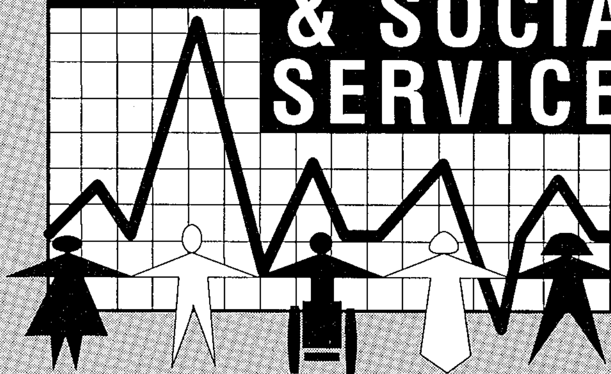

HEALTH
& SOCIAL
SERVICES

MAJOR ISSUES

▌*Assuming Federal Reimbursement for Immigration-Related Costs Entails Risk of Budget Shortfall.* There is a substantial risk that the $1.6 billion in additional federal funds (General Fund savings of $1.4 billion) assumed in the budget for immigration-related costs will not be provided. Consequently, we recommend that the Legislature review the Governor's contingency plan to address this potential shortfall and develop an alternative plan based on its own policy priorities. (See page 15.)

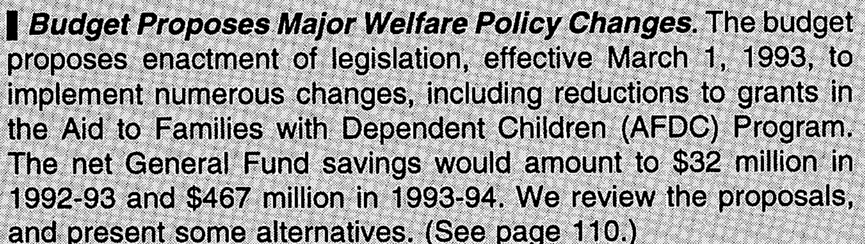
▌*Major Expansion of Medi-Cal Managed Care Is Premature.* The Department of Health Services proposes to expand managed care arrangements to serve nearly half of all Medi-Cal beneficiaries by the end of 1993-94. We recommend that the expansion not occur until the Legislature has reviewed the department's expansion plan. We also identify several key issues that the Legislature should address in reviewing the plan—for example, the exclusion of SSI/SSP beneficiaries, who account for a large share of Medi-Cal costs. (See page 52.)

▌*Pre-Paid Health Plan Rates for Medi-Cal Program Need Review.* The department proposes a $16 million rate increase for the CIGNA Health Plan, but does not propose to adjust rates for other plans. We recommend that the Legislature reject the proposed increase because it has not been justified. We further recommend that the Legislature direct the department to adjust rates for all plans, which would result in an estimated General Fund savings of $23 million. (See page 55.)

▌***Budget Proposes Elimination of Nine Optional Benefits in the Medi-Cal Program.*** The budget proposes legislation to eliminate nine optional benefits, effective March 1, 1993, to achieve total General Fund savings of $219 million in the Medi-Cal Program in the current and budget years. We recommend that the department report on the magnitude of increased hospitalizations that may occur as a result of eliminating the optional benefits. (See page 59.)

▌***A New Reimbursement System for Hospitals Could Achieve Major Savings.*** The Medi-Cal Program spends 36 percent of its budget on inpatient hospitalization, reimbursing hospitals for each day a beneficiary is hospitalized. In lieu of a per day reimbursement rate, we recommend that reimbursement be based on the patient's diagnosis. Ultimately, this approach could result in major General Fund savings—potentially in the range of $100 million annually. (See page 61.)

▌***Medi-Cal Subsidy of University of California (UC) Hospitals is Unnecessary.*** Currently, UC hospitals receive federal "disproportionate share" payments intended to compensate them for serving a large number of indigent persons. We recommend that UC hospitals receive the *minimum* federal disproportionate share payment allowed under state law because the hospitals are profitable without the Medi-Cal subsidy—the UC hospital system is expected to generate a net revenue gain of 4 percent *without* the subsidy. Adoption of our recommendation would result in General Fund savings of about $26 million in the budget year. (See page 64.)



▌***Budget Proposes Major Welfare Policy Changes.*** The budget proposes enactment of legislation, effective March 1, 1993, to implement numerous changes, including reductions to grants in the Aid to Families with Dependent Children (AFDC) Program. The net General Fund savings would amount to $32 million in 1992-93 and $467 million in 1993-94. We review the proposals, and present some alternatives. (See page 110.)

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Overview

General Fund expenditures for health and social services programs are proposed to decrease in the budget year. The savings would be achieved primarily by (1) shifting some of the state's costs of certain programs to the federal government, (2) reductions in grants provided under the Aid to Families with Dependent Children (AFDC) Program, (3) elimination of certain optional benefits provided in the Medi-Cal Program, and (4) the full-year effect of grant reductions implemented during the current year in the AFDC Program and the Supplemental Security Income/State Supplementary Program (SSI/SSP).

Expenditure Proposal and Trends

The budget proposes General Fund expenditures of $12.6 billion for health and welfare programs in 1993-94, which is 34 percent of total proposed General Fund expenditures. The budget proposal represents a reduction of $643 million, or 4.9 percent, from estimated expenditures in the current year.

Figure 1 shows that General Fund expenditures for health and social services programs are projected to increase by $3 billion, or 32 percent, between 1986-87 and 1993-94. This is an average annual increase of 4 percent. General Fund expenditures increased significantly until 1991-92, when realignment legislation shifted $2 billion of health and social service program costs from the General Fund to the Local Revenue Fund, which is funded through state sales taxes and vehicle license fees. This shift in funding accounts for the significant increase in special funds starting in 1991-92, as shown in Figure 1. General Fund spending

shows a downward trend in 1992-93 and 1993-94, due to various reductions implemented in the current year (the largest being welfare grant reductions) and proposed reductions for the budget year, as discussed below.

Combined General Fund and special funds spending is projected to increase by 59 percent between 1986-87 and 1993-94. This represents an average annual increase of 6.8 percent.

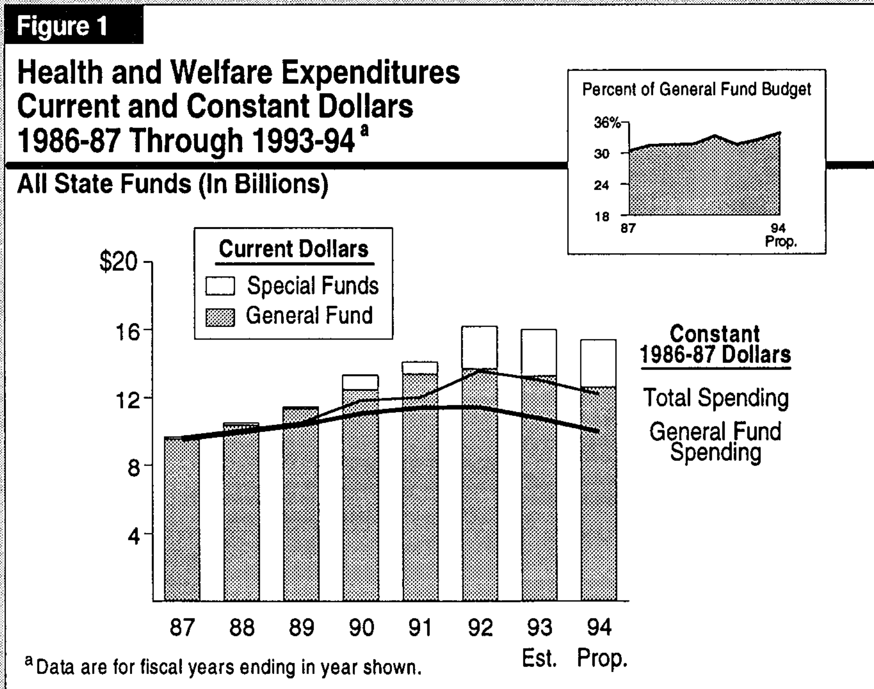


Figure 1 also displays the spending for these programs adjusted for inflation. On this basis, General Fund expenditures increased by 4.7 percent between 1986-87 and 1993-94, which represents an average annual rate of increase of less than 1 percent. Combined General Fund and special funds expenditures are estimated to increase by 26 percent from 1986-87 to 1993-94, on a constant dollar basis. This is an average annual rate of increase of 3.4 percent.

As noted previously, the 1991 realignment legislation significantly altered the structure of health and social services programs by transferring funding for all or part of several mental health, public health, and social services programs to the counties. The sales tax and vehicle license fee revenues dedicated to realignment amounted to $2

billion in 1991-92, which was $239 million short of the amount that was initially estimated. The budget estimates that realignment revenues will be $2.1 billion in the current year and $2.2 billion in the budget year.

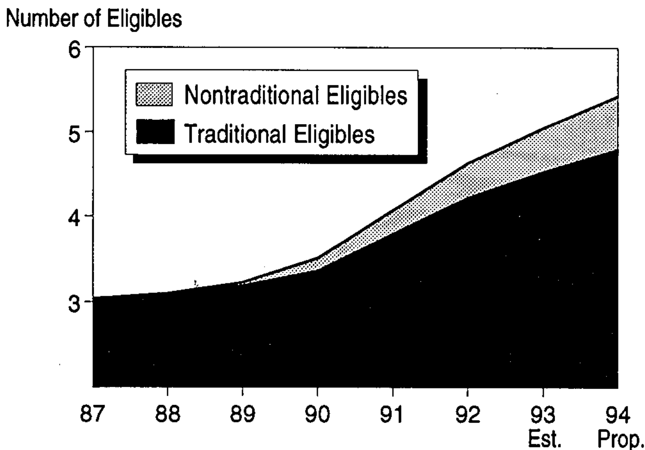
CASELOAD TRENDS

Figures 2 and 3 illustrate the caseload trends for the largest health and welfare programs. Figure 2 shows the Medi-Cal caseload growth, broken out by "traditional" eligibility categories—primarily AFDC and SSI/SSP recipients—and "nontraditional" eligibles—groups recently made eligible by state and federal law, including newly legalized immigrants, undocumented persons, and pregnant women.

Figure 2

Medi-Cal Caseloads
Average Monthly Eligible Persons
1986-87 Through 1993-94[a]

(In Millions)



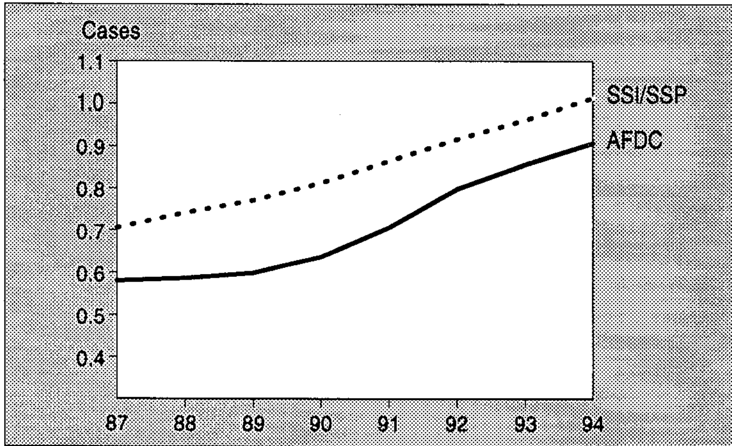
[a] Data are for fiscal years ending in year shown.

As the figure shows, there was a significant upswing in the rate of increase in the Medi-Cal caseload, beginning in 1989-90. This occurred primarily because of growth in the AFDC Program and the rapid growth in the nontraditional categories of recipients. (For a more detailed discussion of this caseload growth, please refer to our *Analysis of the 1992-93 Budget Bill,* p. V-90.)

Figure 3

AFDC and SSI/SSP Caseloads Average Monthly Cases 1986-87 Through 1993-94[a]

(In Millions)



[a] Data are for fiscal years ending in year shown. SSI/SSP cases are reported as individual persons.

Figure 3 shows the caseload trend for the AFDC and SSI/SSP programs. While the number of *cases* in the SSI/SSP Program is greater than in the AFDC Program, there are more *persons* in the AFDC Program—about 2.5 million compared to about 1 million for SSI/SSP. (SSI/SSP cases are reported as individual persons, while AFDC cases are primarily families.)

Caseload growth in these two programs is due, in large part, to the growth of the eligible target populations. The increase in the rate of growth in the AFDC caseload in 1990-91 and 1991-92 was partly due to the effect of the recession. The budget estimates that the caseload will continue to increase in the current year but at a slower rate of growth. This slowdown is due partly to (1) certain population changes, including lower migration from other states, and (2) a lower rate of increase in "child only" cases (including citizen children of undocumented and newly legalized persons), which has been the fastest growing segment of the caseload in recent years. (For a discussion of other factors affecting the AFDC caseload, please see our report on the program in *The 1991-92 Budget: Perspectives and Issues*, p. 189.)

The SSI/SSP caseload can be divided into two components: the aged and the disabled. The aged caseload generally increases in proportion

to increases in the eligible population—age 65 or older. This component of the caseload accounts for about 35 percent of the total. The larger component—the disabled caseload—has been growing faster than the rate of increase in the eligible population group (primarily ages 18 to 64). This is due to several factors, including (1) the increasing incidence of AIDS-related disabilities, (2) changes in federal policy that liberalized the criteria for establishing a disability, (3) a decline in the rate at which recipients leave the program (perhaps due to increases in life expectancy), and (4) expanded state and federal outreach efforts in the program.

SPENDING BY MAJOR PROGRAMS

Figure 4 shows expenditures for the major health and social services programs in 1991-92 and 1992-93, and as proposed for 1993-94. As shown in the figure, the three major benefit payment programs—Medi-Cal, AFDC, and SSI/SSP—account for a large share (66 percent) of total spending in the health and social services area. It is also in these three programs where most of the proposed General Fund savings for 1993-94 would occur.

MAJOR BUDGET CHANGES

Figures 5 (see page 11) and 6 (see page 12) illustrate the major budget changes proposed for health and social services programs in 1993-94. Generally, the major changes can be grouped into the following three categories:

1. ***The Budget Proposes to Fund Caseload Increases.*** This includes funding for projected caseload increases of 7.5 percent in the Medi-Cal Program, 5.9 percent in the AFDC Program, and 5.5 percent in the SSI/SSP Program in 1993-94.

2. ***The Budget Proposes to Shift a Significant Amount of State Costs to the Federal Government.*** This would be accomplished by the following actions:

- Assumes legislation for federal assumption, by October 1, 1993, of the Medi-Cal, AFDC, and SSI/SSP costs resulting from federal immigration policy (General Fund savings of $1.2 billion in 1993-94).

Figure 4

Major Health and Welfare Programs Budget Summary[a] 1991-92 Through 1993-94

(Dollars in Millions)

	Actual 1991-92	Estimated 1992-93	Proposed 1993-94	Change from 1992-93	
				Amount	Percent
Medi-Cal					
General Fund	$5,779.0	$5,454.7	$5,330.1	-$124.6	-2.3%
All funds	13,834.9	13,652.6	14,932.5	1,279.9	9.4
AFDC					
General Fund	2,925.5	2,923.3	2,322.5	-600.8	-20.6
All funds	6,408.6	6,436.4	5,751.4	-685.1	-10.6
SSI/SSP					
General Fund	2,379.1	2,333.7	2,171.3	-162.5	-7.0
All funds	4,809.4	5,148.0	5,385.6	237.6	4.6
County welfare administration					
General Fund	323.1	355.2	379.7	24.5	6.9
All funds	1,310.2	1,474.8	1,592.0	117.2	8.0
In-home supportive services[b]					
General Fund	170.3	163.6	253.3	89.7	54.8
All funds	799.2	837.4	974.5	137.1	16.4
Regional centers					
General Fund	613.7	537.0	552.2	15.2	2.8
All funds	649.1	674.3	746.2	72.0	10.7
Developmental centers					
General Fund	43.0	31.9	32.3	0.4	1.4
All funds	576.0	569.2	584.2	15.0	2.6
Child welfare services[b]					
General Fund	236.3	228.2	159.5	-68.7	-30.1
All funds	541.0	552.7	589.0	36.3	6.6
State hospitals					
General Fund	150.6	139.4	149.2	9.8	7.0
All funds	435.2	405.4	423.1	17.7	4.4

[a] Excludes departmental administrative support.

[b] The General Fund decrease for child welfare services in 1993-94 is due to a proposed transfer of federal funds from the IHSS Program, made possible by the Personal Care Option proposal.

- Implement program changes to increase Medicaid reimbursements for services provided by the Regional Centers

and the IHSS Program ($33 million savings in 1992-93 and $208 million in 1993-94).

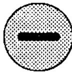
- Reduce state funding for the SSI/SSP Program by the amount of the January 1994 federal SSI COLA ($69 million savings in 1993-94).

Figure 5

Health Services Programs
Proposed Major Changes for 1993-94
General Fund

Medi-Cal	Requested: $5.3 billion
	Decrease: $125 million (-2.3%)

- $632 million to fund caseload, utilization, and other costs
- $96 million (net change between $65 million in current year and $161 million in budget year) for settlement of dental services lawsuit



- $574 million due to federal assumption of costs for refugees, undocumented and newly legalized persons, and citizen children of undocumented persons
- $186 million due to increased federal SLIAG funds (over the current year) for newly legalized persons
- $125 million (net change between $47 million savings in current year and $172 million in budget year) for elimination of various optional benefits

3. *The Budget Proposes Major Program Reductions in the Medi-Cal and AFDC Programs:*

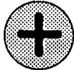
- Eliminate various optional Medi-Cal benefits, effective March 1, 1993 ($43 million savings in 1992-93 and $159 million in 1993-94, after accounting for offsetting costs to maintain these benefits for developmentally disabled persons served by the Regional Centers). Most of the savings would result from elimination of adult dental services.

- Adopt a welfare reform package, with grant reductions effective March 1, 1993 (net state savings of $32 million in 1992-93 and $467 million in 1993-94, including costs for administration and

Figure 6

Social Services Programs
Proposed Major Changes for 1993-94
General Fund

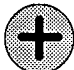
AFDC	Requested:	$2.3 billion	
	Decrease:	$601 million	(-21%)



- $153 million for basic caseload increases

- $468 million (net change between $58 million in current year and $526 million in budget year) in welfare reform savings
- $251 million due to federal assumption of costs for refugees and citizen children of undocumented persons
- $78 million due to full-year savings from current-year grant reductions, AFDC-U rule waivers, and residency requirement

SSI/SSP	Requested:	$2.2 billion	
	Decrease:	$162 million	(-7%)

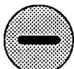


- $196 million for basic caseload increases

- $196 million due to full-year savings from current-year grant reductions and elimination of food stamps cash-out
- $69 million from elimination of the "pass-through" of the January 1994 federal SSI COLA.
- $51 million due to increased federal SLIAG funds for newly legalized persons
- $16 million due to federal assumption of the costs for refugees

In-Home Supportive Services	Requested:	$253 million	
	Increase:	$90 million	(+55%)

- $47 million for caseload increases
- $30 million to restore current-year reduction in hours



- $5 million from implementation of the Personal Care Option (PCO) to obtain Medicaid reimbursement for IHSS services. (The budget assumes additional General Fund savings of $175 million in 1993-94 in other social services programs due to the effect of interprogram transfers of federal funds.)

employment services programs). Most of the savings wouldresult from across-the-board reductions in the AFDC maximum aid payment (MAP).

Elimination of Medi-Cal Optional Benefits

The budget assumes that the Legislature will enact legislation, effective March 1, 1993, to eliminate 9 of the 28 optional service categories in the Medi-Cal Program, for a General Fund savings of $47 million in 1992-93 and $172 million in 1993-94 in the program. These savings would be partially offset by additional costs of $3.7 million in the current year and $12.7 million in the budget year in the Department of Developmental Services in order to maintain these services for Regional Center clients.

The services that would be eliminated are: adult dental; nonemergency transportation; medical supplies, excluding incontinence; speech and audiology; psychology; acupuncture; podiatry; chiropractic; and independent rehabilitation centers. The budget proposes to continue these services for children under age 21, persons in long-term care facilities, and developmentally disabled clients.

Welfare Reform

The Governor's proposed welfare reform package generally consists of those components of last year's proposal (contained in the 1992-93 budget and Proposition 165) that were not enacted, with some modifications and additions. The major proposals are summarized below:

- ***Across-the-Board Grant Reductions.*** The budget proposes a 4.2 percent reduction in the AFDC maximum grant levels and an additional 15 percent reduction for families that have an able-bodied adult and are on aid more than six months. The impact of the reductions would be primarily on nonworking recipients—those who currently get the maximum grants. The grant reductions would be partially offset by increases in federally funded food stamps.

- ***Maximum Family Grant.*** Under this proposal, the MAP, which increases with family size, would not increase for a child born after the parent has been on aid for nine months. (In effect, the MAP would not increase for children conceived while the family is on aid.)

- ***Expansion of Earned Income Disregard.*** The budget proposes to extend indefinitely a rule which permits working recipients to disregard about one-third of their earnings in calculating the amount of income that acts as an offset against their grant. Currently, this earned income disregard is limited to the first four months of employment. This change would have the effect of increasing the grants for recipients who work. The federal administration has approved the waiver, contingent on funding the initial costs, which are proposed in the 1993-94 budget.

- ***Reduction in Pregnancy Benefits.*** AFDC pregnancy-related payments would be eliminated except for the federally assisted program, which provides payments during the last trimester of pregnancy.

- ***Teen Parent Provisions.*** The budget proposes to establish the Cal Learn Program, which would provide grant penalties based on secondary school attendance and bonuses based on progress in school. The budget also proposes to require parents under age 18, with some exceptions, to reside with their parents, legal guardian, or adult relative in order to receive AFDC.

- ***Expansion of the Greater Avenues for Independence (GAIN) Program.*** The budget proposes to increase state funding for the GAIN Program by $15 million in the current year and $41 million in the budget year. When combined with matching federal and county funds, the budget-year proposal is 31 percent higher than estimated current-year spending. (The current-year estimate, however, includes a proposed augmentation of about $34 million for GAIN. The budget proposal is 57 percent more than the amount appropriated in 1992-93.)

CROSSCUTTING ISSUES

ASSUMED INCREASE IN FEDERAL FUNDING ENTAILS RISK OF BUDGET SHORTFALL

There is a substantial risk that the $1.6 billion in additional federal funds ($1.4 billion General Fund savings) assumed in the budget for immigration-related costs will not be provided. Consequently, we recommend that the Legislature review the Governor's contingency plan to address this potential shortfall and develop an alternative based on the Legislature's budget and policy priorities.

Budget Proposal

According to the Health and Welfare Agency, California has 54 percent of the nation's immigrants who have been "newly legalized" under the provisions of the Immigration Reform and Control Act (IRCA) of 1986, almost 40 percent of the refugees (persons who are unable to return to their country of nationality due to fear of persecution), and 50 percent of the undocumented (illegal) immigrants. The federal government shares in the costs of providing public assistance and social services to immigrants and refugees, either through appropriations earmarked for these costs or through regular cost sharing provisions for programs such as Medi-Cal and Aid to Families With Dependent Children (AFDC).

The budget assumes that legislation will be enacted by Congress to appropriate additional funds to California, effective October 1, 1993, to

pay for the state's costs of providing certain benefits and services to immigrants. Specifically, the budget assumes an additional $1.6 billion in federal reimbursements in 1993-94, for a General Fund savings of $1.4 billion.

Figure 7 summarizes the budget proposal. As the figure shows, the budget assumes an additional $564 million for services provided to newly legalized immigrants, $104 million for refugees, $687 million for undocumented persons, and $240 million for citizen children (born in the United States) of undocumented persons.

Newly Legalized Immigrants (IRCA)

The budget assumes that the state will receive funds from the federal State Legalization Impact Assistance Grant (SLIAG) for services already provided to persons pursuant to the IRCA. The budget anticipates $467 million in SLIAG funds in 1993-94, of which $314 million is budgeted for state programs and $153 million is unallocated.

The IRCA (1) allowed certain categories of undocumented immigrants to become legal residents through an amnesty process and (2) established the SLIAG to reimburse state and local governments for health, education, and public assistance grants and social services provided to these individuals during the five-year amnesty period. The act appropriated a total of $4 billion to cover federal administrative costs and the state and local costs of providing these services during the amnesty period for immigrants. Subsequent federal allocations to the states, however, were $800 million below the initial multi-year appropriation. Of this shortfall, California's share is estimated to be $467 million.

Refugees

The funds requested for refugee services are to reimburse the state for its share of Medi-Cal, AFDC, and SSI/SSP costs during the first 36 months of residence by the refugees. Pursuant to the Refugee Act of 1980, the federal government initially funded 100 percent of the states' costs of categorical assistance programs during the 36 month period; but funding has declined since 1986 and no funds have been appropriated specifically for this purpose in 1993-94.

Undocumented Persons

The budget proposal for additional federal funds for costs associated with undocumented persons is based partly on the federal Omnibus

Figure 7

Federal Funds for Immigration-Related Costs Governor's Budget Proposal 1993-94

(In Millions)

	Amount
Newly legalized immigrants	
Medi-Cal	
SLIAG	$254
Post-SLIAG	97
AFDC	
SLIAG	1
SSI/SSP	
SLIAG	53
Other state programs	
SLIAG	6
Unallocated[a]	
SLIAG	153
Subtotal	($564)
Refugees	
Medi-Cal	$9
AFDC	80
SSI/SSP	15
Subtotal	($104)
Undocumented persons	
Medi-Cal	$437
Correctional costs	250
Subtotal	($687)
Citizen children of undocumented persons	
Medi-Cal	$31
AFDC	209
Subtotal	($240)
Total	**$1,595**

[a] These funds are not allocated for any specific programs and will be distributed according to procedures set forth in Control Section 23.50 of the Budget Act.

Budget Reconciliation Act (OBRA) of 1986. The OBRA requires states to provide emergency health and labor/delivery services to undocumented persons, but the federal government provides only the regular federal share of costs (50 percent) for Medi-Cal. The budget proposes federal funds to cover the state's costs. The budget proposal, however, also includes $70 million for the costs of a "state-only" program (not required by federal law) that provides perinatal services to

undocumented persons. In addition, the budget assumes $250 million in federal funds for the state's costs of incarcerating undocumented individuals. The IRCA authorizes federal reimbursement—subject to annual appropriations—for the state costs of incarcerating undocumented immigrants convicted of state felonies, but no funds have been appropriated for this purpose.

Citizen Children of Undocumented Persons

Citizen children of undocumented immigrants are, by virtue of their citizenship, eligible for the full range of public assistance benefits and services. The budget proposal includes an additional $240 million in federal funds to pay for the state costs of Medi-Cal and AFDC benefits for these children in 1993-94.

Basis for Requesting Additional Federal Reimbursements

While the Governor's Budget characterizes the full $1.6 billion of additional reimbursements as funds "owed" to California for services provided, only the $467 million from the SLIAG is based on a specified federal appropriation that has not been allocated. Of the remaining $1.1 billion, $354 million (for refugees and corrections) is associated with a federal statutory provision indicating an intent or an authorization to reimburse states for these costs. Expressions of intent and statutory authorizations, however, do not create legal obligations to appropriate funds. In fact, it is common practice for Congress to authorize a higher level of funding than it ultimately appropriates for a program. Thus, for the most part, the budget proposal appears to be based more on a "moral" than a legal obligation—that is, costs that have been incurred or will occur in 1993-94 as a result of federal policy mandates and which fall disproportionately on California.

Even if Congress and the federal administration are sympathetic to this argument, the concern over the federal deficit may make many Members of Congress reluctant to vote to allocate additional funds to California. Recognizing the possibility that these funds may not be forthcoming, the Governor has indicated that he will propose the following program reductions if Congress does not appropriate the federal reimbursements by May 15, 1993:

- Delay scheduled increases for AFDC-Foster Care group homes and family homes (General Fund savings of $30 million in 1993-94).

- Eliminate the AFDC Homeless Assistance Program ($31 million in grants and $4 million for administration).
- Reduce the state component of SSI/SSP grants to the federal minimum ($243 million).
- Eliminate the following Medi-Cal optional benefits, except for children under age 21, persons in long-term care, and developmentally disabled persons: drugs, optometry, prosthetics, orthotics, heroin detox centers, durable medical equipment, hearing aids, and incontinence supplies ($356 million).
- Eliminate the following Medi-Cal eligibility categories: medically indigent children, state-only medically indigent long-term care, and medically needy except for pregnant women and children up to age eight ($453 million).

Impact of Governor's Contingency Plan

The budget does not include any information related to the effect that these program reductions would have. While the Departments of Health Services and Social Services should be able to discuss the potential effects during the budget hearings, we can provide the following information regarding the potential impact of the contingency plan.

Postpone Increases for AFDC-Foster Care

The contingency plan proposes to suspend for one year the final step of a three-step rate increase for most foster care group homes, for a General Fund savings of $25.2 million in 1993-94. Group home rates currently range from $1,094 to $4,637 per month. Depending on cost pressures, the absence of a rate increase could lead providers to reduce staffing levels, thereby reducing the level of services to the foster children.

The contingency plan also proposes to suspend for one year a 5 percent increase in the appropriation for foster family homes, resulting in a General Fund savings of $4.3 million in 1993-94. Under current law, this increase may be used to (1) increase payments for foster parents who care for children with special needs, (2) recruit and train foster parents for the placement of children with special needs, and (3) develop county systems to encourage the placement of children in family homes. The absence of an increase in these payments could have an effect on the recruitment and retention of foster family providers.

Eliminate AFDC Homeless Assistance (AFDC-HA) Program

Under the contingency proposal, the AFDC-HA Program would be eliminated, resulting in grant and administrative savings of $35 million from the General Fund in 1993-94. Under current law, AFDC-eligible homeless families may apply for a special payment to assist them in obtaining housing. The supplement provides for (1) *temporary shelter* payments to cover short-term housing needs of $30 to $60 per day, depending on family size, for a maximum of 16 days, and (2) *permanent housing* payments, which are generally limited to (a) 80 percent of a family's maximum AFDC grant (currently $624 for a family of three) for security and utility deposits and (b) an additional 80 percent of the grant for the last month's rent. During 1991-92, this program provided assistance to about 9,600 families per month.

Reduce SSI/SSP Grants to the Federal Minimum

The contingency plan proposes reducing the SSI/SSP grants to the federal minimum level, for a General Fund savings of $243 million in 1993-94. All SSI/SSP recipients except those who are in Medicaid-eligible medical facilities or nonmedical out-of-home care facilities would have their grants reduced. Thus, the reduction would affect about 900,000, or 93 percent, of the state's SSI/SSP recipients.

In the current year, an aged or disabled individual—the largest category of recipients—is eligible for a maximum grant of $610 per month. Under the contingency proposal, these recipients would have their total monthly grant reduced by $20, or 3.2 percent.

Eliminate Additional Optional Medi-Cal Benefits

The effect of eliminating additional optional benefits would depend on the behavior of Medi-Cal beneficiaries. To the extent that the beneficiaries are unable or unwilling to pay for the costs of these benefits, the effects could include:

- Beneficiaries seeking alternatives to the eliminated services (such as seeing an ophthalmologist instead of an optometrist) that will continue to be covered under the Medi-Cal Program.
- Delayed treatment that may ultimately require more acute care. For example, the elimination of outpatient drugs could increase admissions to skilled nursing facilities and acute care hospitals because of worsened conditions or because drugs will continue to be provided to individuals in those settings.

- A reduction in beneficiaries' functional abilities, due to the loss of benefits such as hearing aids or wheelchairs.
- Additional fiscal burdens on county health programs. For example, the elimination of outpatient drugs is likely to result in individuals seeking drugs from county programs.

Eliminate Optional Medi-Cal Eligibility Categories

The contingency plan proposes the elimination of the following optional eligibility categories:

- The Medically Indigent Children category, which would affect approximately 113,000 children up to age 21. (This category does not include children in families that are eligible for AFDC or SSI/SSP.) Currently, medically indigent children from families with incomes between 100 percent and 133⅓ percent of the 1990-91 AFDC payment level ($694 to $925 per month) are eligible for Medi-Cal at no cost to the family, and those in families above this level must pay a share of cost (that is, they must "spend down" their incomes to the threshold level).
- The Medically Needy Adults and Children categories, except pregnant women and most children through age eight. This action would affect approximately 462,000 individuals. Persons in these categories meet the eligibility criteria for AFDC or SSI/SSP except that their incomes generally exceed the threshold for these grants. They must pay a share of cost if their family incomes exceed 133⅓ percent of the AFDC payment level, as explained above.
- The "state-only" Medically Indigent Long-Term Care category, which is supported entirely from the General Fund. Eliminating this category would affect approximately 800 individuals. (Most of the Medi-Cal recipients of long-term care are in the state/federal program and therefore would not be affected by this proposal.)

The effect of the first two contingency proposals would be to eliminate health coverage for medically indigent children and medically needy adults and children. Many of these individuals would probably seek services from county health programs. In some cases, people will wait until medical conditions become an emergency before seeking care, resulting in a need for emergency room and inpatient hospital services that are more expensive than physician and other outpatient services. This would increase the uncompensated care burden on hospitals, including county hospitals.

The effect of eliminating the "state-only" Medically Indigent Long-Term category would probably be to increase the burden on the In-Home Supportive Services Program or increase the amount of uncompensated hospital care.

Legislature's Alternatives

As discussed in our companion document, *Perspectives and Issues,* the potential budgetary shortfall created by assuming the receipt of additional federal funds is only part of the state's fiscal problem in the current and budget years. Given this situation and the significant budget reductions enacted in recent years, there are no attractive options for addressing the possibility that the additional federal funds will not be forthcoming in 1993-94. We note, however, that a contingency plan need not be confined to health and social services programs. Thus, in order to help ensure that the budget reflects legislative priorities, we recommend that the Legislature review the Governor's contingency plan during the budget hearings and develop an alternative to address the potential shortfall created by the budget proposal.

Revenue Shift Could Have Significant Impact on Indigent Health Services

The proposal to shift over $2 billion of local property tax revenues to fund public education could result in a substantial reduction in the provision of indigent health care by the counties.

In California, county-provided health care—services provided primarily for indigents who are not eligible for Medi-Cal—is funded almost entirely from three sources: (1) realignment revenues, (2) Proposition 99 revenues (Cigarette and Tobacco Products Surtax (C&T) Fund), and (3) local general fund monies. Of these sources, local general fund monies total about $800 million. This consists of:

- $340 million to match part of the $900 million of realignment revenues allocated to counties for health programs.
- $180 million to match about $200 million in Proposition 99 revenues (C&T Fund) that are used primarily for indigent health care.
- Between $250 million and $300 million in additional county funds for indigent health care services.

Thus, counties are contributing substantially more funding for indigent health care than is specifically required to match realignment revenues. Unless counties compensate with local tax increases, the budget proposal to shift over $2 billion of property tax revenues to fund public education will add to existing pressures on the counties to reduce funding for health services, particularly for indigents. (We discuss the proposed property tax shift in more detail in our companion volume, *Perspectives and Issues*.)

