardians (NRLGs) by the probate courts. However, these children have not been removed from their homes by the dependency court, have been voluntarily relinquished by their parents, and are not at risk of abuse or neglect. Because these children are not receiving the services and regular social worker visits that a foster child receives, they should not be included in the CWS caseload estimates for budgeting purposes.

Analyst's Recommendation. Based upon the current caseload forecasts, these NRLG children account for approximately 9 percent of the permanent placement caseload. Therefore, the \$196.5 million (total dollars) proposed for funding the permanent placement cases should be reduced by 9 percent to \$179 million, which constitutes a savings of \$17.5 million total funds (\$4.8 million General Fund). We recommend reducing the Child Welfare Services budget by \$4.8 million from the General Fund to correct for this overbudgeting.

Because the state remains below the minimal SB 2030 workload standards in four of the five CWS components, the Legislature could redirect identified savings from base funding to this purpose.



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 Governor's budget proposes expenditures of \$1.7 billion (\$413 million General Fund) for the Foster Care Program in 2005-06. This represents a 12 percent decrease in General Fund expenditures from the current year. This decrease is primarily attributable to replacing General Fund support for state-only group home costs with Temporary Assistance for Needy Families federal funds, partially offset by caseload increases in certain high-cost components of the program, and an increase in the average grant cost. The total caseload in 2005-06 is estimated to be approximately 75,934, an increase of 1.4 percent compared to the current year.

FOSTER CARE ADMINISTRATION OVERFUNDED

We recommend reducing the foster care administration budget by 6 percent, so that it corresponds to the projected caseload, resulting in a General Fund savings of \$2.3 million. (Reduce Item 5180-141-001 by \$2,256,000.)

Current Budget Practice. In developing the administrative budget for the foster care program, DSS uses a statistical model to forecast the monthly caseloads for the program for the current and budget year. The department then adjusts the prior-year base funding for administration by the estimated caseload growth to determine the budget for foster care administration. That budget is then adjusted for any new program proposals that would affect the administrative costs. Each May and November, the de-

partment updates its caseload forecasts with more recent actual data, which generally refines the accuracy of the caseload projection.

Significant Adjustments in the Foster Care Caseload. The 2004-05 foster care caseload has changed considerably since it was first forecast. In November 2003, the department first estimated the caseload to be 80,032. In May 2004, DSS revised the estimate downward to 77,179, and in January 2005, it further reduced the estimate to 74,907. This constitutes a reduction of over 6 percent between November 2003 and January 2005.

No Administrative Savings From Caseload Adjustments. Despite the reduction in foster care caseload and the corresponding reductions for 2004-05 foster care grants, the department did not reduce its foster care administrative budget for 2004-05 from the original November 2003 estimate that provided administrative funding for an average monthly caseload of over 80,000 children. This estimating error resulted in excess funding for county foster care administrative staff of over \$6.4 million (total funds).

The 2004-05 overfunding is compounded by the department's decision to not readjust the administrative funding for 2005-06 to correspond with its caseload projections. In fact, DSS slightly increased the funding by 0.2 percent to correspond to its projection of a slight year-over-year growth in caseload. In order to tie administrative funding to revised caseload, the funding should have been reduced by 6 percent to account for the new projection for 2004-05. In other words, the slight increase means that the proposed 2005-06 budget provides administrative funding for a foster care caseload of 80,043 children per month rather than the department's estimated average monthly caseload of 75,934 children.

Analyst's Recommendation. Based on our analysis, we conclude that the proposed foster care administrative budget for 2004-05 and 2005-06 is overbudgeted based on the department's own projections of caseload. Accordingly, we recommend reducing the 2005-06 funding for foster care administration by \$2.3 million General Fund (\$6.4 million total funds). This reduction will help to ensure that funding for administrative activities is tied to the projected caseload of children in the program. Not making this reduction would represent an augmentation to the foster care administration workload-based budget which has not been justified by the department.

FOSTER CARE CASELOADS OVERSTATED

We recommend that proposed General Fund spending for the Foster Care Program be reduced by \$10 million for 2004-05 and \$20.8 million for 2005-06 and that the foster care administrative funding be reduced by \$827,000 in 2005-06 because the caseload projections overestimate the number of children in group homes and foster family agencies, and the number of seriously

emotionally disturbed children. (Reduce Item 5180-101-001 by \$20,797,000 and Reduce Item 5180-141-0001 by \$827,000.)

