MAJOR ISSUES

Health and Social Services

☑ **Agency Secretary to Develop Plan for Health Care Reforms**

- The budget includes $37.3 million from the General Fund that is reserved for expenditure on health care reforms, pursuant to a plan to be submitted by the Secretary of the state Health and Human Services Agency.
- Funding is contingent on federal action because it is tied to federal approval of a waiver to provide Medicaid funding for family planning services currently funded entirely by the state.
- We provide options for (1) expanding health insurance coverage, (2) simplifying administration of Medi-Cal and Healthy Families, and (3) increasing participation in these programs. (See page C-17.)

☑ **Budget Depends on Risky Federal Assumptions**

- The Medi-Cal budget includes a total of $332 million in General Fund savings that depend on federal actions: (1) a revision in the methodology for determining the federal share of costs, and (2) approval of a waiver to provide federal funding for the state-only family planning program. (See page C-35.)

☑ **Medi-Cal Caseloads Overestimated**

- We recommend a General Fund reduction of $2.7 million in the current year and $124.1 million in 1999-00 because the budget overestimates the CalWORKs-related Medi-Cal caseload. (See page C-42.)

☑ **CalWORKs County Incentive Payments Should Be Related to Improved Program Performance**

- The budget includes $545 million in 1998-99 and $479 million in 1999-00 for performance incentive payments to the coun-

ties. The amount is based on estimated savings attributable to recipient earnings and exits from the program.

- We recommend that the portion of savings attributable to earnings be based on 50 percent of the total of such savings. This will more closely reflect the savings that result from changes made in CalWORKs rather than savings that would have occurred even in the absence of these changes. This would result in a savings of $193 million in 1999-00 (federal block grant funds). (See page C-103.)

CalWORKs Employment Services Overbudgeted

- We recommend reductions totaling $171.2 million (federal block grant funds) to account for (1) nonparticipation of recipients in required program activities and (2) estimated savings from the Maximum Family Grant provision of current law. (See page C-102.)

No General Fund Support for the County Medical Services Program

- The budget proposes elimination of the annual $20.2 million General Fund allocation for this program, under which 34 small counties provide indigent health care services to persons not eligible for Medi-Cal. We comment on the proposal and discuss options. (See page C-57.)

Need to Control Medi-Cal Mental Health Expenditures

- Medi-Cal expenditures for mental health services under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program have increased rapidly in recent years.

- To give the counties more incentive to control these costs, we recommend transferring the General Fund allocation of $89 million from the Department of Health Services budget to the Department of Mental Health, where the funds would be distributed to counties as part of their managed care allocations, as is the case for other Medi-Cal mental health services. (See page C-85.)

TABLE OF CONTENTS

Health and Social Services

OVERVIEW

Health and Social Services

General Fund expenditures for health and social services programs are proposed to increase by less than 1 percent in the budget year. This increase is due primarily to a variety of caseload and cost increases and full-year funding of program increases enacted in the current year, partially offset by savings primarily from welfare caseload reductions and proposals that, if approved, will result in increased federal Medicaid funds.

EXPENDITURE PROPOSAL AND TRENDS

The budget proposes General Fund expenditures of $16.4 billion for health and social services programs in 1999-00, which is 27 percent of total proposed General Fund expenditures. The health and social services share of the budget generally has been declining since 1993-94. The budget proposal represents an increase of $74 million, or less than 1 percent, over estimated expenditures in the current year.

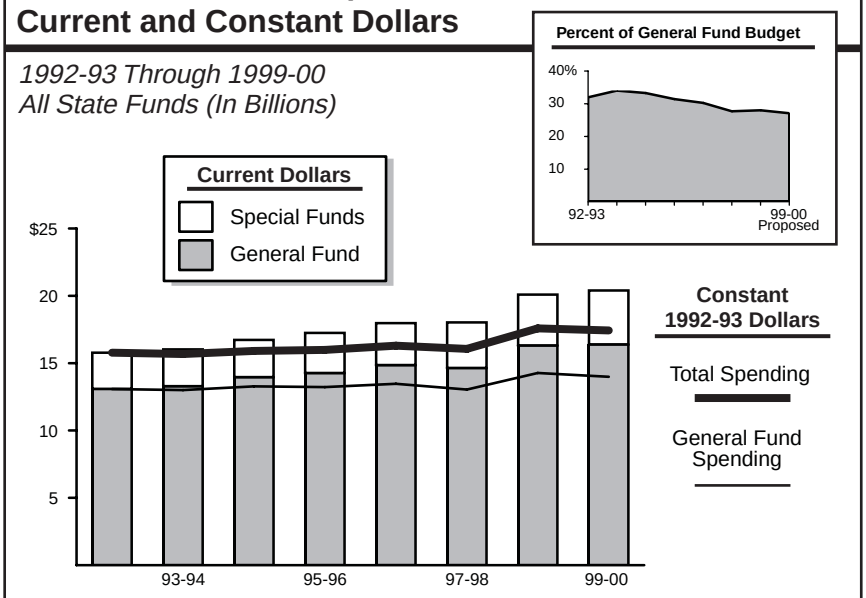
Figure 1 (see next page) shows that General Fund expenditures (current dollars) for health and social services programs are projected to increase by $3.3 billion, or 25 percent, from 1992-93 through 1999-00. This represents an average annual increase of 3.2 percent.

In 1991-92, realignment legislation shifted $2 billion of health and social services 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 accounted for a significant increase in special funds starting in 1991-92. Figure 1 shows that General Fund spending has increased since 1992-93, except for a slight reduction in 1997-98 due primarily to a decline in California Work Opportunity and Responsibility to Kids (CalWORKs, formerly Aid to Families with Dependent Children [AFDC]) program caseloads. Spending is estimated to increase in 1998-99, primarily due to welfare grant increases, expansion of the CalWORKs program, Medi-Cal cost increases, and various program enhancements such as the Foster Care initiative.

Figure 1

Health and Welfare Expenditures Current and Constant Dollars

1992-93 Through 1999-00
All State Funds (In Billions)



Combined General Fund and special funds spending is projected to increase by 29 percent from 1992-93 through 1999-00. This represents an average annual increase of 3.7 percent.

Figure 1 also displays the spending for these programs adjusted for inflation (constant dollars). On this basis, General Fund expenditures are estimated to increase by 7 percent from 1992-93 through 1999-00. Combined General Fund and special funds expenditures are estimated to increase by 10 percent during the same period. This is an average annual increase of 1.4 percent.

As noted previously, the 1991 realignment legislation significantly altered the financing 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. This shortfall was primarily due to the effects of the recession. The budget estimates that realignment revenues will be $2.8 billion in 1999-00.

Special funds expenditures are estimated to increase in the current and budget years, primarily because of the effect of Proposition 10 which

imposes a tax increase on cigarettes and other tobacco products and requires that almost all of the revenues be spent for early childhood development programs. The budget estimates that spending from the new California Children and Families First Trust Fund will amount to $372 million in 1998-99 and $672 million in 1999-00 (excluding monies that are transferred to certain other funds pursuant to the provisions of the proposition). (For a discussion of Proposition 10, please see our report *Proposition 10: How Does it Work and What Role Should the Legislature Play in its Implementation?*, January 13, 1999.)

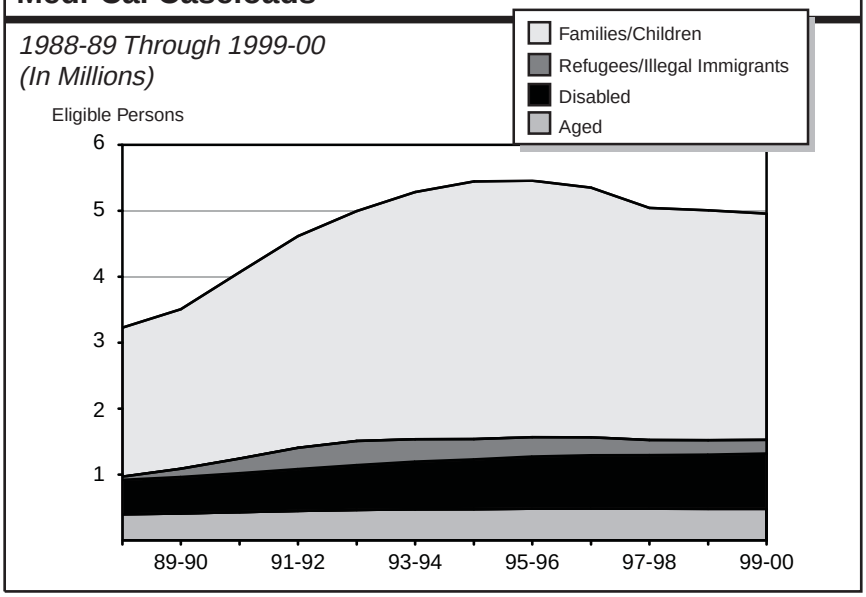
CASELOAD TRENDS

Figures 2 and 3 (see next page) illustrate the caseload trends for the largest health and welfare programs. Figure 2 shows Medi-Cal caseload trends over the last decade, divided into four groups: families and children (primarily recipients of CalWORKs—formerly AFDC), the aged and the disabled (primarily recipients of Supplemental Security Income/State Supplementary Program—SSI/SSP), refugees, and illegal immigrants.

Figure 2

Budget Forecasts Little Change in Medi-Cal Caseloads

1988-89 Through 1999-00
(In Millions)



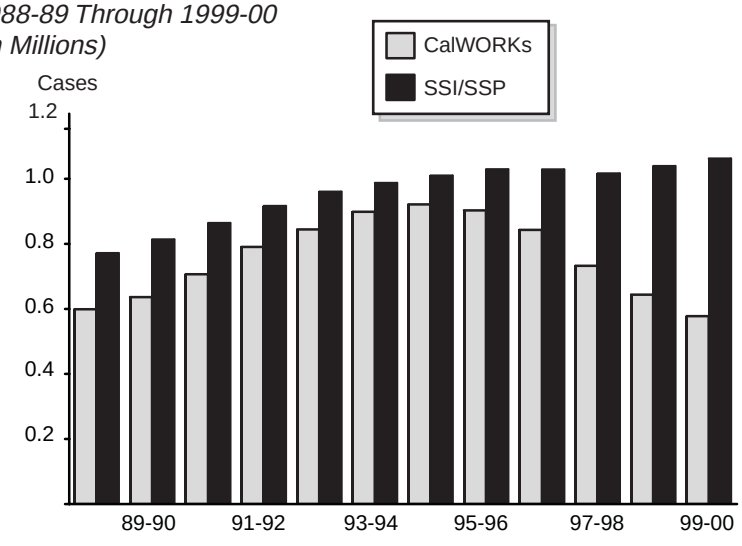
Medi-Cal caseloads increased by 54 percent over the 11-year period shown in Figure 2. As the figure shows, most of this growth occurred during the period from 1989-90 through 1994-95. The growth in the number of families and children receiving Medi-Cal during this period reflects the rapid growth in AFDC caseloads as well as the expansion of Medi-Cal to cover additional women and children with incomes too high to qualify for cash aid in the welfare programs. Coverage of refugees and illegal immigrants also increased caseloads significantly during this period. Since 1994-95, Medi-Cal caseloads have declined, due primarily to a decline in AFDC/CalWORKs caseloads. The figure also shows that the budget forecasts a leveling off of Medi-Cal caseloads in the current and budget years.

Figure 3 shows the caseload trend for the CalWORKs and SSI/SSP programs. While the number of *cases* in SSI/SSP is greater than in the CalWORKs program, there are more *persons* in the CalWORKs program—about 2 million compared to about 1 million for SSI/SSP. (The SSI/SSP cases are reported as individual persons, while CalWORKs cases are primarily families.)

Figure 3

CalWORKs Caseloads Declining; SSI/SSP Caseloads Increasing Slightly

1988-89 Through 1999-00
(In Millions)



Caseload growth in these two programs is due, in part, to the growth of the eligible target populations. The increase in the rate of growth in the CalWORKs caseloads in 1990-91 and 1991-92 was also due to the effect of the recession. During the next two years, the caseload continued to increase, but at a slower rate of growth. This slowdown, according to the Department of Finance, was 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 was the fastest growing segment of the caseload until 1993-94.

Figure 3 also shows that since 1994-95, CalWORKs caseloads have declined. As we discuss in our reports, *California's Fiscal Outlook* (November 1997 and November 1998), we believe that this trend is due largely to various factors affecting welfare caseloads, including the improving economy, lower birth rates for young women, a decline in legal immigration to California, reductions in grant levels, behavioral changes in anticipation of federal and state welfare reform, and—for the current and budget years—the impact of the CalWORKs program interventions (including additional employment services).

The SSI/SSP caseload can be divided into two major components: the aged and the disabled. The aged caseload generally increases in proportion to increases in the eligible population—age 65 or older. This component accounts for about one-third of the total caseload. The larger component—the disabled caseload—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. We note, however, that in recent years the growth of the disabled caseload has slowed.

Total SSI/SSP caseload growth has also moderated in recent years. This is partly attributable to federal policy changes that (1) eliminated drug or alcohol addiction as a qualifying disability and (2) added restrictions on the eligibility of disabled children.

SPENDING BY MAJOR PROGRAM

Figure 4 shows expenditures for the major health and social services programs in 1997-98 and 1998-99, and as proposed for 1999-00. As shown in the figure, the three major benefit payment programs—Medi-Cal, CalWORKs, and SSI/SSP—account for a large share of total spending in the health and social services area.

MAJOR BUDGET CHANGES

Figures 5 and 6 (see pages 12 and 13 illustrate the major budget changes proposed for health and social services programs in 1999-00. (We include the federal funds for CalWORKs because, as a block grant, they are essentially interchangeable with state funds within the program.) Most of the major changes can be grouped into the following categories:

1. ***The Budget Funds Basic Caseload Growth in SSI/SSP and the Healthy Families Program, Reflects Savings From Basic Caseload Reductions in CalWORKs and Medi-Cal, and Funds Other Workload Cost Increases.*** This includes a projected caseload reduction of 1 percent in the Medi-Cal Program, a decrease of 8.2 percent in the CalWORKs program, an increase of 1.8 percent in SSI/SSP, and an increase of 120 percent in the Healthy Families program (before adjusting for policy changes).

2. ***The Budget Proposes to Fund Statutory Cost-of-Living Adjustments (COLAs) for CalWORKs and SSI/SSP and the Full-Year Costs of Grant Increases Enacted in the Current Year.*** This includes a 2.1 percent COLA for CalWORKs and SSI/SSP in 1999-00.

3. ***The Budget Assumes Federal Approval of Proposals That Would Achieve General Fund Savings by Increasing Federal Medicaid Funds.*** This amounts to: (1) $210 million to change the Bureau of the Census methodology for counting the state's population, for purposes of calculating the federal matching rate for California; and (2) $122 million for a waiver proposal to make the state-only Family Planning program eligible for federal funds ($60 million of which would be redirected to continue and expand other health programs, including the set-aside discussed below).

4. ***The Budget Proposes to Keep General Fund Spending for CalWORKs at the Federally-Required Maintenance-of-Effort Level.*** This would be accomplished primarily by using unexpended federal block grant funds carried over from the current year.

Figure 4

Major Health and Welfare Programs Budget Summary[a]

1997-98 Through 1999-00
(Dollars in Millions)

	Actual 1997-98	Estimated 1998-99	Proposed 1999-00	Change From 1998-99 Amount	Change From 1998-99 Percent
Medi-Cal					
General Fund	$6,759.1	$7,398.9	$7,329.8	-$69.1	-0.9%
All Funds	18,311.8	19,902.4	20,888.5	986.1	5.0
CalWORKs (Grants and Services)					
General Fund	$2,154.0	$1,999.5	$1,783.2	-$216.3	-10.8%
All Funds[b]	5,062.4	6,262.5	6,043.8	-218.7	-3.5
AFDC-Foster Care					
General Fund	$366.6	$425.8	$438.3	$12.5	2.9%
All Funds	1,436.4	1,489.5	1,608.3	118.8	8.0
SSI/SSP					
General Fund	$2,025.4	$2,255.6	$2,439.0	$183.4	8.1%
All Funds	5,620.7	6,098.6	6,432.5	333.9	5.5
In-Home Supportive Services					
General Fund	$370.4	$527.4	$538.8	$11.4	2.2%
All Funds	1,195.3	1,405.4	1,482.0	76.6	5.5
Regional Centers/Community Services					
General Fund	$482.7	$660.5	$776.7	$116.2	17.6%
All Funds[c]	1,167.9	1,398.4	1,589.5	191.1	13.7
Developmental Centers					
General Fund	$32.1	$32.5	$33.1	$0.6	1.8%
All Funds[c]	461.7	480.3	498.1	17.8	3.7
Child Welfare Services					
General Fund	$451.0	$539.4	$588.0	$48.6	9.0%
All Funds	1,198.7	1,371.1	1,431.1	60.0	4.4
State Hospitals					
General Fund	$276.0	$302.8	$342.6	$39.8	13.1%
All Funds	473.7	481.6	505.7	24.1	5.0
Children and Families First Commissions[d]					
General Fund	—	—	—	—	—
All Funds	—	$372.4	$671.5	$299.1	80.3%

[a] Excludes departmental support, except for state hospitals.
[b] Includes funds for child care reserve and transfers to Child Care Development Block Grant.
[c] Includes General Fund share of Medicaid reimbursements (costs budgeted in Medi-Cal).
[d] Includes state and county commissions.