Lack of Coordination Impedes Effective AIDS Prevention Efforts

We recommend enactment of legislation to (1) designate the Office of AIDS (OA) as lead agency for human immunodeficiency virus (HIV) education and prevention activities across all state departments and (2) require the OA to plan and coordinate all departments' funding allocations related to HIV education and prevention. We further recommend that the Legislature adopt Budget Bill language providing that the $6.6 million in federal HIV set-aside funds the Department of Alcohol and Drug Programs (DADP) will receive in the budget year be allocated on the basis of HIV-specific epidemiological data and "gaps" in current HIV-related funding rather than the formula currently used to distribute drug treatment block grant funds.

Background

The OA is responsible for funding HIV education and prevention programs, including testing and counseling services, in a variety of settings across the state. These programs target a number of populations, including substance abusers, that engage in high-risk behaviors putting them at risk of acquiring HIV. The DADP is responsible for funding treatment programs for substance abusers, including those who engage in high-risk behaviors for acquiring HIV.

Because the OA and the DADP serve similar target populations, it is important that they coordinate their program and funding decisions related to HIV education and prevention. However, our review indicates a continuing problem of coordination between the OA and the DADP. As a result of similar concerns expressed in 1988, the OA and the DADP entered into a Memorandum of Understanding (MOU), which outlined specific activities they would undertake, including:

- Meeting and conferring prior to making substantive decisions with respect to new funding, expenditure plans, requests for proposals, and needs identification.
- Keeping each other informed with respect to (1) relevant policies, procedures, and guidelines and (2) progress and problems in the area of HIV prevention and substance abuse.

Despite this specific MOU, the OA and the DADP have not institutionalized an ongoing process of coordination *even where funds are awarded for the same purpose.* For example, the DADP received an

additional $3.3 million in federal allocations for HIV testing and counseling in drug treatment centers (known as the "HIV set-aside") for the current year. In allocating these funds, the DADP used the same formula it uses to allocate drug treatment block grant funds. While this formula includes the number of AIDS cases in a county, this measure is not specific enough to ensure that HIV set-aside funds are targeted effectively. The OA has information that should be included in the formula in order to ensure effective targeting: epidemiological data showing HIV infection rates and trends within specific populations (such as drug abusers) and information on the extent to which programs within each county are already targeting this population.

In addition, the DADP did not confer with, or inform, the OA that it was allocating the additional federal funds. This new federal funding for HIV testing and counseling activities continues into the budget year, with a full-year funding level of $6.6 million. (For more information on the HIV set-aside funding, see our analysis of the DADP.)

This lack of coordination is a problem for two reasons:

- ***It Limits the State's Ability to Ensure That Substance Abusers Are Reached By HIV Education and Prevention Efforts.*** While the OA has the primary expertise in HIV education and prevention strategies, the DADP has specific expertise in reaching substance abusers and has well-developed relationships with county and community-based prevention and treatment programs.
- ***It Limits the State's Ability To Ensure That the Funds Available for HIV Education and Prevention Are Spent Effectively.*** Both the OA and the DADP administer funds that are earmarked for HIV education and prevention activities, but there is currently no formal mechanism to prevent duplicative efforts from being funded by both departments or to ensure that funds are consistently targeted to the most effective strategies.

The OA and the DADP Plan to Improve Coordination Activities

In our discussions with the OA and the DADP, they acknowledge that coordination efforts have been inconsistent in the past few years. They have recently developed a new listing of specific activities the agencies intend to undertake in order to ensure coordination, including monthly meetings and a jointly prepared "gap" analysis to determine communities with the highest need for HIV education and prevention

funds. While these recent efforts have merit, the failure of the MOU process raises questions about the ability of the two agencies to sustain these activities over time.

Clear Lines of Authority Are Needed

We believe the underlying problem is that the lines of authority for HIV education and prevention programs and funding decisions are not clear. While the OA is the designated lead agency for HIV-related issues within the Department of Health Services, this clear authority does not extend beyond departmental lines. In the absence of this authority, the DADP can allocate HIV-related funds without any involvement by the OA.

We have not specifically evaluated the degree of coordination between the OA and all *other* departments involved in HIV education and prevention activities. However, we note that when we examined the status of HIV education and prevention activities within correctional facilities several years ago (see our report, *AIDS Education in Correctional Facilities, A Review,* January 1990), we concluded that a lack of coordination between the Department of Corrections and the OA contributed to inconsistent and duplicative HIV education and prevention efforts being undertaken.

Conclusion

Although HIV-related issues affect a number of state departments and programs, the OA has as its specific mission the reduction of the spread of HIV. As such, the bulk of HIV education and prevention funds flow through the OA. In addition, the OA has developed significant expertise in the epidemiology of HIV in California. Therefore, we believe it is appropriate to provide additional authority to the OA to ensure a comprehensive statewide HIV education and prevention effort.

In order to ensure the coordination of HIV education and prevention efforts, we recommend the enactment of legislation to designate the OA as lead agency for HIV education and prevention activities across all departments, and require the OA to plan and coordinate all state departments' funding allocations related to HIV education and prevention. We also recommend that the Legislature adopt Budget Bill language providing that the $6.6 million in federal HIV set-aside funds the DADP will receive in the budget year be allocated on the basis of HIV-specific epidemiological data and "gaps" in current HIV-related

funding rather than using the current formula for distributing drug treatment block grant funds.

Therefore, we recommend that the Legislature adopt the following Budget Bill language in Item 4200-101-890:

> The department shall allocate the HIV "set-aside" portion of the federal substance abuse block grant received for the budget year on the basis of HIV-specific epidemiological data and gaps in current HIV-related funding, as determined jointly by the department and the Office of AIDS.

NO DETAIL ON WHETHER ADMINISTRATION PLANS TO PROPOSE CLOSING STATE FACILITY

We recommend that the Departments of Developmental Services (DDS) and Mental Health (DMH) report jointly at budget hearings on (1) whether the Administration plans to propose closing either a developmental center or a state hospital in the budget year, including which facility and why, and (2) the anticipated costs and savings from such a proposal.

The Governor's Budget makes reference to the possibility of closing either a developmental center or a state hospital in the budget year. However, the budget includes no specific proposal and no estimates of either costs or savings associated with such a plan.

Potential Reasons For Closing a Facility

There are several potential reasons for closing a facility. First, there are sufficient vacancies in both developmental centers and state hospitals to make closure of one or perhaps two facilities possible. Second, the Legislature has indicated that the state should maximize community placement of clients in both the DDS and DMH systems. To the extent that community placements are realized, this will reduce the need for placements in a state facility. Third, the costs of providing care in developmental centers and state hospitals may be significantly higher than similar services provided in a community setting.

Potential Problems With Closing a Facility

There are also potential problems with a proposal to close a facility, however. Perhaps the most important concern is that the match between clients and services, either in the community or at an alternative state facility, should be made so that there are minimal disruptions to the clients' lives. In addition, closing a facility could result in short-term costs that need to be considered in conjunction with the savings.

Given the complexity of a decision to close a state facility, we believe that the Legislature needs adequate time to review and consider such proposals. We therefore recommend that the DDS and the DMH report jointly at budget hearings on (1) whether the Administration plans to propose closing either a developmental center or a state hospital in the budget year, including which facility and why, and (2) the anticipated costs and savings from such a proposal.

DEPARTMENTAL ISSUES

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS (4200)

The Department of Alcohol and Drug Programs (DADP) directs and coordinates the state's efforts to prevent or minimize the effect of alcohol-related problems, narcotic addiction, and drug abuse.

The budget proposes $292.1 million from all funds for support of DADP programs in 1993-94, which is a decrease of 12 percent from estimated current-year expenditures. The budget proposes $83.1 million from the General Fund in 1993-94, which is virtually the same level as estimated current-year expenditures from this funding source.

Federal Changes Affect Allocations for DADP Programs

We recommend that the department report at budget hearings on (1) the estimated costs associated with the new requirements of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) Reorganization Act of 1992, and (2) the department's plan for allocating funds in response to these changes.

On July 10, 1992 Congress passed the ADAMHA Reorganization Act of 1992 (Public Law 102-321). This act transferred the research institutes of ADAMHA to the National Institutes of Health, and incorporated ADAMHA's services programs into a new Substance Abuse and Mental Health Services Administration (SAMHSA).

The act also changed the block grant allocations to states for substance abuse and mental health, and imposed new requirements on programs receiving block grant funds. For DADP programs, these changes have a number of significant effects:

- ***A Reduction of $30.5 Million in Substance Abuse Block Grant Funds for 1993-94.*** This reduction means that counties and other programs funded by the DADP will receive lower allocations in the budget year. The department has not yet determined specifically how this reduction will be distributed across its programs.

- ***A New Requirement That Tuberculosis (TB) Services Be Provided.*** The act requires all treatment programs receiving Substance Abuse Block Grant funds to make available, either directly or through arrangements with other agencies, TB services to people undergoing substance abuse treatment. These services are defined as (1) counseling, (2) testing to determine whether the person has contracted TB and the form of treatment appropriate for the person, and (3) providing this treatment to the person. In addition, the act requires that people denied admission to a treatment program be referred to another provider of TB services.

  The department is unable, at this time, to estimate the likely costs associated with this requirement. Under certain conditions, these costs may be funded from the existing Substance Abuse Block Grant allocation received by the program. However, to the extent this requirement results in new costs to treatment programs, there will be less funding available for other services provided by these programs (and possibly fewer treatment slots).

- ***A New Requirement that "Interim Services" Be Provided.*** The act requires that if a person requesting treatment for intravenous drug abuse cannot be admitted to a program within 14 days because there are no treatment slots available, that person must be provided "interim services" within 48 hours of the request. These services are defined as services for (1) reducing the adverse health effects of substance abuse, (2) promoting the person's health, and (3) reducing the risk of disease transmission. These services must be provided until the person is admitted into a treatment program (which must occur within 120 days of the initial request).

  The department is interpreting this requirement to mean that methadone maintenance services must be provided. It is unable, at this time, to estimate the likely costs of this requirement or to provide any specific information as to how this requirement will be implemented.

- ***A New Requirement for Services to Pregnant and Parenting Women and a Perinatal "Set-Aside"—$4 Million in 1992-93 and $14.8 Million in 1993-94.*** The act requires that pregnant and parenting women be given preference for admission to treatment facilities, and further requires that if no facility has the capacity to admit them, they be provided interim services within 48 hours (see above).

  The act also requires that 5 percent of the total Substance Abuse Block Grant award be "set aside" to increase access to treatment services for pregnant and parenting women in the current year, and that 10 percent of the total award be set aside in the budget year. The department calculates these amounts to be $4 million in 1992-93 and $14.8 million in 1993-94. The act requires that programs receiving these "set-aside" funds must make available, either directly or through arrangements with other agencies, prenatal care and child care. The department is unable, at this time, to estimate the costs associated with this requirement. However, to the extent the requirement results in new costs to treatment programs, there will be less funding available for other services provided by these programs (and possibly fewer treatment slots).

  The act provides for an exemption from the perinatal set-aside requirements if a state can show it is providing an adequate level of treatment services for women (as evidenced by a comparison of the number of pregnant and parenting women seeking treatment and the availability of those services). The department decided not to pursue this waiver in the current year.

- ***A New HIV Services Requirement and an HIV "Set-Aside"—$3.3 Million in 1992-93 and $6.6 Million in 1993-94.*** The act requires the state to carry out one or more projects to provide on-site HIV "early intervention services" to people undergoing substance abuse treatment. These services are defined as (1) pretest counseling; (2) testing to confirm the presence of HIV, diagnose the extent of immune system deficiency, and provide information on appropriate therapeutic measures for preventing and treating immune system deterioration and other conditions; (3) post-test counseling; and (4) providing the therapeutic measures described in (2) above.

  The act also requires a specific "set-aside" for these HIV services—the department calculates the amount to be $3.3 million for 1992-93 and $6.6 million for 1993-94. (For further discussion

of this issue, please see our cross-cutting issues discussion of Office of AIDS/DADP coordination.)

- *Elimination of the Required "Set-Asides" for Intravenous Drug Abusers and Women.* The act eliminated the required "set-aside" for services to intravenous drug abusers (formerly 17.5 percent of the total block grant award) and the required "set-aside" for services to women (formerly 10 percent of the total block grant award).

Conclusion. In summary, the recent changes brought about by the ADAMHA Reorganization Act of 1992 have two major results:

- Less funding available for substance abuse activities.
- More requirements for specific types of services to be provided by substance abuse treatment programs.

Overall, the changes appear to be designed to integrate related services such as prenatal care, TB services, and HIV services into treatment programs. This integration makes sense programmatically, since people undergoing substance abuse treatment are at high risk for other health problems. However, given the reduction in the overall block grant funding level, it may be difficult for local programs to accomplish this integration without a reduction in other services provided (or possibly the number of treatment slots).

In order to facilitate legislative oversight of this issue, we recommend that the department report at budget hearings on (1) the estimated costs associated with the new requirements of the ADAMHA Reorganization Act of 1992 and (2) the department's plan for allocating funds in response to these changes.

Improvement Needed in Efforts to Maximize Drug/Medi-Cal Reimbursements

We recommend that the department report at budget hearings on (1) whether residential treatment programs for pregnant and parenting women are eligible for federal reimbursement, (2) why the budget does not assume an increase in the number of substance abuse programs certified as eligible for Drug/Medi-Cal reimbursement, and (3) what steps the department is taking to increase the number of programs certified.

The budget assumes $23.4 million in Medi-Cal reimbursements for specified drug treatment services (Drug/Medi-Cal reimbursements) for 1993-94. This is virtually the same amount as estimated 1992-93

reimbursements from this source. More specifically, the Drug/Medi-Cal reimbursements for the Perinatal Treatment Expansion Program (PTEP) are projected to remain at about the same level in the budget year ($12.2 million).

In order to receive Drug/Medi-Cal reimbursements, programs must be certified by the DADP to ensure compliance with Medi-Cal regulations. Not all substance abuse treatment services qualify for reimbursement through the Drug/Medi-Cal Program. Only those services provided to Medi-Cal eligible persons—specifically AFDC and SSI/SSP recipients—are eligible for reimbursement. For these eligible persons, most out-patient substance abuse treatment services can be reimbursed. In addition, Ch 429/91 (AB 390, Speier) authorized the DADP to pursue federal reimbursement for residential treatment for pregnant and parenting women. The department, however, has no data on how many people entering treatment are Medi-Cal eligible, or what specific services these people are receiving.

Our review indicates that there are two problems with respect to the department's budget estimates for federal Drug/Medi-Cal reimbursements:

- ***The Budget Assumes That Reimbursements Will Be Provided For Residential Treatment Programs For Pregnant and Parenting Women.*** However, our discussions with the DADP and the Department of Health Services reveal that there is continuing uncertainty as to whether such programs are, in fact, reimbursable under federal law. Thus, the budget may *overstate* reimbursements by as much as $4 million in the current and budget years due to this factor.
- ***The Budget Does Not Assume Any Increase In the Number of Programs Certified As Eligible For Drug/Medi-Cal Reimbursements.*** The department indicates that by June 30, 1993 (1) only 240 of the 745 substance abuse treatment programs in the state will be certified and (2) only about half the potential number of new PTEP programs will be certified. Thus, the budget may *underestimate* reimbursements by an unknown but potentially significant amount.

Accordingly, we recommend that the department address these two issues during budget hearings. Specifically, we recommend that the department report at budget hearings on (1) whether residential treatment programs for pregnant and parenting women are eligible for federal reimbursement, (2) why the budget does not assume an increase in the number of substance abuse programs certified as eligible for

Drug/Medi-Cal reimbursement, and (3) what steps the department is taking to increase the number of programs certified.

Funding for Female Offender Pilot Project Should Be Continued

We recommend that the Legislature adopt Budget Bill language requiring the department to (1) allocate $1.2 million in federal funds to continue funding for the community treatment component of the Female Offender Substance Abuse Program and (2) submit the required evaluation of the project to the Legislature by September 30, 1993.

Background. The 1990 Budget Act required the California Department of Corrections (CDC) and the DADP to initiate two two-year demonstration projects to provide substance abuse treatment services to inmates and parolees. The California Institute for Women (CIW) Female Offender Substance Abuse Program is one of these demonstration projects. It provides comprehensive treatment services to women while they are incarcerated and after their release from the CIW. Specifically, the program includes two major components:

- *Treatment While Incarcerated In the CIW.* Treatment consists of four to seven months of individualized counseling, a variety of workshops and group activities, parole planning, and the increased use of urine testing. Women participating in the project are housed together in a 120-bed unit.
- *Community Treatment After Release From the CIW.* For women paroled to Los Angeles, Orange, Riverside, and San Bernardino Counties, the program provides the opportunity for continued treatment in a community-based residential program for up to six months after release. For women who choose not to continue treatment in a residential setting, or those women paroled elsewhere, the program provides for development of transition plans to continue treatment upon release from the CIW. About one-third of total program participants have chosen residential treatment.

The project began in May 1991, and an estimated 535 women had received services as of January 1993. Preliminary data from the first six months of project operation indicate that a typical participant is a 32 year-old woman of color with two dependent children, who has used heroin extensively over 15 to 20 years, has completed some high school, and has a poor or nonexistent job history.

Funding for the Program From DADP Block Grant Funds. Through an interagency agreement with the CDC, the DADP has provided over $1.8 million in federal Substance Abuse Block Grant funds for the program. However, in light of an anticipated $30.5 million reduction in federal block grant allocations for the budget year, the DADP indicates that funding for this program will not be continued in the budget year. The CDC submitted a budget change proposal requesting expenditure authority for the program, but no funding source had been identified at the time this analysis was prepared.

No Evaluation Completed to Determine If the Program is Effective. The stated objectives of the program are to improve inmate behavior and parole outcomes. Since substance abuse is directly linked to arrest and incarceration for over 38 percent of women inmates, interventions designed to reduce reincarceration by reducing substance abuse have the potential for significant General Fund savings in the long run, both in social services and criminal justice programs.

The 1990 Budget Act required the DADP to contract for an evaluation to determine program outcomes and the effectiveness of the two substance abuse demonstration projects. No completion date was specified for the evaluation, however. At the time this analysis was prepared, the evaluation of the Female Offender Substance Abuse Program had not been completed. Preliminary outcome data (for the period from August 1991 through May 1992) are insufficient for assessing program effectiveness. The results of the evaluation are critical in assessing the future direction of efforts to reduce substance abuse for this population and thereby reduce reincarceration rates.

Discontinuation of Funding is Premature. Because the program is currently being evaluated, the decision to discontinue funding for the program appears premature. The Female Offender Substance Abuse Program is the *only* treatment program currently being funded for incarcerated women with substance abuse problems. If the evaluation indicates the program is effective, and the program has already been dismantled, program structure and staffing will have to be recreated. Based on our discussions with the departments, we believe it is reasonable to expect the evaluation to be completed by September 30, 1993. Therefore, given the relatively small size of the program and the expectation that the evaluation can be completed soon, we believe it makes more sense to continue funding the program until the results of the evaluation are known.

One way of continuing the program in 1993-94 would be to require the CDC to fund the CIW component, and to require the DADP to fund the community treatment component of the program. This would result

in an allocation of $1.2 million in federal block grant funds from the DADP and $620,000 from the CDC in the budget year.

Although the DADP has not determined how the federal block grant funds will be allocated in 1993-94, it has decided not to fund the Female Offender Substance Abuse Program. The DADP subvenes the bulk of these block grant funds to counties for their substance abuse programs, but some funds are also used for such purposes as epidemiological studies and other special projects. Thus, using $1.2 million in block grant funds for the Female Offender Substance Abuse Program would mean that there would be less funding available in 1993-94 for other programs funded from the block grant. We are unable to determine whether the benefits of the Female Offender Substance Abuse Program are greater than the benefits derived from county programs and other state special projects funded with the block grant. However, for the reasons stated above, we believe the allocation of $1.2 million for the Female Offender Substance Abuse Program is justified.

Conclusion. Both the CDC and the DADP have an interest in determining whether the Female Offender Substance Abuse Program is effective. Completion of the required evaluation is therefore critical. Consequently, we recommend that the Legislature adopt Budget Bill language requiring the department to (1) allocate $1.2 million in federal funds to continue funding for the community treatment component of the Female Offender Substance Abuse Program and (2) submit the required evaluation of the project to the Legislature by September 30, 1993. (For the corresponding recommendation on the CIW component, please see our analysis of the CDC.)

The following is suggested Budget Bill language for Item 4200-101-890:

> The department shall allocate $1.2 million of the federal substance abuse block grant received in the budget year to the Female Offender Substance Abuse Program. The department shall submit the required evaluation of this project to the Legislature by September 30, 1993.

CALIFORNIA MEDICAL ASSISTANCE PROGRAM (MEDI-CAL) (4260)

The California Medical Assistance Program (Medi-Cal) is a joint federal-state program to provide health care services to public assistance recipients and to other individuals who cannot afford to pay for these services themselves.

The budget proposes Medi-Cal expenditures of $14.9 billion ($5.3 billion General Fund) in 1993-94. This represents a General Fund decrease of $124.6 million, or 2.3 percent, below estimated current-year expenditures.

At the state level, the Department of Health Services (DHS) administers the Medi-Cal Program. Other state agencies, including the California Medical Assistance Commission (CMAC) and the Departments of Social Services, Developmental Services, Alcohol and Drug Programs, and Mental Health perform Medi-Cal-related functions under agreements with the DHS. At the local level, county welfare departments determine the eligibility of applicants for Medi-Cal and are reimbursed for those activities. The federal Health Care Financing Administration oversees the program to ensure compliance with federal law, and must approve significant policy changes.

Generally, program expenditures are supported on a 50 percent General Fund, 50 percent federal funds basis.

Caseloads and Expenditures

Who is Eligible for Medi-Cal?

Persons eligible for Medi-Cal fall into four major categories:

- *Categorically Needy.* Families or individuals who receive cash assistance under two programs—Aid to Families with Dependent Children (AFDC) and Supplemental Security Income/State Supplementary Program (SSI/SSP)—comprise the "categorically needy." The categorically needy automatically receive Medi-Cal eligibility cards and pay no part of their medical expenses.
- *Medically Needy.* This category includes (1) families with dependent children and (2) aged, blind, or disabled persons with incomes higher than the June 1991 AFDC payment level ($694 for a family of three). These individuals pay no part of their medical expenses if their incomes are between 100 percent and 133⅓

percent of the AFDC payment level for their household size. Individuals with higher incomes can become eligible for Medi-Cal if their medical expenses require them to "spend down" their incomes to 133⅓ percent of the June 1991 AFDC payment level. These persons are said to have a "share of cost." (Medically needy beneficiaries who reside in long-term care facilities are required to pay all but $35 of their monthly income toward the costs of their care.)

- ***Medically Indigent.*** The Medi-Cal Program also provides services to pregnant women and children under the age of 21. Also, these services are available to persons in long-term care facilities who (1) do not belong to families with dependent children and are not aged, blind, or disabled, but (2) meet income and share-of-cost criteria that apply to the medically needy category.
- ***"Nontraditional" Eligibles.*** Recent federal and state law changes have extended coverage under the Medi-Cal Program to newly legalized and undocumented persons, and to pregnant women and children who meet various income criteria.

Figure 8 summarizes the various eligibility categories for the Medi-Cal Program. The highlighted (shaded) categories are required by federal law—that is, the Medi-Cal Program must provide services to individuals meeting these criteria in order for the program to receive federal funds. The remaining eligibility categories are optional—the state has discretion over whether to provide services to individuals in these categories, though it receives federal funds to the extent it chooses to do so.

What Benefits Does Medi-Cal Provide?

Federal law requires the Medi-Cal Program to provide a core of basic services, including hospital inpatient and outpatient care, skilled nursing care, doctor visits, laboratory tests and X-rays, family planning, regular examinations for children under the age of 21, and services in rural health clinics. Many Medi-Cal services require prior state authorization and may not be paid for unless the service is determined by the department's field offices to be medically necessary.

In addition, the federal government provides matching funds for optional services. California currently provides 28 of these 31 optional services, but the budget proposes to eliminate nine of them. We discuss this proposal in more detail below.

Figure 8

Who Is Eligible for Medi-Cal?

(Dollars In Millions)

Income Level	Other Characteristics	Number Eligible	1993-94 General Fund Expenditures[a]
Federally Required Categories			
Categorically Needy			
AFDC or SSI/SSP income standard	• Families with dependent children • Aged, blind, or disabled persons	3,946,300	$3,700
Other Women and Children			
Percent of federal poverty level:			
Up to 185%	• Pregnant women and their infants	141,000	135
Up to 133%	• Children ages 1 to 6		
Up to 100%	• Children ages 7 to 9		
Newly Legalized Persons			
• Up to 133% of June 1991 AFDC payment level	• Persons meeting any Medi-Cal criteria receive emergency and pregnancy related services only	89,200	142
• Persons with higher incomes may "spend down" to this level	• Aged, blind, and disabled persons and children to age 19 receive all services		
Undocumented Persons			
Same as newly legalized persons	• Persons meeting any Medi-Cal criteria may receive emergency services only, including labor and delivery	394,500	411
Additional Categories in California			
Long-Term Care			
Persons of any income must "spend-down" to $35 per month	• Require skilled nursing care	69,700	918
Medically Needy			
• Up to 133% of June 1991 AFDC payment level • Persons with higher incomes may "spend down" to this level	• Families with dependent children • Aged, blind, or disabled persons	514,500	600
Medically Indigent			
Same as medically needy	• Pregnant women • Children to age 21	261,800	193
Other Women and Children (Proposition 99 Funds)			
186% to 200% of federal poverty level	• Pregnant women and their infants	4,100	16
Undocumented Persons			
Same as medically needy	• Pre- and postnatal services	NA	93

[a] Budget assumes $824 million less than amount shown due to requested increase in federal funds.

Proposed Changes for 1993-94

The major changes proposed for the Medi-Cal Program in 1993-94 are in three categories: (1) caseload and cost increases ($630.1 million General Fund), (2) full-year costs of 1992-93 cost-of-living adjustments (COLAs) and other rate increases ($32.9 million General Fund), and (3) proposed program changes (savings of $789.2 million General Fund).

Among the proposed program changes, the following are the more significant items:

- ***Assumed Receipt of Federal Funds (Savings of $828 Million General Fund).*** The budget assumes receipt of $828 million in federal funds to offset state expenditures for "Medi-Cal immigrants." Specifically, the budget assumes receipt of (1) an additional $254 million in funds from the State Legalization Impact Assistance Grant (SLIAG) that the department estimates are due to California for services provided in the *current year* to newly legalized persons, (2) $534 million in federal funds to offset the state's share of expenditures for services to newly legalized and undocumented persons in the *budget year*, (3) $30.9 million to fund services provided to citizen children of undocumented persons, and (4) $8.6 million to fully cover the costs of serving refugees who are eligible for Medi-Cal because they meet AFDC criteria.

- ***Elimination of Optional Services (Combined Current- and Budget-Year Savings of $219.1 Million General Fund).*** The budget proposal assumes that the Legislature will enact legislation to eliminate nine optional services—adult dental, nonemergency transportation, psychology, podiatry, acupuncture, independent rehabilitation centers, chiropractor, speech and audiology, and certain medical supplies—by March 1, 1993. We discuss this proposal in more detail below.

- ***1992-93 County Administration Salary Increases (Savings of $3.8 Million General Fund).*** The budget proposes not to fund the state's share of a 3 percent salary increase for county welfare department employees. Generally, the Legislature has reimbursed counties for salary increases the year after the counties provide them.

- ***Statutory COLAs for Providers ($44.4 Million General Fund).*** The budget contains $59.3 million ($32.1 million General Fund) for a 9.3 percent increase on drug ingredients and $25.1 million ($12.3 million General Fund) for a 7.5 percent increase for noncontract hospital inpatient services.

- ***Rate Increases for Dental Services*—Clark v. Coye *(Two-Year Cost of $225.9 Million General Fund).*** The budget reflects rate increases the department was ordered to implement by a court judgment in the case of *Clark v. Coye,* a lawsuit dealing with access to dental services. We discuss this issue in more detail below. The actual increase in expenditures for dental services will be less, however, due to the proposed elimination of adult dental services as a Medi-Cal benefit. (Most of this increase would be offset by the proposed elimination of optional benefits, which includes adult dental benefits.)
- ***"County Bounty" to Increase Third-Party Recoveries (Savings of $23.2 Million General Fund).*** The budget proposes to pay counties a "bounty" for identifying third-party insurance coverage for Medi-Cal recipients (generally through an absent parent for a Medi-Cal eligible child).
- ***Expanded "Managed Care" Activities (Savings of $48.3 Million General Fund).*** The budget assumes the continued expansion of enrollment of beneficiaries in various "managed care" arrangements (such as prepaid health plans, primary care case management, and targeted case management of high-cost beneficiaries), resulting in estimated savings of $96.6 million ($48.3 million General Fund) over estimated current-year savings from such efforts. We discuss this issue in more detail below.

Medi-Cal Program Growth

Growth in California' Medi-Cal Program over the last few years has been dramatic. As background for the recommendations and options that follow, we review some of the principal reasons for growth in the program and the department's efforts to control Medi-Cal expenditures.

Total Medi-Cal expenditures have increased from $6.2 billion in 1988-89 to an estimated $13.7 billion in 1992-93, reflecting an increase of about $7.5 billion over the four-year period, or about 121 percent. It is important to note, however, that these expenditure totals reflect increased *federal* funding for payments to disproportionate share hospitals under the "SB 855" Program, begun in 1991-92. The purpose of these payments is to recognize the financial burden of uncompensated care on "safety net" hospitals that serve a high number of indigent persons. These payments, and the required county match, comprise $1.8 billion of the expenditure figures for both 1991-92 and 1992-93. Accordingly, the General Fund discussion that follows more accurately reflects growth in program costs.

As Figure 9 indicates, General Fund expenditures for the Medi-Cal Program have increased from $3 billion to approximately $5.5 billion, or 83 percent, from 1988-89 to 1992-93. This represents average annual growth of 16 percent over the four-year period.

Figure 9

Medi-Cal Expenditures[a]
1988-89 Through 1992-93

(Dollars in Billions)

	1988-89	1989-90	1990-91	1991-92	1992-93	Percent Increase 1988-89 Through 1992-93	Average Annual Increase
General Fund	$3.0	$3.5	$4.1	$5.8	$5.5	83.3%	16.4%
All funds	6.2	7.2	8.8	13.8	13.7	121.0	21.9

[a] Figures for 1991-92 have been adjusted to eliminate one-time costs for change from cash to accrual accounting. Figures for 1992-93 are estimated.

Reasons for Increased Medi-Cal Expenditures

The dramatic increase in Medi-Cal expenditures over the last five years has resulted largely from caseload increases, societal changes, medical care inflation, and court decisions. We discuss these factors below.

Caseload Increases. The largest single factor driving program expenditures is the significant increase in the number of persons eligible for Medi-Cal. In 1985-86, 2.9 million persons (one out of ten persons in the state) were eligible for the program, while, in the current year, the number of eligibles is estimated to reach five million persons (about one out of every six residents). As a point of comparison, the number of persons eligible to receive Medi-Cal is now roughly equal to the number of children enrolled in California's public school system.

In general, two factors account for the increase in the number of eligible participants. First, the "traditional" recipients of Medi-Cal services—primarily AFDC and SSI/SSP recipients—have been increasing significantly during the last few years. Secondly, the Medi-Cal Program caseload has increased as a result of state and federal changes that have expanded eligibility to "nontraditional" recipients of these services. Specifically, the federal government has mandated that the state provide medical services to newly legalized and undocumented persons, thereby adding nearly 500,000 persons to the Medi-Cal Program, or about 10 percent of all eligibles for 1992-93. In

addition, the state has expanded eligibility for pregnant women and their infants by increasing the income threshold from 185 percent to 200 percent of the poverty level. Expenditures due to these state and federal policy changes account for about one-third of total expenditure growth since 1989-90.

Societal Changes. One societal change that has affected the Medi-Cal Program is the emergence of the AIDS epidemic. Medi-Cal expenditures for AIDS-related illnesses are estimated to be $140 million during the current year. In addition, the growth in the number of unmarried teenage women having children, and children born to substance-abusing mothers also has increased expenditures. The extent to which these changes have contributed to expenditure growth is difficult to quantify, but it is likely that it is substantial.

Medical Care Inflation. Medical care costs increase at rates that generally exceed significantly other types of inflation. For example, medical care inflation has averaged 8.1 percent annually in California over the last five years, which is roughly twice the rate of inflation for all other types of goods and services. Medi-Cal payment levels for some services (such as for physician services) are discretionary, while others are automatically adjusted pursuant to statute (such as for generic drugs and nursing facilities). Hospital inpatient rates generally are negotiated, but the state has little practical alternative to recognizing at least a portion of the cost increases that hospitals experience. Accordingly, because expenditures for hospital inpatient services, long-term care, and drugs account for the vast majority of Medi-Cal expenditures, medical care inflation has played a significant role in the program's expenditure growth over the last several years.

Court Decisions Concerning Rates. Under federal law, the state must offer access to services comparable to those which are available in the community. The courts have interpreted this provision to require rate increases for certain services. For example, the state recently was ordered to increase rates substantially for dental services, because the courts found that low Medi-Cal rates had the effect of denying access to those services. The Administration estimates that this court decision will result in additional General Fund expenditures of $65 million in the current year and $160 million in 1993-94. We discuss this issue further below.

Efforts to Control Medi-Cal General Fund Costs

This discussion is divided into two parts. First, we summarize efforts to reduce General Fund Medi-Cal costs that were initiated in the 1992-93 Budget Act and related legislation. Second, we describe other efforts that have been ongoing.

1992-93 Budget Act Control Efforts

Figure 10 provides an update on efforts to reduce General Fund expenditures for Medi-Cal in the 1992-93 Budget Act and implementing legislation. As the figure indicates, these actions are estimated to result in General Fund savings of $285 million in the current year. Of this amount, the largest General Fund savings—accounting for 42 percent of the savings—were achieved through funding shifts. The more significant of these fund shifts are $57 million from Proposition 99 revenues and $28 million from federal disproportionate share payments. For 1993-94, the Governor's Budget proposes an additional $828 million funding shift, by assuming the receipt of federal funds to pay the entire cost of serving Medi-Cal beneficiaries who are eligible for the program as a result of federal immigration policy.

The second major source of General Fund savings in the current year is provider rate reductions and mandatory rebates for drugs. These savings were achieved through rate reductions for surgeons, anesthesiologists, and radiologists; limits on payments for medical supplies; reductions in hospital payments; and a mandatory 10 percent rebate for pharmaceuticals. These rate reductions, and the funding shifts described above, comprise about four-fifths of estimated General Fund savings for the current year.

The three remaining strategies—expanded "managed care" activities, additional efforts to prevent fraud and recoup third-party insurance payments, and eligibility and benefit restrictions—make up about one-fifth of current-year savings. They are estimated to provide higher levels of savings in 1993-94, generally due to the time required for implementation during the current year. We discuss the Administration's proposed expansion of managed care in more detail later in this analysis.