Foster care has four caseload components: foster family homes, foster family agencies (FFA), group homes (GHs), and seriously emotionally disturbed (SED) children. Although we concur with the department's caseload forecast for the foster family homes, we believe that the estimates for the GH, FFA, and SED caseloads are overstated, as we discuss below.

Caseload Components

Group Homes. This caseload is made up of foster children who, for various reasons, have been placed in a group home. The GHs are nondetention facilities that provide services for children in a group setting rather than in a more traditional family home. This is the most expensive placement for a child in foster care. For 2004-05 and 2005-06, the department is estimating that the average monthly grant will be about \$5,100 per child.

Foster Family Agencies. This caseload is made up of children who have been placed in a certified foster family home that is overseen by a FFA. Generally, these children need slightly more intensive services than children placed in a licensed foster family home. This is a more expensive placement than foster family homes but considerably less expensive than group homes. For 2004-05 and 2005-06, the department is estimating that the average monthly grant will be about \$1,750 per child.

Historical Growth Rate. From 1990-91 through 2002-03, the GH and FFA caseloads had been growing steadily. However, caseload data from the last 15 months show a decline and flattening of both caseloads. The GH caseload peaked in April 2003 at 11,736. In July 2004, the most recent month available, the GH caseload was down to 11,242. This constitutes a 4 percent reduction over this 15-month period. Likewise, the FFA caseload has moved up and down a little more, but has averaged about 18,700 cases per month over the last 15 months.

Current- and Budget-Year Projected Growth. Despite the recent downward trend, the department's most recent forecast projects that the GH caseload will grow by 3.4 percent in 2004-05 and an additional 3.5 percent for 2005-06. The department's projected caseload for July 2004 was 11,488 and the actual caseload for that month was almost 250 cases below that estimate. Despite the flattening of the FFA caseload over the last 15 months, the department's most recent forecast projects that the caseload will grow by 2.3 percent in 2004-05 and an additional 3.2 percent for 2005-06. Should recent trends continue, the department has significantly overstated both caseloads. As noted above, over the last 15 months the caseload has either

been flat or has actually declined. We believe that both of these caseloads will remain essentially flat as counties, like Los Angeles, step up their efforts to provide up-front, preventive child welfare services in those cases where it may not be necessary to remove a child from the home and make a placement in foster care. This effort in Los Angeles County alone is expected to reduce its child welfare services caseload by about 4 percent between 2004-05 and 2005-06.

Although the most recent data suggest that the caseload in both components, will decline over the next two years, in order to be conservative we have assumed marginal growth of 0.3 percent for 2004-05 and 2005-06. (This 0.3 percent is equal to the projected growth in California's 5- to 17-year-old population.) Based on our forecast, we believe that the budget overstates foster care GH grant costs by \$6.2 million and FFA costs by \$2 million in state General Fund for 2004-05 and an additional \$13.1 million and \$4.9 million, respectively, in state General Fund for 2005-06.

Seriously Emotionally Disturbed Children's Caseload

This caseload is made up of children that the State Department of Education has determined are seriously emotionally disturbed. These children are not wards of the dependency court and are not at risk of abuse or neglect. However, GH-level payments are made on behalf of these children to residential facilities, and in some cases, foster family homes. The DSS has estimated that the average monthly grant will be approximately \$5,500 per child.

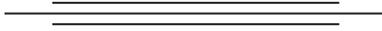
Historical Growth Rate. The SED caseload had been growing steadily since 1990-91. However, caseload data from the last available 17 months show a decline and flattening of that caseload. The caseload peaked in May 2003 at 1,425. In September 2004, the most recent month available, the caseload was down to 1,349. This constitutes a 6 percent reduction during that time.

Current- and Budget-Year Projected Growth. The department's most recent forecast projects that the trend over the last 17 months will reverse and that the SED caseload will grow by 5.1 percent in 2004-05 and an additional 2.9 percent for 2005-06. As noted above, our review of the last 17 months of caseload data shows that the caseload has actually declined.

Despite the recent actual caseload decline, we have assumed a caseload growth of 0.3 percent consistent with the overall projected growth in the 5- to 17-year-old population in California. Based on our forecast, we believe that the budget overstates SED grant costs by \$1.7 million (General Fund) for 2004-05 and an additional \$2.8 million (General Fund) for 2005-06.