5. ***The Budget Includes a Set-Aside to Expand Eligibility in the Healthy Families Program and for Other Unspecified Health Services.*** This consists of (1) $2.7 million to cover the costs of applying the Medi-Cal income deductions (or "disregards") when determining family income for Healthy Families applicants and (2) $37.3 million to implement a plan that will be developed by the Secretary of the state Health and Human Services Agency.

Figure 5

Health Services Programs
Proposed Major Changes for 1999-00
General Fund

Medi-Cal	**Requested:**	**$7.3 billion**	
	Decrease:	**$69 million**	**(-0.9%)**

- ✚ $297 million due to cost increases and higher utilization of services

---

- ▬ $210 million from a proposed change in the census methodology used in determining the federal Medicaid match
- ▬ $122 million from a proposed federal waiver to make the state-only Family Planning program eligible for federal Medicaid funds
- ▬ $51 million for retroactive recoupment of payments related to Medi-Cal/Medicare "crossover" claims

Healthy Families	**Requested:**	**$105 million**	
	Increase:	**$60 million**	**(+136%)**

- ✚ $60 million for program expansion, due primarily to caseload growth

Public Health	**Requested:**	**$341 million**	
	Decrease:	**$43 million**	**(-11%)**

- ▬ $20 million by eliminating General Fund support for the County Medical Services Program

Figure 6

Social Services Programs
Proposed Major Changes for 1999-00
General Fund

CalWORKs	**Requested:**	**$1.8 billion**	
	Decrease:	**$216 million**	**(-11%)**

- ✚ $101 million (federal Temporary Assistance for Needy Families [TANF] funds) due to termination of the federal Welfare-to-Work grant
- ✚ $89 million (federal TANF funds) to provide a 2.1 percent cost-of-living adjustment (COLA)
- ✚ $88 million (federal TANF funds) for the full-year costs of current-year grant increases

---

- ▬ $423 million (federal TANF funds) in grants and services due to a reduction in the basic caseload

SSI/SSP	**Requested:**	**$2.4 billion**	
	Increase:	**$183 million**	**(+8.1%)**

- ✚ $123 million for full-year cost of current-year grant increases
- ✚ $37 million for basic caseload growth
- ✚ $8 million for 1999-00 COLA (effective January 2000)

Regional Centers	**Requested:**	**$777 million**	
	Increase:	**$116 million**	**(+18%)**

- ✚ $113 million for caseload and cost increases
- ✚ $41 million for full-year costs of program increases enacted in current year

CROSSCUTTING ISSUES

Health and Social Services

FEDERAL MEDICAID MATCH

Technical Issue: Budget Proposal to Increase Federal Medicaid Match Understates General Fund Savings

The budget does not reflect the full amount of state savings that would result from the administration's proposal to increase California's federal Medicaid matching rate—specifically, the savings resulting from an increase in federal Title XXI funds (related to the state's Healthy Families Program). Consequently, we recommend a technical correction so the budget will be consistent, for a General Fund savings of $2.3 million in 1999-00. (Reduce Item 4260-113-0001 by $122,000, item 4280-101-0001 by $1,985,000, and item 4440-101-0001 by $232,000.)

The Governor's budget proposes, in the budget for the Department of Health Services (DHS), that the federal administration adopt a methodology change that would increase the federal Medicaid matching rate for California from 51.67 to 53.36 percent in federal fiscal year 2000, effective October 1999 (see our analysis of the California Medical Assistance Program [Medi-Cal]). The budget reflects General Fund savings of $210 million in the Medi-Cal program as a result of the proposed increase in federal Title XIX Medicaid funds. The budget, however, omits the corresponding savings that would be achieved due to the resulting increase in federal Title XXI funds for the state's Healthy Families Program (HFP), which has an enhanced federal matching rate that is tied to the federal Medicaid rate. This would affect the budgets in the Managed Risk Medical Insurance Board, the DHS, and the Department of Mental

Health. Accordingly, we recommend a technical correction to make the budget consistent, which would result in General Fund savings of $2.3 million in 1999-00.

We also note that the budget places all the General Fund savings associated with the Medi-Cal program in the DHS, whereas some of these savings would occur in other departments where the state match for Medicaid funds is budgeted. (The Department of Social Services, for example, indicates that about $8 million of the savings should be reflected in its budget.) According to the DHS, these adjustments will be made in the May revision of the budget.

DEPARTMENTAL ISSUES

Health and Social Services

HEALTH AND HUMAN SERVICES AGENCY (0530)

The Secretary of the California Health and Human Services Agency (formerly the Health and Welfare Agency) is directly responsible to the Governor for general policy formulation in the health and human services area.

The budget proposes $2.3 million ($1.3 million from the General Fund) to support the agency in 1999-00, which is approximately the same as estimated current-year expenditures.

THINKING ABOUT HEALTH CARE EXPANSION

Secretary to Develop Plan for Health Care Reforms

The budget proposes a $37.3 million General Fund set-aside to implement a plan for health care reforms that will be submitted by the Secretary of the California Health and Human Services Agency.

We identify several approaches for the Legislature to consider regarding (1) expansion of health care coverage for uninsured working families in the Healthy Families Program (HFP) and the California Medical Assistance Program (Medi-Cal), (2) simplification of administration, and (3) improved participation.

The budget includes a "set-aside" of $37.3 million from the General Fund that is reserved for expenditure on health care reforms, pursuant to

a plan to be submitted by the Secretary of the Health and Human Services Agency. According to the administration, this plan may be submitted either as a budget proposal or as a proposal for separate legislation. Funding for the set-aside is contingent on federal action because it is tied to federal approval of a waiver to provide Medicaid funding for family planning services currently funded entirely by the state, which the budget assumes will result in $122 million of General Fund savings in 1999-00. In his budget summary, the Governor indicates that the plan will give consideration to the following issues, many of which involve the HFP, a program that currently provides health insurance for children:

- Expanding the family income eligibility limit for the HFP from 200 percent of the poverty level to 250 percent.
- Providing state-only funded HFP coverage to recently-arrived legal immigrant children, who are not eligible for federal funding.
- Streamlining HFP application documentation requirements.
- Seeking federal permission to allow Medi-Cal-eligible families to enroll their children in the HFP rather than Medi-Cal.
- Providing HFP coverage for parents and older siblings of HFP-eligible children, including exploring the use of the federal Children's Health Insurance Program (CHIP) funds to provide this coverage.
- Recommending outreach and education strategies to increase the enrollment of children in Medi-Cal and the HFP.

A Framework for Considering Health Coverage Expansions

Millions of Californians are uninsured—they do not have health coverage, whether job-based, privately purchased, or through a public program such as Medi-Cal. For example, *The State of Health Insurance in California, 1998*, recently published by the Health Insurance Policy Program of the University of California, estimates that seven million nonelderly Californians are uninsured, and California has one of the lowest rates of health insurance coverage in the nation. The large number of uninsured persons has raised concerns about the adequacy of health care services for a significant portion of the state's population, and it has imposed a large burden on county indigent care programs, community clinics, and other components of the state's health care "safety net."

The options presented in the budget for the Secretary's consideration all seek to increase health insurance coverage. Additional coverage has been the goal of many recent legislative proposals, including enactment

of the HFP to expand health coverage for children. However, it is important to remember that health care coverage is a means, rather than an end. Coverage does no good unless it provides effective care. Moreover, increasing the proportion of the population that is insured does not necessarily result in an equivalent increase in the proportion who are healthy since most people are generally healthy regardless of insurance status. A survey reported in *The State of Health Insurance in California, 1998*, indicates that although the uninsured are twice as likely as the insured to report their health status as fair or poor, the great majority of *both* groups reported their health status as either good or excellent (82 percent for the uninsured). This is not surprising, since many of the uninsured are teens and younger adults, who generally tend to be healthy.

Furthermore, while studies have shown that the insured make greater use of health care services than the uninsured, everyone has some access to care. Emergency treatment at hospitals is legally guaranteed to all regardless of ability to pay. County indigent care programs and other elements of the health care safety net provide a significant amount of free or low-cost care to the uninsured. Medi-Cal, in effect, provides "major medical" coverage for unenrolled, but eligible, children and families. Finally, some people still pay directly for care.

Criteria for Evaluating Expansion Proposals. Health care programs can be very expensive, and their cost can grow rapidly if not carefully controlled. Given limited state resources, it is crucial to target any health coverage expansions where they will be the most effective and make the best use of existing resources and funding streams. With this in mind, we suggest the following criteria for evaluating proposals to expand coverage:

- ***Maximize Federal Funds to the Extent Possible.*** Medicaid and the federal CHIP provide half or two-thirds, respectively, of the funding for covered services to eligible persons. Accordingly, it is important to structure coverage expansions so that they qualify for these programs wherever possible. Similarly, coordination with Medicare is important for the elderly or disabled. We recognize that with federal funds often come "federal strings." In some cases, the state may decide that the additional federal funds are not worth the accompanying federal requirements.
- ***Consider Existing Indigent Care Funding.*** Expanded coverage would reduce the burden on indigent care systems. Accordingly, it may be appropriate to redirect a portion of these funds (such as state realignment funds currently provided to counties) to cover some of the expansion cost (for example, to provide a share of the nonfederal match for Medi-Cal or HFP expansions).

- ***Target the Most Needed Services.*** The cost of coverage generally increases with the scope of coverage. Targeting the most essential services allows coverage of more people with limited funds.
- ***Target the People Who Most Need, and Can Best Use, Coverage.*** Many groups with specific health care needs (such as the elderly, disabled, people with AIDS, children, and pregnant women) already are targeted by public health insurance or special benefit programs. Other groups that would be good candidates for expanded coverage include low-income nonelderly adults with chronic health problems, such as diabetes, and low-income working parents, on the basis that their health is important to the well-being of their children.
- ***Insurance Isn't Always the Answer.*** Absent a system of universal or mandatory coverage, some people will remain uninsured, even if coverage is free or heavily subsidized. Many healthy adults without children, the homeless, transients, or persons in the midst of a transition in their lives are likely to remain uncovered. Safety-net programs will continue to be needed to serve this segment of the population.
- ***Include Cost-Sharing On An Ability-to-Pay Basis.*** As coverage is extended to persons at higher income levels, it becomes important to require that those covered contribute to the cost of coverage. Imposing premium contributions on a sliding-scale basis limits incentives to substitute public coverage for private or job-based coverage, provides a partial offset to state costs, and phases out, rather than abruptly eliminating, the coverage subsidy as income rises.
- ***Be Skeptical of Claims of Offsetting Savings from Expanded Coverage.*** Preventive care can produce savings in specific cases, especially through good management of chronic illnesses, but in general it will cost more to provide regular health coverage and broader access to care.

Options for Expanded Coverage

The new federal CHIP program and recent changes in federal Medicaid laws and regulations provide the state with a number of approaches to further expand health care coverage to working families, with federal funds providing one-half to two-thirds of the cost. Expanding coverage will require state (and/or local) funding to cover the nonfederal share of costs. However, we believe that simplifying eligibility could

produce some partially offsetting administrative savings to the state and that expanding coverage could reduce county indigent care costs.

We further suggest that the Legislature consider funding for coverage expansion on its on merits within the Legislature's overall fiscal priorities and available resources rather than tying it to a single action, such as federal approval of the family planning waiver.

We have identified a number of approaches for expanding coverage. These approaches include variations of—or more specific means of implementing—the options mentioned in the Governor's budget, as well as other approaches for the Legislature's consideration, as listed below:

- Expand HFP eligibility to children in families with incomes above 200 percent of poverty.
- Expand Medi-Cal coverage for uninsured parents by increasing Medi-Cal income and asset limits for working families using federal Section 1931(b) flexibility provided in the 1996 welfare reform law and recent revisions to Medicaid regulations.
- Adopt a sliding schedule of premium payments to gradually phase out the public subsidy to families with higher incomes.
- Unify and simplify coverage for low-income working families by (1) allowing access to the same plans and providers through both Medi-Cal and HFP, and (2) by providing Medi-Cal coverage (and redetermining eligibility) in managed care plans on an annual, rather than a quarterly, basis—similar to the current annual eligibility period in the HFP.

Implementing these approaches in a coordinated and cost-effective manner probably would require the state to seek a Section 1115 demonstration project waiver from the federal government. Waiver authority might be needed, for example, to unify eligibility criteria and benefit packages under Medi-Cal and the HFP, and possibly to enable the state to use the federal share of any administrative savings to provide additional financing for extended coverage. Waiver authority also may be needed to allow the state to charge premiums on a sliding-scale basis for Medi-Cal beneficiaries at higher income levels.

In summary, we believe that there are a number of avenues available to the Legislature for expanding health care coverage for working families using available federal matching funds, and building on the existing Medi-Cal and HFP.

DEPARTMENT OF HEALTH SERVICES (MEDI-CAL) (4260)

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

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

Proposed Spending. The budget for DHS proposes Medi-Cal expenditures totaling $21.1 billion from all funds for state operations and local assistance in 1999-00. The General Fund portion of this spending ($7.4 billion) decreases by a relatively small amount ($68.8 million or 0.9 percent) compared with estimated General Fund spending in the current year. The spending total for the Medi-Cal budget includes an estimated $3.5 billion (federal funds and local matching funds) for pay-

ments to disproportionate share hospitals (DSH), and about $1.8 billion of federal funds to match $1.6 billion of state and local funds budgeted elsewhere for programs operated by other departments, by counties, or by the University of California. Including these other state and local funds, total proposed Medicaid spending in California would be about $22.7 billion in 1999-00, according to the budget.

MEDI-CAL BENEFITS AND ELIGIBILITY

What Benefits Does Medi-Cal Provide?

Federal law requires the Medi-Cal Program to provide a core of basic services, including hospital inpatient and outpatient care, skilled nursing care, doctor visits, laboratory tests and x-rays, family planning, and regular examinations for children under the age of 21. California also has chosen to offer 32 optional services, such as outpatient drugs and dental care, for which the federal government provides matching funds. Certain Medi-Cal services—such as hospitalization in many circumstances—require prior authorization from DHS as medically necessary in order to qualify for payment.

How Medi-Cal Works

Most of the Medi-Cal caseload consists of participants in the state's two major welfare programs, which include Medi-Cal coverage in their package of benefits. These programs are (1) the California Work Opportunity and Responsibility to Kids (CalWORKs) program, which provides assistance to families with children and replaces the former Aid to Families with Dependent Children (AFDC) program, and (2) the Supplemental Security Income/State Supplementary Program (SSI/SSP), which assists elderly, blind, or disabled persons. Counties administer the CalWORKs program and county welfare offices determine eligibility for CalWORKs benefits and Medi-Cal coverage concurrently. Counties also determine Medi-Cal eligibility for persons who are not eligible for (or do not wish) welfare benefits. The federal Social Security Administration determines eligibility for SSI/SSP, and the state automatically adds SSI/SSP beneficiaries to the Medi-Cal rolls.

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

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

Managed Care. Prepaid health plans generally provide managed care. The plans receive monthly "capitation" payments from the Medi-Cal Program for each enrollee in return for providing all of the covered care needed by those enrollees. These plans are similar to health plans offered by many public and private employers. By the end of 1998-99, DHS expects to have about half (2.5 million) of the projected 5 million Medi-Cal eligibles enrolled in managed care organizations. Beneficiaries in managed care choose a plan and then must use providers in that plan for most services. Since payments to the plan do not vary with the amount of service provided, there is much less need for utilization control by the state. Instead, plans must be monitored to ensure that they provide adequate care to enrollees.

Who Is Eligible for Medi-Cal?

Almost all Medi-Cal eligibles fall into two broad groups of people. They either are aged, blind, or disabled or they are in families with children. More than two-thirds of Medi-Cal eligibles are welfare recipients. Figure 1 shows for each of the major Medi-Cal eligibility categories the maximum income limit in order to be eligible for health benefits, and the estimated caseload and total benefit costs for 1998-99. The figure also indicates for each category whether an asset limit applies and whether eligible persons with incomes over the limit can participate on a "spend-down" basis. If spend-down is allowed, then Medi-Cal will pay the portion of any qualifying medical expenses that exceed the person's "share of cost," which is the amount by which that person's income exceeds the applicable Medi-Cal income limit.