General, Ongoing Cost Control Efforts

Historically, the department has attempted various strategies to control Medi-Cal expenditures. The most significant of these are (1) the implementation of hospital contracting, (2) various utilization controls,

and (3) constrained reimbursement rates for services. We discuss these efforts below.

Figure 10

Major Medi-Cal Cost Control Efforts 1992-93 Budget Act Estimated General Fund Savings

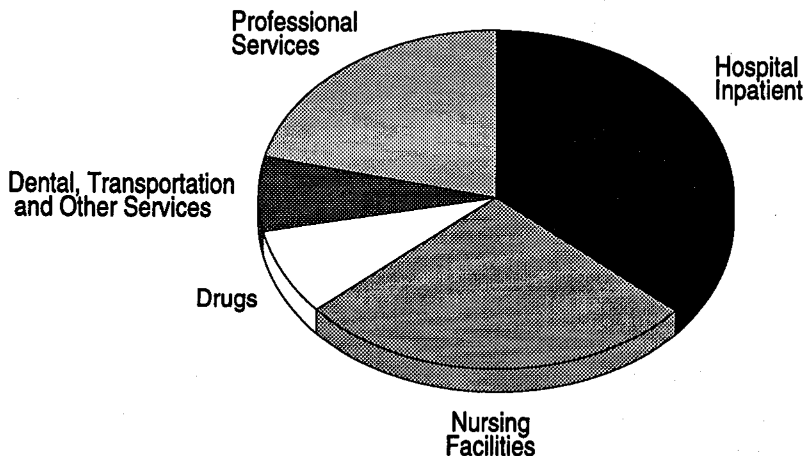
(Dollars in Millions)

	Budgeted 1992-93	Revised 1992-93	Estimated 1993-94
Managed care activities	$91.5	$21.6	$69.9
Expand enrollment in prepaid health plans	54.0	0.9	4.5
Expand beneficiaries assigned to primary care case managers	5.0	1.6	21.8
Case management of high-cost beneficiaries	17.5	13.7	35.0
Limit stays in noncontract hospitals	11.2	1.6	4.8
Transfer patients to lower cost nursing facilities	3.8	3.8	3.8
Provider rate reductions	108.7	106.8	152.1
9.5 percent reduction for surgeons, anesthesiologists, and radiologists	9.0	9.0	12.0
Reduce incontinent supply reimbursements	5.2	5.0	6.7
Reduce contract hospital reimbursement	24.9	24.9	33.3
Limit payment to out-of-state hospitals to average in-state rate	1.5	1.4	2.0
Mandatory 10 percent rebate for pharmaceuticals	8.6	19.8	4.9
Reduce medical supply mark up	0.6	4.0	5.3
Reduce nursing home reimbursement rates	27.9	42.7	46.6
Limit payments on behalf of Medicare crossovers	31.0	—	41.3
Audits, recoveries, and fraud prevention	20.2	6.8	41.3
Establish "county bounty" to collect private insurance	6.5	2.0	25.2
Increase income verification and other fraud prevention	8.9	0.2	6.9
Additional hospital and nursing facility audits	4.8	4.6	9.2
Fund shifts	112.4	120.3	28.0
Increase state share of federal disproportionate share payments	28.0	28.0	28.0
Use Proposition 99 revenues to fund prenatal services expansion	56.8	56.8	—
Shift drug rebate program to accrual accounting	27.6	35.5	—
Service reductions	55.9	29.1	72.1
Impose more stringent residency requirements	35.5	24.3	49.2
Limit prescriptions to ten per month	4.5	—	—
Limit covered drugs to one per therapeutic category	15.9	4.8	22.9
Totals	**$388.7**	**$284.6**	**$363.4**

Hospital Contracting. In reviewing the department's more general cost-containment strategies, it is useful to describe the components of overall Medi-Cal expenditures. Figure 11 shows the proportion of Medi-Cal expenditures by service category, for 1993-94. As the figure indicates, Medi-Cal expenditures for hospital inpatient services account for 36 percent of all expenditures. Accordingly, the most important cost-containment strategies historically have focused on controlling these costs.

Figure 11

Medi-Cal Fee-For-Service Expenditures By Type of Service



The department has two primary strategies for controlling inpatient hospital expenditures: provider contracting and utilization review. As a result of legislation enacted in 1982, the department implemented its Selective Provider Contracting Program through which it contracts with specific hospitals to provide services to Medi-Cal beneficiaries at negotiated rates. In most areas of the state, Medi-Cal beneficiaries can only receive nonemergency inpatient services at contracted hospitals. The CMAC, which administers the program, estimates it has resulted in savings of $350 million annually.

Utilization Controls. The department controls utilization of services through a number of processes. These are:

- Prior authorization, which is required for all nonemergency inpatient hospital services, long-term care, certain drugs, durable medical equipment, and other high-cost services.
- Concurrent review, through which the department reviews at on-site hospital field offices the progress of admitted patients in an effort to reduce lengths of stay.
- Computerized claim reviews, in which the department's claims processing system checks claims for accuracy and assesses the claiming patterns of providers to detect cases where individual providers may be performing high-cost procedures at a significantly higher-than-average rate.

Reimbursement Rates. The department's authority to set rates has been its principal means for controlling costs for physician services. For example, the Medi-Cal Program reimburses physicians at rates that are roughly half the amount paid by private insurers for similar services. With respect to pharmaceutical expenditures, the department implemented in the current year a legislative requirement that drug manufacturers offer the state a 10 percent rebate for drugs in order to be exempt from the state's prior-authorization requirements.

Managed Care

Department Plans Major Expansion of Managed Care

Under the department's strategic plan, almost half of all Medi-Cal beneficiaries would be enrolled in a "managed care" arrangement by the end of 1993-94.

In January 1993, the department released a draft "Strategic Plan" to rapidly move the Medi-Cal Program toward a "managed care" approach throughout California. In this section, we review existing managed care arrangements and the department's proposed expansion of managed care, and offer comments and recommendations for the Legislature's consideration.

Background. The Legislature and the department have, for several years, attempted to increase the number of Medi-Cal beneficiaries enrolled in managed care arrangements. In particular, legislation accompanying the 1992 Budget Act gave the department broad authority to expand managed care in California, with the goals of improving beneficiary access to care and making the Medi-Cal Program more cost-effective. Currently, approximately 600,000 out of more than

5 million Medi-Cal beneficiaries are enrolled in a managed care arrangement.

Under *managed care arrangements,* the Medi-Cal Program attempts to control costs by generally reimbursing providers on a "capitated," or per-person basis regardless of the number of services any given individual uses. In addition, the use of specialists and high-cost services requires a physician referral. This approach contrasts with the *fee-for-service system,* where Medi-Cal pays providers for each service they provide, and the beneficiary has his or her choice in selecting providers. In fee-for-service, utilization is controlled by requiring prior authorization from the Medi-Cal field offices for the more expensive medical services.

The principal managed care arrangements are:

- ***Prepaid Health Plans (PHPs).*** Medi-Cal contracts with private PHPs to provide care to AFDC-linked beneficiaries. The PHPs are paid a monthly capitation payment, based on an estimate of the costs of serving beneficiaries in the fee-for-service system. Generally, PHPs are paid from 95 to 97 percent of the estimated fee-for-service cost, plus an administrative fee. CIGNA Health Plan, Foundation Health, and Kaiser Permanente are among the PHPs that have existing Medi-Cal contracts. The department has not entered into contracts to enroll SSI/SSP-linked beneficiaries in PHPs.
- ***County-Organized Health Systems (COHS).*** Under this approach, the county acts as a prepaid plan, serving all Medi-Cal beneficiaries in the county. The COHS receive a capitated rate for each beneficiary in the county, and assume full financial risk. Currently, Santa Barbara and San Mateo Counties have fully implemented this approach, and three additional counties—Solano, Santa Cruz, and Orange—are in various phases of development. Federal law prohibits additional county-organized systems in California.
- ***Geographic Managed Care (GMC).*** Under this approach, the Medi-Cal Program negotiates contracts directly with providers to accept beneficiaries within a specified area, again paying a monthly rate based on the estimated cost of providing services to similar beneficiaries under the fee-for-service system.
- ***Primary Care Case Management (PCCM).*** PCCM plans are paid a fixed monthly fee (per person) to manage the care of the Medi-Cal beneficiaries enrolled in the plan. They approve referrals to specialists, nonemergency hospitalizations, and other high-cost

procedures. If the costs of care for enrollees in a PCCM plan are less than the estimated fee-for-service cost would have been for similar beneficiaries, the PCCM plan receives a payment equal to half the estimated savings.

In addition, the department is implementing a program to provide case management services to "high-risk" beneficiaries directly. Beneficiaries included in this program are selected on the basis of the expected cost of treating persons with certain diagnoses and demographic characteristics (for example, children with severe infections). The department expects to begin implementation of this program in February 1993.

Figure 12 summarizes the budgeted fiscal effect for 1993-94 of managed care expansion efforts the department initiated in the current year. Although it shows anticipated General Fund savings of $49.3 million in the budget year, we note that some of these efforts had not been implemented at the time this analysis was prepared and the magnitude of savings ultimately realized may be considerably less.

Figure 12

Budgeted Fiscal Effect of Current-Year Managed Care Expansion Efforts For 1993-94

(Dollars In Millions)

	Total Funds	General Fund	Number of Affected Beneficiaries
DHS administrative costs	$9.9	$4.2	—
Prepaid health plan expansion	-8.8	-4.5	249,000
CIGNA health plan rate increase	16.1	8.0	(100,000)[a]
Primary care case management expansion	-43.3	-22.0	274,000
Targeted case management of high-risk beneficiaries	-70.0	-35.0	Unknown
Totals	**-$96.1**	**-$49.3**	**523,000**

[a] Some CIGNA beneficiaries are included in the figure for prepaid health plan expansion.

Principal Components of the Strategic Plan. The department's draft strategic plan proposes to enroll nearly half of all beneficiaries (2.4 million out of an estimated 5.4 million) in a managed care arrangement by the end of 1993-94. The department indicates that it will issue a revised plan in March 1993, following its review of public comments, and will at that time begin implementation of the plan. The budget does not attribute any savings to the expansion proposed in the strategic plan

in 1993-94. Because the plan has not been finalized, we believe that it would be premature to assume savings.

The plan proposes to expand the number of beneficiaries served under managed care arrangements in the following ways:

- Continue current expansion efforts to enroll a total of one million beneficiaries in PHPs or PCCM plans by June 1993. This is an increase of approximately 500,000 beneficiaries over current enrollment levels.
- Continue development of COHS in Solano, Santa Cruz, and Orange Counties, and the GMC project in Sacramento County. These four efforts will serve approximately 410,000 beneficiaries.
- Increase PHP enrollment by an additional one million beneficiaries statewide by the end of 1993-94. (This is in addition to the current expansion effort indicated above.)
- Require the expansion of managed care in 11 additional counties, either through a COHS approach overseen by a consortium at the county level, or through the implementation of GMC, at the option of the county's board of supervisors or other local representatives. The department indicates that these counties will be "closed" to new fee-for-service reimbursement by January 1, 1994.

Figure 13 shows the 11 additional counties the department has selected for the required expansion of managed care.

Figure 13

Counties Designated for Mandatory Implementation of Managed Care in 1993-94

	Total Medi-Cal Beneficiaries	Current Enrollment in Managed Care Plans
Alameda	178,000	4,600
Contra Costa	82,000	13,600
Fresno	192,000	5,000
Kern	106,000	—
Los Angeles	1,500,000	317,000
Riverside	162,000	21,900
San Diego	315,000	63,700
San Francisco	107,000	2,000
Santa Clara	165,000	7,300
Stanislaus	79,000	—
San Bernardino	267,000	41,800
Totals	**3,153,000**	**476,900**

Under the strategic plan, consortia will be formed at the local level to act as the purchaser of services for all AFDC-linked beneficiaries in the county. The consortia must establish governing boards comprised of public and private provider groups, beneficiaries, and at the option of each county, representatives of the board of supervisors. If the department has not received a letter of intent to participate from a consortium within 105 days of its release of the revised strategic plan, the department will implement its GMC model to serve Medi-Cal beneficiaries in the county.

Each consortium must also agree to:

- Accept "prevailing reimbursement rates" for managed care providers.
- Accept financial risk for certain Medi-Cal services within one year, and for all services within two years.
- Serve at least 20 percent of Medi-Cal beneficiaries in the county through subcontracts with independent providers.
- Assure a role for "traditional safety net providers," such as public hospitals and clinics.
- Guarantee specified patient volumes at "disproportionate share" hospitals sufficient to generate federal supplemental payment revenues to those hospitals.
- Assure the state that all parties represented on its governing board, and any providers the consortium subcontracts with, will drop outstanding lawsuits against the state regarding reimbursement rates.

The plan indicates that the department has yet to determine (1) which preventive services it will ultimately require; (2) how it will assure coordination with other publicly funded health, mental health, and alcohol and drug programs; (3) what cost-effectiveness, clinical outcome, and patient satisfaction data it will require; and (4) how it will revise its existing methodology for setting managed care reimbursement rates.

Implementation of Managed Care Strategic Plan Is Premature

We recommend that the department address a number of issues that are key to the fiscal viability of any managed care expansion. Accordingly, we recommend that the department address these issues in a subsequent draft of the plan and present it for the legislature's consideration during budget hearings. We also recommend that no expansion of managed care occur until the Legislature has had an opportunity to consider these and other issues related to the department's strategic plan.

We believe that the department's plan has merit, and serves as a useful point of departure for the Legislature's deliberations on the future of health care policy in California. The department's straightforward acknowledgement of a number of longstanding concerns regarding the Medi-Cal Program—such as constrained access to services, inconsistent provision of care, and rapid increases in the program's costs—and its attempt to present a long-term plan to address them, is commendable. However, we also believe that a number of issues must be addressed before the plan can be implemented.

Specifically, the plan needs to address the following issues:

- *The Consortia May Be Illegal.* Under federal law, California may not implement additional county-organized health systems beyond the five currently operating or under development. The strategic plan refers to consortia that in many cases would be closely tied to county boards of supervisors, though it is not clear how membership on the consortia boards would be determined. If the federal Health Care Financing Administration (HCFA) determines the consortia to be essentially identical to county-operated health systems, the state would be prohibited from implementing the consortia approach described in the plan. The department has not indicated whether it would implement GMC in the designated counties if the HCFA ruled that consortia-based expansion violates federal law.
- *A New Rate-Setting Methodology Has Yet To Be Determined.* The plan indicates that the department will, at some future point, determine reimbursement rates for the consortia through a process of negotiated rates or competitive bidding. In the meantime, the plan requires the consortia to accept "prevailing rates" for managed care services—presumably including rates paid to PHPs. However, the department indicates its existing rate-setting methodology for prepaid health plans is being revised. Thus, it is not clear how rates will be set for services provided through the consortia, and it is therefore difficult for

the Legislature to determine what the fiscal effect of the expansion will be.

- ***The Fiscal Capacity of Counties in 1993-94 is Uncertain.*** The budget proposes a shift of $2.6 billion in property tax revenues from local governments to school and community college districts, but does not specify how much of this reduction would be from counties or whether these funds will be replaced. A significant reduction in county fiscal capacity as appears to be contemplated in the budget would have serious consequences for county indigent health provider networks, which are an integral component of the department's plan. Thus, in the absence of a plan for counties to maintain viable financing for their existing health care delivery systems, it is unclear how expansion through consortia can proceed.

- ***The Plan Does Not Address How Quality of Care Will Be Monitored.*** The plan indicates that a number of issues generally related to ensuring quality of care require further review. Accordingly, the department has yet to specify (1) which preventive health care services it will require the consortia to provide, (2) what types of clinical outcome and cost-effectiveness data it will collect, (3) how it will enforce quality of care standards, and (4) how "access" to services will be measured.

  These questions are crucial from a fiscal standpoint for two reasons. First, from the perspective of counties, they determine what liabilities the consortia will face. Second, from the perspective of the state, the extent to which managed care results in savings depends on whether preventive care is provided, and whether hospitalizations and other high-cost procedures associated with serious illnesses are thereby reduced.

- ***The Plan Does Not Adequately Ensure Competitiveness.*** The plan specifies that it will ensure competitiveness by requiring each consortium to deliver services to 20 percent of the county's beneficiaries through a subcontract with an independent provider. Presumably, the department will compare the rates paid by the consortia to these subcontractors with the overall rates the department has set for the consortium, to ensure that the consortium's rates have not been set too high. However, it seems unlikely that a consortium will negotiate significantly lower reimbursement rates for services to 20 percent of its caseload given the probability that the department will subsequently reduce the *consortium's* rates for the remaining 80 percent of beneficiaries to that lower rate in later years.

In our view, the issues we have identified above are key to the fiscal viability of any managed care expansion. Accordingly, we recommend that the department address these issues in a subsequent draft of the plan and present it for the Legislature's consideration during budget hearings. Because a rapid expansion of managed care may have significant implications both for the quality of care provided to Medi-Cal beneficiaries and for the program's future costs, we also recommend that no expansion of managed care occur until the Legislature has had an opportunity to consider these and other issues related to implementation of the department's strategic plan.

More Deliberative Approach Warranted. In general, we believe that a more deliberative approach to expanding managed care is warranted. In our view, mandatory expansion should proceed in a smaller number of counties than proposed in the plan, and should also include additional elements if it is to result in savings. Specifically, we believe that the following additional components would likely increase the potential fiscal benefits from managed care.

First, we note that the plan focuses on services provided to AFDC-linked beneficiaries only. However, as the department notes in the plan, roughly 17 percent of all Medi-Cal beneficiaries (including many SSI/SSP recipients) account for 80 percent of the program's cost, and AFDC-linked beneficiaries are among the *lowest cost* groups served by the Medi-Cal Program. Accordingly, the department's proposal to expand manage care neglects an area where potential savings may be the greatest: the high-cost groups of recipients. (The department indicates that it intends to require the inclusion of SSI/SSP-linked beneficiaries, but not for several years.)

Second, the department's proposal does not address Medi-Cal services to persons in long-term care or to beneficiaries who require services through county mental health, alcohol, or drug programs. We believe it is important that the plan address management of services to these populations. Not only do they account for a large portion of Medi-Cal expenditures, but access to these programs can result in significant long-term savings because treatment can prevent more serious disability.

Because we believe that the additional elements outlined above would strengthen the prospects for achieving fiscal benefits through managed care expansion, we recommend that the department develop a revised plan that incorporates them.

CIGNA Rate Increase Not Justified

We recommend that the Legislature reject a portion of the proposed rate increase for managed care services provided by CIGNA Health Plan for a General Fund savings of $6.8 million in the current year and $6.8 million in 1993-94 because the proposed increase has not been justified. We further recommend that the department develop a revised rate-setting methodology for all managed care arrangements, and report during budget hearings on the methodology. (Reduce Item 4260-101-001 by $6.8 million.)

The budget proposes $16.1 million ($8.1 million General Fund) in the current and budget years to increase the reimbursement rate the department pays CIGNA Health Plan for managed care services to Medi-Cal beneficiaries.

Background. The CIGNA Health Plan is a health maintenance organization that provides managed care services to approximately 100,000 Medi-Cal beneficiaries. The department reports that its proposal to increase the amount of funds to pay CIGNA reflects (1) a projected higher-than-estimated incidence in the number of newborns requiring neonatal intensive care and (2) an adjustment to partially offset CIGNA's claim that it loses $19 million annually in providing services to Medi-Cal beneficiaries enrolled in the plan. CIGNA claims that it is losing money as a result of the "enhanced access" to services provided by the plan in comparison to fee-for-service providers. The DHS also reports that CIGNA has indicated its intent to terminate its contract with the Medi-Cal Program if the proposed rate adjustments are not forthcoming.

The Department of Finance requested, pursuant to Section 27 of the 1992 Budget Act, the rate increase. In response to our recommendation, the Legislature rejected all but $2.4 million of the request.

Analyst's Findings and Recommendations. Our review indicates that the portion of the proposed increase for projected additional neonatal cases ($2.4 million of the $16.1 million) is justified and should be approved. This recommendation is based on our understanding that the payment will be made only on a per-case basis for high-cost newborns in excess of the 64 cases annually that would ordinarily be expected, given the demographic characteristics of the Medi-Cal beneficiaries enrolled in CIGNA. Because these funds will only be paid to CIGNA on a case-by-case basis, the Legislature may wish to adopt Budget Bill language to specify reversion of the funds to the extent they are not needed for payments to CIGNA.

With respect to the department's proposal to offset CIGNA's claimed losses for "enhanced access," however, we believe that the $13.7 million ($6.8 million General Fund) requested for this purpose raises significant issues for the state's managed care policy and should be denied, for the reasons discussed below.

The DHS reports that CIGNA should be provided an additional payment for "enhanced access" for three reasons. First, it believes that the method in which prepaid health plan rates are set, as generally specified in legislation, results in artificially low reimbursement rates, and that CIGNA's claim of annual losses is therefore credible. However, the department indicates it has received *no information* from CIGNA to substantiate the company's claim that it has lost money providing services to Medi-Cal beneficiaries.

Second, the department believes the additional payment to CIGNA is warranted because the company states that Medi-Cal beneficiaries who are enrolled in its plan use more services than do other Medi-Cal beneficiaries. However, the department has only been able to provide data showing that the utilization patterns of Medi-Cal beneficiaries enrolled in CIGNA are *lower*, not higher, than comparable Medi-Cal beneficiaries. Thus, the Legislature has not been provided with information to support the department's view that Medi-Cal beneficiaries enrolled in CIGNA are more expensive to care for than other Medi-Cal patients; rather, the data indicate that Medi-Cal beneficiaries enrolled in CIGNA may instead be cheaper than average to serve.

Finally, the department has stated its desire to provide the higher payment to CIGNA because, as noted above, the company has indicated it will terminate its contract with the Medi-Cal Program if the additional payment is not provided. The department reports that such an action by CIGNA would affect approximately 100,000 Medi-Cal beneficiaries.

According to the department, however, *other* prepaid health plans have reported profits serving Medi-Cal beneficiaries and have informally indicated to the department their willingness to accept CIGNA enrollees should the plan terminate its contract. The department believes that, at a minimum, roughly one-third of CIGNA enrollees could be signed up immediately with other managed care providers, and that the remaining enrollees would be served by other Medi-Cal providers until they are accommodated by managed care providers—probably within a year. Accordingly, we believe the contention that CIGNA may terminate its contract with the Medi-Cal Program is not, in itself, sufficient reason to approve a higher reimbursement rate.

For these reasons, we conclude that the budget proposal to offset a portion of CIGNA's stated losses due to "enhanced access" should not be approved. Consequently, we recommend that the Legislature delete from the budget $13.7 million ($6.8 million General Fund) in the current year and the same amount in 1993-94.

Better Rate-Setting Methodology Needed. We also believe, however, that a systematic review of the adequacy of the current rate-setting methodology for prepaid health plans (including CIGNA)—and other managed care arrangements—is warranted prior to the awarding of future contracts. We note, for example, that the department does not routinely update rates based on actuarial data collected for all providers. Such a review may find that some managed care providers are underpaid while others are overpaid.

We believe that the legislative deliberations on the budget are an appropriate forum for a review of the department's procedures. Accordingly, we recommend that the department report at budget hearings on a revised rate-setting methodology that can be uniformly applied to all of the various managed care arrangements before future contracts are awarded.

PHP Rate Adjustment Would Save $23 Million

We recommend that the Legislature reduce expenditures for PHP services by $46.3 million ($23.1 million General Fund) to reflect updated adjustments in the rates paid to PHPs in comparison to fee-for-service equivalents. (Reduce Item 4260-101-001 by $23.1 million.)

As discussed above, payments to a prepaid health plan for the services it provides to beneficiaries are determined by estimating the costs the Medi-Cal Program would incur if the plan's enrollees were served under the fee-for-service system. This estimate is derived by dividing total Medi-Cal costs for fee-for-service beneficiaries who match the characteristics of those enrolled in the PHP (for example, the total cost of serving AFDC-eligible women of child-bearing age in the fee-for-service system) by the total number of those beneficiaries. In addition, the department includes in the plan's rate a per-enrollee cost for administration. The sum of these cost-per-eligible figures comprises the department's estimate of the fee-for-service equivalent.

In 1990-91, the Medi-Cal Program paid PHPs a rate equal to 97 percent of the fee-for-service equivalent for each beneficiary enrolled in the plans. Plan rates have been frozen at the 1990-91 level and the budget does not reflect an adjustment for 1993-94 although the

department indicates that it may include such an adjustment in the May Revision.

Since 1990-91, however, the cost *per eligible* has gone down. This has occurred because the number of eligibles has increased at a significantly higher rate than have costs. Accordingly, the department estimates that if PHP rates for 1993-94 were computed using the same methodology as that used in 1990-91 (97 percent of the fee-for-service equivalent), total expenditures for PHP services would be reduced by about 12 percent, or about $46 million ($23 million General Fund).

The department indicates it is developing a new rate methodology for prepaid health plans that may be based on additional factors, such as "enhanced access" the department believes PHPs provide. In the absence of a revised methodology, however, we recommend that the Legislature reduce expenditures for prepaid health plan services by $46.3 million ($23.1 million General Fund) because the rates paid to such plans have not been adjusted to reflect 97 percent of costs that would be incurred if the beneficiaries were served through the fee-for-service providers.

Other Medi-Cal Program Issues

Implementation of Higher Rates for Dental Services

The budget includes funding to implement a court judgment in the matter of *Clark v. Coye,* a lawsuit on access to dental services. In its judgment, the court ordered Medi-Cal to increase its reimbursement rates from 55 to 80 percent of "usual and customary rates," effective November 1, 1992. The department estimates that the higher rates will result in increased costs of $130.3 million ($65.1 million General Fund) in the current year and $321.5 million ($160.8 million General Fund) in the budget year. The department also proposes to eliminate certain optional benefits, including adult dental services. In effect, the elimination of these benefits would offset the cost of providing the higher reimbursement rate for dental services provided to children.

Elimination of Optional Services

The department's proposal to eliminate certain optional services will place an additional burden on county indigent health programs for some of the services that are proposed to be eliminated. In addition, the department's savings estimate is probably optimistic, due to the potential for increased hospitalizations as a result of eliminating certain services. We recommend that the department provide, prior to budget hearings, a revised savings estimate and implementation plan that reflects (1) what emergency dental services will be provided, (2) what mechanism will be used to allow for the provision of those services, and (3) the potential magnitude of increased hospitalizations.

The budget assumes that the Legislature will enact legislation, effective March 1, 1993, that will result in savings of $94.8 million ($46.8 million General Fund) in the current year and $346.9 million ($172.3 million General Fund) in the budget year by eliminating the following optional service categories from coverage through Medi-Cal for most beneficiaries:

- Adult dental services.
- Medical supplies, excluding incontinence supplies. Examples are bandages and syringes for diabetics.
- Outpatient psychology services.
- Chiropractic services.
- Acupuncture services.
- Podiatry services.
- Speech and audiology services.
- Nonemergency transportation.
- Services provided at independent rehabilitation centers, including audiology, speech, occupational, and physical therapy.

The budget proposal would continue to provide these services for developmentally disabled regional center clients, children to age 21, and persons in long-term care. The department indicates that it is proposing elimination of these services solely to reduce Medi-Cal costs. (A similar proposal was included in last year's budget, and was rejected by the Legislature.)

Figure 14 lists the department's estimate of the Medi-Cal savings from eliminating each of these services and the average number of Medi-Cal beneficiaries who use these services each month.

Figure 14

Proposed Elimination of Optional Medi-Cal Services General Fund Savings 1992-93 and 1993-94

(Dollars in Millions)

Service	Average Monthly Users	Estimated Savings	
		1992-93	1993-94
Adult dental	105,000	$33.4	$130.6
Nonemergency transportation	9,358	5.7	18.5
Medical supplies	—[a]	5.8	17.1
Psychology	4,850	0.9	2.8
Acupuncture	5,542	0.5	1.6
Podiatry	6,942	0.4	1.2
Speech and audiology	553	0.1	0.4
Chiropractic	1,983	0.1	0.2
Independent rehabilitation centers	42	0.01	0.03
Totals	—[b]	**$46.8**	**$172.3**

[a] Unknown.
[b] Total monthly users cannot be estimated, since one beneficiary may use more than one optional service.

Legislature Needs Additional Information. The Legislature needs clarification of several issues in order to evaluate this proposal. First, the department's estimate of savings is incomplete, because it does not consider the potential for increased hospitalizations that may result from the elimination of certain services. Second, federal law effectively requires that certain emergency dental services continue to be provided.

Emergency Dental Services. Federal law requires Medi-Cal to provide emergency services, including services to alleviate severe pain. However, it is not clear how Medi-Cal beneficiaries could receive emergency dental treatment if, as the budget is currently proposing, Medi-Cal chooses not to pay dentists to provide these services. Dental services are not generally provided by clinics or hospitals.

Costs May Shift to Other Services. Actual savings from this proposal would depend on behavioral changes on the part of Medi-Cal beneficiaries. In some cases, elimination of optional services may result in savings. In other cases, the savings may be offset because beneficiaries may (1) substitute other Medi-Cal services for the service being eliminated or (2) delay receiving treatment and ultimately require more acute care. The extent to which cost shifts would occur for each category of service is unknown.

- *Substitution of Services.* Examples of where substitution of services could occur include psychology, podiatry, acupuncture, and chiropractic services. Beneficiaries who currently receive these services might, instead, seek physician services or increase the use of prescription drugs, thereby resulting in the substitution of one service for another. The budget estimate assumes cost shifts such as these ranging from 0 to 90 percent, depending on the service.
- *Increased Use of Acute Care.* The elimination of coverage for syringes for diabetics, for example, may result in increased hospitalizations. The budget does not assume any increase in acute hospitalizations as a result of this proposal.

Ironically, because rates for physician and hospital services are higher than those for many optional services, substitution of services or increased use of hospital care could actually *increase* Medi-Cal costs in some cases. In addition, we note that counties are the provider of last resort for health services and may experience increased demand for services they provide, to the extent that beneficiaries are unable to receive care under the Medi-Cal Program.

Recommendation. Because the Legislature needs additional information in order to evaluate this proposal, we recommend that the department provide, prior to budget hearings, a revised savings estimate and implementation plan that reflects (1) what emergency dental services will be provided, (2) what mechanism will be used to allow for the provision of those services, and (3) the potential magnitude of increased hospitalizations.

Diagnosis-Related Hospital Reimbursements Could Result in Significant Savings

We recommend that the Legislature adopt Budget Bill language directing the department and the California Medical Assistance Commission to implement a "per-discharge" or a diagnosis-related reimbursement system for hospital inpatient services. We also recommend that the department and the commission (1) develop and present at budget hearings a plan to implement this approach and (2) provide an estimate of savings that can be realized in 1993-94 and thereafter.

Medi-Cal reimburses hospitals for inpatient services provided to beneficiaries based on rates negotiated by the California Medical Assistance Commission (CMAC). Generally, hospitals are reimbursed for each day a beneficiary is hospitalized.

In some cases, however, the CMAC has negotiated a "per-discharge" reimbursement system where hospitals are paid a lump sum for treating a Medi-Cal patient, irrespective of the number of days the patient is hospitalized. Under this approach, hospitals that are able to shorten the length of time a beneficiary is hospitalized for a given condition are able to save money. When contracts with these hospitals are renewed, the CMAC sets new rates based on the average number of days beneficiaries stayed in the hospital in prior years. Accordingly, over time, the state shares in any savings that result from hospitals that are successful in reducing the lengths of stay for Medi-Cal beneficiaries who require hospitalizations.

Current Hospital Reimbursement System. Under the current system, the Medi-Cal Program reimburses hospitals on a "per day" rate. For example, in the case of pregnant women who give birth without complications, the hospital is reimbursed automatically for up to two days. If the hospital physician believes the beneficiary should stay additional days, Medi-Cal must give prior authorization or the hospital will not be reimbursed. This approach generates a very large volume of workload both for hospitals and for Medi-Cal Program Field Office staff who must review such requests, which are usually for one additional day and are rarely disapproved. Further, to the extent that hospitals seek to maximize Medi-Cal revenues, this system could act as an incentive to keep beneficiaries hospitalized for additional days.

"Per-Discharge" Approach To Hospital Reimbursements. A per-discharge or diagnosis-related reimbursement system would pay hospitals a flat rate for all deliveries, irrespective of the beneficiary's length of stay, based on the average length of stay required for all deliveries in that facility over the previous few years. Under this approach, no additional administrative workload is imposed on either the hospital or the Medi-Cal Field Office to review routine requests. More importantly, the hospitals have an incentive to *reduce* the time a beneficiary must spend in the hospital because this will result in savings "up front," and the state achieves savings as the hospital's rates are renegotiated for future years, based on the shorter average lengths of stay.

The federal Medicare Program uses a similar, though more complex, reimbursement system, in which it sets rates based on "diagnosis-related groups," or DRGs. Under a DRG system, hospitals are reimbursed based on the expected cost of providing an array of services that most likely will be required for a particular diagnosis. Again, rather than having an incentive to provide as many services as possible for a given condition in order to increase its reimbursements, hospitals have

an incentive to provide services only when an individual patient requires them.

Analyst's Recommendation. We believe that the Medi-Cal Program and the CMAC should expand the per-discharge system currently used only for a relative few hospitals. In our view, a per-discharge system could be implemented in most areas of the state beginning in 1993-94 for certain services, such as for vaginal deliveries. Further, the Medi-Cal Program and the CMAC can make use of the methodology developed by the federal Medicare Program to implement a per-discharge or DRG system statewide for most procedures in a relatively short period of time. If a fully implemented DRG system resulted in savings of 10 percent, for example, the state would realize savings of at least $130 million annually.

Accordingly, we recommend that the Legislature adopt Budget Bill language directing the department and the CMAC to implement a "per-discharge" or a diagnosis-related reimbursement system for hospital inpatient services, beginning in 1993-94. We also recommend that the department and the commission (1) develop and present at budget hearings a plan to implement this approach and (2) provide an estimate of the savings that can be realized in 1993-94 and thereafter.

The following Budget Bill language is consistent with our recommendation:

> Medi-Cal reimbursements for inpatient hospitalizations shall be made on a per-discharge basis for all new hospital contracts implemented by the California Medical Assistance Commission, beginning in 1993-94. In addition, the department and the commission shall develop a diagnosis-related group reimbursement system and shall make appropriate provisions for the staged implementation of this system in contracts it implements.

Bulk Purchases of Laboratory and Testing Services Would Save Money

We recommend that the Legislature adopt Budget Bill language directing the department to implement a selective provider contracting program for various clinical laboratory services and for durable medical equipment, for an estimated General Fund savings of about $4 million in 1993-94. (Reduce Item 4260-101-001 by $4 million.)