Analyst's Recommendation

Based on our revised caseload projections, we recommend reducing the funding for foster care grants by \$20.8 million in 2005-06, and recognizing additional savings of \$10 million in 2004-05. Further, this revised caseload projection has a small impact for the amount of funding needed for foster care administration. Therefore, we recommend a state General Fund administrative reduction of \$827,000 for 2005-06.



FINDINGS AND RECOMMENDATIONS

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Crosscutting Issues

Accessing Federal Funds for Prenatal Services

- C-19 ■ **Additional Opportunities for Savings Worth Pursuing.** Recommend that the Legislature approve the administration's proposal to draw down federal funds for prenatal services and also direct the administration to report at budget hearings regarding the possibility of expanding this proposal to include prenatal services provided to incarcerated women. Lastly, we recommend that the enactment of legislation to phase out the Access for Infants and Mothers program and authorize the coverage of low-income pregnant women in the Healthy Families Program.

Child Care

- C-29 ■ **Shifting California Work Opportunity and Responsibility to Kids (CalWORKs) Families to Alternative Payment Programs.** Recommend delaying the shift of the Stage 3 program to Alternative Payment child care until counties have created centralized waiting lists. Further recommend placing current CalWORKs child

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care on the waiting lists based upon the date that they first had earned income in the program.

- C-42 ■ **Proposal to Create Incentives for Quality Makes Sense.** Recommend the Legislature consider the Governor's tiered reimbursement proposal in two parts. First, the Legislature should determine if a tiered reimbursement rate structure that provides incentives for quality makes sense. Then the Legislature should determine the appropriate rates for the tiers.
- C-46 ■ **Transition State Department of Education (SDE) Contracted Provider Reimbursement to Mirror Voucher Program.** Recommend the Legislature transition reimbursement rates for SDE contracted providers to be based on the rate provided to voucher providers.
- C-47 ■ **Structure Reimbursement Rates to Reflect a Systematic Approach to Quality.** Recommend the legislature consider an approach to reimbursement rates that promotes quality and child development while preserving family choice.
- C-48 ■ **"Pick-Five" Regulations Would Enhance Rate Equity.** Recommend the Legislature adopt the Governor's proposal to implement regulations for an alternative rate-setting methodology for subsidized child care provider reimbursements when they serve no private pay customers.
- C-49 ■ **New Regional Market Rate (RMR) Survey Methodology Shows Promise.** Recommend the Legislature require SDE to report at hearings on the new RMR

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methodology, including how the new survey may improve the accuracy of the Pick-Five regulations.

Health and Human Services Agency

- C-54 ■ **Employment Development Department's Project.** Transfer Employment Development Department's (EDD) project to the consolidated data center because the project funds need to remain encumbered consistent with the federal agreement and the Health and Human Services Agency does not have program oversight responsibility for EDD.

- C-55 ■ **Remaining DSS Projects.** Transfer Department of Social Services (DSS) projects currently at the Health and Human Services Agency Data Center to DSS in order to hold the department accountable for project success.

- C-56 ■ **Child Welfare Services/Case Management System Go Forward Plan.** Withhold recommendation on the Child Welfare Services/Case Management System Go Forward Plan pending the review of the cost/benefit analysis of meeting federal requirements.

Medi-Cal Program

- C-63 ■ **Budget Forecasts Increased Caseload and Costs.** We find that the budget's overall estimate for the Medi-Cal caseload is reasonable, but identify both upside and downside risks to the administration's projections of program costs and caseloads.