Aged, Blind, or Disabled Persons. About 1.3 million low-income persons who are (1) at least 65 years old or (2) disabled or blind persons of any age receive Medi-Cal coverage. Overall, the disabled make up more than half (61 percent) of this portion of the Medi-Cal caseload. Most of the aged, blind, or disabled persons on Medi-Cal (86 percent) are recipients of SSI/SSP welfare benefits and receive Medi-Cal coverage automatically. The other aged, blind, or disabled eligibles are in the "medically needy"

Figure 1

Who is Eligible for Medi-Cal? Major Eligibility Categories

1998-99

	Maximum Monthly Income Or Grant[a]	Asset Limit Imposed?	Spend Down[b] Allowed?	Enrollees (Thousands)	Annual Benefit Costs (Millions)[c]
Aged, Blind, or Disabled Persons					
• Welfare (SSI/SSP)	$1,201	✔	—	1,125	$6,299
• Medically needy	934	✔	✔	112	670
• Medically needy—long term care	Special limits	✔	✔	68	2,241
Families, Pregnant Women, Children					
Single-parent or unemployed families					
• Welfare (CalWORKs)	$1,009[d]	✔	—	2,444	$3,057
• Section 1931(b) only	1,009[e]	✔	—	—[f]	—[f]
• Medically needy	1,190	✔	✔	467	783
Any women or children					
Pregnant women					
• 200 percent of poverty—pregnancy services	$2,832	—	—	102	$372
• Medically indigent—all services	1,190	✔	✔	11	96
Children					
• 200 percent of poverty—infants	$2,832	—	—	40	—[g]
• 133 percent of poverty—ages 1 through 5	1,914	—	—	97	$67
• 100 percent poverty—ages 6 through 18	1,461	—	—	57	37
• Medically indigent—ages 0 through 21	1,190	✔	✔	268	409
Emergency-Only					
Undocumented immigrants who qualify in any eligibility group are limited to emergency services (including labor and delivery and long-term care).				216	$502

[a] Amounts are for aged or disabled couple (blind slightly more) or for a four-person family with children (including a $90 work expense disregard).

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

[c] Combined state and federal costs.

[d] Income limit to apply for CalWORKs (including a $90 work expense disregard). After becoming eligible, the income limit increases to $1,680 (family of four) with the maximum earned income disregard.

[e] Applicant income limit; increases to $2,080 after enrollment.

[f] Not fully implemented in 1998-99. Enrollment and costs included in amounts for CalWORKs recipients.

[g] Costs included in amount for 200 percent of poverty pregnant women group.

category. They also have low incomes, but do not qualify for, or choose not to participate in, the SSI/SSP program. For example, aged low-income noncitizens generally may not apply for SSI/SSP (although they may continue on SSI/SSP if they already were in the program as of August 22, 1996). As another example, about 17 percent of the medically needy persons in this category have incomes above the Medi-Cal limit and participate on a share-of-cost basis.

The number of Medi-Cal eligibles in long-term care is small, only 68,000 people or 1.3 percent of the total caseload; but because long-term care is very expensive, benefit costs for this group total $2.2 billion, or 15 percent of total Medi-Cal benefit costs.

Almost 60 percent of the aged or disabled Medi-Cal eligibles also have health coverage under the federal Medicare Program. Medi-Cal generally pays the Medicare premiums, deductibles and any co-payments for these "dual beneficiaries," and Medi-Cal pays for services not covered by Medicare, such as drugs and long-term care. Medi-Cal also provides some limited assistance to a small number of Medicare eligibles who have incomes somewhat higher than the medically needy standard.

Families. About half of all Medi-Cal eligibles are CalWORKs welfare recipients in single-parent or unemployed families, who receive Medi-Cal coverage under the state's "Section 1931(b)" Program (discussed later in this analysis). Although CalWORKs recipients constitute the largest group of Medi-Cal eligibles by far, they account for only 21 percent of total Medi-Cal benefit costs. This is because almost all CalWORKs recipients are children or nondisabled working-age adults, who generally are relatively healthy.

Single-parent or unemployed families who are not in CalWORKs also may enroll in Medi-Cal in the Section 1931(b) Program or in the medically needy family category. Medi-Cal covers both the adults and the children in these families. The income and asset limits for medically needy families are somewhat higher than for Section 1931(b) applicants (who must meet essentially the same requirements as CalWORKs applicants). However, once enrolled, Section 1931(b) families may work and remain on Medi-Cal at higher income levels. Qualifying families with higher incomes also may participate in the medically needy category on a share-of-cost basis.

Women and Children. Medi-Cal includes a number of additional eligibility categories for pregnant women and for children. Women and children in these categories may be in any type of family, including working, two-parent families. Medi-Cal covers all health care services for poor pregnant women in the medically indigent category, which has the same income and asset limits and spend-down provisions as apply to medically needy fami-

lies. However, pregnancy-related care is covered with no share of cost for women up to 200 percent of poverty (an annual income of $33,984 for a family of four, including a $90 monthly work expense disregard).

The medically indigent category also covers children and young adults through age 20. Several special categories provide coverage without a share of cost or an asset limit to children in families with higher incomes—200 percent of poverty for infants, 133 percent of poverty for children ages 1 through 5, and 100 percent of poverty for children ages 6 through 18. Chapter 624, Statutes of 1997 (SB 903, Lee) extended the 100 percent of poverty group to ages 14 through 18 and eliminated the asset limit for poverty-group children. Chapter 624 also authorized the use of a simplified mail-in application for pregnant women and poverty-group children.

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

More Than Half of Medi-Cal Spending Is for the Elderly And Disabled

The average cost per eligible for the aged and disabled Medi-Cal caseload (including long-term care) is much higher than the average cost per eligible for families and children on Medi-Cal (most of whom are CalWORKs recipients). As a result, more than half of Medi-Cal spending is for the elderly and disabled, although they account for only about one-fourth of the total Medi-Cal caseload, as shown in Figure 2 (see next page).

MEDI-CAL EXPENDITURES

Spending Up Sharply in the Current Year

Figure 3 (see page 29) presents a summary of Medi-Cal General Fund expenditures in the DHS budget for the past, current, and budget years.

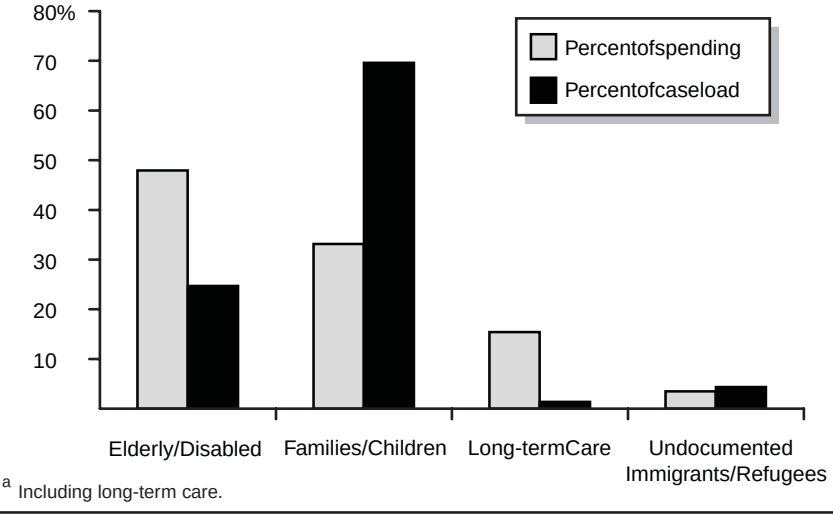
The budget estimates that the 1998-99 General Fund share of Medi-Cal benefit costs will total $6.9 billion—an increase of $538 million (8.4 percent) compared with 1997-98. The primary reason for the higher

spending is an increase in the cost and utilization of services (caseload remains almost flat—a decline of 1 percent). Provider rate increases account for $156 million of added General Fund cost. These rate increases include a 6.1 percent increase for nursing facilities, costing an estimated $80.7 million (partly reflecting the effects of recent increases in the minimum wage on nursing facility operating costs). Additionally, rate adjustments added in the *1998-99 Budget Act* account for $51.6 million of the General Fund cost increases, mostly to enhance rates for primary and preventive care by physicians, which had not been adjusted, in many cases, since the 1980s. The *1998-99 Budget Act* also increased General Fund costs by $40 million by reducing the amount of DSH funds retained by the state to offset General Fund Medi-Cal costs, and it provided $25 million from the General Fund for a Fresno regional burn and trauma center. The department also indicates that drug costs and hospital use have increased significantly in the current year.

Figure 2

The Majority of Medi-Cal Spending Is for the Elderly and Disabled [a]

Medi-Cal Spending and Caseload 1998-99



[a] Including long-term care.

Figure 3

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

1997-98 Through 1999-00
(Dollars in Millions)

	Actual 1997-98	Estimated 1998-99	Proposed 1999-00	Change From 1998-99 Amount	Change From 1998-99 Percent
Support (state operations)	$66.6	$65.5	$66.1	$0.6	0.9%
Local Assistance					
Benefits	$6,384.6	$6,942.4	$6,863.7	-$78.7	-1.1%
County administration (eligibility)	287.3	328.4	355.7	27.3	8.3
Fiscal intermediaries (claims processing)	66.8	72.6	69.5	-3.1	-4.3
Hospital construction debt service	20.4	54.5	39.6	-14.9	-27.3
Subtotals, local assistance	($6,759.1)	($7,397.9)	($7,328.5)	(-$69.4)	-0.9%
Totals	**$6,825.7**	**$7,463.4**	**$7,394.6**	**-$68.8**	**-0.9%**

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

In addition to the higher cost of benefits, other local assistance costs are up by $81 million (General Fund) in the current year compared with 1997-98. County administration costs have increased by $41.1 million, partly due to a new policy of allocating to Medi-Cal a portion of eligibility determination costs for CalWORKs applicants in order to maximize federal funding, and also because of new costs to implement the Medi-Cal portions of the Healthy Families Program. The General Fund cost for hospital construction debt service payments increases by $34.1 million in 1998-99 because several major projects were completed recently.

$507 Million General Fund Deficiency in 1998-99

Although some of the spending increases noted above were anticipated in the *1998-99 Budget Act*, others were not. Furthermore, the budget assumed a number of savings that did not occur, and caseload, although declining, is above the budget estimate. As a result, the *1999-00 Governor's Budget* now estimates that Medi-Cal local assistance spending from the

General Fund will exceed the current-year budget appropriation by $507 million. The major components of the additional spending, are as follows:

"Uncertainty" Savings Did Not Materialize—$132 Million. The *1998-99 Budget Act* assumed that spending on Medi-Cal benefits would be at the bottom of the uncertainty range around the department's mid-point estimate (a 2 percent savings). Actual trends have gone in the other direction, and the *1999-00 Governor's Budget* eliminates the savings from this "uncertainty adjustment."

Caseload Above Estimate—$109 Million. The Medi-Cal caseload is 3.5 percent above the 1998-99 budget estimate. Almost all of the increase is in the CalWORKs-related portion of the Medi-Cal caseload, and results from automatically continuing the Medi-Cal eligibility of former CalWORKs recipients due to delays in implementing the new Section 1931(b) Medi-Cal eligibility category.

Drug Costs Are Up—$78.8 Million. The department primarily attributes this spending increase to a more rapid than anticipated shift to new, more expensive, antipsychotic medications.

Continuation of Prenatal Care for Undocumented Women—$64.4 Million. The *1998-99 Budget Act* assumed savings from the elimination of this state-only Medi-Cal service. The *1999-00 Governor's Budget* funds continuation of this service through the budget year pending the outcome of litigation challenging implementation of regulations to end the program. (The budget also funds state-only long-term care for undocumented immigrants, also the subject of litigation, through the budget year, but funding for this service was included in the *1998-99 Budget Act*.)

Longer Hospital Stays for Labor and Delivery—$31 Million. The budget indicates that recent federal and state legislation mandating minimum hospital stays for labor and delivery have increased the average length of stay and resulted in increased costs for these services over the amount anticipated in the *1998-99 Budget Act*.

Managed Care Rate Increase—$24 Million. The *1998-99 Budget Act* did not include funding for rate increases (averaging 4.7 percent) which have been granted by the department to managed care plans in the 12 counties operating under the "two-plan" model. The budget does not identify the cost of additional rate increases granted by the CMAC to the six county-operated Medi-Cal managed care plans and to plans operating under the "geographic managed care" model in Sacramento and San Diego Counties.

Reduced "Crossover" Savings—$12.6 Million. The department is implementing limits on crossover payments to hospitals for services to Medi-Cal beneficiaries who are also covered by Medicare. Under these limits, Medi-Cal covers patient co-payments only to the extent that the Medicare payment falls short of the equivalent Medi-Cal rate. Detailed claims analysis indicates that savings will be somewhat less than anticipated.

Budget Year

The Governor's budget estimates that total Medi-Cal spending from the General Fund (in the DHS budget) will be $7.4 billion in 1999-00, which is a slight decline of $68.8 million, or 0.9 percent, from estimated current-year spending. The budget also estimates that the total Medi-Cal caseload will decline by 1 percent (about 50,000 persons). The projected spending decline, however, results from assumed increases in federal funds and a one-time recovery of past excess crossover payments. Absent these special adjustments, projected General Fund spending for Medi-Cal local assistance would *increase* by $274 million, or 3.7 percent, in 1999-00. The major General Fund spending changes and assumptions in the budget are discussed in Figure _.

Increased Federal Matching Rate—$210 Million Savings. The budget assumes that the federal government will increase California's Federal Medical Assistance Percentage (FMAP) for federal fiscal year (FFY) 00, beginning October 1, 1999, to 53.36 percent, compared with the announced FFY 00 FMAP of 51.67 percent. The state contends that the announced FMAP is based on faulty population estimates for California by the U.S. Census Bureau, which were used in the formula to determine the state's FMAP.

Family Planning Waiver—$122.2 Million Savings. The budget assumes federal approval of a Medicaid demonstration project waiver that would provide 90 percent federal funding for the existing state-only family planning program, which serves low-income persons who are not Medi-Cal eligible. Currently, this program is supported entirely by the General Fund.

Retroactive Recoupment of Hospital Crossover Payments—$50.5 Million Savings. The department proposes to recoup the portion of Medi-Cal payments made to hospitals in excess of the Medi-Cal/Medicare crossover limits. The recoupment period dates back to May 1994, while the crossover limits were being challenged in the courts. Congress included a provision in the 1997 Balanced Budget Act clarifying

the state's authority to impose crossover limits, and enabling the state to recoup these overpayments. Hospitals will be made whole for this recoupment by the federal government under Medicare's "bad-debt" provisions.

Audit Exception for Institutions for Mental Disease (IMD)—$44.4 Million Cost. The federal government has disallowed payments for the cost of physician and other ancillary services for Medi-Cal eligibles who reside in IMDs, which the state has claimed as Medicaid costs since July 1992. The budget includes $44.4 million from the General Fund to satisfy this federal audit exception, and indicates that the state will no longer fund these services because there is no state authority to do so, and because responsibility for these services was transferred to counties in the realignment of mental health services.

County Administration—$27.3 Million Cost Increase. General Fund costs for county eligibility determination activities increase by 8.3 percent in 1999-00. Most of the increase is for an annual "cost-of-doing-business" adjustment of 3.9 percent ($9.5 million), processing Section 1931(b) eligibility determinations ($7.9 million increase), and expiration of enhanced federal funding for outreach for children's coverage ($2.8 million). The county administration budget also includes an increase of $2.8 million for various Medi-Cal administrative costs incurred by the Department of Developmental Services.

Some Likely Costs Not Included in the Budget. The January budget includes no funding for any rate increases for nursing homes or for managed care organizations in 1999-00. The current-year General Fund cost of these rate increases is more than $100 million. The nursing home rate increase generally is added in the May Revision. The budget also does not include any funds for hospital outpatient rate increases (potentially tens of millions of dollars) that may be necessary, depending on the outcome of a rate study. Hospitals successfully challenged the basis for the state's current rates in *Orthopaedic Hospital v. Belshe*, and a court order in that case requires DHS to set new rates that have a reasonable relationship to costs. The department expects to establish the new rates in early 1999-00. Furthermore, there is no funding in the budget to pay San Diego County's mandate reimbursement claim of $15.2 million for past health care costs for medically indigent adults. The basis for this claim was affirmed by the California Supreme Court, and the claim is likely to be acted on by the Commission on State Mandates before the end of 1999-00.