The Medi-Cal Program provides most services on a fee-for-service basis, which means that beneficiaries choose a provider and the provider is reimbursed by the program for any services provided. With respect to hospital inpatient services, however, the Medi-Cal Program

contracts with one or a few hospitals within a geographic area, and requires all beneficiaries to receive nonemergency inpatient services at those facilities. Consequently, Medi-Cal guarantees a large volume of patients to the designated hospitals. This approach has resulted in considerable state savings.

We believe that the Medi-Cal Program could implement a similar program to contract for durable medical equipment (such as wheelchairs and hearing aids) and certain laboratory services. The 1990 Budget Act assumed that such a program would be established, but the department indicates that staffing constraints at the time prevented its implementation. Based on information provided by the department, we estimate that a contracting program could result in General Fund savings of about $4 million in 1993-94 and $5 million annually thereafter.

Accordingly, we recommend that the Legislature adopt Budget Bill language directing the department to implement a contracting program for certain laboratory services and for durable medical equipment. Because our estimate of the savings is not precise, we also recommend that the department provide, prior to budget hearings an estimate of savings that can be realized in 1993-94 through such a program.

We recommend adoption of the following Budget Bill language in Item 4260-101-001:

> The department shall contract for laboratory services and for durable medical equipment in all geographic areas of the state where such contracting will result in savings to the program and will not pose unreasonable delays on the provision of these services to Medi-Cal beneficiaries.

Medi-Cal Subsidy of UC Hospitals Not Needed

We recommend that the Legislature adopt Budget Bill language specifying that University of California (UC) hospitals receive the minimum federal disproportionate share payments authorized under state law because (1) the facilities are profitable without such payments and (2) the budget does not assume these revenues for the UC for 1993-94. We also recommend that the Legislature use the resulting additional federal funds to make a corresponding reduction of up to $26 million from the General Fund in the Medi-Cal Program. (Reduce Item 4260-101-001 by $26 million.)

In 1991, the Legislature enacted a program to provide supplemental federal payments to hospitals that serve a large number of indigent persons. These hospitals are termed "disproportionate-share" hospitals,

and the supplemental payment program is commonly referred to as the "SB 855 Program" (Ch 279/91, Robbins). Its purpose is to provide financial support to "safety net" hospitals that would otherwise be financially threatened due to the large amount of services provided to persons who are unable to pay for them.

Under the program, counties and the UC regents transfer funds to the state which, when combined with matching federal funds, are used to provide supplemental Medi-Cal payments for inpatient hospital services provided by all disproportionate-share hospitals, including those not owned by public entities. The state retains approximately $104 million of the funds that are "transferred," and uses the rest to generate a total of $812 million in matching federal supplemental payments annually. The department estimates that the UC hospitals will receive approximately $58 million of these payments in the current year, although the UC budget projects about $44 million in 1992-93.

As we note in our analysis of the UC budget, these payments have generated a "windfall" to the three UC hospitals that receive them—those located on the Davis, Irvine, and San Diego campuses. Specifically, our review indicates that the UC hospital system is expected to generate a net gain, *not counting SB 855 revenues*, of around 4 percent, which is the level we estimate it requires for investments in physical plant and equipment. Thus, to the extent that UC receives SB 855 revenues, these amounts constitute a "windfall" to the system.

We note that the UC indicates its budget does not assume the receipt of *any* SB 855 revenues in 1993-94. In contrast, the Medi-Cal Program anticipates payments of about $58 million to the UC in 1993-94, depending on the total number of days that indigent persons stay in UC facilities.

Because the UC hospitals appear profitable without the supplemental federal payments, and because the UC system does not anticipate receipt of the payments, we believe the payments should not be made. However, due to the requirements of federal law, it appears necessary that the UC hospitals receive at least a minimal amount. (Federal law determines which facilities must receive payments, though the state has discretion to determine what the payment levels will be.)

Accordingly, we recommend that the Legislature adopt Budget Bill language specifying that disproportionate share payments to the UC hospitals be set at the minimum rate ($50 per day), or about $6.5 million. We further recommend that the Legislature make a commensurate General Fund reduction of up to $26 million in the Medi-Cal Program. A more precise estimate of the amount of savings that can be realized should be available at the time of the May Revision.

Our recommendation can be implemented through the enactment of the following Budget Bill language in Item 4260-101-001:

> For the 1993-94 fiscal year, UC hospitals shall receive the minimum federal disproportionate share payments authorized under state law, which is $50 per day. In addition, the department shall restructure county contributions to ensure that the resulting unallocated disproportionate share revenues will be transferred to the General Fund.

Elimination of "Bed-Hold" Payments Would Produce Savings

We recommend enactment of legislation repealing provisions of current law requiring the department to make payments to "hold" long-term care beds vacant during the temporary absence of a patient. We estimate the elimination of such payments would save up to $15 million annually ($7.5 million General Fund), beginning in 1993-94. (Reduce Item 4260-101-001 by $7.5 million.)

Current law requires the department to pay skilled nursing and other long-term care facilities a supplemental payment to hold open the bed of a patient temporarily transferred to an acute facility. Under regulations promulgated by the department, "bed-hold" payments are limited to seven days per transfer, and are computed based on the average rate paid to the type of facility in which the patient resides. Based on data provided by the department, we estimate that approximately $15 million ($7.5 million General Fund) will be expended for this purpose in 1993-94.

Bed-hold supplemental payments were required by the Legislature in 1982, due to concerns that nursing home patients who are temporary transferred to an acute hospital—for surgery, for example—would no longer have access to their chosen long-term care facility upon their release from the hospital. This was because, at the time, occupancy rates in nursing facilities were very high. Thus, in the absence of some form of compensation, facilities likely would incur significant revenue losses to the extent that they turned away other patients who wished to reside in the facility. Because nursing facilities were unlikely to incur such losses in order to keep open a certain number of beds, the Legislature was concerned that the absence of "return rights" for long-term care residents would disrupt the continuity of care for such patients.

Further, in situations where hospital patients were ready for discharge but were unable to return to their long-term care residence, it could be necessary to keep the patient at the hospital until an appropriate placement became available. In such cases, the state would incur significant additional costs, due to the higher reimbursement rate for hospitals. Accordingly, the state instituted a "bed-hold" payment to

offset anticipated revenue losses by nursing homes while patients received acute care.

Over the last several years, however, occupancy rates in nursing facilities have dropped significantly. At the time that the bed-hold legislation was passed, for example, nursing facility occupancy rates were in excess of 94 percent. In 1991, the last year for which data are available, they were about 86 percent. Accordingly, it is much less likely that—in the absence of a bed-hold payment—facilities will lose revenues by keeping open beds for temporarily transferred patients, since a large number of vacant beds already exist. Therefore, the expected "cost" (in the form of lost revenues) to the nursing industry as a result of the state's bed-hold requirement in most cases no longer exists.

Because conditions in the nursing facility industry have changed dramatically since the original legislative action, we believe that the Legislature should revisit this issue. Specifically, we recommend the enactment of legislation repealing the requirement that supplemental payments be provided to hold open nursing facility beds. Based on data provided by the department, we estimate that this action would result in savings of about $15 million annually ($7.5 million General Fund), beginning in 1993-94.

Alternatively, the Legislature could continue the bed-hold requirement, but could direct the department to make much lower supplemental payments—commensurate with the much lower "expected losses" of facilities holding beds vacant. A flat rate of $5 per day, for example, would result in savings of approximately $14 million annually ($7 million General Fund).

Additional Federal Reimbursements Can Be Claimed For State-Funded Services to Pregnant Women

We recommend that (1) the Legislature direct the department to claim federal reimbursements for services to pregnant women with family incomes between 185 and 200 percent of poverty because federal law authorizes such reimbursements and (2) the $7.9 million in Proposition 99 funds budgeted for these services be redirected to replace General Fund monies budgeted for programs that can be supported with Proposition 99 funds. In addition, we recommend that the department report at budget hearings on the feasibility of claiming federal reimbursement for county indigent health services and potential savings that could be achieved if these services were provided under Medi-Cal. (Reduce Item 4260-101-001 by $7.9 million.)

Under provisions of federal law, some states have recently expanded Medicaid coverage beyond the levels previously considered reimbursable. Specifically, a 1985 change in federal law allows states to implement "less restrictive criteria" for Medicaid eligibility with respect to pregnant women and children. In Minnesota, for example, this provision is being used to expand Medicaid eligibility to all children in families with incomes of up to 275 percent of the federal poverty level. In Vermont, the expansion covers all children in families with incomes to 225 percent of poverty, and pregnant women with incomes to 200 percent of poverty.

California's Medi-Cal Program currently covers pregnant women and their infants in families with incomes between 185 and 200 percent of poverty, and offsets the cost of these services entirely through Proposition 99 revenues, on the assumption that this "state-only" program is not eligible for federal financial participation. In addition, some pregnant women with incomes above 200 percent of poverty may be served through county indigent health programs, which are funded primarily by realignment revenues and county funds.

Based on the budget's estimated cost of providing Medi-Cal services to pregnant women with family incomes between 185 and 200 percent of poverty, it appears that California is eligible to receive $7.9 million in additional federal reimbursements that the department is not currently claiming. Accordingly, we recommend that the department begin claiming reimbursements for services to these beneficiaries, and that the Legislature redirect $7.9 million in Proposition 99 funds (Cigarette and Tobacco Products Surtax Fund) to replace General Fund monies budgeted for programs that can be supported with Proposition 99 funds, and make a corresponding General Fund reduction.

As noted above, some pregnant women and children may be served through county indigent health programs. However, an expansion of the Medi-Cal Program to cover these individuals may not result in net savings. This is because expanding Medi-Cal coverage to women and children with incomes above 200 percent of poverty could result in a significant increase in persons seeking publicly funded health services because Medi-Cal coverage may be broader than provided by the counties.

Accordingly, we recommend that the department report at budget hearings on the feasibility of expanding the Medi-Cal Program to cover pregnant women and children at income levels above the current eligibility thresholds, and the potential savings to state and county funds that could be achieved by providing services to these individuals through Medi-Cal rather than through county indigent health programs.

Medi-Cal Estimates Will be Updated in May

The proposed expenditures for the Medi-Cal Program are based on actual program costs through August 1992. The department will present revised estimates in May, which will be based on program costs through February 1993. In addition, the May Revision will include statutory rate increases for nursing homes and other long-term care facilities. (Data on which the long-term care rate increase is based are not yet available.) We will make additional recommendations regarding the local assistance portion of the Medi-Cal Program at that time.

PUBLIC HEALTH

The department administers a broad range of public health programs, including (1) programs that complement and support the activities of local health agencies controlling environmental hazards, preventing and controlling disease, and providing health services to populations that have special needs and (2) state-operated programs such as those which license health facilities and certain types of technical personnel.

The budget proposes $1.2 billion ($266.4 million General Fund) for public health local assistance. This represents an increase of 4.2 percent (3.7 percent General Fund) over the current year. For state operations, the budget proposes $337.7 million ($92.3 million General Fund), which is a decrease of 12 percent (7 percent General Fund) from the current year.

Direct Purchase Vaccine Program Can Save $14 Million (General Fund) Yet Plan Is Lacking

We recommend that the Legislature adopt Budget Bill language providing that (1) any savings from the direct purchase vaccine pilot program in 1993-94 be expended to implement activities to increase immunization levels pursuant to Ch 566/92 (AB 2844, Alpert) and (2) $700,000 be allocated for specified immunization activities, pending receipt of addition Maternal and Child Health federal funds in 1993-94. We further recommend that the department report at budget hearings on a plan of action indicating when the direct purchase vaccine program can be expanded and how the savings can be used.

Increasing Immunization Levels Can Be Cost-Effective. Numerous studies have found that childhood immunizations are a cost-effective way to reduce disease and offer substantial health care savings. Several

well-known studies, for example, cite benefit/cost ratios for six of the most common vaccines ranging from $1.70 in savings for every $1 expended for hepatitis "B" vaccine to $16.60 in savings for every $1 expended for measles vaccine.

Infants and Toddlers Significantly Underimmunized. Despite the cost-effectiveness of immunization, significant numbers of preschool children are not immunized. As Figure 15 shows, the department's spring 1992 survey reveals that only 48 percent of children two years old and under are immunized. The figure also reveals that immunization rates for Hispanic and Black children are below the statewide average. By contrast, because immunizations are required for school entry, most children in California have been appropriately immunized by the time they begin kindergarten. Approximately 92 percent of kindergarten students received all required vaccines annually from 1987 through 1991.

Figure 15

Percent of Children with Up-to-Date Immunization at Age Two 1992

	Percent Immunized
White	58%
Asian	56
Black	44
Hispanic	36
Southeast Asian	21
Total average	**48%**

Source: Department of Health Services, Immunization Unit, Retrospective Survey, spring 1992.

Any decline in immunization rates can lead to the increased risk of disease outbreaks, permanent disability, and death. Our review of the literature indicates that the primary reasons for underimmunization among preschool children include: (1) inadequate outreach to underserved populations, (2) public clinic immunization services have not kept pace with the growth in young and low-income populations, and (3) inadequate networking between programs that provide immunization services and other programs that serve families with young children. We discuss resources to address these efforts below.

State's Current Role in Immunization Delivery System. The department administers four programs that provide immunization-related services: (1) the California Immunization Program, (2) the Child Health and Disability Prevention (CHDP) Program, (3) the Medi-Cal Program,

and (4) the Maternal and Child Health (MCH) Program. Under the California Immunization Program, the department (1) purchases and distributes vaccines to local health departments for use in public clinics, (2) assesses and monitors immunization levels of the population, and (3) provides immunization education and promotion. The majority of these activities are federally funded. The Medi-Cal and CHDP programs provide immunizations to low-income children generally through private medical providers. The state reimburses these providers for the cost of the vaccine and its administration. These services are funded by the General Fund, federal funds, and the Cigarette and Tobacco Products Surtax (C&T) Fund.

In addition, federal funds for the MCH Program are used to support (1) hepatitis "B" immunizations for the CHDP Program and (2) special one-time only outreach activities for 1992-93. The MCH Program has as a goal for the year 2000 to increase to 90 percent the proportion of infants and toddlers who are up-to-date on immunizations.

The Direct Purchase Vaccine Program. Chapter 1111, Statutes of 1992 (AB 3354, Gotch) requires the department to purchase vaccines in bulk for use in the Medi-Cal and the CHDP programs. To meet these requirements, the department proposes to contract with manufacturers for vaccines at prices equivalent to prices offered to the state under the California Immunization Program for public clinics, plus a handling fee. These prices will be substantially lower than the prices currently paid by the state under the Medi-Cal and CHDP programs. The manufacturers would distribute the vaccines to medical providers, based on the providers' prior usage. The providers would receive the vaccine for free and would obtain reimbursement from the state for the cost of administering the vaccine.

Chapter 1110, Statutes of 1992 (AB 3351, Gotch), a companion bill to Chapter 1111, requires the department to use savings achieved from the direct purchase program for increasing immunization levels through increased provider (such as physicians and public clinics) participation, community outreach, and access to services. The savings are to be used to supplement, and not supplant, existing state and local funds.

The department states that a direct purchase pilot program will be in place by July 1993 for a measles, mumps, and rubella (MMR) vaccine. The department indicates that the contract with the vaccine manufacturer will be completed in May 1993 and shipments to providers will begin by July 1, 1993. As Figure 16 shows, the department estimates that $1.9 million (93 percent General Fund and 7 percent C&T Fund) in savings will be achieved annually from the pilot program (MMR

vaccine), once fully implemented; but the budget assumes *no* savings in 1993-94.

The department states that though they anticipate savings to occur in 1993-94, they are uncertain what level of savings can be achieved because they must (1) determine the volume and schedule of vaccine shipments with the manufacturer, based on provider's vaccine needs, and (2) evaluate how the pilot program progresses.

While we cannot provide a precise estimate of savings at this time, it seems reasonable to anticipate some level of savings and to plan for this eventuality. If, for example, we were to assume that 50 percent of the estimated annualized savings could be realized in 1993-94, we would have an additional $950,000 (93 percent General Fund and 7 percent C&T Fund) available for expenditure. We believe this level of savings is achievable because (1) the pilot program will be operational beginning July 1, 1993 and (2) the contractor is the nationwide sole source manufacturer of MMR vaccine and is operating similar direct purchase vaccine programs with six other states.

Figure 16

Potential Annual Savings From Direct Purchase Vaccine Program

(In Millions)

	Current Annual Cost	Direct Purchase Annual Cost	Potential Savings	
			Total[a]	General Fund and C&T Fund
Oral polio	$10.4	$3.5	$6.9	$4.8
Diphtheria	12.5	8.4	4.1	2.9
Hepatitis "B"	5.7	4.4	1.3	0.9
Measles/mumps/rubella (MMR)	8.7	6.0	2.7	1.9
Hemophilus influenza type B	11.4	5.8	5.6	3.9
Totals	**$48.7**	**$28.1**	**$20.6**	**$14.4**

[a] Total potential savings reflect 30 percent federal funds, 65 percent General Fund, and 5 percent C&T Fund monies.

Source: Department of Health Services, January 1993.

Program Expansion Potential for 1993-94. The department states that there is no schedule for developing contracts with other manufacturers of vaccines until after the pilot has been implemented and evaluated. However, because the department (1) has already accomplished many

administrative functions required to implement the program without any additional positions and (2) is requesting two new positions for 1993-94, we do not see any reasons why contracts with additional vaccine manufacturers cannot be implemented in 1993-94. Moreover, we note that the amount of savings that can be achieved from just one additional contract is significant. For example, if 50 percent of the annual doses for oral polio vaccine can be purchased under the program, an estimated savings of $2.4 million in state funds can be obtained.

Analyst's Recommendation. In order to address the problem of underimmunization in California, particularly for infants and toddlers, we make the following recommendations:

- ***Use Savings to Enhance Immunization Levels.*** Our analysis indicates that the direct purchase vaccine pilot program will result in savings that are not reflected in the budget. Because of the documented cost-effectiveness of immunizations and the low level of immunizations of children ages three and under in California, we recommend that the Legislature adopt Budget Bill language requiring that savings from the direct purchase vaccine pilot program in 1993-94 be expended to implement activities to enhance immunization levels, pursuant to Ch 566/92 (AB 2844, Alpert). This statute directs the department to establish an immunization outreach program if funds are available. The purpose of the outreach program would be to focus on childhood populations that are most at risk of not being adequately immunized, with priority being given to children at and under three years of age. We believe this is consistent with the requirements of Chapter 1110 (regarding the use of savings from the direct purchase vaccine program) and would be a cost-effective way to target the funds.

- ***Continue MCH Funding in 1993-94.*** The budget does not propose to continue $700,000 (MCH federal funds) allocated to the department in 1992-93 to improve access to immunizations by expanding community and public clinic hours, purchasing supplies, and conducting community outreach. Based on recent experience, however, we anticipate that *additional* MCH federal funds will be available later in the year. Thus, we believe that (1) funds will be available to continue this effort and (2) doing so would be consistent with the MCH "year 2000" objective of increasing to 90 percent the proportion of infants and toddlers who are up-to-date on immunizations. Consequently, we recommend that the Legislature adopt Budget Bill language providing that the first $700,000 in MCH federal funds received

in excess of the January budget estimate be allocated toward continuation of the current immunization activities.

- *Report at Budget Hearings.* In order to address the possibility that expansion of the direct purchasing program will result in additional savings in 1993-94, we recommend that the department report at budget hearings on a plan of action indicating (1) when contracts with other manufacturers of vaccines can be implemented, (2) what level of savings can be achieved in 1993-94, and (3) how the additional funds can be used to improve immunization levels.

The following Budget Bill language is consistent with the above recommendations:

(1) **Use of Savings (Item 4260-101-001):**

Savings realized from the direct purchase vaccine program shall be expended to implement activities to increase immunization levels, pursuant to Chapter 566, Statutes of 1992.

(2) **Continue MCH Funding (Item 4260-111-890):**

To the extent that additional Maternal and Child Health federal funds are received, $700,000 will be used to provide immunizations to children in local health jurisdictions with low immunization rates. These funds may be used to pay for all efforts associated with increasing immunization levels in children, including staff, medical supplies, and outreach.

Options For Reducing General Fund Costs Without Reducing Program Services in the CHDP Program

We present two options for reducing General Fund support of the CHDP Program without affecting program services: (1) purchase Hepatitis B vaccine through the direct purchase vaccine program and (2) redirect MCH federal funds for the purchase of the vaccine.

Background. The CHDP Program is a public health program for the early detection and prevention of diseases and disabilities in children and young adults under the age of 21. The CHDP (1) reimburses providers for health assessments (such as physical examinations, nutritional, and dental assessments, vision and hearing tests, and immunizations) and (2) provides funding to public health departments for case management and resource development. The CHDP is funded by the General Fund, the C&T Fund, MCH federal funds, and the Childhood Lead Poisoning Prevention (CLPP) Fund.

The budget proposes a total of $79.2 million ($39.3 million General Fund, $34 million C&T Fund, $5.4 million MCH federal funds, and $500,000 CLPP Fund) in 1993-94 for local assistance. This is an increase of $11 million ($5.9 million General Fund and $5.1 million C&T Fund), or 12 percent, over the current year. The proposed increase is due to (1) a 9.8 percent increase in health assessments and (2) the full-year cost of administering Hepatitis B vaccine.

Options for Reducing General Fund Costs Without Reducing Services. We believe that the following options are available to reduce General Fund support in the program without reducing program service levels:

- ***Direct Purchase of Hepatitis B Vaccine.*** The budget proposes total expenditures of $7 million in state funds ($2.9 million General Fund, $400,000 C&T Fund, and $3.7 million MCH federal funds) for the provision of the Hepatitis B vaccine in 1993-94. This assumes a cost of $17.91 per dose of vaccine, which consists of the cost of the vaccine ($13.39) and administration ($4.52). This would provide immunization shots for an estimated 490,000 children.

  As we discuss in our analysis of the direct purchase vaccine program, the department will have a direct purchase pilot program for the MMR vaccine in operation by July 1, 1993. We also recommend in our analysis that the department report on a plan to implement a direct purchase arrangement for other vaccines, including the Hepatitis B vaccine. Based on data provided by the department, we estimate that direct purchase of the vaccine could result in a savings of up to $1.5 million in the CHDP Program.

- ***MCH Federal Funds.*** A total of $3.7 million in MCH federal funds is budgeted in the current and budget years for the CHDP Program's Hepatitis B vaccine. The Legislature could redirect MCH federal funds from other MCH programs to reduce General Fund expenditures in the CHDP Program. We note, for example, that the budget proposes $1.3 million in MCH federal funds for various data management projects in the MCH Program.

Therefore, if both of these options are taken, a savings of $2.8 million (General Fund) could be achieved.

Proposition 99 Programs: Declining Revenues Result in Program Reductions

Because of the methodology used to calculate pro rata reductions when C&T Fund revenues are declining, some Proposition 99 programs will be impacted more heavily than others. (We discuss other programs funded by the C&T Fund in our analysis of the County Medical Services Program and the Access for Infants and Mothers Program.)

Background. Proposition 99 of 1988, the Tobacco Tax and Health Protection Act, established a surtax on cigarettes and tobacco products. The proposition allocates specified percentages of the revenues to six accounts: (1) Health Education (20 percent), (2) Hospital Services (35 percent), (3) Physician Services (10 percent), (4) Research (5 percent), (5) Public Resources (5 percent, nonhealth related), and (6) Unallocated (25 percent). The act requires that revenues allocated to the six accounts be spent for specified purposes, and also requires that the funds be used to supplement and not supplant services.

Chapter 278, Statutes of 1991 (AB 99, Isenberg) and Ch 1170/91 (SB 99, Watson) appropriated the C&T Fund monies for three fiscal years (1991-92, 1992-93 and 1993-94) primarily to fund various health programs. However, in the event of insufficient C&T Fund revenues, Chapter 278 authorizes the Department of Finance (DOF) to reduce appropriations on a pro rata basis, except for five specific programs, which are either caseload driven or are otherwise exempt from reductions. Chapters 278 and 1170 will sunset on June 30, 1994 unless extended.

Figure 17

Proposition 99 Programs[a] Pro Rata Reductions for 1993-94

(Dollars in Thousands)

	Statutory Appropriations	Pro Rata Reductions	Revised Amounts[b]	Total Percent Pro Rata Reduction From Statutory Appropriations
Health Education Account	**$123,844**	**$16,289**	**$105,965**	**13.2%**
State Department of Education (SDE) administration	900	168	732	18.7
SDE County Offices of Education	2,000	374	1,626	18.7
SDE local assistance	24,300	4,539	19,761	18.7
Department of Health (DHS) administration	1,178	220	958	18.7
Media campaign	16,000	2,989	13,011	18.7

Continued

	Statutory Appropriations	Pro Rata Reductions	Revised Amounts[b]	Total Percent Pro Rata Reduction From Statutory Appropriations
Child Health Disability Prevention Program	35,646	—	34,056	—
Competitive grants	15,820	2,955	12,865	18.7
Tobacco Oversite Committee	2,300	430	1,870	18.7
Local lead agencies	24,700	4,614	20,086	18.7
Perinatal services/Medi-Cal	1,000	—	1,000	—
Hospital Services Account	**193,273**	**14,296**	**178,977**	**7.4**
Children's hospitals	1,422	127	1,295	8.9
County Medical Services Program (CMSP) expansion	4,961	—	4,961	—
California Health Care for Indigents Program (CHIP)	153,752	13,706	140,046	8.9
County medical services/managed counties	1,650	147	1,503	8.9
Rural health services	1,807	161	1,646	8.9
DHS administration	1,268	113	1,155	8.9
Perinatal services/Medi-Cal	5,000	—	5,000	—
Office of Statewide Health Planning and Development	474	42	432	8.9
Major Risk Medical Insurance Board (MRMIB)	18,000	—	18,000	—
Access for Infants/Mothers (AIM)	4,939	—	4,939	—
Physicians Services Account	**62,194**	**8,483**	**53,711**	**13.6**
Clinic grants	3,438	1,085	2,353	31.6
Perinatal services/Medi-Cal	8,646	—	8,646	—
CMSP expansion	1,986	—	1,986	—
CHIP	21,831	6,888	14,943	31.6
Rural health services	1,189	375	814	31.6
DHS administration	428	135	293	31.6
MRMIB	11,000	—	11,000	—
AIM	13,676	—	13,676	—
Unallocated Account	**122,215**	**8,871**	**111,885**	**7.3**
Clinic grants	13,123	1,662	11,461	12.7
Perinatal services/Medi-Cal	9,700	—	5,641	—
CMSP expansion	2,471	—	5,071	—
CHIP	50,721	6,424	44,297	12.7
Rural health services	1,177	149	1,028	12.7
DHS administration	4,523	573	3,950	12.7
SDE local assistance	500	63	437	12.7
MRMIB	1,000	—	1,000	—
AIM	39,000	—	39,000	—

[a] The Research Account and Public Resources Account are not affected by the pro rata reductions.
[b] The revised amount includes caseload adjustments of (1) a reduction of $1.6 million in the CHDP Program, Health Education Account and (2) a reduction of $1.5 million overall to the Unallocated Account.

Declining Revenues Result in Reductions for Second Year. Figure 17 shows how each C&T Fund account and program are proposed to be reduced in the budget year. Because of declining revenues, the budget

proposes a reduction of $47.9 million from the C&T Fund, or about 10 percent of the 1993-94 statutory appropriation, pursuant to Section 43 of Chapter 278. This is the second year of pro rata reductions. As the figure shows, some program accounts receive a greater pro rata reduction than others as a result of the rate reduction methodology.

Pro Rata Reduction Methodology. In applying the pro rata reductions per Section 43, the DOF (1) calculates the 1993-94 revenues available for each C&T Fund account according to Proposition 99, (2) establishes a fund reserve (2 percent is used in 1993-94), (3) provides sufficient funding for the five programs protected from pro rata reductions—Access for Infants and Mothers (AIM), the Medi-Cal perinatal program, the Major Risk Medical Insurance Program, the CHDP Program, and the County Medical Services Program (CMSP)—and (4) allocates remaining funds proportionately to all other programs in the account.

For example, under current law, the total appropriation for the Hospital Services Account should be $193.3 million. However, as a result of declining revenues only $179 million is available for allocation in 1993-94, after setting aside a 2 percent reserve. Therefore, a pro rata reduction of $14.3 million is needed to balance the revenues with the appropriation.

Because the Hospital Services Account funds four programs that are protected from pro rata reductions, the remaining four programs and related state administration activities in the account—Children's Hospitals, the California Health Care for Indigents Program (CHIP), County Medical Services for Managed Counties, the Rural Health Services Program, and state operations costs for the Department of Health Services (DHS) and the Office of Statewide Health Planning and Development (OSHDP)—must absorb the pro rata reduction for the entire account.

The Legislature has not undertaken a comprehensive review of how Proposition 99 funds are allocated since 1991. Given the trend of declining Proposition 99 revenues, it may not be viable to continue to fund Proposition 99 programs as currently required. Consequently, the Legislature may wish to consider changes in the way these funds are allocated. For example, new priorities could be established to supplement services where General Fund reductions had a significant impact or where services are known to reduce future state costs (such as primary care clinic services and family planning services). Another alternative—within the existing framework—would involve changing the pro rata methodology to exempt fewer (or no) programs from

reductions in order to provide more funds for the existing nonexempt programs.

Budget Proposes Significant Reductions in the County Medical Services Program (CMSP)

We recommend that the department report during budget hearings on what effect the overall reductions to the CMSP will have on indigent health care services and how the unallocated reductions proposed for the CMSP will be taken.

Background. Legislation enacted in 1982 transferred responsibility for the medically indigent adult (MIA) population from the Medi-Cal Program to the counties. State funding was subsequently provided through two programs—the Medically Indigent Services Program (MISP) and the CMSP. Generally, under the MISP, large counties received most of their funding from the state (primarily block grant and AB 8 funds) but administered their own programs. Under the CMSP, counties with populations under 300,000 could choose to contract with the state to administer their medically indigent adult programs (see Figure 18). Historically, the CMSP paralleled the Medi-Cal Program, generally offering the same medical benefits.

Figure 18

Counties Participating in the County Medical Services Program 1992-93

Alpine	Humboldt	Mariposa	Sierra
Amador	Imperial	Mendocino	Siskiyou
Butte	Inyo	Modoc	Solano
Calaveras	Kings	Mono	Sonoma
Colusa	Lake	Napa	Sutter
Del Norte	Lassen	Nevada	Tehama
El Dorado	Madera	Plumas	Trinity
Glenn	Marin	San Benito	Tuolumne
		Shasta	Yuba

Funding of the CMSP. In 1991-92, realignment legislation repealed the MISP but retained the CMSP. Funding responsibility for the CMSP generally shifted to counties, with revenues generated from vehicle license fees and sales taxes (deposited into the Local Revenue Fund) serving as the primary funding source. However, the state continued to

have fiscal responsibility for program costs that exceeded the growth in county realignment revenues.

The state's fiscal responsibility was modified in 1992. Chapter 722, Statutes of 1992 (SB 485) limited the state's General Fund responsibility for CMSP in 1992-93 and future years to $20.2 million, which was the estimated amount of General Fund support needed for the program in 1991-92. This "cap" resulted in General Fund savings to the state of $16.4 million in 1992-93. Thus, beginning in 1992-93, any CMSP costs above the cap will (absent other appropriations) be the responsibility of the counties participating in the program.

As a result of these changes, funding for the CMSP is primarily provided now through (1) realignment revenues, (2) the General Fund ($20.2 million), (3) C&T Fund revenues, which are Proposition 99 funds, (4) CMSP county participation fees, and (5) State Legalization Impact Assistance Grant (SLIAG) funds.

Funding Reductions In the Current and Budget Years. As Figure 19 shows, the budget assumes significant program reductions in the current and budget years for the CMSP in order to adjust for shortfalls in revenues (primarily realignment) and increasing program expenditures. The budget assumes a total reduction of $24.7 million in the current year and $54.5 million for the budget year. In the current year, the budget estimates that the program reductions would not be sufficient to avoid a deficit of roughly $2.9 million; so the budget proposes a $2.9 million loan from the General Fund, to be repaid in 1993-94. We discuss the proposed reductions below.

Funding Reductions Likely to Reduce Access to Services. The largest reduction for both years is a 30 percent reduction in inpatient provider payments (excluding the seven CMSP county hospitals), implemented on November 1, 1992. This reduction is projected to save $18.7 million in 1992-93 and $32.1 million in 1993-94. With this reduction, CMSP inpatient rates are 70 percent of the corresponding Medi-Cal rates. While the information is anecdotal, we understand that a few hospitals may decide not to accept CMSP patients on a nonemergency, inpatient basis unless the county agrees to pay for certain additional costs. We note that refusal to accept patients on this basis may violate state and federal regulations.

The CMSP also implemented a 5 percent rate reduction for outpatient providers, effective November 1, 1992, and a reduction in dental rates (for specified procedures) and benefits, effective February 1, 1993. With these reductions, (1) outpatient provider rates are 5 percent less than the Medi-Cal Program and (2) dental rates, depending on the procedure, will either be at the *Clark v. Coye* lawsuit settlement rates or from 30 to

70 percent less than the *Clark v. Coye* lawsuit settlement rates. (In *Clark v. Coye*, the court ruled that Medi-Cal Program dental rates must be 80 percent of the "usual and customary" rate, effective November 1, 1992. The *Clark v. Coye* decision does not directly address dental rates paid under the CMSP.)

Figure 19

County Medical Services Program Proposed Reductions 1992-93 and 1993-94

(Dollars in Thousands)

	1992-93	1993-94
Baseline expenditures	$154,511	$179,091
Reductions		
30 percent inpatient rate reduction	-$18,658	-$32,106
5 percent outpatient reduction	-1,062	-1,855
Eligibility reduction	-1,500	-1,500
Hospital settlements and recoupments	-1,000	-1,000
Unallocated reduction	-1,000	-15,230
Recovery project	-500	-500
Proposition 99 caseload reduction	-985	-2,272
Total reductions	**-$24,705**	**-$54,463**
Percent reduction from baseline expenditures	-16%	-30%
Proposed expenditures	$129,806	$124,628
Total revenues	**$126,881**	**$127,553**
General Fund loan and repayment[a]	$2,925	-$2,925

[a] The budget proposes a loan from the General Fund in 1992-93 and assumes repayment in 1993-94.

The range of dental benefits were also reduced. Generally, routine procedures, other than teeth cleaning, were eliminated. The revised benefits basically cover procedures that alleviate pain and suffering, such as abscess draining and teeth removal. (We note that the budget proposes to eliminate adult dental services in the Medi-Cal Program in 1993-94.)

The budget also assumes unallocated reductions of $1 million in 1992-93 and $15 million in 1993-94. At the time this analysis was prepared, it was unknown how these reductions will be taken and how they will affect indigent health benefits and program service.

These reductions, in conjunction with other reductions for program administration, most likely will result in fewer providers participating

in the program. If providers discontinue participation in the program, indigents' access to health care will diminish.

In order for the Legislature to have sufficient information to assess the impact that the proposed reductions will have on the CMSP, we recommend that the department report at budget hearings on how the counties would address the unallocated reductions and the potential effect that the reductions, in total, would have on indigent health care services.