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- C-66 ■ **Fee Revenues Not Recognized in Governor's Budget.** Recommend the Legislature adjust its revenue assumptions by \$58 million in 2004-05 and by \$236 million in 2005-06 to recognize revenues from fees imposed on intermediate care facilities for the developmentally disabled and Medi-Cal managed care plans.
- C-67 ■ **Redesign Proposal Sound but Needs Further Development. Reduce Item 4260-001-0001 by \$602,000.** The proposal would result in broad changes in Medi-Cal managed care and hospital financing as well as some limited changes in benefits, cost-sharing, and eligibility administration. Overall, we find that the Governor's proposals are conceptually sound but that the Legislature needs more information about some aspects of the package and that some refinements of the proposals are warranted.
- C-83 ■ **Hospital Financing Plan Could Begin to Right Ailing System.** In response to continuing financial troubles for hospitals and recent federal threats to alter central aspects of federal funding provided for them, the administration is negotiating with the federal government for a comprehensive redesign of hospital financing. Our review suggests that it could help preserve the financial stability of California's public hospitals but raises some significant fiscal and policy issues.
- C-101 ■ **Financial Assistance to Los Angeles County Ending.** Adopt budget bill language to withhold a total of \$29 million in General Fund provided to the Department of Health Services (DHS) and to Los

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Angeles County (LA County) for administrative funding until Legislature receives copies of completed monitoring reports of the LA County Medicaid Demonstration Project prepared by the contractor. The Legislature should also direct DHS to report at budget hearings on the fiscal impact on LA County of the proposed hospital financial waiver and Medi-Cal redesign.

C-105 ■ **Part “D” Stands for “Deficit.”** Our analysis indicates that the new Medicare Part D drug benefit will probably be a losing proposition for the Medi-Cal Program over the next several years. While the effects of the new federal law are beyond the state’s control, we recommend a series of actions that the Legislature can take to keep a difficult state fiscal challenge from getting worse.

C-121 ■ **Disease Management Pilot Program.** Recommend the Legislature approve the Governor’s request for funds for disease management (DM) contractors. The Legislature should also direct DHS to take steps to encourage beneficiary and physician participation in the DM program. Finally, the Legislature should direct DHS to report at budget hearings on the fiscal and programmatic interaction of the DM program with Medi-Cal redesign.

Public Health

C-129 ■ **Restructuring of Proposition 99 to Address Long-Term Program Demands Warranted.** Recommend that the Legislature approve the Governor’s budget for Proposition 99-funded programs, which we believe

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presents a reasonable approach to maximize resources for health programs and achieve General Fund savings. Further recommend that the Legislature begin this year to address the long-term issues posed by the present structure of Proposition 99 and seek the approval of the voters to reform Proposition 99 in a way that would enable the state to focus its funding more effectively as the funding derived from tobacco revenues continues to diminish.

- C-138 ■ **Initiative to Reduce Obesity Should Be Slimmed Down. Reduce Item 4260-001-0001 by \$2,803,623 and Item 4260-111-0001 by \$3,050,000.** While additional state public health efforts to combat the spread of obesity are warranted, the Governor's proposal launches new anti-obesity projects before an assessment of existing Department of Health Services (DHS) efforts in this area is complete and does not sufficiently take advantage of alternative funding sources available to DHS.
- C-142 ■ **Genetically Handicapped Persons Program (GHPP) Accounting Adjustment Would Provide Savings and Consistency.** Recommend that the department report at budget hearings on its estimate of the fiscal effect of shifting the GHPP from an accrual to cash basis of accounting. This change would make the accounting basis for the program consistent with other DHS programs and could achieve net onetime program savings of potentially several millions of dollars in the General Fund.
- C-143 ■ **Information on AIDS Drug Assistance Program (ADAP) Federal Allocation and Drug Rebates Pending.** Withhold recommendation on budget request

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for local assistance for the ADAP until more information is available on the state's federal funding allocation and supplemental rebates with drug manufacturers used to help support the program. Recommend approval of additional staff positions requested for negotiating better price discounts with drug manufacturers.

Health Services—State Operations

- C-146 ■ **Information Technology Projects.** Withhold recommendations for new or modified information technology systems pending the review of feasibility study reports to support the requests.

Managed Risk Medical Insurance Board

- C-153 ■ **Mixed Signals From Administration, Staff Request Must Be Clarified. Reduce Item 4280-0001-0001 by \$775,000 and Item 4280-001-0890 by \$1,440,000.** The administration is sending mixed signals with regard to its requests for administrative support for the Managed Risk Medical Insurance Board (MRMIB) that must be clarified before the Legislature can consider its request for additional staff. We recommend the Legislature reject this proposal.
- C-156 ■ **Cost Uncertainties in Major Risk Medical Insurance Program (MRMIP).** Recommend the Legislature direct MRMIB to provide updated caseload and expenditure estimates in May. Additionally, we recommend MRMIB be directed to submit a detailed estimate of caseload and

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program spending to the Legislature each January and May.