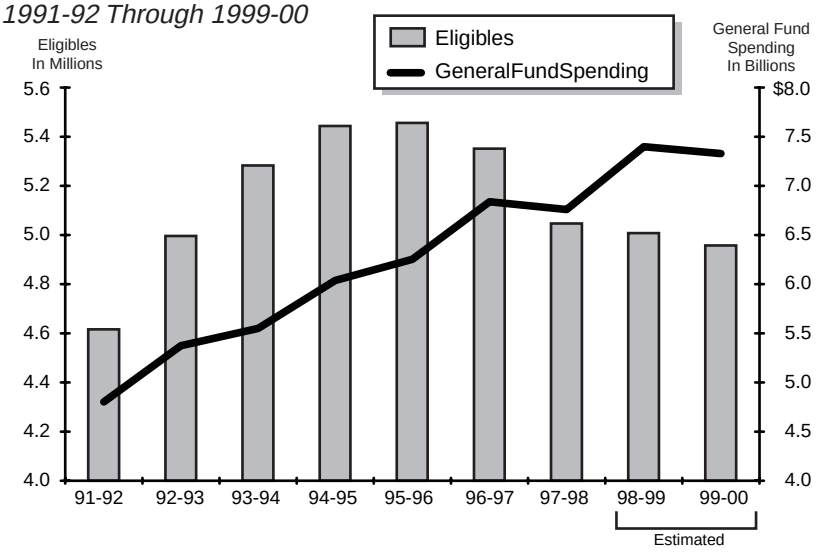
MEDI-CAL SPENDING AND CASELOAD TRENDS

Figure 4 shows Medi-Cal caseload and General Fund spending since 1991-92. During the period 1991-92 through 1995-96, both caseload and spending rose in a roughly similar manner. The average annual growth rates were 4.3 percent for caseload and 6.8 percent for spending. Starting in 1996-97, however, the two trends diverge sharply, as caseload has declined while costs have continued to grow. From 1995-96 through the current year (as estimated in the budget) caseload has *declined* at an average annual rate of 2.7 percent, but costs have continued to *rise* at an annual rate of 7.8 percent. The "spread" between the growth rates for spending and caseload has grown from 2.5 percent in the earlier period to 9.7 percent from 1995-96 through the current year.

Figure 4

Medi-Cal Caseload and General Fund Spending Trends

1991-92 Through 1999-00



Growth in Cost Per Eligible Is Driving Spending

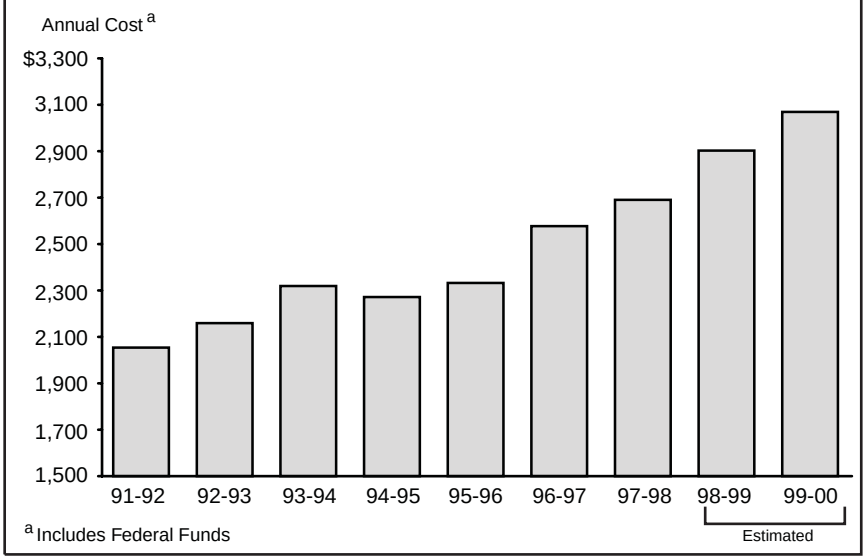
The continued upward trend in spending reflects, in part, costs for recently completed hospital construction projects and the ongoing increase in county administration costs. The primary driver of the spending

growth, however, is an increase in the cost and utilization of services by Medi-Cal beneficiaries. Figure 5 illustrates this trend. From 1991-92 through 1995-96, the average cost per Medi-Cal eligible grew at an annual rate of 3.2 percent. Between 1995-96 and 1998-99, however, the annual rate of growth has increased to an average of 7.8 percent.

Figure 5

Medi-Cal Cost-per-Eligible Growth Resumes

1991-92 Through 1999-00



Case Mix Change Contributes to Increased Cost Per Eligible. Higher costs and greater utilization of services are the main reasons why Medi-Cal spending is increasing in the face of declining caseload. But a changing caseload mix also contributes to a higher cost per eligible and dampens any caseload savings. This is because the number of elderly and disabled Medi-Cal eligibles is holding steady, while the number of families and children on Medi-Cal declines (primarily due to declining CalWORKs welfare rolls). On average, the cost per eligible for the elderly or disabled is about four and one half times that for families and children. Consequently there has been a gradual shift to a more expensive mix of eligibles.

Between 1995-96 and 1998-99, the percentage of the Medi-Cal caseload that are elderly or disabled increased from 23 percent to 26 percent. Since the average Medi-Cal cost per eligible for the elderly and disabled is more than four times higher than for children and families, even this relatively

modest change in the mix contributes to the increasing overall cost per eligible. We estimate that about 10 percent of the increase in the average cost per eligible in the current year is due to this case mix effect. Harder to estimate, is the possible effect of a selective decline in the CalWORKs caseload. This would occur to the extent that persons leaving CalWORKs (or choosing to stay off welfare) tend to be healthier than those who remain on CalWORKs.

Has Managed Care Slowed Spending Growth?

The significant cost increases since 1995-96 happen to coincide with the implementation of the two-plan model for Medi-Cal managed care in most of the larger counties, and the implementation of a county-organized health system in Orange County. During this time, enrollment of Medi-Cal eligibles in managed care plans has increased from roughly 25 percent to almost 50 percent. Consequently, the expansion of Medi-Cal managed care has not resulted in any readily apparent slowing of spending growth, although it is possible that spending might have grown even faster without the managed care expansion.

Budget Depends on Risky Federal Assumptions

The Medi-Cal budget includes a total of $332 million of General Fund savings that depend on two federal actions: (1) an increase in the Federal Medical Assistance Percentage (the federal sharing ratio for Medi-Cal benefit costs) and (2) approval of a Medicaid waiver to provide federal funding for the current state-only family planning program. Neither of these assumed actions is assured.

As mentioned in our earlier description of the 1999-00 Medi-Cal spending proposal, the budget assumes that the federal government will approve two state requests that would result in a total of $332 million of General Fund savings in the Medi-Cal Program.

The FMAP Increase—$210 Million. On January 12, 1999, the Secretary of the U.S. Department of Health and Human Services announced the FMAPs that will be in effect for each state during FFY 00 (October 1999 through September 2000). California's FFY 00 FMAP is 51.67 percent. The budget assumes that the federal government will revise California's FFY 00 FMAP to 53.36 percent. This increase in the federal share of Medi-Cal costs would reduce state General Fund costs by $210 million (a small portion of these savings would occur in the budgets of other departments, and will be reallocated in the May Revision of the budget).

The FMAP is calculated according to a federal statutory formula based on the relationship of per capita personal income in each state to the national average over a moving three-year period. The *lower* a state's per capita personal income relative to the nation, the *higher* its FMAP. Per capita personal income is derived by taking the U.S. Department of Commerce's estimate of total state personal income and dividing it by the U.S. Census Bureau's estimate of state population. Accordingly, a higher population estimate for a state will reduce the calculated per capita personal income and result in a larger FMAP.

The Governor's budget indicates that the Census Bureau's population estimates for California are too low because they continue to show a net movement of people from California to other states, whereas the Department of Finance (DOF) estimates that California has been gaining population from other states in recent years in response to an improved economy. The bureau uses federal tax return information, which tends to have a significant lag, to track population movement between states. The DOF, however, uses more recent drivers' license information to estimate net migration for California.

We believe that the administration is correct, and an increase in the state's FMAP is justified. However, no mechanism currently exists to make that adjustment for FFY 00. Under federal law, the determination of FMAPs by the federal Health and Human Services Secretary is "conclusive," and therefore there is no process for appealing it. Furthermore, allocating more population to California requires reducing the population estimates of other states and adjusting their FMAPs accordingly. This probably is not feasible in the short term, since there is no national database of drivers' license information. Alternatively, Congress could address the state's concern by adding funds to the federal FFY 00 budget to provide an *ad hoc* adjustment for California. In any case, the budget's assumption of an increase in California's FMAP creates a General Fund risk.

Family Planning Waiver—$122.2 Million. Currently, California's family planning program serves both Medi-Cal eligibles and those whose incomes are under 200 percent of poverty, but exceed the normal Medi-Cal income limits. The state receives 90 percent federal funding for family planning services for those who are Medi-Cal eligibles, but no federal funds for those who are not Medi-Cal eligible. The budget proposes to shift the state-only portion of the existing family planning program to 90 percent federal funding under a Medicaid demonstration project waiver that will require federal approval.

Several states have received family planning waivers or are currently applying for them. Oregon, for example, recently received this type of

waiver to substantially expand its family planning program to individuals not previously served by that state. Waiver programs, however, must be "budget neutral" (that is, have no net cost) to the federal government. In the Oregon expansion, the additional federal costs for expanding coverage will be more than offset by the estimated federal Medicaid savings from reduced pregnancies. California's proposal is similar to Oregon's, but does not involve an expansion of coverage beyond that which currently is provided by the state.

IMPLEMENTATION OF CALIFORNIA'S SECTION 1931(b) PROGRAM BEGINS

The 1996 federal welfare reform legislation created a new Medicaid eligibility category, often referred to as "Section 1931(b)" (established in Section 1931(b) of Title XIX of the Social Security Act [the Medicaid law]). This new eligibility category replaces the previous automatic ("categorical") link to Medicaid for families on welfare.

Section 1931(b) makes anyone eligible for Medicaid who would have met their state's former requirements for Aid to Families with Dependent Children (AFDC) in effect on July 16, 1996. This guarantees Medicaid eligibility to people who would have met the former AFDC rules, regardless of whether states chose to be more restrictive in their Temporary Assistance for Needy Families (TANF) welfare programs, which replaced AFDC.

Section 1931(b) also allows states to expand Medicaid eligibility for low-income families by adopting income or resource standards that are more liberal than the former AFDC standards. This flexibility generally allows states to maintain automatic Medicaid coverage for TANF welfare recipients even if they adopt TANF eligibility criteria that are more liberal than their former AFDC requirements. For example, two factors used by the state to determine eligibility known as "earned-income disregards" and "asset limits" under California's TANF welfare program—CalWORKs—are somewhat higher than under the state's July 1996 AFDC rules. The CalWORKs legislation, required DHS to increase the state's Section 1931(b) income and asset limits to the amounts needed in order to provide automatic Medi-Cal coverage to all CalWORKs recipients.

However, Section 1931(b) eligibility is not limited to welfare recipients. Families who meet the state's Section 1931(b) requirements are eligible for Medi-Cal regardless of whether they are on welfare. Furthermore, states can use their Section 1931(b) flexibility to expand Medicaid eligibility beyond their TANF welfare limits.

Overlaps With the Medically Needy Program Increase Medi-Cal's Complexity. For many years, California's Medically Needy Program has provided no-cost Medi-Cal coverage for poor families who are not on welfare. The requirements for Section 1931(b) eligibility are very similar to those for the Medically Needy Program, but they are not the same, and these differences increase the complexity of the county eligibility determination process without necessarily expanding coverage by very much. Section 1931(b) eligibility has *higher* earned-income disregards than the Medically Needy Program, but *lower* income limits for initial qualification. Section 1931(b) eligibility also provides up to two years of transitional Medi-Cal coverage when earnings increase above its income limits, whereas the Medically Needy Program does not include transitional coverage. Both programs have complex asset limits that differ in a number of details. The 1998-99 budget trailer bill for health (Chapter 310, Statutes of 1998 [AB 2780, Gallegos]) took one step toward simplification by increasing the general asset limit under Section 1931(b) from the CalWORKs limit of $2,000 to the asset limit used in the existing Medi-Cal Medically Needy Program—$3,300. However, other differences in the asset rules still exist, particularly with respect to vehicles.

Delay in Implementing Section 1931(b) Eligibility is Costly

More than 250,000 former California Work Opportunity and Responsibility to Kids recipients have been kept on the Medi-Cal rolls indefinitely due to delays by the Department of Health Services in issuing criteria and implementation guidelines for Section 1931(b) eligibility. We estimate that the General Fund cost of Medi-Cal coverage for these beneficiaries will total about $90 million through 1998-99, and that most of this cost will be for persons who would not otherwise be enrolled in Medi-Cal.

Section 1931(b) eligibility became effective in California on January 1, 1998, along with the implementation of the CalWORKs program. However, DHS did not issue any guidance to the counties for determining Section 1931(b) eligibility at that time. Instead, DHS directed counties to indefinitely hold persons leaving welfare in the existing "Edwards" Medi-Cal eligibility category pending the development of specific Section 1931(b) eligibility criteria.

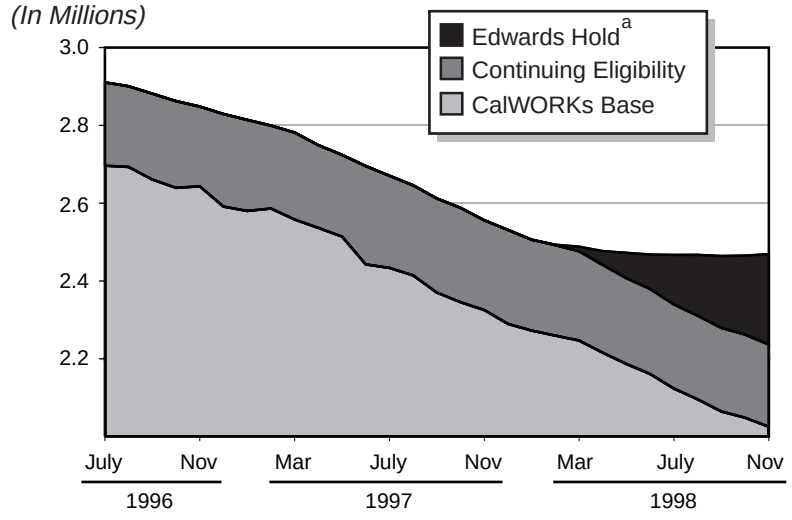
More Than 250,000 Persons Retained on Medi-Cal in the "Edwards Hold." The purpose of the Edwards category (named after the *Edwards v. Kizer* court case) has been to provide a brief (one- to two-month) period of extended eligibility for persons terminated from CalWORKs, or the former AFDC program, during which counties attempt to contact those

persons and determine whether they qualify for transitional Medi-Cal coverage or coverage under another Medi-Cal category. Persons who respond and qualify are placed in the appropriate category. Others are dropped from the Medi-Cal rolls.

Figure 6 shows that the Edwards Hold has had a significant effect on the CalWORKs-related component of the Medi-Cal caseload. During 1997, prior to the hold, this caseload declined steadily by between 25,000 to 30,000 persons per month. After counties began to implement the Edwards Hold in February 1998,the regular CalWORKs caseload on Medi-Cal (the CalWORKs "base") continued its steady decline. However, the "continuing eligibility" portion of the CalWORKs-related caseload (Edwards cases and transitional Medi-Cal) has grown rapidly, so that the total CalWORKs-related Medi-Cal caseload has remained essentially flat. Figure 6 illustrates the growth in the Edwards caseload since January 1998. In the figure, we allocate this growth in the Edwards caseload to the Edwards Hold component, while retaining the baseline January 1998 number of Edwards eligibles in the regular Continuing Eligibility caseload component. Each month, persons terminated from CalWORKs are

Figure 6

"Edwards Hold" Increases Medi-Cal Caseload CalWORKs-Related Eligibles



[a] Growth in number of Edwards eligibles since implementation of Edwards Hold in January 1998.

added to the Edwards category, and remain there indefinitely, so that as of November 1998, this additional caseload in the Edwards Hold had accumulated to about 250,000 persons.

On September 30, 1998—nine months after the effective date of Section 1931(b) eligibility—DHS issued an "all-county letter" that provided procedures for determining Section 1931(b) eligibility, and instructed counties to immediately send out redetermination forms to Edwards Medi-Cal eligibles, terminate eligibility for those who do not respond, and complete eligibility reviews by April 30, 1999 for those who do respond. By May 1999, under the schedule in the letter, all of the Edwards Hold should be eliminated—either by termination from Medi-Cal or by reclassification into transitional Medi-Cal, Section 1931(b), or another regular Medi-Cal eligibility category.

Only a small proportion of the Edwards Hold eligibles are likely to remain on Medi-Cal after the redetermination process is completed. The primary eligibility categories for which families in the Edwards Hold caseload might qualify would be transitional Medi-Cal or Section 1931(b) coverage. However, only about 15 percent of the eligibles in the Edwards category made use of transitional Medi-Cal (which has no income limit initially) prior to implementation of the Edwards Hold. Although some families who have gone off of welfare will qualify for Section 1931(b) coverage, the caseload impact probably will be modest since Section 1931(b) eligibility duplicates other existing Medi-Cal eligibility categories (such as Medically Needy and transitional coverage) to a large extent. Finally, counties often do not have current addresses or phone numbers for Edwards beneficiaries, and a significant number who do receive redetermination forms do not return them. Information concerning many of the Edwards Hold beneficiaries now may be more than 12 months old, making contacting them more problematic.

Managed Care Costs Continue Regardless of Use of Services. Most Edwards Hold beneficiaries are enrolled in Medi-Cal managed care plans because the Edwards category is one of the mandatory enrollment categories for Medi-Cal managed care (in those counties with mandatory managed care). This means that the state has continued to pay monthly premiums to managed care plans for those Edwards Hold beneficiaries, regardless of whether they use services, have other coverage, or even have left the state. For those Edwards beneficiaries still in fee-for-service Medi-Cal, the state would also be overpaying because some of those beneficiaries would not otherwise qualify for Medi-Cal.