What Can Be Done To Maintain A Viable CMSP?

Given declining revenues and increasing program expenditure requirements for the CMSP, the Legislature should consider restructuring the program. We discuss both short-term and long-term options for accomplishing this.

As we indicated above, revenues to support the CMSP are projected to fall significantly below projected baseline expenditures in the current and budget years. In order to accommodate this shortfall, the Administration has proposed significant expenditure reductions for the program. In this section, we discuss short-term and long-term options for restructuring this program given these revenue shortfalls.

Short-Term Options. We present three short-term options to provide additional revenue sources for the CMSP. The first two options are discussed in detail elsewhere in this *Analysis*: (1) increase the level of C&T Fund appropriations for the CMSP (see our analysis of the AIM Program) and (2) increase the General Fund cap to the revised 1991-92 expenditure amount—an additional $1.8 million (see the following issue).

The third option is to reduce the size of the program so the state operates the CMSP for only a few small counties. This would concentrate the state revenues where needs are greatest. Because it can be difficult for small rural counties to provide indigent health care, this option would increase the level of state assistance for these counties to help them provide basic health care. Under this option, the larger CMSP counties—for example, Solano, Sonoma, Napa, and Mendocino—would not receive General Fund support. They would have to design and operate their own indigent health care programs, operating as independent counties or forming consortia with other counties.

Long-Term Options. The state does not have a uniform policy in assigning responsibility for providing indigent health care services in California. Generally, in large counties, the county is responsible for making the programmatic decisions for providing these services.

However, in small counties the state plays a major role through the CMSP (and, in addition, provides some level of General Fund support). This can result in corresponding variations in the provision of services.

This difference in program responsibility and the significant program reductions and revenue shortfalls since 1991-92 suggest a need to restructure the CMSP and indigent health care in general. We address this issue in our analysis of state/local restructuring in our companion document, *The 1993-94 Budget: Perspectives and Issues.* In this analysis, we suggest that indigent health care be a state responsibility, funded primarily by the General Fund. We believe that state intervention is needed to ensure that certain minimum service levels are provided for income maintenance and basic health care programs. Under the existing system, counties provide widely differing service levels for indigent health care and—as we indicated above—are coming under increasing pressure to reduce access to services. We conclude that it is impossible to achieve, effectively, the basic objective of these programs—redistributing income—without state-level control and funding.

Finally, if counties develop successful managed care arrangements, as proposed in the department's draft strategic plan for managed care in the Medi-Cal Program, the Legislature should consider such an approach for indigent health care. We discuss managed care in detail in our analysis of the Medi-Cal Program.

General Fund Support in CMSP Raises Question of Legislative Intent

Current law provides that General Fund support for the CMSP shall be $20.2 million in 1992-93 and annually thereafter; but it is not clear whether the Legislature intended to maintain General Fund support for the program at this specified amount or at the actual 1991-92 level of spending, which was subsequently revised to $22 million. Consequently, we recommend that the Legislature clarify its intent.

Background. Under realignment legislation, enacted in 1991-92, the funding responsibility of the CMSP generally shifted to counties, with revenues generated from vehicle license fees and sales taxes (deposited into the Local Revenue Fund) serving as the primary funding source. The state, however, continued to have fiscal responsibility the program costs that exceeded the growth in county realignment revenues.

This fiscal responsibility was modified by Chapter 722. Chapter 722 limited the state's responsibility for funding CMSP expenditures in 1992-93 and subsequent years to $20.2 million, which, at the time, was

the estimated amount of General Fund support needed for the program in 1991-92. Thus, beginning in 1992-93, any CMSP costs above the General Fund cap will (absent other appropriations) be the responsibility of the counties participating in the program.

Expenditures For 1991-92 Revised to $22 Million. Because there is an 18-month time period for processing claims and providing reimbursement, the expenditures for 1991-92 were revised in December 1992. Based on this revision, the Department of Finance submitted a deficiency authorization to the Legislature for $1.8 million from the General Fund to meet the revised 1991-92 expenditure estimate ($22 million).

The budget proposes $20.2 million from the General Fund for the CMSP in 1993-94. While this complies with the specific language of Chapter 722, it may not be consistent with legislative intent, depending on whether the intent was to maintain General Fund support at a specified amount ($20.2 million) or at the actual 1991-92 level, which based on more recent information is estimated at $22 million. Consequently, we recommend that the Legislature clarify its intent regarding this issue.

Current Trends in the AIDS Epidemic and Their Implications for Prevention Programs

We recommend that the department release the Office of AIDS (OA) education and prevention evaluation report prior to budget hearings to assist the Legislature in its review of the proposed budget for human immunodeficiency virus (HIV) education and prevention. Because the AIDS epidemic continues to increase, and the budget proposes no changes to HIV education and prevention efforts, we further recommend that the Legislature use a portion of the MCH federal funds for HIV education and prevention efforts.

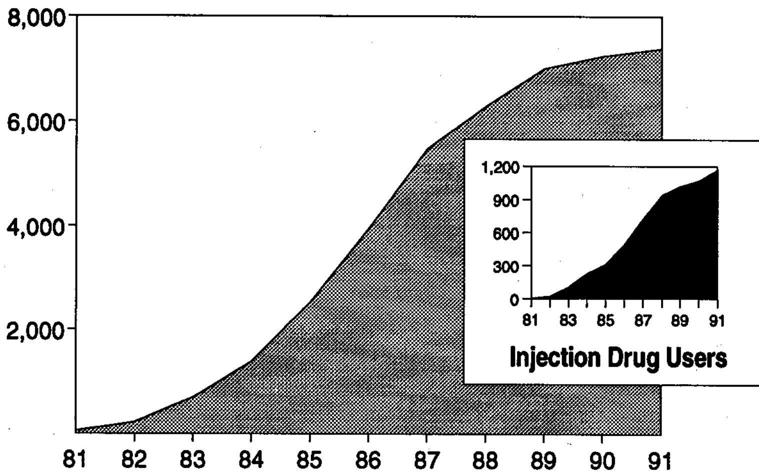
Responding to AIDS has been described as the nation's number one public health priority. AIDS results from infection with the HIV, typically acquired six to ten years previously. The primary modes of HIV transmission include (1) sexual contact, (2) contact with blood, primarily through needle-sharing, and (3) maternal transmission to fetus or infant.

The AIDS Epidemic Has Changed in California. As of January 1, 1993, almost 47,700 Californians had been diagnosed with AIDS and almost 34,000 have died. This is 8,200, or 21 percent, more diagnosed cases than had been reported one year earlier. California accounts for 20 percent of all reported AIDS cases in the United States. Figure 20

shows the annual number of new AIDS cases by year of diagnosis. The OA estimates that 150,000 individuals, or roughly 1 out of every 200 persons in California, may be infected with HIV but not diagnosed as having AIDS.

Figure 20

New Aids Cases in California 1981 Through 1991



Department of Health Services, Office of AIDS, November 1992.

The primary mode of HIV transmission continues to be from unprotected sexual contact by gay and bisexual men, which accounted for over 72 percent of new AIDS cases in 1992. The incidence of new AIDS cases in gay and bisexual men has been gradually declining since 1987 according to OA data. However, because of high risk behaviors, the AIDS epidemic in California has expanded to additional populations, including:

- ***Injection Drug Users.*** The number of reported AIDS cases attributable to injection drug use is increasing both in absolute numbers (see inset on Figure 20) and as a percentage of new AIDS cases. Of the estimated 150,000 persons with HIV infection, about 13,000 are estimated to have contracted the disease through injection drug use alone. Injection drug use is the leading cause of HIV transmission for heterosexual and perinatal HIV infection.

Surveys of out-of-treatment drug addicts in selected geographical areas of San Francisco, Richmond, and Oakland show HIV infection rates at more than 15 percent. Though other geographic regions probably do not have infection rates as high as these, it is estimated that nine out of ten addicts are *not* in treatment in any single year. Accordingly, unless efforts are taken to mitigate the spread of HIV infection for injection drug users and out-of-treatment addicts, it is likely that HIV infection rates will continue to increase significantly.

- ***Ethnic and Racial Groups.*** The incidence of AIDS continues to increase in all ethnic and racial groups other than whites. In 1992, the number of new AIDS cases among Blacks increased 17 percent over the previous year, and for Hispanics there was an increase of almost 10 percent. In comparison, the number of new AIDS cases among Whites generally remained the same.

The Cost of the AIDS Epidemic. Current trends indicate that by the end of 1993, death from AIDS may be the leading cause of "lost years of life" (see Figure 21). This is because HIV infection is continuing to grow and AIDS predominantly occurs in young adults.

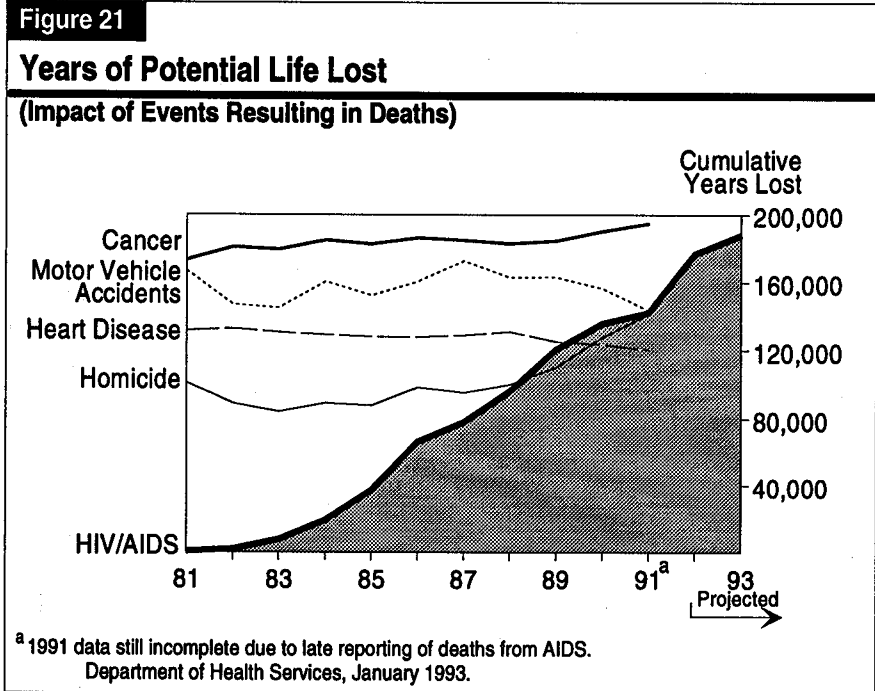


Figure 21

Years of Potential Life Lost

(Impact of Events Resulting in Deaths)

[a] 1991 data still incomplete due to late reporting of deaths from AIDS.
Department of Health Services, January 1993.

The federal Department of Health and Human Services (DHHS) estimates that the average yearly cost of treating a person with AIDS is $38,000 and the average yearly cost of treating a person with HIV, but who has not yet developed AIDS, is $10,000. The DHHS also estimates that the lifetime cost of treating a person with AIDS from diagnosis until death is $102,000. Using these estimates, the 47,700 Californians diagnosed with AIDS may represent total lifetime costs of roughly $5 billion. In the Medi-Cal Program, it is estimated that HIV-related illnesses will account for expenditures of $140 million in the current year.

Given the high cost of treating HIV infection and AIDS, education and prevention programs that have even limited success in preventing infection would be very cost-effective. For example, if the proposed $18.1 million ($15.1 million General Fund) for OA prevention and education efforts have the effect of preventing AIDS in less than 1 percent of the estimated 400,000 people who would receive these services, it is likely that the cumulative savings would more than offset the costs.

Education and Prevention Efforts. Public health experts believe that to be effective, prevention programs need to (1) be guided by surveillance (for example, tracking the incidence and prevalence of AIDS) and epidemiological studies, (2) focus on high-risk behaviors and the needs of individuals and the community, (3) be outcome oriented, and (4) use strategies that affect long-term behavioral change.

Within the OA, education and prevention efforts include (1) primary education and prevention projects ($18.1 million all funds, $15.1 million General Fund), (2) HIV testing and counseling ($9.8 million all funds, $8.3 General Fund), and (3) early intervention projects ($2.5 million General Fund). General Fund support has essentially remained at the same baseline level since 1990-91, with the exception of a one-time expenditure of an additional $4 million in 1991-92 for HIV testing and counseling. The projected level of federal funds for prevention efforts reflects a reduction of almost 29 percent since 1991-92. Other state departments also fund some education and prevention efforts to mitigate the spread of HIV infection, including the Department of Mental Health, the Department of Corrections, the State Department of Education, and the Department of Alcohol and Drug Programs (DADP). (The majority of these other efforts are concentrated within the DADP. We discuss their efforts in the section on crosscutting issues.)

The goals of these education and prevention efforts are to (1) prevent HIV transmission, (2) promote the development of individual risk

reduction skills, and (3) change community norms that may sanction risk-taking behaviors such as unprotected sex and needle sharing.

The department indicates that a majority of the OA's primary education and prevention funds in 1993-94 ($11 million) will be disseminated through a competitive request-for-proposal (RFP) process to local health jurisdictions, community-based organizations, and service provider groups. The RFP focuses on several high-risk groups, including (1) gay and bisexual men, (2) substance abusers, and (3) other persons at high risk of infection. The OA has restructured the 1993-94 RFP process to reflect recent surveillance and epidemiology information. To date, over 300 applicants have submitted proposals.

Evaluation Completed But Not Released. A key question facing the Legislature is whether education and prevention efforts funded by the OA could be made more effective. In order to address this question and to respond to the *Supplemental Report of the 1990 Budget Act,* the OA conducted a collaborative evaluation with the Institute for Health Policy Studies at the University of California, San Francisco. This evaluation was completed in December 1992.

At the time our analysis was prepared, this evaluation had not yet been released despite repeated requests by our office. The evaluation should contain specific recommendations for improving the present education and prevention efforts as well as information on what efforts are working. This information is critical for the Legislature in determining how to allocate education and prevention funds in the budget year. Consequently, we recommend that (1) the Legislature direct the department to release the evaluation report for legislative review and (2) the department report at budget hearings on how it will implement the evaluation's recommendations in 1993-94.

More Funds Needed For Education and Prevention Efforts. As we indicated earlier, funding for HIV education and prevention efforts potentially can be a very cost-effective approach to mitigating the AIDS epidemic.

One potential source of funds for these efforts is the federal MCH block grant. Based on the experience of the last several years, we anticipate that additional funds (beyond the budgeted level) will be forthcoming later in the year—potentially about $3 million. We believe that utilization of the MCH federal funds for HIV education and prevention is consistent with the department's MCH "year 2000" objective of reducing the prevalence of HIV infection among women. Consequently, we recommend that the Legislature use existing or new MCH federal funds for HIV prevention efforts. We suggest that these MCH federal funds be spent according to specific criteria, including

surveillance and epidemiologic data and high risk behaviors in order to focus these resources where the needs are greatest.

Consolidation of Primary Care and Family Planning Administrative Units Would Avoid Duplicative Activities

We recommend that the department consolidate the Primary and Rural Health Care Systems (PRHCS) Branch with the Office of Family Planning (OFP) for a savings of $1.6 million ($1.3 million General Fund, $300,000 C&T Fund). We further recommend that (1) the $1.3 million in General Fund monies be deleted from the 1993-94 budget and (2) the $300,000 in C&T Fund monies be directed to replace General Fund monies budgeted for health programs that are eligible for C&T Fund support. (Reduce Item 4260-001-001 by $1.3 million and reduce Item 4260-111-001 by $300,000.)

Background. The PRHCS Branch and the OFP in the DHS provide funds to nonprofit clinics for the provision of health care services.

Under the PRHCS Branch, the department provides funds to nonprofit primary care clinics through four separate programs—the Expanded Access to Primary Care Services Program, the Seasonal Agricultural and Migratory Workers Health Program, the Indian Health Program, and the Rural Health Services Development Program. For 1993-94, the budget proposes a total of $3.7 million for state operations ($1.5 million General Fund, $900,000 C&T Fund, $1 million federal funds, and $300,000 reimbursements) and $23.1 million for local assistance. The proposed funding for state operations would fund 32.5 positions to (1) perform contract compliance activities, which accounts for the majority of the branch's workload, (2) provide technical assistance, and (3) conduct activities associated with a federal grant project.

The OFP contracts with local agencies to provide clinical services primarily related to contraceptives and/or family planning information and education. For 1993-94, the budget proposes General Fund expenditures of $2.2 million for state operations and $61.9 million for local assistance. Under state operations, the budget proposal would fund 30.8 positions to (1) perform contract compliance activities, which accounts for the majority of the office's workload, (2) provide technical assistance, and (3) provide health education information.

Though we believe that the programs operated by the PRHCS Branch and the OFP have merit, our analysis indicates that the two departmental units can be consolidated and the contract process can be streamlined, thereby resulting in reduced state operations costs.

Numerous Duplicative Contracts. The PRHCS Branch has over 240 contracts with clinics. The majority of the clinics that receive funds from one of three categorical programs—the Rural Health Services Development Program, the Seasonal Agricultural and Migratory Workers Health Program, and the Indian Health Program—also receive funding from the Expanded Access to Primary Care Services Program. However, each of these clinics has a separate contract for each of these programs, and often times a different state contract administrator. If these contracts were consolidated, the number of PRHCS Branch contracts would be reduced by over 30 percent.

The OFP has over 160 contracts with clinics for the provision of family planning services and health education and information. Of these contracts, over 30 percent are with clinics served under the PRHCS Branch. In addition, of the remaining OFP contracts, over 20 percent are duplicative contracts—that is, there is a separate contract for OFP clinical services and a separate contract for education and information services.

We estimate that if the duplicative contracts within these two branches were consolidated, the number of total contracts would be reduced by over 40 percent.

Administrative Consolidation Would Permit Staff Reductions. For 1993-94, the budget proposes a total of 32.5 positions in the PRHCS Branch and 30.8 positions in the OFP. The department has acknowledged that staff reductions of up to 15 percent could be made within the PRHCS Branch if contract consolidation were implemented, and that managerial positions could also be reduced. It is our understanding that the department is reviewing options for some consolidation activities.

However, we believe that additional reductions can be made if the OFP and PRHCS branches are consolidated. Because contract administration accounts for a large part of the workload in both agencies, consolidation of contracts would permit a significant reduction in staff. Furthermore, contract administration is not the only area of duplication. Both branches have (1) administrative support sections (15 total positions) and (2) research analyst positions (7 total positions), in addition to program-specific contract staff and clerical support that we believe can be consolidated.

Such consolidation, moreover, should result in a more comprehensive approach in working with clinics and in providing technical assistance. Because clinics are designed to address the many needs (including medical services, family planning services, health education services, and psychosocial services) of the communities they serve, they have a

need for comprehensive state technical assistance. Thus, a comprehensive approach to technical assistance from an overall clinic perspective can best meet these diverse needs.

If technical assistance and contract compliance were provided by the same state contract administrator or team (for example, using contract staff with clinical staff in a partnership), a comprehensive approach to clinic administration issues (such as funding) and medical service issues could be achieved. This would also reduce contract administration workload at the local level. In addition, fiscal and program monitoring and evaluation reports could be significantly reduced, and communication with the state could be streamlined.

Recommendation. Because of duplicative contract functions and related administrative activities, we believe that consolidating the PRHCS and OFP state operations could achieve a savings of 35 percent, or $1.6 million, excluding federal funds and reimbursements ($1.3 million General Fund, $300,000 C&T Fund). Because this would make the C&T Fund monies available for expenditure, we also recommend that these funds be used to replace General Fund monies budgeted for certain health programs that are eligible for C&T Fund support, including (1) prenatal services for undocumented persons and (2) the CMSP.

Ward Valley Low-Level Radioactive Waste Disposal Facility

We recommend that the department release, prior to the budget hearings, its contingency plan on the management of low-level radioactive waste (LLRW), shipping, storage, and disposal as required by the 1992 Budget Act.

Further, we find that $2.3 million appropriated in 1992-93 for an adjudicatory hearing may not be expended in the current year and may need to be appropriated in 1993-94 unless the court determines that such a hearing is not required.

Background. Various hospitals (including University of California and county hospitals), utilities, research organizations, and medical companies produce LLRW. According to the department, there are approximately 500 generators of LLRW in California, of which about 200 are active generators, all licensed by the state. Previously, the waste produced in California was shipped to three LLRW sites located in Nevada, Washington, and South Carolina. However, because federal law permits states to refuse to accept waste from other states as of January 1, 1993, both the Washington and Nevada sites were closed to California as of that date.

In 1992, the United States Supreme Court declared unconstitutional another provision of the federal law that required states to be liable for the commercial waste produced within their borders as of January 1, 1996 if they had not made certain provisions for disposing of such waste.

California is a member of the "Southwestern Compact" with Arizona, North Dakota, and South Dakota. The Southwestern Compact and state law require that (1) a LLRW facility be developed in California and (2) the department license and regulate the facility. The proposed facility would be located in the Ward Valley, in the southeastern portion of the state (near Needles).

Department Has Not Released Contingency Plan. The 1992 Budget Act required the department to provide the Legislature with a contingency plan by July 15, 1992 in the event the Ward Valley disposal site would not be operational by January 1, 1993. The department indicates that the plan has been completed and that release of the plan has been delayed pending resolution of numerous issues, including potential federal policy changes, a pending adjudicatory hearing, and negotiations with the Southeastern Compact.

We understand that a principal component of the contingency plan is an agreement with the Southeastern Compact to have generators of LLRW dispose of their waste at Barnwell, South Carolina. The Southwestern Compact has negotiated an 18-month contract, from January 1993 through June 30, 1994, with the Southeastern Compact for this purpose. This contract will enable generators of LLRW to dispose of waste at Barnwell for a cost of about $280 per cubic foot of waste (depending on waste volume and the frequency of disposal), not including transportation costs.

Because the department has not released its contingency plan, it is not known whether it contains any recommendations regarding (1) the reuse of some wastes (such as tritium—an LLRW product, often used as a radioactive tracer in medicine), (2) the possible need to modify the licenses of California LLRW generators and waste disposal brokers to increase storage capacity or radiation level, or (3) other issues regarding the storage, transport, or disposal of these wastes.

At the time this analysis was prepared, the contingency plan was more than six months overdue. Consequently, we recommend that the department release the contingency plan for legislative review prior to budget hearings.

Adjudicatory Hearing Still Pending. The 1992 Budget Act provided that $2.3 million from the General Fund was to be available for

encumbrance until March 31, 1993 for the department to pay for an adjudicatory hearing on Ward Valley. At the time this analysis was prepared, the Third District Court of Appeals was reviewing whether an adjudicatory hearing can proceed. Because the adjudicatory hearing has not yet been scheduled, the $2.3 million appropriated in 1992-93 probably will revert to the General Fund and may need to be appropriated again in 1993-94, depending on the court's ruling. The 1993-94 budget does not propose any funds for an adjudicatory hearing in the budget year.

CONTROL SECTION 23.50—STATE LEGALIZATION IMPACT ASSISTANCE GRANT

Control Section 23.50 appropriates federal funds made available under the federal Immigration Reform and Control Act (IRCA) of 1986. This act authorizes a general amnesty for certain groups of undocumented persons, holding out eventual citizenship to these individuals.

The IRCA legislation included $4 billion for federal grants—known as State Legalization Impact Assistance Grant (SLIAG) funds—of which $3.5 billion was to pay for the costs of certain state and federal services provided to newly legalized persons. The $4 billion consists of $1 billion each year for four federal fiscal years (FFY 88 through FFY 91); however, this level of funding has not been allocated. Rather, Congress reduced the amount for FFYs 90, 91, 92 (no funding provided), and 93. Congress has expressed its intent to provide the remaining amounts during FFY 94.

As a result of these actions, California has received $1.6 billion to date instead of an anticipated $2.1 billion.

SLIAG Entitlement Funds May Be Less Than Budgeted in Current Year

We recommend that the Health and Welfare Agency report at budget hearings on how several federal requirements may affect the amount of SLIAG funds available for state entitlement programs in the current year.

For FFY 93, Congress appropriated $309.1 million in SLIAG funds, of which California received $170.1 million, or 55 percent of the total allocation. Of this amount, the budget assumes that $72 million will be

available to pay for state entitlement program costs. However, two factors may affect the final amount of SLIAG funds available for state entitlement programs: (1) a federal requirement to allocate funds for state and local programs using a pro rata methodology and (2) federal resolution of public health funding requirements

Pro Rata Allocation Methodology. Congress recently amended the IRCA to require that California first reimburse on a pro rata basis unpaid state and local costs incurred between October 1990 and September 1992 (FFY 91 and FFY 92) before reimbursing costs incurred during FFY 93. The effect of this requirement at the local level is to increase the amount of SLIAG funds that some local entities will receive. At the time this analysis was prepared, the state pro rata methodology had not yet been approved by the federal government. Final federal approval could result in changes to the methodology and, in turn, affect the amount of funds available for entitlement programs.

Public Health Funding. The IRCA generally requires that states use, if needed, at least 10 percent of their SLIAG funds for public health program expenditures. It is estimated that California will have used 7 percent of its SLIAG funds (not 10 percent) for public health over the seven-year period, as shown in Figure 22.

Figure 22

State Legalization Impact Assistance Grant State Expenditures by Category Seven-Year Summary

(Dollars in Thousands)

	1987-88 Through 1991-92	1992-93	1993-94	Total	Percent
Public health	$129,102	$1,365	—	$130,467	7.0%
Public assistance	940,872	74,431	$313,792	1,329,095	71.3
Antidiscrimination/ education	1,853	—	—	1,853	0.1
Education	377,741	26,009[a]	—	403,750	21.6
Subtotals (allocated)	($1,449,568)	($101,805)	($313,792)	($1,865,165)	(100.0%)
Unallocated	—	$81,624	$153,211	$234,835	
Totals	**$1,449,568**	**$183,429**	**$467,003**	**$2,100,000**	

[a] Includes $8.8 million carried over from the previous fiscal year.

The IRCA exempts a state from the 10 percent requirement if the state does not require the use of the full 10 percent. Federal law, however, is not clear as to how the state can qualify for this exemption.

In a letter to the Department of Health and Human Services (DHHS), the Administration states that California is making a formal finding that (1) the state does not require any of the FFY 93 funds for public health costs and (2) public health costs to local entities through June 1992 have been fully reimbursed. If the federal government determines that California must spend additional funds on public health programs, this would reduce the amount of funds available for entitlement programs.

Recommendation. In view of the above, we recommend that the Health and Welfare Agency report during the budget process on (1) any changes in the budget needed to comply with federal requirements and (2) how this will affect estimated General Fund expenditures for state entitlements in the current year.

Governor Proposes $70 Million Reduction to Local Governments

The budget proposes to shift $2.6 billion in local property tax revenues to school districts. The budget also indicates that of this amount, about $70 million is intended to come from certain counties because they received increases in federal SLIAG funding in 1992-93 pursuant to FFY 93 pro rata payments. We note that this proposal, if adopted, may need to be adjusted to conform to any adjustments made to the SLIAG allocations.

Governor's 1993-94 Budget Assumes Full Funding

Because the President's FFY 94 budget was not available at the time this analysis was prepared, it is unknown whether he will propose to provide California with the SLIAG funds assumed in the Governor's Budget for 1993-94.

The Governor's Budget for 1993-94 assumes that the Congress will provide California with $467 million of SLIAG funds—the difference between California's anticipated total amount of IRCA funding ($2.1 billion) and the amount allocated to date ($1.6 billion). However, because the President's FFY 94 budget was not available at the time this analysis was prepared and Congress probably will not complete action on the budget until September, it is unlikely that the Legislature will know how much SLIAG funds will be allocated for California until after action on the state budget has been completed.

The budget proposes to allocate $314 million of these funds to entitlement programs and to leave the remaining amount, or about $153 million, unallocated (see Figure 23). If sufficient SLIAG funds are not

received, the state General Fund will have to provide $314 million to cover entitlement program costs in 1993-94.

Figure 23

State Legalization Impact Assistance Grant 1992-93 and 1993-94

(In Thousands)

	1992-93	1993-94	Two-Year Total
Allocated	$101,805	$313,792	$415,597
Unallocated	81,624[a]	153,211	234,835
Totals	**$183,429[b]**	**$467,003**	**$650,432**

[a] The unallocated amount for 1992-93 is to be used to fund valid unpaid local claims for FFY 91 and FFY 92 (October 1990 through September 1992).

[b] Total 1992-93 funds available equals (1) $170.1 million allocated for FFY 93 and (2) $13.3 million in carry-over funds unspent from previous state fiscal years.

Regarding the unallocated funds, the budget proposes language that (1) would permit the Department of Finance to allocate the $153 million in 1993-94, subject to legislative notification, and (2) specifies the following priorities for the use of these funds:

- Fund entitlements—primarily Medi-Cal and SSI/SSP—for a total of $314 million, as specified in the schedule for Control Section 23.50 of the Budget Bill.
- Fund any other programs required by law or regulations. Funds would be used to meet those federal requirements necessary in order to receive SLIAG funds. (As we discussed above, this relates to the funding for public health services.)

MAJOR RISK MEDICAL INSURANCE BOARD (4280)

The Major Risk Medical Insurance Board (MRMIB) administers (1) the Major Risk Medical Insurance Program (MRMIP), which provides health insurance to California residents who are unable to obtain it for themselves or their families because of pre-existing medical conditions, (2) the Small Employers Purchasing Pool Program, which will establish and operate a health insurance purchasing pool for small employers, and (3) the Access for Infants and Mothers (AIM) Program, which

provides coverage for women seeking pregnancy-related and neonatal medical care.

The budget proposes $88.3 million from all funds for support of MRMIB programs in 1993-94, which is a decrease of 17 percent from estimated current-year expenditures.

Proposed Expansion of the AIM Program

We find that the AIM Program is likely to have a significant level of unexpended balances at the end of 1993-94. Accordingly, we recommend that the Legislature redirect $15 million in Cigarette and Tobacco Products Surtax (C&T) Fund monies from the AIM Program to replace General Fund monies budgeted for programs that are also funded by the C&T Fund.

Further, we recommend that the MRMIB report during the budget hearings on (1) the projected level of unexpended funds available at the end of the current year, based on the most recent enrollment pattern, and (2) the projected enrollments in the budget year and the related impact on spending and year-end balances. We will modify our recommendation for redirection, if appropriate, based on our review of this information.

Background. The AIM Program is a perinatal insurance program under which the state enters into contracts with private health plans to provide health services to pregnant women and their infants. Health coverage is provided to pregnant women, and their infants up to two years after birth, who (1) have no health insurance coverage for their pregnancy, (2) have incomes below 250 percent of the federal poverty level, and (3) are not eligible for services through Medi-Cal. Women receive health coverage from the time of enrollment until 60 days after birth. Program participants pay an initial fee of 2 percent of their family income toward the costs of services received by the mother and the infant (up to the infant's first birthday). (For example, a two-person family with an annual income of $18,381 would pay a fee of roughly $370.) A second fee of $100 is assessed to continue infant health coverage through the second year.

The AIM Program is funded by the Perinatal Insurance Fund, which receives revenues from the C&T Fund established by Proposition 99. Program funds are appropriated through Ch 278/91 (AB 99, Isenberg), as revised by Ch 1170/91 (SB 99 Watson), subject to the annual budget acts. The AIM Program's funding will sunset on June 30, 1994 unless reauthorized through legislation.

Enrollment Projections. The board estimates that at the end of the current year, $25.7 million will be unexpended and will be carried forward to the budget year. When this balance is added to the statutory appropriation of $57.6 million in 1993-94, this would bring available resources to $83.3 million in the budget year.

Our review indicates that the board's estimate of the current-year ending balance may be too low. This is because the board's estimate assumes that monthly enrollments during the first half of 1993 will be more than double (1,200 enrollees per month) their most recent experience (500 enrollees per month), thereby resulting in increased expenditures.

The increased enrollment projections for 1993 assume an expanded outreach campaign. However, we note that enrollment from June through December 1992 has been at roughly 500 new subscribers per month in spite of outreach strategies that include (1) participation in the Baby-Cal perinatal outreach campaign; (2) extensive community-based outreach activities, including multi-media presentations, special mailings, and special event participation; and (3) participating health plan provider outreach activities.

To increase enrollment, an expanded outreach campaign, at a projected cost of $1.5 million, began in December 1992. The goal of this effort is to increase the number of new subscribers to 1,200 per month during the last half of the current fiscal year.

Board's Enrollment Projection Seems Unrealistic. Given the fact that the board has already implemented an extensive outreach program for AIM, we find no basis for accepting the board's assumption that additional outreach will more than double the level of new enrollments. While we cannot provide a definitive estimate of the level of increased caseload that the expanded outreach campaign will achieve, we believe it is reasonable to assume that a 20 percent increase—to 700 new enrollees per month—could be obtained (beginning in January 1993). If this level is achieved *and sustained* through 1993-94, the AIM Program would still have $15 million in unexpended balances at the end of the budget year. Consequently, we recommend that the Legislature redirect $15 million (C&T Fund) proposed for the AIM Program to other program efforts. We believe two options are available for expending these funds.

Redirect Funds to Other Proposition 99 Programs. One option available is to redirect funds from the AIM Program to fund other C&T Fund (Proposition 99) programs. These funds could be used to (1) restore some portion of the proposed budget-year $48 million pro rata reductions (the AIM Program is one of five programs that are

statutorially exempt from pro rata reductions), (2) fund mental health services, which previously received C&T Fund monies, or (3) fund other health programs, such as primary care clinics.

Use Funds to Replace General Fund Support for Other Health Programs. The second option available is to redirect AIM funds (C&T Fund) to replace General Fund support in other programs. We believe that the C&T Fund monies could be used to backfill General Fund monies budgeted for certain health programs, including (1) prenatal services for undocumented persons (Ch 1441/88), as was done in the 1992 Budget Act, and (2) the County Medical Services Program. We believe that this redirection could be accomplished in the Budget Bill because (1) these programs are partially funded by the C&T Fund and (2) the AIM receives a portion of its funds from the C&T Fund Unallocated Account (the account with the most flexibility).

Analyst Recommendation. Although both of the above options are available to the Legislature, because of the fiscal condition of the General Fund we recommend the option to redirect the estimated unexpended C&T Fund monies to replace General Fund obligations, for an estimated savings of $15 million in 1993-94.

Board Should Update Its Estimates. The board will have several months of additional enrollment data available by the time of the budget hearings, which will help the Legislature to assess the impact of the expanded outreach campaign. Consequently, we recommend that the MRMIB report during the budget hearings on (1) the projected level of unexpended funds available at the end of the current year, based on the most recent enrollment pattern, and (2) the projected enrollments in the budget year and the related impact on spending and year-end balances. If the new data indicate that the program can sustain a level of new enrollments higher than we have projected, we will revise our recommended redirection, as appropriate.

DEPARTMENT OF DEVELOPMENTAL SERVICES (4300)

The Department of Developmental Services (DDS) administers services in the community (through the regional centers) and in developmental centers for persons with developmental disabilities. A developmental disability is defined as a disability related to certain mental or neurological impairments originating before a person's 18th birthday that is expected to continue indefinitely and that constitutes a substantial handicap.