- C-157 ■ **Reserve Requirement Unnecessary.** Recommend the Legislature repeal the statutory requirement for a separate state reserve in the Major Risk Medical Insurance Fund and state law that authorizes unspent funds to be carried forward to the succeeding fiscal year. We further recommend the Legislature redirect \$18.2 million in Proposition 99 funding for the support of other Proposition 99 programs in a way that would result in an equivalent amount of savings to the state General Fund. Lastly, we recommend the Legislature increase the Proposition 99 reserve by \$2 million to reflect the additional potential risk of a MRMIP deficiency.

Developmental Services

- C-162 ■ **Regional Center Caseload. Reduce Item 4300-101-0001 by \$9,000,000.** Recommend reducing \$9 million General Fund (\$12 million all funds) from the regional center budget in the current year and the budget year to adjust for lower-than-anticipated caseload levels.
- C-167 ■ **Towards a More Systematic Rate-Setting Model.** Recommend the continued funding of the rate-reform initiative and continuation of existing rate freezes. Also recommend enactment of statute requiring quality and access measurements to be incorporated into rate-setting methodologies, and enactment of statute providing authority to impose upper payment limits.

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- C-176 ■ **Agnews Closure Plan Emphasizes Community Placements.** We recommend the Legislature carefully consider the fiscal and policy implications of the Agnews closure plan. We will provide the Legislature with an updated analysis of the Agnews closure plan at budget hearings.
- C-178 ■ **Developmental Centers Appear Overbudgeted. Reduce Item 4300-003-0001 by \$4,000,000.** Recommend reducing \$8 million (\$4 million General Fund) from the developmental center budget both in the current year and the budget year to adjust for lower-than-anticipated caseload levels.

Department of Mental Health

- C-182 ■ **Some Proposition 63 Provisions Ambiguous.** Uncertainty over the meaning of some provisions of the voter-approved initiative to expand mental health services could complicate its implementation and create state budget problems in the future. Recommend that the Legislature enact legislation to add new provisions to the Mental Health Service Act that would clarify the major ambiguities in the law.
- C-188 ■ **Population Growth and New Facility Increasing Hospital Expenditures.** Generally recommend approval of the administration's funding requests related to the state hospital population and the activation of the Coalinga hospital, but withhold recommendation at this time on the two proposals for policy changes to reduce the Sexually Violent Predator program costs until the proposed statutory language to implement them is available for legislative review.

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- C-193 ■ **Technical Budget Adjustments Warranted.** A number of largely technical budgeting issues warrant consideration by the Legislature relating to lease-payment debt service for the new Coalinga State Hospital, staffing of certain hospital units at Napa and Metropolitan, and other matters. Recommend a reduction of \$560,000 in reimbursement funding and eight positions from the staffing request for Metropolitan, among other actions, to address these issues.

Department of Child Support Services

- C-197 ■ **Administrative Expenditures Excessive. Reduce Item 5175-101-0001 by \$6,200,000.** We recommend adoption of legislation establishing a 20 percent cap on administrative expenditures and the reduction of funding for those counties that exceeded 25 percent of the total funding on administration in the prior year.
- C-199 ■ **California Child Support Automation System.** Withhold recommendation on the proposed transfer of \$79 million to the Franchise Tax Board pending renegotiation of contract amendment and review of early system certification cost/benefit analysis.

California Work Opportunity and Responsibility to Kids (CalWORKs)

- C-203 ■ **Maintenance-of-Effort (MOE) and Transfers Outside of CalWORKs.** By recognizing additional countable MOE spending on State Department of Education (SDE) child care and by increasing the amount of Temporary Assistance to Needy Families (TANF) federal funds used

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to offset General Fund costs in other programs, the proposed budget achieves savings of \$443 million. We review recent history with respect to the CalWORKs MOE expenditures and TANF expenditures for other programs and comment on the Governor's proposals.