General Fund Costs for Edwards Hold Beneficiaries Will Total About $90 Million. We estimate that the cumulative General Fund cost for

Edwards Hold eligibles will total approximately $90 million, assuming that counties complete their redeterminations by the end of 1998-99. For the reasons discussed above, it is likely that most of the persons in the Edwards Hold would not have been on the Medi-Cal rolls (beyond the normal one or two months in the Edwards category) if Section 1931(b) eligibility had been implemented in a timely manner. Accordingly, most of the $90 million General Fund cost is attributable to the implementation delay, and would not have been incurred had there been timely implementation of Section 1931(b) eligibility.

Lagging Redeterminations Could Increase Costs Further

We recommend that the department (1) provide a progress report at budget hearings on the Section 1931(b) redeterminations and (2) identify any additional resources or county incentives needed to complete the redeterminations expeditiously.

The cost of the Edwards Hold could increase further if counties do not complete their Section 1931(b) eligibility redeterminations in the next few months. As of January 1999, few, if any, redeterminations had been completed. Moreover, the County Welfare Directors Association indicates that there may be additional delays in completing redeterminations because of (1) the large number of Edwards Hold cases, (2) staffing limitations, (3) the complexity of the process (the DHS guidance letter with attachments was more than 100 pages long), and (4) the need for clarification by DHS of the eligibility rules in some special circumstances.

No Incentive for Counties to Complete Redeterminations Quickly. Fiscal incentives for most counties run counter to quick completion of these redeterminations. Counties pay none of the benefit costs of Medi-Cal, and continuation of Medi-Cal coverage may reduce their indigent health care costs (by providing services to individuals who otherwise would be the responsibility of county indigent care programs). Also, county hospitals and health systems that participate in Medi-Cal managed care may benefit from continued capitation payments on behalf of individuals in the Edwards Hold.

Redeterminations Should Be Expedited. Section 1931(b) redetermination delays could result in tens of millions of dollars of additional General Fund costs for benefits and managed care premiums for individuals who do not qualify for (or may not want to participate in) Medi-Cal. Furthermore, additional delays will reduce the likelihood that counties will be able to reach those persons in the Edwards Hold who qualify for, and wish to receive, continued Medi-Cal coverage, as ad-

dresses and phone numbers become more outdated. In view of these facts, DHS should require counties to (1) send out eligibility redetermination packages immediately, (2) remove those who cannot be located or who do not respond from the Medi-Cal rolls, and (3) perform redeterminations on an expedited basis for those who respond and request continued coverage. In those instances where an eligibility determination requires further clarification from DHS, eligibility can be continued pending that clarification. Accordingly, we recommend that the department (1) provide a progress report at budget hearings on the Section 1931(b) redeterminations and (2) identify any additional resources or county incentives needed to complete the redeterminations expeditiously.

Budget Overestimates CalWORKs-Related Medi-Cal Caseload

We recommend General Fund reductions totaling $126.7 million ($2.7 million in 1998-99 and $124 million in 1999-00) because we project that Medi-Cal caseloads for the California Work Opportunity and Responsibility to Kids (CalWORKs)-related eligibles will be lower than the budget estimates due to (1) elimination of the Edwards Hold cases and (2) ongoing large declines in the CalWORKs welfare caseload. (Reduce 1998-99 deficiency appropriation by $2,653,000 and Item 4260-101-0001 by $124,077,000.)

The budget estimates that the CalWORKs-related portion of the Medi-Cal caseload will decline by 3.9 percent (98,700 eligibles) in the current year and by an additional 3.3 percent (80,400 eligibles) in 1999-00. These caseload declines are much smaller than the DSS' estimate of the percentage declines in the number of persons in the CalWORKs welfare caseload—14.4 percent in the current year and 11.1 percent in 1999-00.

Effect of Edwards Hold Should Be Temporary. As we discuss in the preceding issue, the Edwards Hold is the major reason why the Medi-Cal caseload declines more slowly than the CalWORKs welfare caseload in the current year. However, this should be a temporary phenomenon limited to the current year. If DHS and the counties focus their efforts, then redetermination of eligibility for the great majority of the Edwards Hold caseload should be completed prior to 1999-00, and we expect (for the reasons explained above) that most of the Edwards Hold caseload will not remain on the Medi-Cal rolls.

Underlying Caseload Decline Continues. Aside from the Edwards Hold, the trend for the CalWORKs-related Medi-Cal caseload has been steadily downward (as shown in Figure 6), and this trend has been consistent with the declines in the CalWORKs welfare caseload. Moreover,

our projection of the caseload trend for CalWORKs-related eligibles (excluding the Edwards Hold) yields essentially the same 11.1 percent decline forecasted by DSS for the CalWORKs welfare caseload. In other words, we believe that the decline in the CalWORKs-related Medi-Cal caseload in 1999-00 should reflect the underlying trend, after adjusting for the elimination of the excess caseload in the Edwards Hold. In doing so, the caseload decline in 1999-00 is larger than in the current year—not smaller, as the budget estimates.

According to DHS, the reason why the budget's projected decline in the CalWORKs-related Medi-Cal caseload is much less than the decline in the CalWORKs welfare caseload is because the budget assumes that most of the eligibles currently in the Edwards Hold and most of those who leave the CalWORKs welfare rolls in 1999-00 will remain eligible and enrolled in Medi-Cal. This has not been the case in the past, and recent trends appear no different. However, DHS cites two new developments as the basis for expecting a much slower caseload decline—the new Section 1931(b) eligibility category and the imposition of sanctions on adult CalWORKs recipients who fail to participate in work activities.

We see no reason to expect that Section 1931(b) eligibility, as currently structured, will significantly increase the proportion of former CalWORKs recipients who remain enrolled in Medi-Cal in 1999-00. This is because the Section 1931(b) eligibility criteria primarily duplicate coverage that has been available for some time to former CalWORKs recipients, especially transitional Medi-Cal. Furthermore, the use of transitional Medi-Cal already is reflected in the underlying caseload trend.

Failure of able-bodied adult CalWORKs recipients to participate in work activities will result in elimination of their portion of the grant and their removal from the CalWORKs rolls. However, sanctioned adults will remain eligible for Medi-Cal, and this will cause the number of CalWORKs-related eligibles in Medi-Cal to be somewhat larger than the number of individuals in CalWORKs. According to the DSS CalWORKs estimate, however, this effect will be small—affecting only about 2 percent of the CalWORKs caseload in 1999-00.

Analyst's Projections Indicate Caseload Savings of $126.7 Million. We have developed our own projections of the eligibles in the CalWORKs-related Medi-Cal caseload for the current year and 1999-00. Our projections phase out the Edwards Hold caseload by July 1, 1999, and then assume an 11.1 percent decline in the basic Medi-Cal CalWORKs-related caseload (consistent with the DSS estimate of CalWORKs recipients and with recent trends in the basic Medi-Cal caseload for this group). However, we have added an additional 62,223

eligibles to our base projection in 1999-00. The addition is the sum of DSS's estimates of (1) the number of sanctioned CalWORKs recipients and (2) the additional CalWORKs recipients who will leave welfare for work due to the new work requirements (assuming that they *all* remain on Medi-Cal). Based on our projections, the Medi-Cal caseload will be less than the budget estimate by 5,800 eligibles in the current year and by 274,300 eligibles in 1999-00 (on an average monthly basis). We estimate that the lower caseloads will reduce General Fund spending below the budget estimate by $2.7 million in the current year and by $124 million in 1999-00—a total General Fund savings of $126.7 million.

The DHS Expands Section 1931(b) Eligibility Above CalWORKs Income Limits

The department has adopted income limits for Section 1931(b) Medi-Cal eligibility significantly higher than necessary to meet the Legislature's mandate to cover California Work Opportunity and Responsibility to Kids recipients. Furthermore, while the budget includes additional administrative costs for this new eligibility category, it fails to recognize added benefit costs. We recommend that the Department of Health Services provide an estimate of additional Medi-Cal benefit costs associated with Section 1931(b) eligibility at budget hearings.

As noted above, existing state law extends Section 1931(b) Medi-Cal coverage to CalWORKs recipients. Specifically, Section 14005.30 of the Welfare and Institutions Code directs DHS to use the state's flexibility under federal law to adopt less restrictive income and resource eligibility standards and methodologies "to the extent necessary" to allow all CalWORKs recipients to be eligible for Medi-Cal. The department's Section 1931(b) eligibility standards, however, go significantly beyond the CalWORKs standards.

Section 1931(b) Income Limits Exceed CalWORKs Limits. Figure 7 compares the maximum allowable monthly income (for a family of three with one earner) under the department's Section 1931(b) guidelines with the comparable income limits under CalWORKs and under the former AFDC standards (as of July 16, 1996). These income limits are those that apply after families have initially qualified for coverage. As in CalWORKs and the former AFDC program, families must meet a lower income standard for initial qualification, but once in the program they are entitled to earned income disregards that allow them to retain additional earnings. As the figure shows, the Section 1931(b) monthly income limit is $343 above the CalWORKs limit (the income at which the grant is reduced to zero), and $569 above the former AFDC income limit.

Figure 7

Comparison of Monthly Income Limits Under Section 1931(b) Medi-Cal , CalWORKs, and AFDC 1998-99

(Family of Three With One Earner)

	Monthly Income / percent of poverty level	Difference from Section 1931(b) Limit
Section 1931(b)	$1,790 / 157 percent	—
CalWORKs[a]	$1,447 / 127 percent	-$343
AFDC[a] (July 16, 1996)	$1,221 / 107 percent	-$569

[a] High cost counties. Cases without an able-bodied parent can qualify for a higher income limit of $1,589 if they have sufficient earned income.

The reason for the higher Section 1931(b) limit is that DHS mixed elements of CalWORKs and AFDC eligibility rules in a way that results in a standard that is considerably higher than in either of the welfare programs. Primarily this involves using the "need" standard to set the basic income limit (as in AFDC) instead of the maximum grant (as in CalWORKs), and allowing the more generous CalWORKs earned income disregard. Because the need standard is higher than the maximum grant, the DHS guidelines result in an income limit that is significantly greater than allowed in *either* CalWORKs or the former AFDC program.

The DHS Bases Action on Federal Guidance. The department indicates that its expansion of Section 1931(b) income standards is necessary to comply with guidance from the federal Health Care Financing Administration (HCFA), which administers Medicaid law. That law generally requires each Medicaid eligibility category to have a single eligibility standard. Both CalWORKs and the former AFDC program use the need standard as the basis for determining the income eligibility of *applicants* (who do not qualify for the earned income disregard). Substituting the CalWORKs maximum grant level for the need standard for Section 1931(b) eligibility is not possible, according to DHS, because it would disqualify some applicants from Medi-Cal who would meet the welfare qualifications. Consequently, DHS retained the need standard as the basic income standard for Section 1931(b) applicants, and believes that it is required to use the same standard for recipients as well under the federal requirement for a single Medi-Cal income standard.

Implementation of Section 1931(b) raises complex issues, and federal policy still is evolving as specific issues arise in each state. The depart-

ment's understanding of HCFA's position, however, was based on informal communications, not specific written guidance. Nor did the department submit an eligibility proposal to HCFA that was more consistent with the limitations of the Legislature's mandate. Additionally, the department did not alert HCFA to the significant eligibility expansion that would result from the interaction of the CalWORKs and AFDC methodologies in approach that HCFA suggested. Furthermore, DHS did not explore alternatives to avoid expanding Section 1931(b) eligibility more than necessary to cover CalWORKs recipients. Such approaches might include, for example, adopting an income disregard formula for Medi-Cal eligibility that lies between the AFDC and CalWORKs formulas to offset the use of the more generous need standard as the basic income test.

No Funding In Budget for Section 1931(b) Benefit Costs Outside of CalWORKs-Related Caseload. The budget includes $18.1 million from the General Fund for Section 1931(b) eligibility administration for nonwelfare recipients in 1999-00. However, it does not include any benefit costs for this new Medi-Cal eligibility category other than for the CalWORKs-related caseload. For example, some families in the existing Medically Needy Program will qualify under Section 1931(b) and remain eligible for Medi-Cal without a share of cost when their income increases. Accordingly, we recommend that DHS provide an estimate of additional Medi-Cal benefit costs associated with Section 1931(b) eligibility at budget hearings.

BENEFITS, RATES, AND COSTS

Smoking Cessation Drugs Overbudgeted

We recommend a General Fund reduction of $1,550,000 in the amount proposed for smoking cessation drugs for Medi-Cal enrollees because the budget overestimates the number of enrollees who are smokers. (Reduce Item 4260-101-0001 by $1,550,000.)

The department added smoking cessation drugs (such as the nicotine patch) to the Medi-Cal drug formulary on January 1, 1999, and the budget estimates that this action will increase General Fund drug costs by $9.1 million in 1999-00. The cost estimate assumes that 25 percent of Medi-Cal enrollees over the age of 15 are smokers, based on national smoking prevalence data. Due in part to the state's antismoking efforts, however, smoking is less prevalent in California than in the rest of the nation. Furthermore, the Medi-Cal population has a disproportionately large number of women, who tend to smoke less than men.

Based on smoking prevalence data in California according to age, sex, and ethnicity, we estimate that the number of Medi-Cal enrollees who are smokers is 426,000 versus the budget estimate of 500,000. Our estimate is based on smoking prevalences listed in *Tobacco Control in California: Who's Winning the War?*, an evaluation of the tobacco control program reported to DHS in June 1998 by the Cancer Prevention and Control Program of the University of California, San Diego. The difference of 74,000 smokers reduces the cost estimate by $1.6 million (General Fund). Accordingly, we recommend a General Fund reduction of $1.6 million.

Department Should Report on Potential New Rate Setting Approaches

We recommend that the department report at budget hearings on its progress in developing new methods of setting Medi-Cal rates for Medi-Cal managed care plans, nursing homes, and hospital outpatient services.

The department has been considering basic changes in its approaches to setting rates for the following three major categories of Medi-Cal services.

- ***Managed Care Plans.*** Most of the families on Medi-Cal now are enrolled in managed care plans. Generally, the department has used the equivalent fee-for-service cost of providing Medi-Cal services to those same eligibles as its benchmark for setting monthly capitation payments for managed care plans. However, this approach is no longer feasible because there are too few families remaining in fee-for-service care to provide valid cost comparisons. The next major set of managed care rate changes will take effect October 1, 1999, so the department must develop a revised rate setting approach in the next few months.

- ***Nursing Homes.*** Under existing state law, the department annually sets nursing home rates using cost surveys of nursing homes providing a particular level of care in each of several geographic areas of the state. The rates are then set at the median cost for the homes in each category. The 1997 repeal of the federal "Boren Amendment" no longer makes it necessary to have rates directly related to costs, and the department indicated last year that it would propose a new rate setting methodology. There also are concerns that the current rate structure may provide an undue incentive for nursing homes to provide inadequate care to reduce costs, since

the rates currently are not linked directly to costs at any individual facility.

- ***Hospital Outpatient Services.*** As mentioned earlier in this analysis, the department has contracted for a study in order to adopt a new rate methodology that will comply with the court order in *Orthopaedic Hospital v. Belshe.*

Spending on these services totals billions of dollars annually, and they affect most Medi-Cal enrollees. Accordingly, we recommend that the department report on its rate setting plans at budget hearings.

Hospital Construction Program— Spending Estimates and Future Projections Needed

We withhold recommendation on $39.6 million requested from the General Fund (plus $42.4 million of federal matching funds) for debt-service payments for hospital construction projects, pending receipt and analysis of the basis for the request. We recommend that the department report at budget hearings with a projection of future annual program costs for projects that have received a state funding commitment.

The budget proposes a total of $82 million ($39.6 million General Fund) for the Hospital Construction/Renovation Reimbursement Program established by Chapter 1635, Statutes of 1988 (SB 1732, Presley). Estimated spending for the program in the current year is $112.3 million ($54.5 million General Fund). Under the SB 1732 program, the Medi-Cal Program makes supplemental payments to qualifying "disproportionate share" hospitals that contract with CMAC to serve Medi-Cal patients. These payments cover a portion of the debt-service costs for constructing or renovating hospital facilities. Federal matching funds for these debt-service payments are financed out of the Medicaid savings that result from CMAC's hospital contracting program, which operates under a federal waiver.

At the time this analysis was prepared, the department had not provided the Legislature with a specific basis for its 1999-00 budget request, such as a status update for each hospital construction project, a listing of the debt-service costs by project, and a calculation of the required state contribution by project. A number of major projects have been completed recently or are nearing completion, which could affect costs significantly. Accordingly, we withhold recommendation on the 1999-00 budget request for the SB 1732 program pending receipt of justification for the amount requested.