The budget proposes $1.4 billion from all funds for support of the DDS programs in 1993-94, which is an increase of 7 percent over estimated current-year expenditures. The budget proposes $622.6 million from the General Fund in 1993-94, which is $34.2 million, or 5 percent, above estimated current-year expenditures from this funding source.

Potential Medicaid Waiver Savings Uncertain

We find that the budget does not reflect an additional $16.6 million in General Fund savings that would result if the Medicaid waiver expansion is approved as proposed. However, in the event the waiver expansion is not approved as proposed, the budget may overestimate General Fund savings by up to $80.5 million. We recommend that the department report at budget hearings on the status of the waiver.

Background. The Title XIX Medicaid Waiver, also known as the Home and Community-Based Waiver Program, authorizes reimbursement for community-based services provided to people who would otherwise be placed in a developmental center due to the level of care they require. Under the waiver program, costs for providing these services to Medi-Cal eligible people are reimbursed through the Medi-Cal Program, with 50 percent of the funds coming from the federal government, matched by 50 percent support from the state General Fund. Eligible enrollees are served through the regional center system.

The current federally approved waiver authorizes reimbursement for services provided to a total of 3,360 clients a year. The DDS applied for an expansion of this waiver to a total of 10,000 clients in 1992-93 with an increase of 2,000 clients per year thereafter until a total of 20,000 clients are enrolled in the program. Although the federal government has not approved the waiver expansion at this time, the department anticipates that it will be approved this spring. The budget assumes reimbursements in both the current and budget years as a result of this expansion.

Budget Assumes Additional Reimbursements. The budget proposes a total of $128 million ($64 million General Fund, $64 million federal funds) in Medi-Cal reimbursements in the current year, an increase of $37.1 million over the level of reimbursements assumed in the 1992 Budget Act. The budget proposes a total of $166.1 million ($83.1 General Fund, $83 million federal funds) in Medi-Cal reimbursements in the budget year, an increase of $75.2 million over 1992 Budget Act levels and $38.1 million over revised current-year reimbursements. Figure 24 summarizes these increases in proposed Medicaid waiver reimbursement levels.

Figure 24

Medicaid Waiver Reimbursements 1992-93 and 1993-94

(In Millions)

	1992-93		1993-94	
	Budget Act[a]	Revised[b]	Governor's Budget	LAO Estimate
Existing waiver program—3,360 clients[c]	$65.9	$78.0	$84.3	$84.3
Waiver expansion				
10,000 clients in 1992-93	25.0	50.0	66.8	100.0
2,000 clients in 1993-94	—	—	15.0	15.0
Totals	**$90.9**	**$128.0**	**$166.1**	**$199.3**

[a] Assumes April 1, 1993 implementation date.
[b] Assumes January 1, 1993 implementation date.
[c] Includes increased reimbursements resulting from identification of higher-cost clients.

Budget Does Not Reflect Potential General Fund Savings. Based on the budget's assumptions regarding implementation of the waiver, the potential savings from the waiver expansion are underbudgeted. Specifically, our review indicates that the budget does not account for full-year 1993-94 reimbursements resulting from the current-year expansion from 3,360 to 10,000 clients. The budget assumes 1993-94 reimbursements totaling $66.8 million from this expansion. We estimate that, if approved as proposed, these reimbursements will amount to $100 million, or $33.2 million higher than budgeted in 1993-94, as shown in Figure 24. Since half of these reimbursements would be federal funds, we estimate that an additional $16.6 million in General Fund savings would result if the waiver is approved under the terms assumed by the budget.

Reimbursement Increases May Not Materialize. Depending on federal action, these reimbursements may not materialize or may be lower than projected. For example, if the federal government approves an expansion to less than 12,000 clients for the budget year, or approves a later implementation date than January 1, 1993, reimbursements would be correspondingly reduced. If the level of reimbursements is lower than projected in the budget, the DDS would incur additional General Fund costs for providing services to these eligible clients. We estimate that these costs could be up to $80.5 million—$23 million in 1992-93 and $57.5 million in 1993-94.

Conclusion. The actual level of Medicaid waiver reimbursements is uncertain, depending on actions taken by the federal government in

approving the waiver expansion. Therefore, we find that the budget does not reflect an additional $16.6 million in General Fund savings that would result if the Medicaid waiver expansion is approved as proposed. However, in the event the waiver expansion is not approved as proposed, the budget may overestimate General Fund savings by up to $80.5 million. We recommend that the department report at budget hearings on the status of the waiver.

Lawsuit May Result in Major Costs

We recommend that the department report at budget hearings on (1) the status of the Coffelt v. Department of Developmental Services lawsuit and (2) how it proposes to fund any costs resulting from resolution of the suit.

The department is currently involved in settlement talks with respect to the lawsuit *Coffelt v. Department of Developmental Services*. This lawsuit claims that the DDS has not placed developmental center residents in community services despite the fact that they desire such placement and are entitled to these services. While the outcome of this lawsuit is currently unknown, the department acknowledges that it could result in costs of $10 million to $20 million to the General Fund in the budget year. The budget does not include any funding for this purpose. We therefore recommend that the department report at budget hearings on (1) the status of the *Coffelt v. Department of Developmental Services* lawsuit and (2) how it proposes to fund any costs resulting from resolution of the suit.

Decision Due on Early Intervention Program

The budget proposes federal funds, but no General Fund expenditures, to continue the Early Intervention Program (EIP) in 1993-94. We recommend that the department report at budget hearings on its decision as to whether to continue the EIP. If the decision is to continue the EIP, we further recommend that the department report on (1) its plan for implementing the EIP in the budget year and (2) any General Fund costs associated with implementing the program.

Background. The EIP is a federally authorized program (under Public Law 99-457, Part (H), enacted in 1986 and amended in 1991) to provide integrated, family-centered services to infants and children up to age three who are developmentally disabled or at risk of becoming developmentally disabled. The DDS is the designated lead agency for the state, responsible for program implementation.

Under the EIP, local planning areas are identified in which a variety of agencies (including regional centers, mental health, social services, education, and alcohol and drug programs) coordinate their activities in order to provide a comprehensive set of services. The purpose of the EIP is to provide services to the target group of children as soon as possible after birth in order to prevent or minimize the degree of disability experienced by the children later in life.

The federal government provided funding for a three-year EIP planning phase, which was later extended for an additional two years (through September 1993). Prior to termination of the planning phase, states are required to submit an application if they wish to continue the program into the implementation phase.

Among other things, program implementation would require the state to (1) define developmental delay and developmental disability, (2) provide an Individualized Family Service Plan (IFSP) for every child identified as eligible for EIP services, (3) adopt statewide personnel standards for the EIP, (4) ensure procedural safeguards consistent with federal guidelines, and (5) establish a central resource directory for EIP services. Although the federal government will provide ongoing funding for specific activities identified in PL 99-457, the state will be responsible for any additional implementation costs. In addition, the state will be required to maintain a level of funding for these services equal to the amount spent in each prior year.

Budget Assumes Continuation of the Program. The state has received a total of $40.8 million in federal funding over five years for purposes of developing a comprehensive plan for implementing the EIP statewide. Current-year funding totalling $10.4 million represents the final federal allocation authorized for pre-implementation activities. The state must now decide whether to continue the program—into the implementation phase—and bear responsibility for any associated General Fund costs that are not federally reimbursable. An application to continue the EIP must be submitted to the federal government by June 30, 1993.

The budget proposes $10.4 million in *federal* funds to continue the EIP in the budget year. However, the department indicates that no decision has been made at this time to implement the EIP. This inconsistency raises several questions:

- Does the department intend to implement the EIP in the budget year?
- If so, what is the department's specific plan for implementing the program?

- What General Fund costs does the department anticipate will be associated with implementing the program?

The decision as to whether to implement the EIP has significant policy and fiscal implications for the state. Therefore, we recommend that the department respond at budget hearings to these questions.

Workers' Compensation Costs Underbudgeted

We estimate that workers' compensation costs at the developmental centers are underbudgeted by about $3 million in the current year and $4 million to $5 million in 1993-94. We recommend that the department report at budget hearings on a plan to (1) reduce workers' compensation costs in the budget year or (2) fund the anticipated increase in these costs within the proposed budget.

The budget proposes a total of $15.9 million for workers' compensation costs in the seven developmental centers administered by the DDS. This is the same level of estimated expenditures as in the current year. However, our review indicates that the costs of workers' compensation are underbudgeted.

Workers' compensation costs have been increasing for the past several years. The department indicates that actual expenditures for workers' compensation totalled $15.9 million in 1990-91 and $17.9 million ($2 million, or 13 percent, higher) in 1991-92. The department further estimates that actual workers' compensation costs will total about $19.1 million in 1992-93—about $1.2 million, or 6.7 percent, higher than 1991-92 costs. Although the *rate* of increase in actual costs appears to be declining, total costs continue to increase every year. Based on the overall trend in total costs, we estimate that workers' compensation costs will be in the range of $20 million to $21 million in the budget year.

Despite these trends, the budget proposes a level of funding for workers' compensation that does not cover the projected costs in either the current or budget years. The department estimates the gap in current-year funding to be about $3.2 million, and we estimate the gap in the budget year will be in the range of $4 million to $5 million.

Underfunding these workers' compensation costs could result in funds being shifted from other parts of the developmental centers' budgets. For example, staff positions may be held vacant in order to achieve salary savings that can be used to cover the increased workers' compensation costs. This could have an adverse impact on the provision of services, possibly leading to stress on existing staff and higher workers' compensation costs.

Based on our review, we recommend that the department report at budget hearings on a plan to (1) reduce workers' compensation costs in the budget year or (2) fund the anticipated increase in these costs within the proposed budget.

DEPARTMENT OF MENTAL HEALTH (4440)

The Department of Mental Health (DMH) directs and coordinates statewide efforts for the treatment of mental disabilities. The department's primary responsibilities are to (1) administer the Bronzan-McCorquodale and Lanterman-Petris-Short Acts, which provide for delivery of mental health services through a state-county partnership and for involuntary treatment of the mentally disabled, (2) operate five state hospitals and the acute psychiatric units at the California Medical Facility at Vacaville, and (3) administer six programs directed at specific populations.

The budget proposes $747.6 million from all funds for support of DMH programs in 1993-94, which is an increase of 4.4 percent over estimated current-year expenditures. The budget proposes $237.2 million from the General Fund in 1993-94, which is $22.6 million, or nearly 11 percent, above estimated current-year expenditures from this funding source.

School-Based Prevention Program Augmentation Should Be Deleted

We recommend a reduction of $10.4 million ($10 million Proposition 98) to the DMH budget in order to free up funds to restore school general purpose funding or reduce the Proposition 98 loan. (Reduce Item 4440-001-001 by $428,000 and Item 4440-102-001 by $10 million.)

The School-Based Prevention Program is supported by $10 million from the General Fund in the current year. The budget proposes a $10.4 million General Fund augmentation to the program in 1993-94. Of this amount, $10 million is for local assistance and would be funded under the Proposition 98 guarantee. The additional $428,000 is for related administrative costs. The School-Based Prevention Program was established by Ch 757/91 (AB 1650, Hansen) to provide school-based early mental health intervention and prevention services.

In the K-12 education section of this *Analysis*, we recommend that the Legislature delete growth funds for most K-12 categorical programs and almost all of the proposed K-12 augmentations—regardless of their

individual merit. In addition, we recommend that these funds be redirected within the Proposition 98 guarantee to restore general purpose funding (which the budget reduces) or to reduce a loan to K-12 schools.

With respect to the DMH budget, we recommend that the proposed $10 million (Proposition 98) augmentation for expansion of the School-Based Prevention Program be redirected. Although the proposal has merit, we believe that restoring K-12 general purpose funding or reducing the loan amount should take priority over augmenting this program. We further recommend that the associated administrative costs (non-Proposition 98) be deleted, for a General Fund savings of $428,000.

New Federal Funds Present Opportunity for Legislature

We recommend that the Legislature determine its own priorities for allocating an additional $12.2 million in federal block grant funds for mental health services. We further recommend the adoption of Budget Bill language directing the department to allocate some or all of these funds according to legislatively determined priorities.

On July 10, 1992, Congress passed the ADAMHA Reorganization Act of 1992 (Public Law 102-321). This act changed the block grant allocations for substance abuse and mental health, increasing the amount of funding the DMH will receive from $26 million in 1992-93 to $38.2 million in 1993-94, an increase of $12.2 million. In addition, the act imposed new requirements on the allocation of these funds, most notably that 10 percent of the total allocation be "set aside" for children's services in 1993-94 and an additional 10 percent be "set-aside" for these services in 1994-95. In addition, block grant funds must be used to promote systems of care for (1) children who are severely emotionally disturbed, (2) adults and older adults who are seriously mentally ill, and (3) seriously mentally ill homeless persons.

The budget proposes to use the additional block grant funds to provide support for (1) local mental health services—$10.8 million, (2) the AB 3777 (Ch 982/88, Wright) demonstration program for seriously mentally ill adults—$215,000, (3) the performance outcome evaluation mandated by program realignment legislation—$556,000, (4) the State Planning Council—$257,000, and (5) state planning and administrative activities related to the block grant—$401,000. While the department indicates that the bulk of these funds—$10.8 million—will be allocated for local mental health services, it has not yet specified how the funds will be allocated.

We believe that these additional federal block grant funds present the Legislature with an opportunity to augment programs or services it views as top priorities. For example, the Legislature could choose to provide funding for specific programs that have proven to be effective, such as the AB 377 (Ch 1361/87, Wright) program providing integrated mental health services for children. The federal funds could also be used to design and implement programs that offer incentives to counties to provide services to specific groups of people, such as people who are diagnosed with both mental impairment and substance abuse problems.

Given the availability of this new federal funding, we recommend that the Legislature determine its own priorities for allocating these funds. We further recommend the adoption of Budget Bill language directing the department to allocate the funds according to these priorities.

Aid to Families with Dependent Children (5180)

The Aid to Families with Dependent Children (AFDC) Program provides cash grants to families and children whose incomes are not adequate to provide for their basic needs. Families are eligible for the AFDC-Family Group (AFDC-FG) Program if they have a child who is financially needy due to the death, incapacity, or continued absence of one or both parents. Families are eligible for grants under the AFDC-Unemployed Parent (AFDC-U) Program if they have a child who is financially needy due to the unemployment of one or both parents. Children are eligible for grants under the AFDC-Foster Care (AFDC-FC) Program 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 or probation department.

The budget proposes expenditures of $5.9 billion ($2.4 billion General Fund, $3 billion federal funds, and $431 million county funds) for the AFDC Program in 1993-94. This is a decrease of $655 million, or 10 percent, below estimated total expenditures in the current year.

AFDC Caseload

AFDC Caseload Likely to Be Lower Than Budget Projections

The budget may significantly overestimate AFDC Program costs because the department's caseload projections appear to be too high, based on an analysis of more recent data. The department will present revised estimates in May.

The proposed expenditures for AFDC grants in 1993-94 are based on actual caseloads and costs through September 1992, updated to reflect the department's projections through 1993-94. The budget estimates that the AFDC-FG basic caseload will increase by 4.8 percent in 1993-94 and the AFDC-U basic caseload will increase by 9.7 percent. (This excludes the effects of the welfare reform proposals contained in the budget.)

Based on recent data that were not available when the budget was prepared, we estimate that AFDC-FG and U costs could be as much as $40 million ($19 million General Fund) lower in the current year and $90 million ($43 million General Fund) lower in the budget year than the department's estimate. In May, the department will present revised estimates of AFDC costs based on actual caseload and grant costs through February 1993. Because the revised estimate of AFDC costs will

be based on more recent information, it will provide the Legislature with a more reliable basis for budgeting 1993-94 expenditures.

Current-Year Statutory Changes in AFDC Grant Policy

Chapter 722, Statutes of 1992 (SB 485) enacted several significant changes to the AFDC Program:

Reduces Maximum Aid Payments (MAPs) by 5.8 Percent. Chapter 722 reduces the MAPs by a total of 5.8 percent in 1992-93 (4.5 percent effective October 1, 1992 and an additional 1.3 percent effective December 1, 1992). Thus, a family of three with no other income experienced an AFDC grant reduction of $39 per month, from $663 to $624. This family was eligible for an additional food stamps allotment of about $12. Therefore, the net reduction in monthly benefits, including food stamps, was about $27.

12-Month Residency Requirement. Chapter 722 also provides that AFDC recipients from another state, during their first 12 months of residence in California, are eligible to receive the lesser of (1) the California grant or (2) the maximum grant in their former state. The department assumes that about 7 percent of AFDC recipients lived in another state within the preceding 12 months. This provision, however, has been ruled unconstitutional by a federal district court. At the time this analysis was prepared, it was not known whether the case would be appealed. (The fiscal impact of this decision is discussed in the following section.)

Changes in Rules for Computing Grants. The department requested federal waivers required in order to implement two "work incentive" provisions of Chapter 97, Statutes of 1991 (SB 724, Maddy): (1) the elimination of the "100-hour," which denies aid to AFDC-U recipients if they work more than 100 hours per month, and (2) the indefinite extension of the "$30 and one-third earned income disregard." The department obtained federal approval of the 100-hour rule waiver and it was implemented on December 1, 1992. The federal government made approval of the $30 and one-third disregard contingent on the state funding the initial costs of this policy change. (This change initially results in costs because by disregarding the first $30 and one-third of earned income, an AFDC recipient will receive a higher grant than he/she would receive otherwise.) However, because the 1992 Budget Act did not include funds for these initial first-year costs, the policy change was not implemented.

Other Provisions. Chapter 722 also requires the department to seek federal approval for two proposals that would affect AFDC recipients:

- ***Regional AFDC Grants.*** The department was directed to seek a federal waiver to establish regional AFDC MAPs as an alternative to the 5.8 percent across-the-board MAP reductions. Implementation of this proposal was linked to federal approval that would allow the state to establish a specific four-region Supplemental Security Income/State Supplementary Program (SSI/SSP) grant schedule. The Social Security Administration denied approval for the regional SSI/SSP grant proposal contained in Chapter 722 because it called for four regions instead of the maximum three regions required by federal law; therefore, the AFDC regional grant provision has not been implemented.
- ***Additional Federal Funds for the Greater Avenues for Independence (GAIN) Program.*** The department was directed to seek federal waivers that would allow the state to redirect any *federal funds* saved as a result of other waivers granted pursuant to Chapter 722. These redirected funds were proposed to be used to augment the GAIN Program. The U.S. Department of Health and Human Services refused to grant a waiver for this provision.

Residency Requirement Found Unconstitutional

The budget includes net grant and administrative savings of $41 million ($20 million General Fund) in 1993-94 and $15 million ($7.6 million General Fund) in the current year from the residency requirement. A federal district court, however, has ruled that this provision is unconstitutional.

As described above, the residency requirement for AFDC applicants was implemented in December 1992. A federal district court, however, has found it to be unconstitutional. Thus, unless the court ruling is reversed on appeal, the budget overstates savings from this provision by $15 million ($7.6 million General Fund) in the current year and $41 million ($20 million General Fund) in 1993-94.

Governor's Welfare Proposals

The Governor's Budget proposes several major changes in welfare policy that would significantly affect the AFDC-FG and U programs. The General Fund fiscal impact of the proposed changes is summarized in Figure 25. It shows that the proposal would result in grant savings of $58 million in 1992-93 and $526 million in 1993-94. These savings would be partially offset by General Fund administrative and support services costs of $26 million in 1992-93 and $59 million in 1993-94. These

provisions (except for the increase in GAIN funding) would require legislation and, in most cases, a waiver of federal regulations.

Figure 25

Governor's Welfare Proposals
General Fund Budget Summary
1992-93 and 1993-94

(In Thousands)

	1992-93		1993-94	
Proposals	Grants	Administration/ Services	Grants	Administration/ Services
4.2 percent MAP reduction	-$40,585	$304	-$125,378	—
15 percent additional MAP reduction	—	977	-247,520	$5,973
Earned income disregard expansion	3,645	—	22,514	—
Exclusion from MAP of children conceived while on aid	—	—	-14,084	591
Reduction in pregnancy-related benefits	-6,513	-434	-20,115	-1,451
Savings due to reduced dependency	-14,731	-57	-141,674	-4,863
Minors required to live with adult relatives	—	17	—	71
Cal Learn administration and services	—	6,386	—	17,076
GAIN reform and funding augmentation	—	15,000	—	40,991[a]
County data processing changes	—	3,712	—	—
State administration	—	—	—	797
Totals	**-$58,184**	**$25,905**	**-$526,257**	**$59,185**

[a] An additional $29 million is proposed to replace a current-year ETP loan. Because this does not represent an increase in state funds, it is not shown in this figure.

Most of the budget's welfare proposals require federal approval in the form of waivers of existing statutes. This is not the case for the proposals to (1) limit pregnancy-related benefits and (2) require that AFDC teen parents under age 18 live at home.

Components of the Governor's Proposal

Budget Proposes to Reduce MAPs By 4.2 Percent

The budget proposes legislation to reduce the MAP to all AFDC recipients by 4.2 percent for a net savings of $262 million ($125 million General Fund) in 1993-94 and $84 million ($40 million General Fund) in the current year. The grant reduction would be offset partially by an increase in food stamps, thereby resulting in a reduction of about 2.2 percent in the total income available to AFDC recipients with no outside income.

The budget contains three separate proposals that would have the effect of reducing AFDC grants below the levels specified in current law. These are (1) a 4.2 percent reduction in the MAP for all AFDC recipients, (2) an additional 15 percent MAP reduction for AFDC recipients (with some exceptions) who have been on aid for more than six months, and (3) a prohibition on MAP increases due to increased family size when additional children are conceived while the parent is on aid.

The budget proposes legislation to reduce the MAPs by 4.2 percent for all AFDC-FG and U recipients. Currently, the MAP ranges from $307 for a one-person family to $1,322 for a family of ten or more persons. Figure 26 displays the effect of the proposed MAP reduction for family sizes between one and five. It shows that the MAP for a family of three, for example, would be reduced from $624 to $597 per month.

Proposal to Reduce MAP an Additional 15 Percent After Six Months

The budget proposes legislation to reduce the MAP by an additional 15 percent for AFDC recipients (with some exceptions) after they have been on aid for six months, for a net savings of $500 million ($242 million General Fund) in 1993-94. The grant reduction would be offset partially by an increase in food stamps, thereby resulting in a reduction of about 9.8 percent in the total income available to AFDC recipients with no outside income.

The budget proposes legislation to reduce AFDC MAPs by an *additional* 15 percent after a family (1) has been on assistance for more than 6 months or (2) went off aid after 6 months and returned to the program within 24 months. This reduction would not occur if all parents or caretaker relatives in the home are age 60 or over, disabled

(receiving SSI/SSP or In-Home Supportive Services), pregnant, the caretaker is a nonneedy relative or all parents in the family (assistance unit) are under age 19 and attending high school or other equivalent schooling.

Figure 26

Department of Social Services
AFDC MAP and Need Standard
Budget Proposal Compared to Current Law
1993-94

		Maximum Aid Payment		
			Budget Proposal	
Family Size	Need Standard[a]	Current Law	First Six Months	After Six Months
1	$351	$307	$293	$249
2	576	504	482	410
3	714	624	597	507
4	848	743	709	603
5	967	847	809	688

[a] Assumes a CNI for 1992 of 2.26 percent, resulting in a COLA of 1.58 percent in 1993-94. (The authorized COLA is 70 percent of the CNI.)

Proposal to Expand the Earned Income Disregard

The budget proposes $3.6 million in 1992-93 and $22.5 million in 1993-94 from the General Fund for the costs of extending indefinitely—beyond the existing four-month limit—the "$30 and one-third disregard" of employment earnings in computing AFDC grants. Current law directs the department to request a federal waiver to implement this change.

The 1993-94 budget proposes $7.6 million ($3.6 million General Fund) in 1992-93 and $47 million ($22.5 million General Fund) in 1993-94 to fund the costs of expanding the "30 and one-third disregard." This would have the effect of reducing the amount of employment earnings used to offset the grants, thereby increasing the incentive to work. As explained previously, current law (Ch 97/91) directs the Department of Social Services (DSS) to request a federal waiver to implement this change.

Proposal to Exclude From the MAP Any Children Conceived While on Aid

The budget proposes legislation to exclude, for purposes of determining a family's MAP, any children who are conceived while the family is on AFDC, for a net savings of $28 million ($13 million General Fund) in 1993-94. Savings would increase significantly annually thereafter, amounting to several hundred million dollars in ten years.

The budget proposes legislation that would exclude any children conceived when a family is receiving AFDC for purposes of determining the family's MAP. Such children would continue to be excluded if the family leaves and returns to the program, unless the absence was for at least 24 consecutive months. Children excluded for purposes of determining the MAP would be eligible for both Medi-Cal benefits and food stamps.

Proposal to Limit Pregnancy-Related Benefits

The budget proposes legislation to eliminate pregnancy-related AFDC benefits, except for the federally assisted program that covers the third trimester, for a savings of $46 million ($22 million General Fund) in 1993-94 and $15 million ($7 million General Fund) in the current year. We find that this proposal could result in a transfer of responsibility to the counties for many of those recipients who would lose these benefits.

The budget proposes legislation to limit AFDC pregnancy-related benefits. Specifically, the budget proposes to terminate the following benefits:

- *State-Only AFDC Program.* Under current law, the state operates a state-only (no federal financial participation) program, whereby grants are provided to pregnant women without other children during the first six months of pregnancy.
- *$70 Monthly Special Needs Payment.* Current law provides for a $70 monthly special needs payment to *all* pregnant women who are receiving AFDC.

Under the budget proposal, the state would continue to participate in the federally assisted AFDC Program for pregnant women who are in their last three months of pregnancy (and for the month in which their baby is born).

Limiting the pregnancy benefits to the last three months of pregnancy would cause about 3,000 women to lose all of their AFDC benefits (those with no other children). These women could apply for general assistance in the counties where they reside. Thus, the elimination of these programs would, in effect, transfer responsibility for many pregnant women to the counties. Under existing law, these women would, however, be eligible for pregnancy-related medical benefits under Medi-Cal and for food stamps.

Budget Imposes Requirements on Teen Parents

The budget proposes legislation to (1) require parents under age 18 to reside in the home of their parent or certain other adults in order to receive AFDC and (2) establish the Cal Learn Program, an incentive program for AFDC parents under age 19 to remain in school. To the extent this proposal increases school attendance, it would result in increased job readiness as well as additional school apportionment costs, potentially in the tens of millions of dollars.

Teen Parent's Residence. Under this proposal, parents under age 18 who receive AFDC would be required to live in the home of their parent, legal guardian, adult relative, or in certain other living arrangements in order to receive aid. The proposal includes exceptions under which the teen could maintain a separate residence. This program requirement is optional under the federal Family Support Act of 1988 and would not require any federal approval other than acceptance of an amended state plan.

The budget does not reflect any savings from this proposal; however, to the extent that the teen parents stay with certain adults, such as parents or stepparents, part of the adult's income could be used to offset the teen parent's AFDC grant. This would result in unknown General Fund savings, probably less than $500,000.

Cal Learn Program. The budget proposes to create the Cal Learn Program for parents under age 19 who receive AFDC and have not completed high school. If these parents remain in school and progress to the next grade level they would receive a $100 bonus and if they graduate from school they would receive a $500 bonus. If these parents have more than two unexcused absences per month they would have their AFDC grant *reduced* by $50. Otherwise their grant would remain unchanged.

The budget proposes administrative and supportive services expenditures for Cal Learn of $35 million ($17 million General Fund) in 1993-94 and $13 million ($6 million General Fund) in the current year.

Of these costs, $32 million ($16 million General Fund) in 1993-94 and $12 million ($6 million General Fund) in the current year are for child care, case management, and transportation for Cal Learn participants. The remaining expenditures are for program administration by the counties. The budget assumes that the costs of the bonuses would offset the savings from the penalties, resulting in no net change. We note, however, that to the extent the program increases school attendance, it will result in increased job readiness as well as additional state apportionment costs, potentially in the tens of millions of dollars.

Proposal to Increase Funding for the GAIN Program

The budget proposes to increase funding for the GAIN Program by $93 million in 1993-94 and $42 million in the current year (all funds).

We find that (1) the program has shown potential to reduce AFDC grant expenditures and (2) fiscal constraints are likely to cause counties to spend less than the budgeted amount for the program. Consequently, we recommend the enactment of legislation to (1) eliminate the county share of funding for the GAIN Program, resulting in a General Fund cost of $42 million in 1993-94, and (2) increase the county share of AFDC grants by about two-thirds of 1 percent in order to offset the increased state costs for buying out the county share of the program.

The budget proposes $330 million ($99 million General Fund) for the GAIN Program in 1993-94. This is an increase of $120 million ($41 million General Fund), or 57 percent, over the 1992 Budget Act appropriation (which includes a $29 million loan from the Employment Training Fund, the repayment of which the budget proposes to defer). The budget also proposes to increase funding for the GAIN Program by $42 million ($15 million General Fund) in the current year. The proposed funding increase for 1993-94 would allow the state to match all available federal funds.

Prior to 1991-92, the state funded all of the nonfederal costs of the GAIN Program. Pursuant to the realignment legislation, counties pay for approximately 15 percent of the total costs of GAIN. Realignment also reduced the counties' share of costs for AFDC grants from approximately 5 percent to 2.5 percent. During 1991-92, the counties expended almost all funds allocated for the GAIN Program. In the current year, however, fiscal pressures have reportedly caused many counties to significantly limit their spending for the program from their own sources.

It is likely that these fiscal pressures will continue or worsen in 1993-94. We are concerned that this will cause counties to reduce their

contributions to the GAIN Program, which in turn will reduce matching state and federal spending below budgeted levels. To the extent the program is successful in reducing AFDC grant expenditures—and the recent interim evaluation reported favorable results in this respect—any reduction in spending below the amounts assumed in the Budget Act could have an adverse fiscal impact on the state, which funds almost half the costs of the grants.

In order to assure that all funds assumed in the Budget Act for GAIN are expended, we recommend that legislation be enacted to eliminate the county share of costs for the program, at a General Fund cost of $42 million in 1993-94. Further, in order to offset the $42 million in increased General Fund costs and the corresponding savings to counties, we recommend an increase in the county share of cost (reducing the state share of cost) for AFDC-FG and U grants by about two-thirds of 1 percent.

As discussed in the state/local restructuring analysis in our companion document, *Perspectives and Issues,* we do not view this as a long-term structural change in the funding of the program. Rather, it is intended to be a short-term solution to a temporary problem.

Costs of Proposals to Increase Transitional Assistance Are Not Reflected in Budget

The budget includes various proposals to provide transitional assistance to persons who go off AFDC due to employment. To the extent that these program changes increase the proportion of recipients who work and improve the ability of recipients to remain self-sufficient, the proposed changes could result in long-term savings. While the first-year fiscal impact of the proposals is not clear, we believe that some of the proposals would result in costs not reflected in the budget.

The budget proposes legislation to implement the following initiatives that are intended to increase work incentives for AFDC recipients. Each of these initiatives would require federal approval.

Transitional Child Care (TCC). Under current law, an AFDC recipient who becomes ineligible for aid because of earnings from employment would be eligible for 12 months of TCC. Recipients who work but continue to receive an AFDC grant are eligible for the regular child care allowance, but not the higher allowance provided under the TCC Program. The budget proposes legislation to provide TCC to a working AFDC recipient who is eligible for an AFDC grant but chooses to refuse it.

The budget assumes that the cost of the additional TCC would be offset by savings from AFDC recipients who choose to refuse to accept their grants. While we believe that the proposal is more likely to result in net costs than savings in the first year, it could have significant long-run benefits if it causes more recipients to work.

Transitional Child Support. Under current law, all but $50 of monthly child support payments for AFDC recipients are used to offset the costs of the AFDC grant. This also applies for the month when a family goes off aid. The budget proposes legislation that would allow the former recipient to keep the last month's child support payment.

The budget does not assume any net cost for this proposal; however, the department estimates that this provision could result in net costs of up to $2.7 million ($1.3 million General Fund) in 1993-94.

Transitional Food Stamps. Under current law, a family loses its eligibility for AFDC when its gross income exceeds 185 percent of the AFDC "need standard." (Under the budget proposal, the monthly gross income limit would be $1,321 for a family of three in 1993-94.) If a family becomes ineligible for AFDC, it would also become ineligible for food stamps. Thus, the gross income limit could act as a disincentive either to work or increase work earnings. The budget proposes to seek approval to use federal savings anticipated from the other welfare reform proposals in order to provide one year of "transitional" food stamps to families that lose AFDC eligibility due to the gross income limit. We note that the state currently has a 12-month transitional Medi-Cal Program, as required by federal law; and, as will be discussed later in this analysis, New Jersey has implemented a demonstration project to evaluate an extension of this transitional benefit to 24 months.

The budget assumes no cost for this program because federal funds would be used to pay for the food stamps costs. We note, however, that there would be unknown state and county administrative costs to implement this proposal in 1993-94. This is because food stamp administrative costs are shared by the federal, state, and county governments. To the extent the proposal results in an increase in the number of recipients who go off aid, it could result in long-run grant and administrative savings.

Other Eligibility-Related Proposals. The budget proposes legislation to change three eligibility-related provisions for AFDC recipients (but not applicants). These changes would require federal approval.

- ***Asset Limit.*** Currently, families are ineligible for AFDC if they have assets that exceed $1,000 (not counting a house or an automobile). The budget proposes to increase this limit to $2,000.

- ***Equity in Automobile.*** Under current law, families are ineligible for AFDC if they have more than $1,500 equity in an automobile. The budget proposes to increase the equity limit to $4,500.
- ***Restricted Accounts.*** The budget proposes to permit recipients to save up to $5,000 in a special account. This account would be restricted so it could be used only for specified purposes such as providing for a child's education or starting a business.

Each of these proposals is expected to allow recipients to remain on aid while accumulating additional financial resources, thereby enhancing the ability of these recipients to become self-sufficient.

The budget assumes no costs for these proposals. We would expect, however, some net costs in the short run because recipients who would otherwise become ineligible for aid will instead remain on aid longer. Net savings could result—probably in the long run—depending on the extent that the proposals induce more recipients to become self-sufficient.

Budget Includes Savings Anticipated From "Reduced Dependency"

The budget includes grant and administrative savings of $310 million ($147 million General Fund) in 1993-94 and $31 million ($15 million General Fund) in the current year from reduced dependency (lower caseloads) because of the financial incentives to work due to the reduced grant levels and other provisions contained in the proposed changes. While the Governor's proposals are likely to result in some reduction in dependency, the budget estimate of savings must be viewed with caution.

The budget anticipates grant and administrative savings in the AFDC Program resulting from "reduced dependency" because work would become a more attractive alternative. Specifically, the budget assumes that there will be 4 percent fewer cases added each month and that discontinuances—those leaving assistance—will increase by 4 percent. The budget also assumes that the proposals would result in an additional 15 percent of AFDC families reporting employment earnings.