- C-206 ■ **Overestimate of CalWORKs Caseload. Reduce Item 5180-101-0890 by \$17.4 Million.** Recommend that proposed spending for CalWORKs grants be reduced by \$17.4 million in 2005-06 because the caseload is overstated.
- C-207 ■ **Budget Deletes Statutory COLAs and Reduces Grant Payments.** The Governor proposes to reduce grant payments by 6.5 percent and permanently eliminate the statutory cost-of-living adjustments (COLAs) currently provided each July. These proposals result in state savings of \$355 million in comparison to the requirements of current law. In addition, the Governor proposes trailer bill language to retroactively delete the October 2003 COLA in the event that the state loses its appeal of the *Guillen* court case requiring payment of the October 2003 COLA.
- C-209 ■ **Unspent TANF Funds Identified.** The Governor's budget has identified \$407 million in additional unspent TANF funds from past years in comparison to the May 2004 estimate. We review the sources of these additional TANF carry-over funds. Recommend eliminating the child care "hold back" and midyear supplemental allocations to counties so as to reduce future under spending.

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- C-212 ■ **Current-Year Costs Overstated. Increase Item 5180-101-0890 by \$118.5 Million.** Our review of actual caseload and expenditure data through October 2004 indicates that the Governor's budget overstates CalWORKs costs for 2004-05 by \$118.5 million. We recommend that the Legislature recognize these savings and increase the TANF carry-forward balance available for 2005-06 by \$118.5 million.
- C-214 ■ **Proposal to Reduce Earned Income Disregard.** Under current law, the first \$225 of earned income and 50 percent of each additional dollar earned is disregarded (not counted) for purposes of determining a family's grant. The Governor proposes to reduce the disregard to \$200 and 40 percent. This proposal reduces the grants for all working recipients and results in savings of \$80 million. We comment on the Governor's proposal and present alternative approaches.
- C-221 ■ **Rewards and Sanctions Depending on County Performance.** Effective in 2006-07, the Governor proposes to increase or decrease county block grant allocations by up to 5 percent based on county performance with respect to specified participation measures during 2005-06. In advance of this bonus/sanction system, the Governor's budget assumes that counties will increase the hours of employment for recipients resulting in savings of \$22 million during 2005-06. We review and comment on the Governor's proposal.

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In-Home Supportive Services

- C-225 ■ **Reducing State Participation in Provider Wages.** The budget proposes to limit state participation in provider wages to the minimum wage, rather than the \$10.10 per hour currently authorized, resulting in General Fund savings of \$195 million in 2005-06, increasing to \$260 million in 2006-07. We review and comment on the Governor's proposal.

**Supplemental Security Income/
State Supplementary Program**

- C-230 ■ **Budget Proposes COLA Suspensions.** By suspending the January 2006 state cost-of-living adjustment (COLA) and capturing General Fund savings equal to the January 2006 federal COLA, the budget achieves combined savings of \$229 million in 2005-06 compared to current law.
- C-232 ■ **Caseload Overestimated for Cash Assistance Program (CAPI) for Immigrants. Reduce Item 5180-111-0001 by \$3,497,000.** Recommend that proposed General Fund spending for CAPI be reduced by \$2 million in 2004-05 and \$3.5 million in 2005-06 because the caseload is overstated.

Child Welfare Services

- C-234 ■ **Measuring Progress in the Child Welfare Services (CWS) Workload Standard.** We recommend enactment of legislation requiring the Department of Social Services to provide an annual report to the Legislature

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which shows where each county, based on total funding and caseload, stands in relation to the workload standards. This will assist the Legislature in monitoring progress toward meeting the SB 2030 standards. Our review of the entire child welfare services budget and caseload indicates that California has made substantial progress toward meeting the minimum workload standards.

- C-241 ■ **CWS Overbudgeted. Reduce Item 5180-151-0001 by \$4,786,000.** We recommend that the CWS basic funding be reduced by \$4.8 million because Non-Related Legal Guardian cases do not receive services from the child welfare department and should not be included in the caseload.

Foster Care

- C-243 ■ **Foster Care Administration Overfunded. Reduce Item 5180-141-0001 by \$2,256,000.** We recommend reducing the foster care administration budget by 6 percent to reflect the Department of Social Services' updated foster care caseload projections.
- C-244 ■ **Foster Care Caseloads Overstated. Reduce Item 5180-101-001 by \$20,797,000 and Item 5180-141-001 by \$827,000.** We recommend reducing the proposed budget for the foster care program by \$21.6 million because the caseload projections are overstated for children living in group homes, foster family agency-certified homes, and seriously emotionally disturbed children.