Projection of Future Costs Needed. Several major projects—including the Riverside, San Bernardino, and Santa Clara County hospitals—have been completed recently and several others are nearing completion, including the UC Davis Medical Center expansion, Natividad Medical Center in Monterey, and the Tower project at St. Francis Hospital in Los Angeles. These projects will have a significant effect on future annual state costs for this program. Cost projections for this program also are important for determining how much "room" will remain available for federal funding within the CMAC waiver savings for additional hospital construction projects, such as the replacement of the Los Angeles County-University of Southern California Hospital. Cost projections also are important in determining the amount of funds available for financing other waiver programs, such as SB 1255 hospital supplemental payments (Chapter 996, Statutes of 1989 [SB 1255, Robbins]) and supplemental payments to teaching hospitals. Accordingly, we recommend that the department report at budget hearings with a projection of the future annual costs of the program for projects to which the state already has committed.

BRINGING THE MEDI-CAL ESTIMATE UP TO DATE

Medi-Cal Estimating Methodology Needs Revision

We recommend enactment of legislation directing the department to revise the Medi-Cal estimate process in order to make it a much more useful and timely tool for budgeting, monitoring, and evaluating the Medi-Cal Program.

The Medi-Cal Program is huge, with General Fund spending in the DHS budget totaling $7.4 billion in the current year—almost as much as the $7.8 billion of General Fund spending for all segments of higher education and more than any other program outside of education. Including all other federal, state, and local funds, total annual Medi-Cal spending is almost $23 billion—a significant component of total health care spending in the state. About 5 million people are enrolled in Medi-Cal. However, the basic tool used by the administration, the Legislature, and other parties to monitor the program and evaluate proposed changes—the annual Medi-Cal estimate—is outdated and inadequate for the task.

Outdated Approach. The estimate's format and approach have changed little for 20 years. Meanwhile, the Medi-Cal Program has changed substantially, and the capabilities of computers and software have grown exponentially. The estimate's focus remains limited to generating a fixed group of statistical trends of fee-for-service utilization and

cost for certain categories of services. These trends may or may not do a reasonable job of forecasting spending (to our knowledge, DHS has not performed a rigorous analysis of the estimate's accuracy), but they provide almost no help in explaining *why* changes occur. Modern computers and database software are much more powerful and flexible. They are not rigidly confined to broad trends, but can explore many potential relationships and "drill down" in the data to find specific causes of changes.

The estimate combines regular Medi-Cal spending with various programs outside of DHS (sometimes only portions of programs) that also flow through Medi-Cal, and it combines all funding sources in its trend presentations. Consequently, it is not possible, in many cases, to readily identify the General Fund impact of a cost trend or whether that trend results from regular Medi-Cal services or from ancillary programs operated by other departments.

Finally, the estimate treats Medi-Cal managed care, which now serves about half of all enrollees, as an afterthought. An estimate of managed care spending is added onto the fee-for-service estimate without presenting any meaningful information about caseload and rates for the managed care plans.

The Past is Forgotten. The estimate presents no actual spending figures for the past year. There is no update to the previous May Revision estimate to take account of developments after February (the cutoff for May Revision data). The department produces an *Annual Statistical Report* for Medi-Cal several years in arrears, but this report is for calendar years rather than fiscal years; on a cash basis, rather than the budget's accrual basis; and excludes most managed care data. As a result there are no actual spending trends for Medi-Cal, only trends of past May Revision estimates.

New Proposals Are Buried in the Estimate. The 1999-00 Medi-Cal estimate for benefit costs and county administration includes a total of 127 "policy changes." In reality, there are only a handful of *new* policy changes proposed in the Medi-Cal budget (the major ones being the federal funding assumptions). The other policy changes merely track the effects of past actions or external factors, such as regular changes in the federal funding percentage on the spending estimate. While the tracking information is useful, new proposals should be separated out to highlight them for the Legislature's consideration.

Linkages With Other Programs Not Addressed. The estimate does not include any analysis or discussion of developments and trends in other major programs that have substantial effects on Medi-Cal spending and

services. These other programs include Medicare, county mental health systems, and programs for the developmentally disabled. Medi-Cal caseload estimates are not coordinated with welfare caseload estimates by DSS.

Basis for Estimates Often Not Given. The spending estimates presented in many of the policy changes are explained by a simple set of calculations using assumptions that are simply asserted. For example, the estimate includes $11.8 million due to the addition of the heart medication Coreg to the Medi-Cal formulary. This figure is based on 263,841 prescriptions at $89.70 each (with a phase-in period), but the policy change is silent as to the basis for these assumptions.

Baseline Estimate Should Be Made Available When Completed. The department completes work on the Medi-Cal estimate in November of each year, except for the addition of new policy proposals for the Governor's budget that still await administration decisions. However, none of the estimate is made available to the Legislature until January, when the budget is submitted. We see no reason why the basic estimate (absent new policy proposals) should not be provided to the Legislature as soon as it is done.

An Opportune Time for Change. There are two reasons why 1999-00 presents a particularly opportune time for change. First, revising the estimate will require focus and commitment by department leadership over a period of time. This perspective may be easier to take at the beginning of an incoming administration. Second, work is rapidly advancing on a major new Medi-Cal information system—the Management Information System/Decision Support System, which is expected to be operational this summer. This system, costing more than $40 million, is a modern database information system that should be able to provide the type of analytical power and flexibility needed to make the Medi-Cal estimate a much more useful tool for monitoring and evaluating the program.

Recommendation. For the reasons above, we believe that it is time to fundamentally revise the Medi-Cal estimate. Accordingly we recommend enactment of legislation directing DHS to restructure the estimate in the following ways:

- Include a summary presentation of all of the program components of Medi-Cal, identifying the specific components that are administered by other departments or entities, and showing the sources and amounts of funding for each one.

- Provide a comprehensive analysis and spending forecast for DHS Medi-Cal services, including *actual* past spending trends and identification of specific factors responsible for those trends.
- Include an estimate of Medi-Cal managed care costs, built up from specific rate assumptions, caseload projections, and cost trends for "carved-out" services.
- Identify General Fund cost trends for each group of Medi-Cal eligibles and services, including dual (Medicare/Medi-Cal) eligibles.
- Include concise, but informative, explanations of the basis and assumptions for each premise in the estimate.
- Separate out and highlight new policy proposals.
- Require submission of the annual *baseline* Medi-Cal estimate to the legislature by December 1.

We recognize that revising the approach for the Medi-Cal estimate is a significant task for the department, and that some additional temporary resources may be needed to accomplish it. If so, then we further recommend that the department identify and report on those needs at budget hearings.

PUBLIC HEALTH

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

The Governor's budget proposes $1.9 billion (all funds) for public health local assistance. This represents a decrease of $98 million, or 4.9 percent, from estimated current-year expenditures. The budget proposes $341 million from the General Fund, which is an 11 percent decrease from estimated current-year expenditures. The main reason for this is the proposed elimination of General Fund support for the County Medical Services Program.

PROPOSITION 99

Proposition 99, the Tobacco Tax and Health Protection Act of 1988, established a 25-cent surtax on the sale of cigarette and tobacco products in California. The proposition requires that the revenues from the surtax be distributed to six accounts within the Cigarette and Tobacco Products Surtax Fund (C&T Fund) according to specified percentages, and further provides that expenditures from each account must be used for specific kinds of activities.

While Proposition 99 has long been a diminishing revenue source due to decreasing use of cigarettes, recent events are projected to result in a greater reduction in these revenues (see Figure 1, next page). Specifically:

- ***Proposition 10.*** This measure, enacted by voters in 1998, increases the excise tax on cigarettes by 50 cents per pack. The measure also increases the excise tax on other types of tobacco products. The tax increase results in a price increase on cigarettes and other tobacco

products, which has the effect of reducing consumption (sales), thereby reducing Proposition 99 revenues. Proposition 10 provides that some of its revenues will be used to backfill some of these Proposition 99 revenue losses—specifically in the health education and research accounts—but not for other Proposition 99 accounts. The budget estimates that the net impact on Proposition 99 revenues (after accounting for the Proposition 10 backfill) will be reductions of $27.9 million in the current year and $5 million in the budget year.

- ***Lawsuit Settlement.*** In response to the recent lawsuit settlement with the states, the major tobacco companies have increased the price of cigarettes by 45 cents per pack. The budget estimates that this price hike will reduce Proposition 99 revenues by $18.1 million in the current year and $44.3 million in the budget year.

Figure 1

Proposition 99 Revenues Declining

1990-91 Through 1999-00
(Dollars in Millions)

Year	Revenues	Percent Change
1990-91	$539	—
1991-92	518	-3.9%
1992-93	499	-3.7
1993-94	473	-5.2
1994-95	465	-1.7
1995-96	462	-0.6
1996-97	463	0.2
1997-98	450	-2.8
1998-99 (est.)	399	-11.3
1999-00 (est.)	390[a]	-2.3

[a] Includes $8.7 million transfer of Proposition 10 funds.

After accounting for these impacts, the Governor's budget estimates that Proposition 99 revenues will decline by more than 11 percent in the current year and by 2.3 percent in 1999-00.

Certain Health Programs Hit Hard

Due to sharp declines in Proposition 99 revenues resulting primarily from the effects of Proposition 10 and the tobacco lawsuit settlement, the budget proposes to reduce most programs that are supported by this fund source. However, funding for state programs that are caseload-driven would be maintained.

In response to the projected declines in Proposition 99 revenues, the budget proposes reductions in expenditures from the C&T Fund in the current and budget years for most of the programs that receive funding from Proposition 99 (see Figure 2). In general, reductions hit hardest in the budget year because the availability of carry-over balances from 1997-98 help support spending in the current year.

The Governor's budget proposes to reduce most programs on a pro-rated basis (within each C&T Fund account), while maintaining funding for caseload-driven programs that might otherwise be supported by the General Fund—specifically the Major Risk Medical Insurance Program, the Access for Infants and Mothers program, the Child Health and Disability Prevention program, and the Breast Cancer Early Detection Program.

In considering the Proposition 99 reductions, the Legislature should keep the following in mind. When Proposition 99 was enacted, it was anticipated that it would be a diminishing revenue source for a number of reasons, including the effects of the antismoking components of the measure itself. The sharp revenue reductions that are expected to result from the combined effects of Proposition 10 and the tobacco lawsuit settlement underscore the continuing problems associated with using this revenue source for ongoing programs.

As Figure 2 (see next page) shows, the Proposition 99 revenue losses lead to significant reductions in a variety of programs, including primary care clinics and other indigent health care activities. Because county health programs receive a large share of Proposition 99 revenues, they would be subject to significant reductions under the budget proposal. While the counties would lose a significant amount of revenues, Proposition 99 is not the main source of funds for county indigent health care. We estimate that this source accounts for roughly 10 percent to 15 percent of the total expenditures for this purpose—although this could vary significantly among the individual counties.

Figure 2

Proposition 99 Expenditures
Cigarette and Tobacco Products Surtax Fund

1997-98 Through 1999-00
(Dollars in Thousands)

Departments/Programs	Actual 1997-98	Estimated 1998-99	Proposed 1999-00	Percent Change From 1998-99
Department of Health Services				
Chronic Diseases/Smoking Prevention				
Breast Cancer Early Detection	—	—	$13,541	N/A
Media Campaign	$31,224	$24,503	18,848	-23%
Competitive Grants	27,258	34,780	17,000	-51
Committee and Evaluation	3,509	5,433	4,309	-20
Local Lead Agencies	33,092	22,101	16,744	-24
Primary Care and Family Health				
Clinic Grants	$17,764	$13,419	$8,000	-40%
Comprehensive Perinatal Outreach	4,796	3,162	1,892	-40
Child Health and Disability Prevention	47,878	47,490	52,908	11
Children's Hospitals	1,078	990	543	-45
County Health Services				
Managed Care Counties	$2,551	$2,343	$1,294	-45%
County Medical Services Program Expansion	12,107	9,983	6,175	-38
California Healthcare for Indigents	161,041	146,387	88,087	-40
Rural Health Services	2,779	4,306	2,486	-42
State Administration	6,180	6,874	3,549	-48
Managed Risk Medical Insurance Board				
Major Risk Medical Insurance Program	$35,021	$40,094	$40,820	2%
Access for Infants and Mothers	39,914	34,649	38,098	10
Office of Statewide Health Planning and Development	$1,899	$1,837	$1,736	-5%
University of California	$16,095	$84,431	$28,991	-66%
Department of Education	$45,746	$33,311	$26,910	-19%
Resources programs[a]	$33,896	$34,233	$28,315	-23%
State Board of Equalization	$1,263	$1,191	$1,211	2%
Pro rata charges	$921	$1,497	$1,822	22%
Totals	**$526,012**	**$553,014**	**$403,279**	**-27%**

[a] Includes transfers to Habitat Conservation Fund and Natural Resources Infrastructure Fund.

Also, the counties have the option of allocating their tobacco lawsuit settlement funds in 1999-00 to help compensate for the Proposition 99 reductions. Finally, we note that anticipated enrollment growth in the Healthy Families Program, as well as potential health coverage expansions contemplated in the budget (discussed in our analysis of the Health and Human Services Agency) could reduce some of the cost pressures on county indigent health programs.

Whether these revenue reductions should be backfilled, in whole or in part, by the state is an issue for the Legislature when balancing its competing policy interests. We would note, however, given the historical declines in this funding source, that the Legislature is likely to face similar funding pressures in the future from programs primarily supported by this revenue source.

OTHER PUBLIC HEALTH PROGRAMS

Budget Proposes Elimination of General Fund Support For County Medical Services Program

The Governor's budget proposes to eliminate the state's General Fund allocation of $20.2 million to the County Medical Services Program. We comment on the proposal and present some options for the Legislature.

Background. The County Medical Services Program (CMSP) was established in 1983 to provide medical and dental care to low income "medically indigent adults" (MIAs) who are not eligible for the state's Medi-Cal Program and who reside in small counties (see Figure 3, next page, for participating counties). The CMSP governing board, comprised of ten county officials, is responsible for the administration of pooled funds from 34 counties to provide services to approximately 40,000 CMSP clients at an estimated cost of $182 million in 1997-98. The governing board sets eligibility requirements, benefit levels, and provider reimbursement rates, but contracts with the DHS to administer a program offering uniform benefits and to provide claims processing functions.

History Behind General Fund Contribution. Prior to 1983, the MIA population was eligible for Medi-Cal coverage. However, in response to the state's budget problems, this population was transferred from the Medi-Cal Program to the counties who were made responsible for their health services. Small counties, with populations of 300,000 or less, were permitted to contract with the state for administration of their programs, and this became known as the CMSP. Thirty-four counties initially chose the option. The counties adopted uniform eligibility criteria and benefits

similar to the Medi-Cal Program. Initially, the state allocated $23.2 million to the program for health care services, which was 30 percent less than the estimated amount that would have been spent for services under the Medi-Cal Program. Until 1992-93, the state bore the risk for CMSP cost increases above specified revenue amounts.

Figure 3

Counties Participating in the County Medical Services Program

1998-99

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

Legislation was enacted in 1992 to cap the General Fund responsibility for CMSP at $20.2 million, which was the *estimated* amount needed for the program in 1991-92.

The CMSP Fund Sources. Funding for CMSP includes realignment revenues (from the 1991-92 realignment legislation), Proposition 99 revenues, county funds (participation fees), hospital settlements (audit recoveries for overpayments to hospitals), and the state General Fund. Figure 4 displays the program's 1997-98 revenues.

Governor's Proposal. The Governor's budget proposes trailer bill legislation to eliminate the state's appropriation of $20.2 million from the

General Fund to CMSP. The budget indicates that (1) CMSP has substantial fund reserves in its local program account and (2) the counties can reduce costs if necessary.

Figure 4

County Medical Services Program Estimated Revenues

1997-98
(Dollars in Thousands)

Source	Amount	Percentage of Total
Realignment	$110,749	61%
Hospital settlements	27,929	15
General Fund	20,237	11
Proposition 99	12,514	7
County participation fees	5,459	3
Interest	4,000	2
Third party payers	2,083	1
Unclaimed warrants	8	—
Totals	**$182,979**	**100%**

The CMSP Account Fund Balance. At the end of 1997-98, the most recent year in which its fund condition statement is complete, the CMSP Account showed a balance of $102 million. Of this amount, $10.5 million was allocated for legal costs associated with a pending lawsuit. While the board has not updated its fund condition through 1999-00, we estimate that without the General Fund allocation, the fund will have sufficient resources to support the program for two years beyond the budget year.

Potential Expenditure Reductions. As noted above, the budget indicates that, if necessary, the counties can address revenue shortfalls by reducing expenditures. Such reductions could come in the form of program efficiencies, although the budget does not identify any specific means of achieving savings in this manner. Another way to reduce costs would be to make program changes such as tightening eligibility requirements, limiting benefits, or reducing provider reimbursement rates. These options, however, either directly affect the level of services provided or, in the case of the reimbursement rates, could lead to a reduction in the number of providers which, in turn, could adversely affect patient access to services.

Options. The board should be prepared to discuss potential expenditure reductions during the hearings. As we indicated, the most obvious means of reducing expenditures generally run the risk of adversely affecting patient access to health services. Thus, the Legislature may wish to consider other options in addition to the budget proposal. One possibility would be to adopt the budget proposal only as a one- or two-year reduction. Based on the current trend, however, the board would still need to reduce expenditures at some point in the future.