While it is true that MAP reductions, excluding children from grants, making the transition to work easier, and increasing funding for GAIN would make employment relatively more attractive or feasible, the DSS was unable to provide any studies to document short-run behavioral responses of the magnitude assumed in the budget estimates.

In summary, while the welfare proposals are likely to result in some reduction in dependency, the estimate of short-run savings must be viewed with caution.

Delayed Implementation Could Reduce Savings Substantially

The budget assumes that legislation will be enacted to implement the proposed welfare changes on March 1, 1993. We estimate that if the proposals are implemented on July 1, General Fund savings will be less that the amount budgeted by $32 million in the current year and up to $180 million in 1993-94.

As noted above, implementation of the budget proposals will require legislation and, in most cases, federal approval. Given these requirements and the controversial nature of the proposals, the budget assumption of a March 1 implementation date appears to be unrealistic. Delayed implementation of even a few months would reduce the General Fund savings substantially.

Alternatives to the Governor's Welfare Package

We present several alternatives to the Governor's proposals. These include (1) options that we presented last year, (2) the major provisions of welfare legislation introduced in the current session (SB 34, Thompson), and (3) other alternatives, including proposals from other states.

In presenting his welfare proposals, the Governor offers several reasons why change is needed, including (1) the need to promote personal responsibility, (2) the need to reinforce the premise that AFDC is a temporary program, and (3) the need to make work an attractive alternative to AFDC. These are reasonable premises; but in evaluating the proposals, the Legislature needs to weigh the identified budgetary savings against its policy objectives for the AFDC Program and the potential impact of the proposed changes on needy families.

Reforming AFDC is difficult because the families on assistance are there for different reasons and have different needs. Many of the families will leave the program within a relatively short period of time. On the other hand, many families have been on aid repeatedly or are long-term recipients. It is also important to note that only a small percentage of AFDC parents are working. The Governor's proposal attempts to address this problem by increasing the financial incentives for AFDC recipients—or potential recipients—to work. Further, his proposal significantly increases the funds available for training programs within the GAIN Program.

Below we present several options to the Governor's proposal that, while resulting in a lower level of savings in the short run, reflect the likely employment prospects of AFDC recipients and could result in significant long-term savings.

Options From Last Year

In the *Analysis of the 1992-93 Budget Bill* (please see pages V-194 through V-196), we presented several options that would result in lower short-term savings than the Governor's proposal, but reflect the likely employment prospects of AFDC recipients and could result in significant long-term savings. These include the following:

- ***Exempt Active GAIN Participants From the 15 Percent Additional MAP Reduction.*** We note that the 15 percent additional MAP reduction (effective after 6 months on aid) exempts teen parents who are in school. Along these lines, we suggest that, if adopted, this proposal also exempt for a period of time (such as an additional 6 to 12 months) all "active" GAIN participants. This would give GAIN participants a reasonable time to complete their training prior to the grant reduction and would encourage participants to expedite their training.

- ***Refine the Work Incentive.*** In order to increase the work incentive without increasing caseloads or reducing the MAP, the Legislature could request a waiver to create a "two-tier need standard" under which recipients who have been on aid for a period of time (six months, for example) would have a higher need standard, which has the effect of allowing them to retain a greater portion of their earned income.

- ***Time-Limited AFDC Grants.*** While most families leave assistance in less than three years, there are a significant number who are on assistance for much longer spells. To address this problem, several members of the academic community have recently advocated limiting lifetime eligibility for AFDC recipients to some specified period (for example, four years). A family could use the benefits all at once or in increments; however, once the time limit was reached, the family would no longer be eligible for AFDC. One variation of the proposal would be to phase out the grant over a period of time so the recipient would not lose the grant all at once. In another variation, only the adult members of the family would be removed from the assistance unit once the time limit was reached—leaving the children on assistance.

We believe that any proposal to establish time-limited AFDC grants should consider programmatic efforts to increase access to employment training and other services needed by families to become self-sufficient when grant eligibility runs out. In addition, a time-limited grant proposal should consider provision for jobs in the public sector or with nonprofit organizations for those recipients who are unable to obtain private sector jobs but could instead "earn" their grant in this manner. This option could also include provision for emergency grant assistance for persons who are considered unemployable.

This proposal would result in additional "up front" costs in order to provide employment training and other services to recipients, but long-term savings would be substantial. Under a four-year limit, for example, General Fund savings in reduced grant expenditures could be over $1 billion annually, beginning four years from the date of implementation. This excludes the costs of any services that would be provided.

Senate Bill 34

Senate Bill 34 contains a number of proposals for changing the AFDC, food stamps, and Medi-Cal programs. Its provisions are drawn primarily from SB 1834 (Thompson) of last year's session.

Welfare Administration. SB 34 proposes a number of changes in both state and county administration of the AFDC, Medi-Cal, and food stamps programs.

- ***Consolidated Public Assistance Eligibility Determination Project.*** This provision conforms a number of AFDC, Medi-Cal, and food stamps eligibility rules in order to reduce the cost of eligibility determination for these programs. Currently, these programs have eligibility requirements that differ in important respects (such as the manner in which each program calculates the worth of an automobile). Many of these proposed changes would require federal approval. The State of Alabama operates a consolidated eligibility determination demonstration project that includes some of the changes proposed in SB 34.

- ***State Administrative Reforms.*** SB 34 also proposes changes in state administration of public assistance programs. Specifically, the bill requires that state allocations to county welfare departments be based on specified productivity standards (for similar size counties), county caseloads for each program, and annual random time studies. Further, under current law, all

public assistance recipients must file monthly eligibility verification forms. SB 34 requires the department to test a system based on periodic reporting by a random sample of recipients.

Family Planning Accessibility Project. The bill (1) requires counties to provide information about family planning services to AFDC recipients at specified times and (2) encourages counties to improve access to family planning services through means such as establishing facilities in or near public assistance offices and providing transportation vouchers when facilities are located away from public assistance offices.

California Work-Grant Program. The bill creates the California Work-Grant (CWG) Program to replace the GAIN Program. It retains the basic components of GAIN, but also requires AFDC recipients who have been on aid for 22 out of the last 24 months to either obtain employment or participate in a "preemployment preparation" assignment; otherwise the recipients' MAP would be reduced by 75 percent. In addition, the bill directs the department to seek federal approval to increase the number of available preemployment preparation jobs. (Currently, federal law contains restrictions on such jobs for GAIN participants.) The CWG proposal also authorizes expenditure of support funds to provide family planning information and services. Finally, it modifies the GAIN participation requirement by limiting the exemptions for persons with young children to a one-time exemption for a child under two years of age. Currently, the parent of a child under three years of age is exempt.

Cal Learn Program. SB 34 creates a Cal Learn Program for teen parents within the new CWG. The program requires all teen parents under age 19 who have not completed high school to attend school. The program—similar to the budget proposal—would include both bonuses ($100 per school attendance reporting period) and penalties ($100 every two months) based on progress in school. Satisfactory progress is defined as maintaining at least a 1.0 (a "D" average) grade point average on a four-point scale.

AFDC MAPs. SB 34 makes two changes in AFDC MAPs:

- ***Maximum Family Grant.*** The bill excludes from the AFDC MAP any child born to a family who has been receiving aid continuously for ten months prior to the birth of the child. This provision is similar to the budget proposal. SB 34, however, exempts children conceived as a result of rape, incest, or failed contraceptive devices. SB 34 also provides that child support payments received by the family for children "excluded" from the MAP will not be used to offset the family's AFDC grant.

- *Regional AFDC MAPs.* The bill groups the counties into four regions, presumably to serve as the basis for the establishment of regional AFDC grants.

Child Care. Under current law, an AFDC recipient who reports income from work can deduct from these earnings up to $175 per month ($200 per month for children under two years of age) for each child, for purposes of determining the family's AFDC grant. SB 34 provides a supplemental child care payment to cover the actual child care costs that exceed the "disregard" in current law (up to a limit based on surveys of local child care costs). The bill also directs the department to develop and distribute information about the state's TCC Program, which is available to AFDC recipients who go off aid due to employment.

Food Stamps Administration. SB 34 requires counties to pay 100 percent of the nonfederal share of costs (50 percent of the total costs) for administering food stamps provided to individuals who are also receiving county general assistance. Under current law, the county share is 15 percent of the total costs and the state share is 35 percent of total costs. Thus, the bill would require the county to assume the state share for costs associated with certain individuals.

What Other States Are Testing

Many states have proposed or implemented changes in the AFDC Program. Some of these proposals include components that are similar to those proposed in the budget (for example, grant reductions and the Maximum Family Grant). In this section, we outline some other proposals from these states.

New Jersey Family Development Program. New Jersey has received federal approval for a package of proposals that focuses on increasing work incentives, providing incentives regarding family formation, and increasing participation in the JOBS Program (the federal nomenclature for California's GAIN Program). The proposals include the following:

- *Benefits For Two-Parent Families Where the Husband Is Not the Father.* This provision would allow AFDC benefits for families in two-parent, low-income families when the husband is not the father of the children. The intent, presumably, is to provide a marriage incentive to single parents on AFDC.

- *State's JOBS Program.* This provision makes changes in New Jersey's JOBS Program to (1) make participation mandatory for a larger number of persons than required under federal

regulations and (2) reduce AFDC grants by specified amounts for failure to participate in JOBS when participation is mandatory.

- *Earned Income Disregard.* The program establishes a 50 percent "earned income disregard" in computing AFDC grants for JOBS participants who are employed as family day care providers. This would provide larger grants to these persons. In addition, JOBS participants under age 25 with earnings from non-Job Training Partnership Act training programs will have all their earned income disregarded.

- *Medicaid.* The program provides 24 months of Transitional Medicaid for families who leave aid due to employment. Federal law currently provides for a 12-month program.

Oregon JOBS Waiver Project. Oregon has received federal approval to make a number of changes to its JOBS Program.

- *Mental Health and Drug and Alcohol Dependency.* Mandatory JOBS participants can be required to participate in mental health or drug and alcohol dependency programs as part of their JOBS contract.

- *Extended Job Search.* JOBS participants who are assessed as "job ready" may be required to engage in job search beyond the current federally required eight-week and four-month JOBS limits.

- *Participation and Eligibility.* The program expands JOBS participation requirements and expands eligibility to include pregnant women not on AFDC, but who are eligible for Oregon's Poverty Level Medical Program.

Wisconsin Parental and Family Responsibility Demonstration Project. Wisconsin has recently received federal approval to establish a demonstration project directed at both custodial and noncustodial teen parents.

- *Earned Income Disregards.* The program expands the earned income disregard to the first $200 and 50 percent of remaining earnings and, for two-parent families, eliminates the 100-hour rule for AFDC-U recipients. As discussed earlier in this analysis, expanding the disregard and eliminating the 100-hour rule would have the effect of increasing the incentive for recipients to work or to increase their hours of employment.

- *Maximum Family Grant.* For those families in the demonstration, the first child born after coming on aid would receive one-half of

the standard MAP increment and there is no increase in the MAP for any additional children born while on aid.

- *Other Provisions.* All participants in the demonstration are assigned a case manager who assists the family in developing a comprehensive education, employment, and services plan. Parents are required to participate in JOBS, including parenting and life skills instruction. Noncustodial parents of families in the demonstration who are not paying child support may be ordered by the court to participate for up to 40 hours per week in a combination of activities that include work, JOBS, and parenting and life skills instruction.

Maryland Primary Prevention Initiative. Maryland has received federal approval to provide bonuses and apply sanctions to families who fail to participate in specified preventive health or education programs.

- *Pregnant Mothers.* Pregnant AFDC recipients will receive a $14 monthly special needs allowance if they receive regular prenatal care. An additional $14 monthly allowance will be provided for prenatal care during the last trimester of pregnancy.

- *Annual Health Checkups.* Families with school-age children will receive a $20 annual allowance per person if they receive an annual health checkup.

- *Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Standards.* Families that do not meet the federal EPSDT Program's minimum standards for child health screening are subject to a $25 per month sanction for each child. The EPSDT Program provides preventive health screens and assessments to Medi-Cal eligible children.

- *School Attendance.* Families with school-age children who attend school less than 80 percent of the time without good cause are subject to a $25 per month sanction for each child not meeting the standard.

Michigan Program To Strengthen Families. Michigan has recently received approval for a demonstration that focuses on preservation of two-parent families, increasing work incentives, and increasing employability of noncustodial parents.

- *AFDC-U Eligibility.* Michigan has received approval for waivers of several employment-based AFDC-U rules, including the 100-hour rule.

- ***Earned Income Disregard.*** The current earned income disregard will be replaced by a disregard of the first $200 of earned income plus 20 percent of any remaining earned income.
- ***Other Provisions.*** All income earned by dependent children of AFDC recipients will be excluded when considering the family's eligibility for AFDC. In addition, noncustodial parents will be eligible for Michigan's JOBS Program.

New York Child Assistance Program. New York has received federal approval to establish a Child Assistance Program (CAP), which is a "child support assurance" demonstration for custodial parents on AFDC. The program offers parents with child support orders an alternative to AFDC. Under this alternative, families are eligible to receive a basic annual maximum grant of $3,000 for the first child with a support order and $1,000 for each additional child with an order. This grant is less than what these families would receive if on AFDC. In addition, the $50 monthly "pass-through" of child support payments to recipients is eliminated, so all child support payments (up to the grant amount) go to the state. Working recipients, however, are permitted to retain a much higher amount of earnings—90 percent of earned income below the federal poverty guideline and 33 percent of earnings above the poverty guideline. Further, the CAP has received other waivers affecting eligibility, including the gross income limit rule and the limit on resources (savings).

Alternatives for the Legislature

In the preceding section, we review a variety of welfare reform proposals being implemented, on a demonstration basis, by other states. While the cost-effectiveness of these projects has not been determined, the Legislature might wish to consider them for further testing on a pilot basis in California. We also develop two additional proposals for legislative consideration:

1. Require that AFDC families obtain certain immunization shots for children under four years of age or be penalized by a specified reduction in the family's grant.

2. Provide transitional Medi-Cal benefits to AFDC recipients who go off aid due to marriage.

While the cost-effectiveness of the other states' proposals has not been determined, they have the potential to reduce health and welfare costs in the long run, and therefore similar programs may warrant further testing on a pilot basis in California. We offer two additional proposals for legislative consideration:

Child Immunization Incentive. The basis for this proposal is Maryland's project which reduces monthly AFDC grants by $25 for each child who does not receive preventive health screenings provided through the federal EPSDT Program. The goal of the EPSDT Program is to achieve long-term savings in health costs by providing early detection and prevention of disease and disability. Whether the Maryland project proves to be cost-effective will depend on whether the resulting savings in health expenditures, in conjunction with any grant savings from the penalties, exceed the costs (generally in the Medi-Cal Program) resulting from the additional health screens and associated treatments.

The Legislature might also wish to consider a more focused variation of this project, which would be limited to immunizations for children under four years of age. As we discuss in our analysis of the Department of Health Services' direct purchase vaccine program (please see Public Health), the percentage of immunized children in ages three years and under is very low, even though immunizations are provided free of charge to children in low-income families by public clinics throughout the state. The state could realize significant long-term savings by increasing the level of immunization of these children. Compared to Maryland's EPSDT project, this variation would not capture as much long-term savings but probably would have lower costs and would be more accessible due to a broader network of providers.

Transitional Medi-Cal for Recipient Who Gets Married. Federal law requires all states to provide transitional Medicaid, for up to 12 months, to AFDC recipients who lose their eligibility because of an increase in employment earnings. The Legislature might wish to consider a demonstration project to evaluate a transitional Medi-Cal benefit that is structured so as to provide a "marriage incentive" for AFDC recipients. Given the rising costs of health insurance, it stands to reason that the loss of Medi-Cal coverage, in conjunction with the loss of an AFDC grant and food stamps, has dissuaded AFDC recipients from getting married. To address this, a transitional Medi-Cal benefit could be offered to recipients who go off aid because they get married. (As is the case with the existing program, such a benefit would, in effect, be means-tested and would not be provided if alternative health insurance were available.) Like the other transitional assistance proposals in the budget and in other states, this would result in short-term costs, but could prove to be cost-effective in the long run, depending on the extent to which more recipients get married and thereby go off aid.

County Administration of Welfare Programs

Budget May Overestimate Spending

The budget proposes $1.6 billion ($380 million General Fund) for county administration of welfare programs in 1993-94. We note, however, that the General Fund proposal may be more than the amount that will be expended because counties may be unable to match all of the state and federal funds assumed in the budget due to fiscal constraints at the local level.

The proposed expenditures for county administration of welfare programs in 1993-94 are based on 1992-93 budgeted costs, updated to reflect the department's caseload estimates for 1993-94. The budget estimate for the current year includes a savings of $45 million ($15 million General Fund). These savings reflect (1) the most recent expenditure data from the counties and (2) the results of a departmental survey of county ability to match the funds appropriated for the current year. The budget, however, does not assume these savings in 1993-94.

Due to the continuing fiscal pressure on counties, we anticipate that they will be unable to match all of the funds assumed in the budget. In May, the department will present revised estimates of county administration costs, and should address this issue.

Aid to Families with Dependent Children—Foster Care

Foster Care Rate-Setting System Needs Statewide Assessment Guideline

We find that counties do not use standardized criteria to assess the special needs of foster children, thereby resulting in wide variations in the grant amounts provided to these children. We recommend that the department report, during budget hearings, on the feasibility of developing a standardized assessment guideline to determine foster care grant amounts for children with special needs.

Background. Most of the children placed in foster care (approximately 75 percent of the total caseload) are placed in foster family homes. Individuals caring for these children generally receive a grant equal to the basic foster family home grant, ranging from approximately $345 to $484 per month (depending upon the age of the child), for the basic care and supervision of the foster child. Children with special medical and/or behavioral needs are eligible for a specialized care increment over and above the basic foster family home

rate for the cost of supervision to meet their additional daily care needs. According to the Department of Social Services (DSS), approximately 20 percent of the children placed in family homes receive a specialized care increment. The average specialized care rate (the basic rate plus the specialized care increment) is approximately $642 per month.

California's current Specialized Care Rate-Setting System was developed in 1982. The system authorizes counties to develop, administer, and maintain a specialized care rate-setting system that meets the needs of their foster care population. Since 1984, counties have been required to obtain approval from the DSS prior to adopting or modifying a specialized care rate-setting system. Counties must demonstrate that the adoption or modification does not increase General Fund expenditures for foster care payments.

At the time this analysis was prepared, 48 of the 58 counties had a specialized care rate-setting system approved by the DSS. (Alpine, Calaveras, Colusa, Lake, Lassen, Modoc, Plumas, San Benito, Sierra, and Sutter do not have a system in place.) Figure 27 lists the 48 counties and identifies the minimum and maximum amounts of the specialized care increment, as reported by the counties. (The amounts listed exclude the *basic* foster family home rate.)

There Is a Large Variation Among the Counties In the Specialized Care Increments (SCIs) for Special Needs Children. Figure 27 shows significant differences among the counties for the minimum and maximum monthly SCIs that can be authorized by county social workers for special needs children. For example, *minimum* monthly SCIs range from $1 dollar (Trinity County) to $494 (San Francisco). *Maximum* monthly SCIs range from $62 dollars (Kings County) to *no* maximum limit (Alameda, San Francisco, and Santa Clara Counties). According to our conversations with state officials, these differences in minimum and maximum grants generally reflect county *differences in rate-setting systems* rather than differences in the needs of children among counties; although state officials also indicate that urban areas have higher maximum grants than rural areas to reflect higher costs of living and the resulting difficulties in recruiting and retaining foster parents. Even in high cost areas, however, the variation is significant. The maximum in Santa Barbara, for example, is $218 whereas in San Mateo it is $1,419.

All of the 48 counties have specified *minimum* payments and 15 have minimums of $100 or more. Our review indicates that there is no basis for requiring a minimum SCI because this could arbitrarily require the social worker to provide a payment higher than the amount needed or not to provide *any* SCIs. Similarly, a *maximum* SCI may arbitrarily cap

the payment below the amount needed; but in recognition of fiscal constraints, a maximum funding level may be necessary.

Figure 27

AFDC-Foster Care Program
Minimum/Maximum Specialized Care Increments[a]
October 1992

	Specialized Care Increments			Specialized Care Increments	
	Minimum	Maximum		Minimum	Maximum
Alameda	$13	No Maximum	Placer	242	375
Amador	118	$365	Riverside	11	555
Butte	10	160	Sacramento	36	875
Contra Costa	45	846	San Bernardino	25	805
Del Norte	100	300	San Diego	35	1,470
El Dorado	336	503	San Francisco	494	No Maximum
Fresno	44	574	San Joaquin	84	1,352
Glenn	118	352	San Luis Obispo	56	392
Humboldt	59	82	San Mateo	61	1,419
Imperial	46	157	Santa Barbara	50	218
Inyo	200	400	Santa Clara	29	No Maximum
Kern	20	441	Santa Cruz	300	810
Kings	5	62	Shasta	364	813
Los Angeles	125	831	Siskiyou	240	330
Madera	54	175	Solano	82	331
Marin	429	1,497	Sonoma	20	394
Mariposa	30	30	Stanislaus	71	800
Mendocino	168	529	Tehama	201	600
Merced	60	178	Trinity	1	400
Mono	200	400	Tulare	5	529
Monterey	82	279	Tuolumne	5	122
Napa	31	442	Ventura	41	340
Nevada	28	619	Yolo	25	803
Orange	60	1,221	Yuba	5	100

[a] The Specialized Care Increments were compiled based on the most recent county data provided to the California Department of Social Services.

Specialized Care Rate-Setting System Needs Statewide Assessment Tool. Our review of the SCI data indicates that counties do not use statewide standardized criteria to define what constitutes special needs or determine whether a child has such needs. In addition, the counties lack a statewide assessment mechanism to determine the amount of the SCI grant. Instead, each county has developed its own guidelines for determining whether a child has special needs, assessing the special needs, and determining the amount of the SCI. We believe that a

statewide standardized assessment guideline would help to ensure that children with special needs are *identified* and *assessed* according to a standardized definition, and that children with similar special needs are assessed in a uniform manner throughout the state.

In order to determine the appropriate SCI grant amount for each child, the assessment tool could establish a statewide system to assign special needs "points" to each child, to be used to determine an SCI grant. The system could be designed to account for legitimate variation among counties for factors such as regional costs of living. We note that there is literature that could provide guidance in the development of such a system. In addition, we note that the department is currently developing a Level-of-Care Assessment Tool to assess the needs of group home children and to "match" these children with group homes that meet their specific needs.

Accordingly, we recommend that the department report, during budget hearings, on the feasibility of developing a standardized assessment tool to define special needs of children placed in foster family homes, determine whether a child has special needs, and determine the amount of the SCI grant.

Program Effectiveness Has Not Been Determined for Family Preservation

The DSS has not submitted to the Legislature two reports on the Family Preservation Program that were due in December 1991 and June of 1992. We also note that the budget does not assume any net savings for the program in 1992-93 or 1993-94. We recommend that the department report during budget hearings on the status of the reports and the cost-effectiveness of the program.

Background. The Family Preservation Program was created in 1988 by Chapter 105, Statutes of 1988 (AB 558, Hannigan) as a pilot program to provide intensive short-term family maintenance and family reunification services designed to avoid out-of-home placement of children and reduce the length of stay of such placements when they occurred. Services may include (but are not limited to) counseling, substance abuse treatment, respite care, parent training, crisis intervention, and teaching and demonstrating homemaking.

Under the program, counties are authorized to "draw down" up to 25 percent of the state share of the *projected* foster care costs to provide family preservation services. If counties are successful at reducing their actual foster care costs, any resulting General Fund savings are shared by the state (75 percent of savings) and counties (25 percent of savings).

If counties' actual foster care costs (including the amount forwarded to counties for family preservation services) exceed projected foster care costs by over 5 percent, counties are required to fund 100 percent of this overage.

Chapter 91, Statutes of 1991 (AB 948, Bronzan) authorized the expansion of the program on a statewide basis in 1991. Twelve counties currently participate. The budget includes $25.1 million from the General Fund for the program in 1993-94.

The DSS indicates the pilot program in the three demonstration counties (Alameda, Solano, and Napa) was completed by June 1991. According to Chapter 105, the pilot is determined to be successful if at least 75 percent of the children receiving services remain in their own home for six months after termination of services, and if at least 60 percent remain at home one year after services are terminated. With respect to children selected to receive project services who have already been removed from their home and placed in out-of-home care, the project is successful if the average length of stay in out-of-home care is 50 percent less than the average length of stay for corresponding children who do not receive program services.

The department is required to determine that a county has met the program's criteria for success prior to authorizing continuation of the advance fund-claiming mechanism. Either the department or the county may terminate a county's participation in the program if the project is deemed unsuccessful by either party.

Mandated Reports Have Not Been Submitted. Chapter 105 requires the DSS to submit a report to the Legislature that includes data from each participating county demonstrating to what extent each has met the above criteria. The act requires an interim report to be submitted by the department six months after the conclusion of the three pilot projects (to determine whether the projects met the six month success criteria), followed by a final report to determine whether the projects met the one year success criteria. These reports were required to be submitted by December 1991 and June 1992, respectively. Our review indicates that these reports have not yet been submitted to the Legislature.

Budget Does Not Assume Savings for Family Preservation. Our review indicates that the budget does not assume any *net* savings for the Family Preservation Program for 1992-93 or 1993-94. Rather, the budget assumes that savings are equal to expenditures for this program. The department, however, indicates that estimates of savings will be revised for this program and will be available prior to budget hearings.

Analyst's Recommendation. We recommend that the department report, during the budget hearings, on (1) the status of the family preservation reports and (2) the cost-effectiveness of the program in 1992-93 and 1993-94.

Budget Action Shifts Costs to Schools

We find that budgeted state savings due to increased federal support for nonprofit group homes are overstated, thereby creating a potential deficiency of $150,000 in the current year and $300,000 in 1993-94. We also find that the authority to reimburse group home costs for severely emotionally disturbed children within the Foster Care Program has been inadvertently terminated. Accordingly, we recommend enactment of legislation to reimburse group homes providing residential care to severely emotionally disturbed children.

Background. The 1992 Budget Act, as implemented by Ch 722/92 (SB 485) requires all group homes to be organized and operated on a nonprofit basis by January 1, 1993 as a condition of receiving state reimbursement under the AFDC-Foster Care (AFDC-FC) Program. The intent of this act is to maximize federal funds because for-profit homes are not eligible for these funds.

The budget assumes increased federal funds of $11.3 million in 1992-93 and $23.4 million in 1993-94 related to this change. The budget also includes corresponding savings of $4.5 million and $9.4 million to the General Fund, and $6.8 million and $14 million to the counties in 1992-93 and 1993-94, respectively. This is based on an assumption that all children were placed in nonprofit group homes by January 1, 1993, and that all group homes operated on a nonprofit basis are eligible for federal funds.

Chapter 1747, Statutes of 1984 (AB 3632, Willie Brown) established a program to reimburse foster care group homes that provide care for seriously emotionally disturbed (SED) children who have been placed out of home pursuant to an individualized education program (IEP).

Estimated Foster Care Savings Are Overstated. The department's estimate of savings from increased federal funds in the current and budget years assumes that the costs of all for-profit group homes, including those that care for SED children, will be eligible for 50 percent federal funding upon conversion to nonprofit status. Our review, however, indicates that group homes that care for SED children are *ineligible* for federal funding because no court adjudication is involved in their placement (a condition of receiving federal funds). The DSS acknowledges that SED children are ineligible for federal

reimbursement, and that the budgeted General Fund savings are overstated in 1992-93 and 1993-94. We estimate that General Fund savings are overstated by approximately $150,000 in 1992-93 ($375,000 total funds) and approximately $300,000 in 1993-94 ($750,000 total funds). Because group home care for SED children is an entitlement, these costs must be funded regardless of budgeted levels. The department indicates that it will modify its estimate in the May Revision.

Budget Action Inadvertently Terminates Authority for Reimbursement of Group Home Costs for SED Children. As noted above, Chapter 722 requires providers of out-of-home care to be organized and operated as nonprofit entities in order to receive AFDC-FC reimbursements. According to information provided by the State Department of Education (SDE), as of December 1992 there were eight group homes providing residential care to 76 SED children (74 in out-of-state homes and 2 in-state) that had not converted (or are not in the process of converting) to nonprofit status. Consequently, they are currently *ineligible* for state and county reimbursement under the Foster Care Program. These SED children are still required to receive residential care to meet their special education needs, according to their IEPs. Because the DSS is not authorized to reimburse for-profit homes, the responsibility for reimbursing the residential costs for these 76 SED children will fall upon the SDE and local education agencies (LEAs).

We estimate that the costs of these SED placements would be approximately $1.5 million in 1992-93 and $2.8 million in 1993-94. These costs would be funded from Proposition 98 education funds. Because the SDE and the LEAs would be responsible for paying the *total* costs of this group home care (including the county share), we estimate that the costs for these SED placements will *exceed* those that would otherwise be funded by the state under the Foster Care Program by approximately $900,000 in 1992-93 and $1.7 million in 1993-94. According to the SDE, these costs would be paid by the state with funds redirected from special education apportionments to school districts and county offices of education in 1992-93 and 1993-94. (Please see our analysis of the State Department of Education for more information on the impact on education programs.)

Analyst's Recommendation. In order to carry out the Legislature's intent in Chapter 1747 to provide funding for residential care of SED children from the Foster Care Program (rather than from education funds), we recommend the enactment of legislation authorizing the DSS to reimburse group homes providing residential care to SED children. In order to mitigate any effects on LEA funding, the provisions could be implemented retroactive to January 1, 1993. Because the funds for

providing these services are already included in the budget, no augmentation would be required.

Closure of County Probation Facilities Could Have Major Impact on Foster Care

We recommend that the Legislature direct the DSS and the Department of Finance to consider the impact of potential closures of county juvenile camps and ranches on the foster care caseload when developing the May Revision.

Background. In general, counties have four major choices for the treatment of youthful offenders whom the juvenile court declares as wards. These choices are: (1) placement at home on probation; (2) commitment to a county juvenile hall, camp, or ranch; (3) placement in AFDC-FC, usually in a group home setting; or (4) commitment to the California Youth Authority.

Placements on probation or in a county facility are supported almost entirely by county funds. Placement in AFDC-FC is supported by state, county, and federal funds. Youth Authority commitments are supported almost entirely by the state (counties pay only $25 per month for each commitment).

Counties Consider Closure of Camp Programs. Because of fiscal constraints on county governments, two counties have recently closed camps and ranches and many more are considering closure, including Contra Costa, Los Angeles, Riverside, and Santa Clara Counties. Los Angeles County recently announced it tentatively plans to close most or all of its 19 camps at the end of April 1993. These camps house about 2,100 juvenile offenders.

Our analysis indicates that closure of county camps and ranches could result in large increases in foster care caseloads, increasing General Fund costs substantially. In addition, the closure would result in a large increase in the ward population of the Youth Authority, thereby increasing General Fund costs. This will be especially true if Los Angeles County carries forth on its plan to close its camps. (Please see our analysis of the Department of the Youth Authority for more information on this impact.)

Closure of Camps Could Increase Foster Care Caseloads and Costs. Because alternative placement options for wards are limited, any reduction in camp programs is likely to increase placements in foster care group homes and family homes. For example, Los Angeles County estimates closure of the camps will result in 1,000 commitments being

placed in family homes and group homes. Of these 1,000 foster care placements, 100 are expected to be placed in family homes, while 900 are expected to be placed in group homes. Since the state pays for 20 to 40 percent of the costs of foster care (depending upon the percentage of cases eligible for federal funding), such placements could increase state costs by about $13 million in 1993-94. To the extent that any wards are placed in group homes and family homes in May and June of the current year, state costs could be approximately $2 million in 1992-93.

Analyst's Recommendation. In our view, the number of counties considering closing camp facilities is only likely to grow in the coming months given the deteriorating local fiscal situation. Given the fiscal and programmatic consequences that these actions could have on the Foster Care Program, we recommend that the Legislature direct the DSS and the Department of Finance to consider the impact of the camp closures on the foster care caseload and cost estimates when developing the May Revision.

Adoptions Assistance Program

Capping Adoptions Assistance Program (AAP) Grants May Have Adverse Impacts

We find that the cap on AAP grants may not comply with federal law. We also find that the cap may reduce AAP adoptions of children with serious medical and/or behavioral problems. We recommend that the Department of Social Services (DSS) collect additional data in order to assess the impact of the reduction in grants.

Background. The AAP provides grants to parents who adopt "difficult to place" children. State law defines these children as those who, without assistance, would likely be unadoptable because of their age, racial or ethnic background, or handicap, or because they are a member of a sibling group that should remain intact. Adoptive parents receive AAP grants until their child is 18 years of age, or until age 21 if the child has a chronic condition or disability that requires extended assistance. Children adopted under the AAP typically reside in a foster family home prior to adoption. Often, AAP adoptive parents were the foster parents of the child.

Prior to October 1, 1992, generally the amount of adoption assistance grant was equal to the grant amount the child would have received if he or she had remained in foster care. In most cases, this means that the grant did not exceed the basic foster family home rate, ranging from approximately $345 to $484 per month, depending on the child's age.

However, adoption workers were able to supplement the basic rate with a specialized care increment (SCI) (at an average monthly grant of approximately $642) for children who required additional supervision because of health and/or behavior problems. Generally, this was provided if the child had been receiving a SCI in a foster family home. Adoption workers could also set AAP grants as high as the foster care *group home* rate (at an average monthly grant of approximately $2,780) for children who required residential care (after they had been adopted) as a result of their special needs. In other words, prior to October 1, 1992, a child was eligible to receive up to the *same* amount under the AAP as he/she would under the Foster Care Program.

1992 Budget Act Caps AAP Grant Amount. The 1992 Budget Act, as implemented by Ch 722/92 (SB 485) limits AAP grants to the basic foster family home rate for all new AAP agreements signed on or after October 1, 1992. Thus, an AAP grant would not include a SCI or a group home rate because they exceed the basic family home rate. This change is estimated to result in General Fund savings of $1.3 million in 1992-93 and $1.5 million in 1993-94.

Federal Financial Participation. Federal law (Public Law 96-272) authorizes federal financial participation in AAP grants. The act requires the AAP grant to be based upon the *special needs* of the child and the *circumstances* of the family. As a condition of federal financial participation for the AAP, the act prohibits payments from exceeding the foster care payment levels for that child if he or she were in a foster family home. (A SCI would be eligible for federal reimbursement because it is part of the foster family home payment, while the costs for a group home would not.)

AAP Cap May Not Comply With Federal Law. Our review of the federal law, which includes discussions with federal AAP officials, indicates that California's 1992 cap on AAP grants may not comply with the intent of federal law. Specifically, a foster child who is receiving a SCI as a result of a special need (at a rate *above* the basic foster family home rate) would have his or her grant reduced to the basic rate upon adoption under the AAP. Because federal law requires the AAP payment to consider the special needs of the child being adopted, it appears that the changes in state law may not be in compliance with this requirement. According to our conversations with federal officials, if the federal government officially determines that the AAP Program is out of compliance with federal law, penalties of up to $12 million and $31 million could be assessed in 1992-93 and 1993-94, respectively.

Cap on AAP Grants May Reduce Adoptions of Children With Serious Medical and/or Behavioral Problems. The budget assumes that

adoptions of special needs children will increase by 23 percent in 1993-94, despite the cap on AAP grants. The effect of the cap is to prohibit adjustment of the AAP grant for the additional supervision required to care for a child with a medical and/or behavioral problem. The cap also prohibits adjustment of the grant to cover group home costs, if residential care becomes necessary. Our conversations with county adoptions officials indicate that foster children with the most serious medical and/or behavioral problems are less likely to be adopted as a result of the cap on the AAP grant, because the basic foster care rate is not sufficient to meet the special needs of the child. According to the California Association of Adoptions Agencies, a pattern is emerging on a statewide basis indicating that fewer children with serious medical and/or behavioral problems are being adopted after implementation of the cap, because the basic foster family home rate does not cover the additional costs of caring for these children. Since most children with serious health and behavioral problems are *already* living in a long-term foster family home and receiving a SCI, these children are expected to remain in foster care.

At the time this analysis was prepared, the DSS indicated that data were not yet available on the number of special needs adoptions after implementation of the AAP cap. We expect that data on the number of these adoptions will become available within a few months. We note, however, that in the month of September 1992 (the month prior to the AAP cap), there were 533 AAP adoptions, compared with an average of 268 AAP adoptions in prior months. This represents an increase of *99 percent*. According to county administrators, adoptions workers accelerated the processing of adoptions agreements before implementation of the cap because they anticipated that otherwise the adoptions applications would be withdrawn.

Analyst's Recommendation. At the time this analysis was prepared, it was unclear if the cap on AAP grants had reduced the number of adoptions. However, a survey of adoption agencies could be conducted to determine the extent to which the AAP cap has affected the *total* number of adoptions. In addition, such a survey could determine the extent to which the cap has specifically affected the number of adoptions of children with serious medical and behavioral problems. Our analysis indicates that this information will be necessary in order for the Legislature and Administration to fully evaluate the impact of the AAP cap. For this reason, we recommend that the DSS collect this survey data and, if feasible, present the findings prior to the May Revision. We believe that this information will assist the Legislature in assessing the impact of the cap.

CHILD WELFARE SERVICES

The Child Welfare Services (CWS) Program provides services to abused and neglected children and children in foster care and their families. The program has four separate elements:

- *The Emergency Response Program* requires counties to provide immediate social worker response to allegations of child abuse and neglect.
- *The Family Maintenance Program* requires counties to provide ongoing services to children (and their families) who have been identified through the Emergency Response Program as victims, or potential victims, of abuse or neglect.
- *The Family Reunification Program* requires counties to provide services to children in foster care who have been temporarily removed from their families because of abuse or neglect.
- *The Permanent Placement Program* requires counties to provide management and placement services to children in foster care who cannot be safely returned to their families.

The budget proposes expenditures of $585 million ($156 million General Fund, $311 million federal funds, $114 million county funds, and $4 million in reimbursements) for the CWS Program in 1993-94. The proposed General Fund amount represents a decrease of $69 million, or 30 percent from the current year. This reduction does not reflect a programmatic change, but rather a substitution of available federal funds for General Fund support for this program.

State Guideline May Not Result In Standardized Screening Decisions Among Counties

We find that the new guideline for screening emergency response cases may not standardize the process statewide as intended by the Legislature because it does not preclude substantial variation in screening decisions due to differences in county policies. We recommend that the department report during budget hearings on the effect of the guideline.

Background. In March 1991, the Department of Social Services (DSS) promulgated emergency regulations for the CWS Program that required counties to screen (by use of telephone assessments) reports of child abuse or neglect to determine whether an in-person investigation is necessary. The practical effect of these regulations was to reduce the

number of investigations of alleged abuse and neglect. The regulations listed 34 types of situations that *would not* be considered appropriate for an in-person investigation of alleged abuse and neglect. Counties, however, were permitted to adopt their *own* policies on the types of situations that would not be considered appropriate for investigation. Thus, a report of abuse or neglect could be determined as appropriate for investigation in one county, while another county may consider the same report inappropriate and therefore no investigation would be conducted.

In 1991, an average of 27 percent of Emergency Response cases statewide were screened out. This ranged from zero cases screened out in Modoc County to 66 percent in Humboldt County. According to the department, this wide variation was the result of differences in local policies and in interpretation of the definition of abuse and neglect, rather than differences among counties in the types of reports received.

New Screening Guideline Developed. In order to address concerns that the process focused on screening out appropriate referrals and to ensure that screening is conducted in a uniform manner, Ch 780/91 (AB 60, T. Friedman) required the DSS to contract for the development of a statewide protocol, or guideline, for telephone screening of Emergency Response reports. Regulations to implement the guideline became effective December 1, 1992.

The new guideline is based on an "inclusionary" approach. The focus is placed on gathering sufficient information in order to screen appropriate cases *into* the CWS system, rather than screening *out* inappropriate cases. In other words, cases that meet the definition of abuse or neglect will be referred for investigation. Screening decisions are premised on using broad legal definitions of child abuse and neglect. However, the guideline is not specific—screening decisions are, to a large degree, based upon the screener's professional judgment. In addition, counties are not prohibited from continuing to use their *own* screening policies in the decision-making process.

New Guideline May Not Result in Standardized Screening Decisions Among Counties. Our analysis indicates that the guideline may not result in standardized screening decisions among counties as intended by the Legislature. Some counties, for example, screen out all reports of neglect based on a child being home after school without supervision ("latch key" children) or "screen in" all calls regarding children under age five. Therefore, the guideline may not meet the apparent intent of Chapter 780, in that it does not result in a uniform policy throughout the state.

Evaluation Will Determine Effects of Guideline. The department indicates that a study is underway to determine the effects of the guideline on the screening process, and the extent to which the guideline results in standardized screening decisions among counties. The study will assess data from three counties (Santa Clara, Kings, and Riverside) and one region within Los Angeles County. The study is expected to be completed in June 1993, but preliminary data are expected to be available prior to the budget hearings.

Recommendation. We find that the new guideline for screening Emergency Response cases may not standardize the process statewide. In order to facilitate legislative oversight of this issue, we recommend that the department report during the budget hearings on the effects of the guideline. This report should include a comparison of the percentage of counties' Emergency Response cases that are determined inappropriate for in-person response (screened out) before and after implementation of the guideline. To the extent that the new guideline does not result in a standardized screening process among the counties, the Legislature could direct the department to make the guideline more specific so as to achieve a reasonable level of uniformity among counties in the screening process.

Legislative Oversight: Counties Fail State Compliance Reviews

We recommend that the department report during budget hearings on the status of counties' efforts to comply with statutory and regulatory requirements governing the CWS Program.

Background. The DSS began conducting statewide compliance reviews of county CWS programs in 1986 to determine whether county programs were in compliance with state and federal law. These reviews indicated that 37 counties were out of compliance with program requirements. Each of these counties was required to develop a corrective action plan to bring their CWS Program in to compliance with state and federal law.

In 1986, the DSS began a four-year cycle of compliance reviews of county CWS programs. The 37 criteria selected for these reviews were based on (1) federal Title IV-B funding requirements, (2) state regulatory requirements, and (3) research conducted by the state of Pennsylvania. The review criteria were divided into seven critical elements and 30 essential elements. Counties were expected to achieve a 90 percent "compliance" score on *all* critical elements and on at least 83 percent of the essential elements.

Department Determined That 12 of 14 Counties Were Out of Compliance. Of the 14 counties reviewed (Alameda, Humboldt, Kern, Kings, Lassen, Los Angeles, Sacramento, San Francisco, Santa Barbara, Santa Clara, Santa Cruz, Tulare, Tuolumne, and Yuba), only *two* (Kern and Yuba) were in overall compliance. Our review of the data on the 12 counties not in compliance indicates that, on average, counties were out of compliance in approximately 8 of the 37 review criteria. San Francisco, Kings, and Tulare Counties were not in compliance on the *highest* number of criteria (failing on 10-11 criteria) while Los Angeles was out of compliance on the *lowest* number of criteria (5). We note that Los Angeles County made significant improvement in its efforts towards compliance in 1991-92 and the current year (Los Angeles County was out of compliance in 26 areas in 1990-91).

Our review of the data indicates that the area where counties were the most deficient related to "contacts" or visits. State regulations require that the county social worker have face-to-face contact with the child, parents, and foster parents. The frequency of these visits is dependent upon the type of case (Emergency Response, Family Maintenance, Family Reunification, or Permanent Placement). The regulations also require that county social workers arrange for monthly visits with parents. Our review also indicates that counties were frequently out of compliance in areas relating to hearings, service plans, and adoption reviews.

California Fails Federal Compliance Review. Recently, the DSS recently was informed by the federal Department of Health and Human Services (DHHS) that California has failed a compliance review for federal fiscal year 1990 (FFY 90). Specifically, the review indicated that California was ineligible for Section 427 (Title IV-B) funding for the CWS Program because, based on a sample of cases, the state did not meet the "periodic review requirement." Under this requirement, the status of each child in foster care must be reviewed by a court or by an administrative panel at least every six months, in 90 percent of the cases sampled.

Because California failed to meet this requirement, the DHHS "disallowed" $11.1 million in Title IV-B funds for FFY 90. California has not been required to repay these funds, however, as a result of a temporary federal moratorium on these fiscal sanctions.

Budget Proposes Funding For County Monitoring Activities. The budget proposes $563,000 from the General Fund and 7.6 personnel-years to create a Statewide Child Welfare Monitoring Unit to assist counties in the development, implementation, and evaluation of corrective action plans to achieve compliance with CWS statutes and

regulations. The DSS indicates that the monitoring activities will also assist the state in passing federal compliance reviews. We note that the 1992-93 budget included $559,000 from the General Fund and 7.6 limited-term positions for monitoring CWS Program activities in Los Angeles County. These positions will terminate on June 30, 1993.

Recommendation. At the time this analysis was prepared, some of the counties had only recently begun efforts to resolve compliance problems, and the results of these efforts had not yet been reviewed by the department. The department indicates that additional information should be available over the next several months. In order to facilitate legislative oversight of this issue, we recommend that the department report during budget hearings on the status of counties' efforts to correct statutory and regulatory areas of noncompliance.

Given the problems uncovered in the state and federal compliance reviews, we also recommend approval of the proposed new positions.

SUPPLEMENTAL SECURITY INCOME/ STATE SUPPLEMENTARY PROGRAM

The Supplemental Security Income/State Supplementary Program (SSI/SSP) provides cash assistance to eligible aged, blind, and disabled persons. The budget proposes an appropriation of $2.2 billion from the General Fund for the state's share of the SSI/SSP Program in 1993-94. This is a decrease of $162 million, or 7 percent, from estimated current-year expenditures.

Budget Proposes to Suspend "Pass-Through" of Federal Cost-of-Living Adjustment (COLA)

The budget proposes legislation to suspend the "pass-through" of the federal COLA to SSI/SSP recipients, for a General Fund savings of $69 million in 1993-94. This proposal would prevent recipients from receiving an increase of about 2 percent in the total grant.

The budget proposes legislation to suspend the "pass-through" of the January 1994 federal COLA, for a savings of $69 million to the General Fund in 1993-94. The federal government annually provides a COLA to SSI/SSP recipients, increasing the amount of the SSI payment (the federal component of the SSI/SSP grant) by the percentage increase in the Consumer Price Index. Under Ch 97/91 (SB 724, Maddy), the statutory annual COLA provided by the *state* has been suspended

through calendar year 1996. In addition, Ch 94/91 (AB 385, Epple) requires the "pass-through" (to the recipients) of all *federal* COLAs through calendar year 1996.

The effect of the proposal not to "pass-through" the federal COLA is to keep the total SSI/SSP grant at its current level. Thus, the SSI portion of the grant would increase (to reflect the federal COLA) while the SSP portion of the grant would be reduced by an equivalent amount (thereby resulting in a state savings). This proposal would not require a waiver of federal regulations.

If the budget proposal is *not* adopted, the federal COLA would increase the SSI/SSP monthly grant for an aged or disabled individual from $610 to $623.

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. While this implies that the program prevents institutionalization, eligibility for the program is not based on the individual's risk of institutionalization. Instead, 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) for the aged, blind, and disabled.

The types of services available through the IHSS Program are domestic and related services, such as meal preparation and cleanup; nonmedical personal services, such as bathing and dressing; essential transportation; protective supervision, such as observing the recipient's behavior to safeguard against injury; and paramedical services, which are performed under the direction of a licensed health care professional and are necessary to maintain the recipient's health.

The IHSS Program is administered by county welfare departments under broad guidelines that are established by the state. Each county may choose to deliver services in one or a combination of ways: (1) by individual providers (IPs) hired by the recipients, (2) by private agencies under contract with the counties, or (3) by county welfare staff.

The budget proposes $878 million ($210 million General Fund, $160 million federal funds, $196 million county funds, and $311 million in reimbursements) for the IHSS Program in 1993-94. This is an increase

of $115 million, or 15 percent, above estimated current-year expenditures. The General Fund proposal represents an increase of $82.3 million, or 64 percent, above current-year expenditures. This increase is primarily attributable to costs for caseload increases ($47 million) and restoration of service reductions ($30 million).

General Fund Savings From Personal Care Option May Be Overstated

We find that General Fund savings due to implementation of the Personal Care Option may be overstated in 1992-93 and 1993-94, to the extent that federal Medicaid (Title XIX) funds do not fully materialize. We recommend that the department report during budget hearings on the status of implementation of the Personal Care Option.

Background. Chapter 939, Statutes of 1992 (AB 1773, Moore) required the State Department of Health Services (DHS) to submit a State Plan Amendment (SPA) to the federal Department of Health and Human Services to include personal care services as a federally reimbursable service under the Medicaid Program. The federal Medicaid regulations allow 50 percent federal funding to be claimed for direct services and administrative costs for personal care services. The DHS received approval of the SPA on November 2, 1992. As required by Chapter 939, the personal care services would be provided under the IHSS Program.

According to the SPA, personal care services are services needed to provide care to recipients who have an illness that has been diagnosed to be chronic and lasting at least one year (referred to as a "disabling condition") and who are unable to remain safely at home without this assistance. Personal care services may include one or more activities, such as (1) assisting with the administration of medications, (2) providing needed assistance or supervision with basic personal hygiene, (3) assisting with eating, and (4) grooming and toileting. Other incidental services may also be provided.

The SPA also limits eligibility for IHSS personal care services (referred to as the Personal Care Option, or PCO) to categorically eligible Medi-Cal recipients (AFDC and SSI/SSP recipients). To be eligible under the PCO, these recipients must satisfy the disabling condition requirement.

General Fund Savings May Be Overstated in 1992-93 and 1993-94. The budget proposal assumes that implementation of the PCO will result in General Fund savings of $16 million in 1992-93 and $180 million in 1993-94. Our review indicates that the budget estimates of savings are based on optimistic assumptions. Specifically, the budget

assumes that (1) the PCO will be implemented on April 1, 1993 and (2) 63 percent of the caseload will be eligible for PCO services. We have the following concerns with these assumptions.

Implementation of the PCO Could Be Delayed. Our conversations with state and county officials indicate that the PCO implementation date of April 1, 1993, may be unrealistic. Implementation of the PCO could be delayed because the following requirements may not be met by that deadline: (1) determination of PCO eligibility (disabling condition) of aged IHSS recipients, (2) completion of PCO regulations and forms, (3) data base changes, and (4) hiring of nurses and obtaining physician certifications.

To the extent that the PCO is delayed, and federal Medicaid funds are reduced, General Fund costs would increase. As a result, General Fund savings of up to $16 million may not materialize in 1992-93.

The PCO Caseload May Be Overstated. The budget assumes that 63 percent of the caseload, or 71 percent of total IHSS service hours, will be eligible under the PCO. The budget assumes that all of the service hours for these cases will be considered PCO eligible. However, it is possible that for any given case, some of the current hours of IHSS service will qualify for federal funding under the PCO, while other hours will not qualify.

Recommendation. We find that General Fund savings due to implementation of the PCO may be overstated in 1992-93 and 1993-94, to the extent that federal Medicaid funds do not fully materialize. The department may have more information on this issue in a few months. Consequently, we recommend that the department report during the budget hearings on the status of the PCO.

Regulation Change Could Increase Eligibility for PCO Services

We recommend that the Legislature direct the Departments of Social Services (DSS) and Health Services (DHS), during budget hearings, to amend the PCO regulations to include IHSS "income eligibles." This action would result in General Fund savings of approximately $8 million in 1993-94. (Reduce Item 5180-151-001 by $8 million.)

Background. In order to be eligible for services under the IHSS Program, a person must be living in his or her own home and either "status eligible" or "income eligible." An individual is considered status eligible if he or she is receiving SSI/SSP. An individual is considered income eligible if he or she:

- Meets all SSI/SSP eligibility requirements but has "nonexempt" income that exceeds the maximum SSI/SSP payment levels. Persons in this category may have to pay for a share of IHSS costs.
- Meets all SSI/SSP eligibility requirements, but chooses not to accept SSI/SSP benefits. These individuals would not be required to pay a share of cost.
- Has been eligible for SSI/SSP based on a disability (and is still disabled) but has lost eligibility due to employment. These individuals may be required to pay a share of IHSS costs.

Federal Funds Could Be Obtained For IHSS Income Eligibles. Our review of the budget indicates that it *excludes* the IHSS income eligibles from the PCO caseload. These cases are currently funded in the IHSS Program at a ratio of 65 percent General Fund and 35 percent county funds. The income eligibles represent approximately 13,000 cases that could be eligible for 50 percent federal funding under the PCO. We estimate that including the income eligibles within the PCO caseload would result in additional federal Medicaid funds of about $13 million in 1993-94, for a net savings (after accounting for administrative costs) of approximately $8 million to the General Fund and $4 million in county funds.

Recommendation. We recommend that the Legislature direct the DSS and the DHS to amend the PCO regulations to include IHSS income eligibles. This action would result in General Fund savings of approximately $8 million in 1993-94.

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Crosscutting Issues

Immigration-Related Costs

1. **Assuming Federal Funds for Immigration-Related Costs Entails Risk of Budgetary Shortfall.** Recommend that the Legislature review the Governor's contingency plan for addressing a potential General Fund shortfall of $1.4 billion and develop an alternative plan, based on legislative priorities. 15

Indigent Health Care

2. **Revenue Shift Could Have a Significant Impact on Indigent Health Services.** The budget proposal to shift over $2 billion of property tax revenues to fund public education will add pressure on counties to reduce funding for indigent health services. 23

AIDS Prevention

3. **Lack of Coordination Impedes Effective AIDS Prevention Efforts.** Recommend enactment of legislation designating the Office of AIDS as lead agency for HIV education and prevention activities and requiring it to plan and coordinate all related funding decisions. Further recommend adoption of Budget Bill language to revise the formula for allocating federal HIV set-aside funds received by the Department of Alcohol and Drug Programs. 24

State Hospitals/Developmental Centers

4. **No Detail on Whether Administration Plans to Propose Closing State Facility.** Recommend that the Departments of Developmental Services and Mental Health report 28

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jointly at budget hearings on whether the Administration will proceed with such a proposal and the anticipated fiscal impact.

Department of Alcohol and Drug Programs

5. **Federal Changes Affect Allocations for the Department of Alcohol and Drug Programs (DADP).** Recommend the department report on estimated costs associated with new federal requirements and its plan for allocating funds in response to these changes. — 29

6. **Improvement Needed in Efforts to Maximize Drug/Medi-Cal Reimbursements.** Recommend that the DADP report at budget hearings on (a) its estimates of Drug/Medi-Cal reimbursements and (b) steps being taken to increase the number of programs certified. — 32

7. **Funding for Female Offender Pilot Project Should Be Continued.** Recommend adoption of Budget Bill language requiring the department to continue funding for the Female Offender Substance Abuse Program, and to submit the required evaluation of the project by September 30, 1993. — 34

California Medical Assistance Program (Medi-Cal)

8. **Department Plans Major Expansion of Managed Care.** Plan would enroll nearly half of all Medi-Cal beneficiaries in a "managed care" arrangement by the end of 1993-94. — 47

9. **Implementation of Managed Care Strategic Plan Premature.** Recommend that the department address several key issues before implementing plan. Further recommend that no expansion of managed care occur until the Legislature has had an opportunity to review the department's plan. — 52

10. **CIGNA Rate Increase Unjustified. Reduce Item 4260-101-001 by $6.8 million.** Recommend that the Legislature reject a portion of proposed $16 million rate increase for CIGNA — 55

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Health Plan because the proposal has not been justified. Further recommend that a new rate-setting methodology be developed.

11. **Prepaid Health Plans (PHPs) Rate Adjustment Would Save $23 Million. Reduce Item 4260-101-001 by $23.1 million.** Recommend that the Legislature reduce expenditures for PHP services because rates have not been adjusted to reflect lower costs. — 57

12. **Elimination of Optional Services.** Recommend that the department report, prior to budget hearings, on technical aspects of proposal, and potential magnitude of increased hospitalizations. — 59

13. **Diagnosis-Related Reimbursements Could Result in Significant Savings.** Recommend that the Legislature adopt Budget Bill language requiring the department to implement diagnosis-related reimbursements, and report on potential savings for 1993-94. — 61

14. **Bulk Purchases For Laboratory And Other Services Would Save Money. Reduce Item 4260-101-001 by $4 million.** Recommend that the Legislature adopt Budget Bill language requiring implementation of contracting for laboratory services and durable medical equipment. — 63

15. **Medi-Cal Subsidy of University of California (UC) Hospitals Not Needed. Reduce Item 4260-101-001 by $26 million.** Recommend that the Legislature adopt Budget Bill language specifying that UC hospitals receive the minimum federal disproportionate share payment allowed under state law because these hospitals are profitable without such subsidies. — 64

16. **Eliminating "Bed-Hold" Payments Would Produce Savings. Reduce Item 4260-101-001 by $7.5 million.** Recommend enactment of legislation repealing provisions of current law requiring payments to "hold" long-term care beds vacant. — 66

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17.	**Additional Federal Reimbursement Available for Medi-Cal. Reduce Item 4260-101-001 by $7.9 million.** Recommend that the department begin claiming federal funds for services to pregnant women between 185 and 200 percent of federal poverty level.	67

Public Health

18.	**Direct Purchase Vaccine Program Can Save $14 Million Yet Plan Is Lacking.** We recommend Budget Bill language to use these savings and federal funds on activities that should increase immunization levels.	69
19.	**Options for Reducing General Fund Costs Without Reducing Program Services.** We present two options for reducing General Fund support of the Child Health and Disability Prevention Program without affecting program services: (a) purchase Hepatitis B vaccine through the direct purchase vaccine program and (b) redirect Maternal and Child Health (MCH) federal funds for the purchase of the vaccine.	74
20.	**Proposition 99 Programs: Declining Revenues Result in Program Reductions.** Because of the methodology for calculating pro rata reductions due to declining C&T Fund revenues, some Proposition 99 programs will be impacted more heavily than others.	76
21.	**Budget Proposes Significant Reductions in the County Medical Services Program (CMSP).** We recommend that the department report during budget hearings on what effect the overall reductions to the CMSP will have on indigent health care services and how the unallocated reductions proposed for the CMSP will be taken.	79
22.	**What Can Be Done To Maintain A Viable County Medical Services Program (CMSP)?** Given declining revenues and increasing program expenditure requirements for the CMSP, the Legislature should consider restructuring the program. We discuss both short-term and long-term options for accomplishing this.	82

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23. **General Fund Support in CMSP Raises Question of Legislative Intent.** Current law provides that General Fund support for the CMSP shall be $20.2 million in 1992-93 and annually thereafter; but it is not clear whether the Legislature intended to maintain General Fund support for the program at this specified amount or at the actual 1991-92 level of spending, which was subsequently revised to $22 million. Consequently, we recommend that the Legislature clarify its intent.	83
24. **Legislature Needs Information on Effectiveness of HIV Education and Prevention Efforts to Determine 1993-94 Funding Levels.** We recommend that (a) the department release the Office of AIDS education and prevention evaluation report prior to budget hearings and (b) the Legislature use MCH federal funds for HIV education and prevention efforts.	84
25. **Consolidation of Administrative Units Would Avoid Duplicative Activities.** Recommend the department consolidate the Primary and Rural Health Care Systems Branch with the Office of Family Planning and recommend deletion of $1.6 million ($1.3 million General Fund, $300,000 C&T Fund) in state operations from the 1993-94 budget to reflect savings achieved from this reorganization. We further recommend that the Legislature redirect the $300,000 in C&T Fund monies freed up from this consolidation to replace General Fund monies budgeted for health programs that are eligible for C&T Fund support. (Reduce Item 4260-001-001 by $1.3 million and reduce Item 4260-111-001 by $300,000.)	89
26. **Ward Valley Low-Level Radioactive Waste (LLRW) Disposal Facility.** Recommend that the department release, prior to budget hearings, its contingency plan on the management of LLRW.	91

State Legalization Impact Assistance Grant

27. **SLIAG Entitlements May Be less Than Budgeted in Current Year.** Recommend that the Health and Welfare	93

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Agency report, during budget hearings, on how several federal requirements may affect the amount of SLIAG funds available for state entitlement programs.

28. **Governor's 1993-94 Budget Assumes Full Funding.** Because the President's fiscal year 1994 budget was not available at the time this analysis was prepared, it is not known whether he will propose to provide California with the SLIAG funds assumed in the Governor's Budget for 1993-94. — 95

Major Risk Medical Insurance Board

29. **Access for Infants and Mothers Program Likely to Have Unexpended Balances That Can Be Redirected to Replace General Fund Monies Budgeted for Other Programs.** We recommend that $15 million in Cigarette and Tobacco Products Surtax Fund monies be redirected. — 97

Department of Developmental Services

30. **Potential Medicaid Waiver Savings Uncertain.** The budget does not reflect an additional $16.6 million in General Fund savings that would result if the waiver expansion is approved as proposed. However, in the event the waiver expansion is not approved as proposed, the budget may overestimate General Fund savings by up to $80.5 million. Recommend that the department report at budget hearings on the status of the waiver. — 100

31. **Lawsuit May Result in Major Costs.** Recommend that the department report at budget hearings on the status of *Coffelt v. Department of Developmental Services* and how it proposes to fund any costs resulting from resolution of the suit. — 102

32. **Decision Due on Early Intervention Program.** The budget proposes federal funds but no General Fund expenditures to continue the Early Intervention Program in 1993-94. Recommend the department report at budget hearings on its decision as to whether to continue the program, its — 102

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specific implementation plan, and associated General Fund costs in 1993-94.

33. **Workers' Compensation Costs Underbudgeted.** We estimate that workers' compensation costs at the developmental centers are underbudgeted by about $3 million in the current year and $4 million to $5 million in 1993-94. We recommend the department report at budget hearings on a plan for reducing workers' compensation costs or funding the anticipated increase in these costs. — 104

Department of Mental Health

34. **School-Based Prevention Program Augmentation Should Be Deleted. Reduce Item 4440-001-001 by $428,000 and Item 4440-102-001 by $10 million.** Recommend a reduction of $10.4 million ($10 million Proposition 98) to the Department of Mental Health budget in order to free up funds to restore school general purpose funding or reduce the Proposition 98 loan. — 105

35. **New Federal Funds Present Opportunity for Legislature.** Recommend that the Legislature determine its own priorities for allocating an additional $12.2 million in federal funds, and adopt Budget Bill language requiring the department to allocate the funds according to these priorities. — 106

Aid to Families with Dependent Children (AFDC)

36. **Caseload Estimate Likely Too High.** The budget may have overestimated Aid to Families with Dependent Children (AFDC) Program costs by as much as $90 million ($43 million General Fund) in 1993-94 and $40 million ($19 million General Fund) in the current year because the department's caseload projections appear to be too high. — 108

37. **Residency Requirement Found Unconstitutional by District Court.** Unless the decision is reversed on appeal, the budget overestimates General Fund savings by $7.6 million in the current year and $20 million in 1993-94. — 110

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38. **Proposal to Reduce Maximum Aid Payment (MAP) By 4.2 Percent.** The budget proposes legislation to reduce the MAP to all AFDC recipients by 4.2 percent. This reduction would be partially offset by an increase in food stamps, thereby resulting in a reduction of about 2.2 percent in total income available to recipients.	112
39. **Proposal to Reduce MAP an Additional 15 Percent After Six Months.** The budget proposes legislation to reduce the MAP by an additional 15 percent for AFDC recipients (with some exceptions) after they have been on aid for six months. This reduction would be partially offset by an increase in food stamps, thereby resulting in an additional reduction of about 9.8 percent in total income available to recipients.	112
40. **Proposal to Expand the Earned Income Disregard.** The budget proposes $3.6 million in 1992-93 and $22.5 million in 1993-94 to fund the costs of extending indefinitely—beyond the existing four-month limit—the "$30 and one-third disregard" of employment earnings in computing AFDC grants. Current law directs the department to request a federal waiver to implement this change.	113
41. **Proposal to Exclude From the MAP Any Children Conceived While on Aid.** The budget proposes legislation to exclude, for purposes of determining a family's MAP, any children who are conceived while the family is on AFDC. Estimated savings are $28 million ($13 million General Fund) in 1993-94 but would increase significantly in subsequent years, reaching several hundred million dollars in ten years.	114
42. **Proposal to Limit Pregnancy-Related Benefits.** The budget proposes legislation to limit pregnancy-related AFDC benefits. We find that this proposal could result in a transfer of responsibility to the counties for many of those recipients who would lose these benefits.	114
43. **Budget Imposes Requirements on Teen Parents.** The budget proposes legislation to establish the Cal Learn Program, an incentive program for AFDC parents under	115

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age 19 to remain in school. To the extent this proposal increases school attendance, it would result in increased job readiness as well as additional school apportionment costs, potentially in the tens of millions of dollars.

44. **Budget Proposes to Increase Funding for the Greater Avenues for Independence (GAIN) Program.** The budget proposes to increase funding for the GAIN Program by $93 million (all funds). We recommend that the Legislature eliminate the county share of funding for this program in order to ensure that budgeted funds will be expended. We further recommend that the Legislature increase the county share of AFDC grant costs by about two-thirds of 1 percent in order to offset the increased General Fund cost of buying out the county share of GAIN. — 116

45. **Costs of Proposals to Increase Transitional Assistance Are Not Reflected in Budget.** The budget proposes changes in a number of rules affecting AFDC eligibility in order to increase the incentive to work. This includes transitional child care, food stamps, and child support for persons leaving AFDC due to employment. While the proposals may result in savings in the long term, they are likely to impose first-year costs not reflected in the budget. — 117

46. **Budget Includes Savings Anticipated From "Reduced Dependency."** The budget includes savings of $310 million ($147 million General Fund) in 1993-94 and $31 million ($15 million General Fund) in the current year from lower caseloads because of the financial incentives to work due to the reduced grant levels, increased GAIN funds, and other work incentives contained in the proposed changes. While the Governor's proposals are likely to result in some reduction in caseloads, the budget estimate of savings must be viewed with caution. — 119

47. **Delayed Implementation of Welfare Proposals Could Reduce Savings Substantially.** The budget assumes that the Governor's welfare proposals will be implemented on March 1, 1993. If full implementation is delayed until July 1, the estimated General Fund savings would be reduced by $32 million in the current year and up to $180 million in the budget year. — 120

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48. **Alternatives to the Governor's Welfare Package.** We present several alternatives to the Governor's proposals. These include options that we presented last year and which have not been proposed or implemented, the major provisions of reform legislation introduced in the current session, and other alternatives. 127

49. **Demonstration Projects to Reduce Health and Welfare Costs.** We review welfare reform proposals being implemented in other states, and develop two additional proposals for legislative consideration. 129

50. **Budget May Overestimate Spending for County Administration of Welfare Programs.** Counties may be unable to match all of the state and federal funds assumed in the budget, due to fiscal constraints at the local level. 129

AFDC-FC

51. **Foster Care Specialized Rate-Setting System Needs Statewide Assessment Guideline.** Counties do not use standardized criteria to assess the special needs of foster children, resulting in a large variation in grants. We recommend that the department report, during budget hearings, on the feasibility of developing a standardized assessment guideline to determine foster care grant amounts for children with special needs. 129

52. **Program Effectiveness Has Not Been Determined for Family Preservation.** Recommend that the department report during budget hearings on the status of two reports on the Family Preservation Program that were due in December 1991 and June 1992, respectively. 132

53. **1992 Budget Action Shifts Costs to Schools.** Budgeted state savings due to increased federal support for nonprofit group homes are overstated, thereby creating a potential deficiency of $150,000 in the current year and $300,000 in 1993-94. The authority to reimburse group home costs for severely emotionally children has been inadvertently terminated. We recommend legislation to reimburse group homes providing residential care to severely emotionally disturbed children. 134

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54. **Closure of County Probation Facilities Could Have Major Impact on Foster Care.** Recommend that the Legislature direct the Department of Social Services and the Department of Finance to consider the impact of potential closures of county juvenile camps and ranches on the foster care caseload when developing the May Revision. — 136

Adoptions Assistance Program

55. **1992 Budget Action to Cap Adoptions Assistance Program Grants May Have Adverse Impacts.** The cap on AAP grants (a) may not comply with federal law and (b) may reduce adoptions of children with serious medical and/or behavioral problems. We recommend that the Department of Social Services collect additional data in order to assess the impact of the reduction in grants. — 137

Child Welfare Services

56. **State Guideline May Not Result In Standardized Screening Decisions Among Counties.** Recommend that the department report during budget hearings on the effect of a new guideline designed to standardize statewide the process for screening Emergency Response cases. — 140

57. **Counties Fail State Compliance Reviews.** Recommend that the department report during budget hearings on the status of counties' efforts to comply with statutory and regulatory requirements governing the Child Welfare Services Program. — 142

Supplemental Security Income/State Supplementary Program

58. **Budget Proposes to Suspend "Pass-Through" of Federal Cost-of-Living Adjustment (COLA).** The budget proposes legislation to suspend the "pass-through" of the federal COLA to SSI/SSP recipients, for a General Fund savings of $69 million in 1993-94. This proposal would — 144

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prevent recipients from receiving an increase of about 2 percent in the total grant.

In-Home Supportive Services

59. **General Fund Savings From Personal Care Option May Be Overstated.** We find that General Fund savings due to implementation of the Personal Care Option may be overstated in 1992-93 and 1993-94, to the extent that federal Medicaid funds do not fully materialize. We recommend that the department report during budget hearings on the status of implementation of the Personal Care Option. 146

60. **Additional IHSS Recipients Could Be Eligible For the Personal Care Option. Reduce Item 5180-151-001 by $8 million.** We recommend that the Legislature direct the Departments of Social Services and Health Services to amend the Personal Care Option regulations to include IHSS "income eligibles." This action would result in General Fund savings of approximately $8 million in 1993-94. 147