We presented another option for CMSP in the *Analysis of the 1993-94 Budget Bill*, when the program was facing potential revenue shortfalls. We raised the possibility of restricting the program to the smallest counties, where the need for state assistance is the greatest, and thereby requiring the larger CMSP counties to operate as independent counties or form consortia with other counties.

Finally, with respect to the larger issue of how indigent health care services should be provided, we note that in our report on state/local restructuring (*Making Government Make Sense*, in the *1993-94 Perspectives and Issues*), we indicated that the state should adopt a more uniform policy for providing indigent health care, and recommended that the state assume responsibility for this function.

Budget Underestimates Federal Funds for ADAP

Federal funds for the AIDS Drug Assistance Program (ADAP) will be $5 million above the amount assumed in the budget. These additional federal funds can be used to reduce General Fund support for the program, but the General Fund savings may need to be redirected to other HIV-related activities in order to meet the federal maintenance-of-effort (MOE) requirement for future federal grants. We recommend that the department develop a projection of state spending that would count toward the MOE requirement in 1999-00 in order to assess the potential for General Fund reductions.

Program Description and Budget Proposal. The ADAP provides AIDS drugs to HIV-infected persons with (1) incomes below 400 percent of the poverty level, (2) valid prescriptions from a California licensed physician, and (3) no coverage under Medi-Cal or other insurance. Persons with incomes between 400 percent of poverty ($31,560 for one individual) and $50,000 may also receive drugs through ADAP at a share of cost. The budget proposes $136.6 million ($47.5 million General Fund) for ADAP in 1999-00, which is expected to fully fund caseload and costs. This is an increase of 12 percent in total funds, but a decrease of 8 percent

($4.1 million) from the General Fund. The General Fund reduction is the result of an increase in federal funds.

The ADAP's Federal Funding. The ADAP receives its federal funding under Title II of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, which is administered by the Health Resources and Services Administration (HRSA) in the U.S. Department of Health and Human Services.

Title II of the act authorizes grants to states to provide health care and support services for people with HIV, and consists of both a base grant and supplemental grant. While the Title II base grant can be used for a variety of services, the supplemental grant solely supports the state's ADAP program. California's Title II base grant for the budget year is expected to increase only slightly, to $30.7 million, but ADAP's supplemental grant will increase significantly from its current-year amount of $43.1 million. In fact, the Governor's budget estimates that the state will receive $60.3 million in federal supplemental funds in 1999-00. Final confirmation of California's share of the next annual grant will not be received until HRSA sends out Notice of Grant Award letters in March 1999.

Subsequent to publication of the budget, HRSA has informed the state that, although the figure will not be made official until the release of the award letter, the state is scheduled to receive $65.3 million, or $5 million more than estimated in the budget.

State MOE Requirement. Federal law includes a state MOE requirement to receive Title II funds. States must maintain nonfederal HIV/AIDS-related spending levels (which can include the state share of related Medicaid costs) that are at least equal to that of the prior year. According to HRSA staff, a state that fails to meet this requirement forfeits receipt of its entire Title II grant.

The DHS estimates that the state will meet the MOE requirement for the 1999-00 federal grant, which is based on 1997-98 state expenditures compared to 1996-97. It is important, however, to maintain the level of state spending to qualify for future federal grants. In this respect, the Department of Finance indicates that HIV-related Medi-Cal costs are expected to increase by an amount sufficient to offset the proposed $4.1 million reduction in General Fund support for ADAP in the budget year, for purposes of meeting the MOE requirement. We note, however, that DHS has not developed an estimate of the HIV-related costs within the Medi-Cal Program for the budget year.

The DHS Should Develop Projections. Estimates of MOE-countable state spending in the budget year are needed, not only to provide some assurance that the proposed General Fund reduction will not lead to a violation of the requirement but to determine whether the anticipated increase of $5 million in federal funds can be used to achieve additional General Fund savings. Consequently, we recommend that the department provide the estimate to the Legislature prior to budget hearings.

Options for the Legislature. As noted above, the budget proposal for ADAP is based on the assumption that program caseloads and costs will be fully funded. Consequently, the additional $5 million in federal funds could be used to offset proposed General Fund spending in the program. These General Fund savings, however, may need to be redirected to other HIV-related activities in 1999-00—such as the Early Intervention Program—in order to meet the MOE requirement for future federal grants (specifically for 2001-02). An alternative under this scenario would be to maintain the level of General Fund support proposed for ADAP and carry the additional federal funds over to 2000-01, although this would be subject to approval by the federal administration.

Budget Proposes One-Year Extension for Community Challenge Grant Program

The budget proposes to extend the Community Challenge Grant Program for one additional year. We recommend adoption of budget bill language to require the department to revise its grant guidelines to award only tested program designs, similar to the model used by the State Department of Education for its teen pregnancy prevention program.

Program Description and Budget Proposal. The Community Challenge Grant Program (CCGP) was established in 1996-97 to support local community projects to reduce teen pregnancy. Since 1996-97, the Legislature has appropriated $20 million from the General Fund annually to the DHS for competitive grant awards under the CCGP.

Under current law, the program sunsets on June 30, 1999. The budget proposes to extend the program for one additional year and to continue funding it at $20 million in 1999-00. The budget indicates that funding is contingent on savings that would be achieved under another budget proposal that would, if approved by the federal administration, result in federal funding for the state-only family planning program within the Medi-Cal Program.

Background. To provide background, Figure 5 contains a brief description of state-supported programs whose primary focus is teen pregnancy prevention.

Figure 5

State-Supported Teen Pregnancy Prevention Programs

1998-99
(In Thousands)

Agency/Program	Program Description	General Fund Expenditures
Department of Health Services		
Community Challenge Grant Program	Competitive awards to local organizations	$20,000
Male Involvement Program	Local projects that focus on male's role in teen pregnancy prevention	2,507
Information and Education Program	Local family life health education projects in schools and community settings	3,260
Adolescent Sibling Pregnancy Prevention Program	Case management for "at-risk" siblings of parenting teens	3,000
State Department of Education		
Teen Pregnancy Prevention Grant Program	Competitive awards to local educational agencies	$10,000

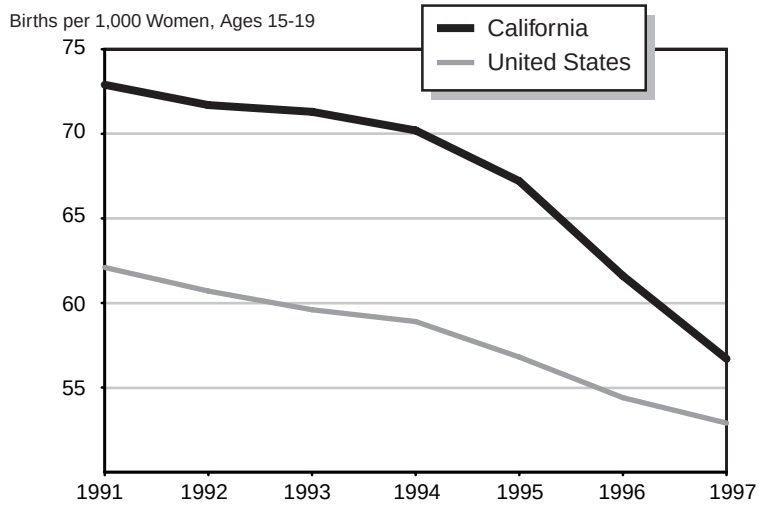
Figure 6 (see next page) illustrates that the teen birthrate has been declining in California and the U.S. in recent years. Between 1991 and 1997, California's teen birthrate declined 22 percent, compared to an average national decline of 14.8 percent. Although California's decline in teen birthrates has out-paced the nation's, the state's rate still exceeds the national average. In 1997, California had 56.7 live births per 1,000 15- to 19-year-old women, while the national rate was 52.9. This may be due, in part, to demographic differences between California and other states.

Department Late in Submitting CCGP Evaluation. The CCGP's authorizing legislation—Chapter 197, Statutes of 1996 (AB 3483, Friedman)—requires that the department "conduct a statewide independent evaluation of the program" and submit its findings to the Legislature on or before January 1, 1999. To meet the requirement, the department contracted with an independent evaluator, who submitted an interim report to the department in January, essentially describing the implementation of program components. The final evaluation, however, will not be submitted until December 1999.

Figure 6

Birthrates to Teens, 15- to 19-Year-Olds California and United States

1991 Through 1997



Recommend Improvements in DHS Grant Proposal Guidelines. The three-year cycle for existing grants ends in the current year. The department plans to initiate a request for new proposals, subject to the availability of funding in the budget act.

We recommend that the DHS model its selection criteria for all new grants after the State Department of Education's (SDE's) Teen Pregnancy Prevention Grant Program. In its 1996 award process, SDE provided applicants with a "menu" of tested program designs upon which to base their grant proposals. The SDE researched and identified program designs that had been proven effective in delaying the onset of sexual activity and reducing the incidence of teenage pregnancy. We believe that funding such grant proposals increases the probability of cost-effectiveness.

Our recommendation can be implemented by adoption of the following language in Item 4260-001-0001:

> In awarding grants for the Community Challenge Grant Program, the department shall use criteria to encourage projects based on research and tested program designs, similar to the guidelines used in the State Department of Education's Teen Pregnancy Prevention Grant Program.

Cancer Research Fund Balance Should Be Transferred to General Fund

We recommend that the year-end unexpended balances in the Cancer Research Fund (projected to be $1.6 million) be transferred to the General Fund because (1) these balances will not be needed to fund the program in 1999-00 and (2) the original source of these funds is the General Fund. (Increase General Fund revenues by $1,555,000.)

The Cancer Research Fund was created by Chapter 755, Statutes of 1997 (AB 1554, Ortiz) to support cancer research. The department administers the Cancer Research Program by contracting with research entities such as the University of California, nonprofit organizations, and foundations. Chapter 755 appropriated $2 million from the General Fund to the Cancer Research Fund in 1997-98 and indicated the intent of the Legislature to appropriate $25 million the following year. The fund received the $25 million from the General Fund in the *1998-99 Budget Act*, and the Governor's budget proposes another General Fund transfer of $25 million for 1999-00.

About $1.6 million of the initial $2 million was not expended in 1997-98, and this balance has essentially rolled forward annually to 1999-00. Given that (1) the source of the funds for the Cancer Research Fund is the General Fund and (2) program expenditure requirements are limited to the amount of the budget act appropriation, we see no reason to leave the unexpended balances in the special fund. Moreover, adoption of this recommendation would not impact anticipated expenditures as proposed in the budget. Consequently, we recommend adoption of the following budget bill language (in Item 4260-001-0589) to transfer year-end balances to the General Fund, which would result in an estimated increase of $1.6 million in General Fund revenues:

> All unexpended balances in the Cancer Research Fund, as of June 30, 2000, shall be transferred to the General Fund.

Budget Does Not Maximize Federal Funds For Drinking Water Program

We recommend increasing the General Fund amount budgeted for transfer to the Safe Drinking Water State Revolving Fund by $285,000 in order to obtain all available federal funds from the federal fiscal year 1998 grant (an additional $1.4 million). We also recommend that the department report at budget hearings on the advisability of expediting the receipt of additional federal funds available for federal fiscal year 1999. (Increase Item 4260-111-0001 by $285,000 and increase Item 4260-111-0890 by $1,408,000.)

Background. The department maintains the Safe Drinking Water State Revolving Fund to assist public water systems in financing the costs of infrastructure to comply with the requirements of the federal Safe Drinking Water Act. Federal funds are received from the U.S. Environmental Protection Agency (EPA), which provides capitalization grants to states according to a need-based formula.

State Match Requirements. Federal law requires that states match 20 percent of the federal funds. States must appropriate the match no later than the end of the following federal fiscal year (FFY). For example, in order for a state to draw down federal funds from FFY 1998 (October 1997 through September 1998), the 20 percent match must be appropriated by September 30, 1999. The state then has until September 30, 2000 to obligate the funds to local water projects.

Available Federal Funds. By appropriating $15.1 million from the General Fund in the *1998-99 Budget Act*, the state received its first federal grant of $75.7 million from FFY 97. Currently, both the FFY 98 federal award of $77.1 million and the FFY 99 federal award of $82.4 million are available for California's use to the extent that the state provides the matching funds.

Budget Proposal. The budget proposes to maintain current-year expenditures of $15.1 million from the General Fund in the budget year in order to draw down $75.7 million in FFY 98 federal grants.

Under this proposal, the state will not receive the balance of the FFY 98 federal award—$1.4 million. We note that according to the EPA, upgrading the state's local public water systems to meet current and anticipated federal regulations will cost $18 billion. Thus, it is apparent that there is a need for additional funds in this program. Accordingly, we recommend augmenting the budget by $285,000 from the General Fund, which is the match needed to obtain the full FFY 1998 grant.

The FFY 99 Funds Also Available. Although the state has until September 30, 2000 to draw down any part or all of the FFY 99 federal grant award, it also has the option to appropriate the state match and thereby acquire these additional federal funds in the budget year. Consequently, we recommend that the department report at budget hearings on the advisability of expediting the receipt of these funds, the ability of the local systems to "ramp up" their spending, and how this would affect these programs in subsequent years. The Legislature, of course, will also have to weigh these factors against the competing demands for state funds in the budget year.

MANAGED RISK MEDICAL INSURANCE BOARD (4280)

The Managed Risk Medical Insurance Board (MRMIB) administers several programs designed to provide health care coverage to adults and children. The Major Risk Medical Insurance Program provides health insurance to California residents unable to obtain it for themselves or their families because of preexisting medical conditions. The Access for Infants and Mothers program provides coverage for women seeking pregnancy-related and neonatal medical care and whose family incomes are between 200 percent and 300 percent of the federal poverty level. The Healthy Families Program provides health coverage for uninsured children in families with incomes up to 200 percent of the federal poverty level and not eligible for Medi-Cal. The MRMIB also contracts for the administration of the Health Insurance Plan of California, which operates an insurance purchasing pool for small employers.

The budget proposes $288.7 million from all funds for support of MRMIB programs in 1999-00, which is an increase of 88 percent over estimated current-year expenditures. This is due primarily to an increase of $91 million in federal funds and $46 million from the General Fund for caseload growth in the Healthy Families Program.

HEALTHY FAMILIES PROGRAM

The Healthy Families Program implements the federal Children's Health Insurance Program enacted in 1997. Funding for California generally is on a 2-to-1 federal/state matching basis. Families pay a relatively low monthly premium and can choose from a selection of managed care plans for their children. Coverage is similar to that offered to state employees and includes dental and vision benefits. The program began enrolling children in July 1998.

The Budget Proposal. The Governor proposes $210 million ($71.3 million General Fund) in MRMIB's budget for the Healthy Families Program in 1999-00, which is an increase of about 220 percent over estimated current-year expenditures. After accounting for program expenditures (outreach and related Medi-Cal expansion) in the Department of Health Services (DHS) and related expenditures in other departments, the budget proposes $323 million ($104.7 million General Fund) for the Healthy Families Program, which is an increase of 146 percent over the current year. The proposed increase is due primarily to an expected 133 percent increase in caseload in the budget year. We note that the budget does not include funding for provider rate increases in 1999-00. The rate increases will be negotiated in February and will be included in the May Revision of the budget. The budget projects that enrollment will increase to 138,000 by the end of the current year and 321,100 by the end of the budget year.

New Policies Adopted to Increase Enrollment

To address lower-than-expected enrollment in the Healthy Families Program, the Managed Risk Medical Insurance Board and the Department of Health Services shortened the application form and prepared fact sheets on immigration status.

Enrollment in the Healthy Families Program was initially much lower than anticipated. It is also significantly below the revised estimates by the University of California at Los Angeles Center for Health Policy Research that 400,000 children are eligible for the program. In order to increase enrollment, the Legislature appropriated additional funds in the current year for outreach activities. In addition, MRMIB and DHS made certain administrative changes to the program, including the following.

Application Simplified. A new Healthy Families Program application is due to be released in March that reduces the original 28-page booklet to 7 pages. Under the original application procedures, families had to calculate their monthly income, complete financial worksheets, ascertain which programs their children were eligible for—Healthy Families, no-cost Medi-Cal, or share-of-cost Medi-Cal—and then mail in their forms to either Medi-Cal or Healthy Families (or both) to be processed. With the new application, families will send their information to an organization that will determine their eligibility. If families wish, they can still calculate their income, complete a supplemental application, and send it directly to the Healthy Families Program for processing.

Immigration Fact Sheets—the "Public Charge" Issue. Also by March, MRMIB and DHS intend to disseminate two fact sheets about Medi-Cal and Healthy Families to address concerns regarding an immigration-related issue known as "public charge."

Public charge is a term used by the Immigration and Naturalization Service (INS) to describe persons who are likely to depend on public benefits. Depending on immigration status, the INS can refuse to allow immigrants to enter the U.S., reenter, or become permanent residents if it determines that they are likely to rely on public benefits in the future. Also, if a citizen or permanent resident wants to sponsor a family member who wishes to immigrate, past or current receipt of public benefits may jeopardize his or her ability to be a sponsor.

This has led to concern as to whether immigrant parents will be considered "public charges" if their children enroll in the Healthy Families Program. Because of these concerns, and their potential effect on program enrollment, the state administration requested clarification from the INS on its policy. In an "interim" response, INS stated that "receipt of benefits by a child—either U.S. citizen or an alien—is not attributed to the alien parent or other family members for public charge purposes. The only time this general rule would not apply would be if the family were reliant on the child's benefits as its sole means of support." Based on this letter, MRMIB and DHS plan to release public charge fact sheets to local communities.

Monthly Enrollments Falling Behind Budget Projections for Current Year

Actual enrollments for the Healthy Families Program in October 1998 through December 1998 are about 5 percent lower than the budget estimates. The administration will submit revised estimates for the current and budget years in the May Revision of the budget.

After reviewing three months of actual enrollment data (October 1998 through December 1998) that were not available to MRMIB when the budget was prepared, we find that enrollments during this period are, on average, 5.3 percent lower than estimated in the budget. If this trend were to continue, the resulting General Fund savings would be about $845,000 in the current year. The impact of the revised application form and the immigration fact sheets, however, could bring enrollments closer to the budget projection. The administration will update their projections in the May Revision of the budget.

Budget Proposes to Apply Income Deductions For Determining Eligibility

The budget proposes a $2.7 million General Fund set-aside to reflect the impact of applying the Medi-Cal income deductions to the Healthy Families Program for purposes of determining eligibility. Funding the proposal is contingent on savings from another budget proposal to secure federal funding of the state-only family planning program.

Budget Proposal. The budget proposes a set-aside of $2.7 million from the General Fund (and $5.3 million in matching federal funds) to expand the Healthy Families Program by applying Medi-Cal income deductions when determining eligibility. This is part of a $40 million set-aside, of which $37.3 million is for health care reforms, pursuant to a plan to be developed by the Secretary of the Health and Human Services Agency (discussed in our analysis of the agency's budget). The budget indicates that funding for this set-aside is contingent on savings that would be achieved under another budget proposal that would, if approved by the federal administration, result in federal funding for the state-only family planning program within the Medi-Cal Program.

Expansion Via Income Deductions. The proposed Healthy Families Program expansion would apply Medi-Cal income deductions—such as those for work expenses, child and dependent care, and court-ordered alimony/spousal and child support—to applicants' gross income levels when determining program eligibility. This would expand eligibility for families with incomes above 200 percent of the poverty level if the allowable income deductions bring their net income level to 200 percent of the federal poverty level or below. The MRMIB estimates that this will expand enrollment by 17,500 children in the budget year.

By using the same income deductions as the Medi-Cal Program, this proposal would result in administrative efficiencies and avoid confusion on the part of applicants (some of whom will have children enrolled in both the Medi-Cal and Healthy Families Programs). Thus, from an administrative perspective, this proposal has merit. With respect to the broader issue of eligibility expansion for the Healthy Families Program, we note that the budget includes such expansion as one of the options to be considered by the Secretary of the state Health and Human Services Agency. (For a discussion of this and other options, please see our analysis of the agency's budget.)

DEPARTMENT OF DEVELOPMENTAL SERVICES (4300)

A developmental disability is defined as a disability, related to certain mental or neurological impairments, that originates before a person's eighteenth birthday, constitutes a substantial handicap, and is expected to continue indefinitely. The Lanterman Developmental Disabilities Services Act of 1969 entitles individuals with developmental disabilities to receive a variety of services, which are overseen by the state Department of Developmental Services (DDS). The department contracts with 21 nonprofit regional centers (RCs) to coordinate educational, vocational, and residential services for approximately 140,000 clients each year. In addition to providing some services directly, such as diagnosis and case management, RCs purchase a variety of services from providers in the community.

Individuals with developmental disabilities have a number of residential options. While most live with their parents or other relatives, thousands live in their own apartments, with roommates, or in group homes that are designed to meet their medical and behavioral needs. An additional 4,000 live in state-run developmental centers (DCs).

The budget proposes $2.1 billion from all funds for support of DDS programs in 1999-00, an increase of 11 percent over estimated current-year expenditures. The budget proposes $836 million from the General Fund, which is $118 million, or 16 percent, above estimated current-year expenditures from this funding source. The increase is primarily due to (1) caseload and cost increases for community-based services and (2) the full-year cost of program augmentations enacted in the current year.

COMMUNITY SERVICES PROGRAM

The DDS Community Services Program provides community-based services to clients through the RCs. These services include assessment and diagnosis of children and adults, early intervention services for young children, placement in residential care facilities and daytime treatment/activity programs, arrangements for transportation when needed, and family supports such as respite care and counseling.

Self-Determination Holds Promise, Needs Further Evaluation

We recommend enactment of legislation requiring the department, along with regional centers and area boards, to incorporate the following issues into the self-determination pilot projects authorized by Chapter 1043, Statutes of 1998 (SB 1038, Thompson): (1) the extent to which consumer choice should be limited, (2) how "life quality" assessments can be used to enhance the service planning process, (3) whether case management services can be provided outside the traditional regional center model in a cost-effective manner, and (4) how to incorporate objective performance measures into a format that consumers can use to make informed choices about the services they receive.

The idea of "self-determination,"—in which developmentally disabled consumers determine which services they need and directly control the funds that are used to purchase those services—has gained some popularity nationwide in the past few years. In this analysis of the self-determination approach, we commonly refer to consumers as the decision makers. We note, however, that in many cases a consumer's family, legal guardian, or conservator would also be involved. We also use the terms "consumer" and "client" interchangeably.

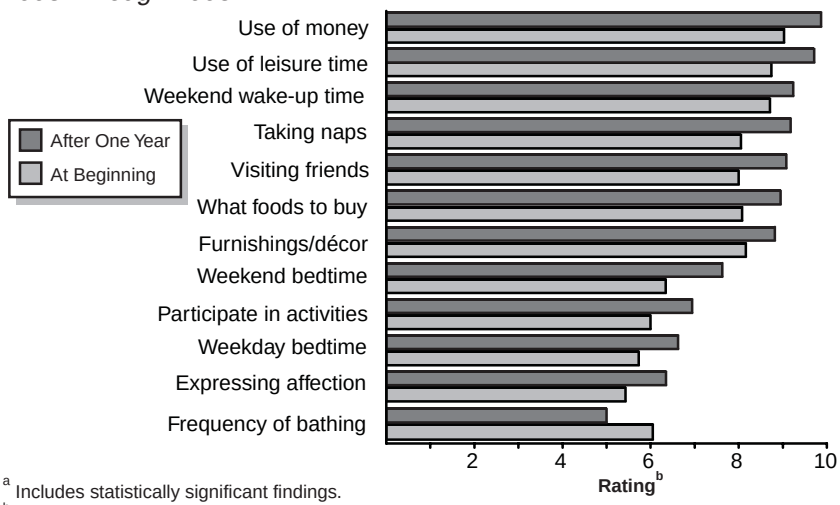
New Hampshire Project Considered Successful. The trend toward self-determination was spurred by the Monadnock Project in New Hampshire, which was started in 1992 using a Robert Wood Johnson Foundation (RWJF) grant. Consumers involved in the project controlled the planning process for all of their needs and purchased services through a variety of methods, including contracting directly with providers. The consumers were initially given 85 percent of their existing service expenditures, including federal and state funds, and were allowed to purchase services as they wished. The remainder was put into a "risk pool" as a safeguard in case participants needed additional funds.

An external evaluation of the project found that Monadnock participants had more control over their daily lives, yet spent 12 percent to 15 percent less on average than before the project was implemented. The evaluators measured the amount of control participants felt they had over a number of lifestyle decisions, ranging from control over personal finances, leisure time, and living arrangements to choosing restaurants, clothing, and bedtimes. They found statistically significant increases in consumer control for 11 of the 26 outcome measures and a significant decrease in only one of the measures (the researchers did not attempt to explain this decrease). Figure 1 shows the significant changes that were identified. The researchers also asked participants to rate the quality of their lives based on a number of factors, such as general health and happiness, relationships with family and friends, and their living situations. Results were again positive, as shown in Figure 2 (see next page).

Figure 1

Significant Changes in Consumer Control Among Monadnock Participants[a]

1993 Through 1995



[a] Includes statistically significant findings.

[b] Ratings were on a scale of 1 to 10, with 10 representing maximum control.

The above measures are subjective, measuring consumers' perceptions of their life quality and the amount of control they exercised over daily activities. The evaluators also included more objective measures such as the frequency of outings to visit friends, shop, see movies, and go to church. They reported an increase in the number of times participants engaged in these activities, although it was not statistically significant.

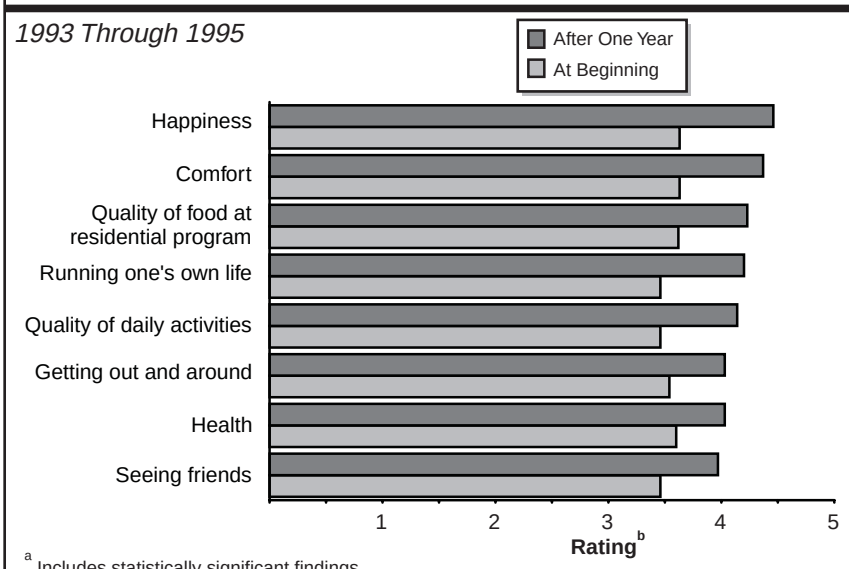
The Monadnock evaluation has several limitations. The researchers did not include a comparison group, which limits the conclusions that can be drawn from their findings. In addition, incomplete data forced them to estimate some costs associated with client services. Finally, because every self-determination project is unique, the Monadnock findings may not be generalizable.

Despite these limitations, the Monadnock project—which by design provided consumers with more control and less funding—indicates that the concept of self-determination holds promise for states wishing to increase consumer choice while decreasing system costs. We note that further research might help to establish a causal relationship between consumer control and life quality, as measured by outcome indicators such as health status.

Figure 2

Quality of Life Changes for Monadnock Participants[a]

1993 Through 1995



[a] Includes statistically significant findings.
[b] Ratings were on a scale of 1 to 5, with 1 being "very bad" and 5 being "very good."

Additional Projects Underway. After the Monadnock success, RWJF funded additional projects in 29 states, which will be evaluated to determine the effectiveness and cost-effectiveness of different self-determination models. The models being tested include changes in the way that needed services are identified and provided as well as the use of vouchers, debit cards, and cash grants controlled by consumers. California did not receive

a grant from the foundation, although a second round of funding might become available for which the state could apply. The project director indicates that external evaluations of each project have been initiated, although results will not be published for at least another year.

California Projects May Test Variety of Models. In California, Chapter 1043, Statutes of 1998 (SB 1038, Thompson) provides $750,000 over three years for pilot projects assessing the effectiveness of different self-determination models. The department is working with the Tri-Counties, Eastern Los Angeles, and Redwood Coast RCs and their local area boards to structure the projects. California's projects offer an opportunity to examine the cost-effectiveness of various aspects of self-determination. Specifically, SB 1038 authorizes a number of options, such as:

- ***Flexible Payments.*** This includes allowances or subsidies provided to consumers and families, debit cards, and vouchers.
- ***Nontraditional Service Provision.*** Parents could be paid to provide services, and/or payments could be made directly to providers without going through a purchase authorization process.
- ***Alternative Case Management.*** This might entail the consumer, family, legal guardian, or conservator arranging for needed services or hiring a service coordinator who does not work for a regional center to serve as a service broker for the consumer.
- ***Individual Budgeting.*** After identifying the services that are needed, the consumer would prepare a budget, receive the money to purchase the services, and manage the funds either independently or with the help of family, friends, or a paid bookkeeper. Groups of consumers could also pool their resources to hire money managers and purchase services.

While it remains to be seen which of these options are chosen by the participating RCs, we believe that alternative case management should be included among the models tested. (We discuss this later in our analysis.) We also suggest that each project be evaluated. These evaluations should include comparison groups; an analysis of cost-effectiveness; and attention to the advantages, drawbacks, and difficulties encountered while implementing the various options. In addition, the evaluation should measure several different types of outcomes, recognizing that consumer perceptions of life quality and the amount of control they feel they have over their lives is one way to measure project success, but that more objective measures such as health and safety, living arrangements, employment, and the achievement of goals set forth in each consumer's program plan should also be included.

Additional Unanswered Questions. While the Monadnock Project results suggest that consumer choice can be increased even with a lower level of funding, it is unclear whether increasing consumer choice is always cost-effective. In addition to testing some or all of the options listed above, we believe that the department and participating RCs and area boards should incorporate into the SB 1038 pilot projects several additional questions related to the cost-effectiveness of increasing consumer choice. These questions include:

- ***To What Extent Should Limits be Placed on Choice and How Can This Best be Accomplished?*** The Lanterman Act gives consumers the right to make choices about many aspects of their lives, yet requires RCs to operate within their budget allocations. These requirements create inherent tension between consumers who desire certain services and RCs that attempt to control costs. The pilot self-determination projects offer a chance to determine (1) how RC practices affect consumer choice, (2) whether giving consumers more choice is inherently cost-effective, and (3) whether limits should be placed on choice. We suggest that the department or the pilot projects examine RC purchase-of-service guidelines, which are policies adopted by each RC spelling out the services they will typically purchase. The department recently reviewed these guidelines for compliance with state and federal law, identifying more than 90 violations and areas of concern. The RCs have been asked to revise and resubmit their guidelines, which was scheduled to occur in late December 1998 and early January 1999. We recommend that DDS examine the revised guidelines to determine how different guidelines affect consumer choice and the cost-effectiveness of services.

- ***Can Life Quality Assessments be Better Integrated With the Formulation and Implementation of Consumer Program Plans?*** Life quality assessments (LQAs) are periodic, structured interviews of consumers who live in the community. They are primarily designed to collect information on the quality of services that consumers receive and to ensure that their legal, civil, and service rights are not being violated. In addition, the assessments were originally intended to be used as a tool to help identify consumers' desires when planning for the services they would receive. The RCs conducted LQAs from July 1996 to July 1998, when the Organization of Area Boards assumed control of the process. A 1997 evaluation of the LQA process indicated that RCs had established procedures for using LQA information in the planning process as well as their overall quality monitoring activities, but it is not

known how well the procedures are being followed. We recommend that the self-determination pilot projects examine ways to incorporate LQA information into consumers' planning processes.

- ***Can Adequate Case Management Services be Provided in a Cost-Effective Manner by Non-RC Employees, and in What Cases Is This an Appropriate Option?*** Section 4647of the Welfare and Institutions Code allows consumers, family members, legal guardians, or conservators to assume all or part of the case management duties performed by RCs, "if the regional center agrees and it is feasible." This law gives clients the flexibility to implement their Individual Program Plans or find someone who will help them do so, outside of the traditional RC case management process. The law also requires RCs to provide information and support to anyone designated as an outside case manager for a consumer. According to the department, this provision of law has rarely been used and has not been assessed to determine whether it is cost-effective for a large segment of RC consumers or in specific cases. As noted above, SB 1038 identifies alternative case management as an option for the self-determination pilot projects. We believe the concept has the potential to be cost-effective and, therefore, recommend that the Legislature require that alternative case management be included in at least one of the pilot projects so it can be evaluated further.

- ***How Should Performance Outcomes Identified by the Service Delivery Reform Workgroup Be Incorporated Into Useful Quality Assurance Tools For Consumers and Families?*** The workgroup has been meeting since October 1998 to examine and restructure day, infant, and respite services provided to RC clients. The group, which is scheduled to meet through July 2000, is working to identify objective, measurable performance outcomes that can be used to measure service quality systemwide. We believe that the group's findings should be used to create a provider "report card" or similar document that consumers can use when deciding what programs and services to utilize. The self-determination pilots offer an opportunity to test how quality assurance information can be presented to consumers and families in a way that helps them make informed decisions about the services they receive. Consequently, we recommend that the department incorporate these measures (and any other outcome measures that may be identified during the course of the self-determination projects) into the projects.

Conclusion. In summary, we believe that the self-determination concept holds promise as a way to increase consumer control over services and funding while potentially reducing costs, but that further evaluation is needed to determine which aspects of self-determination are the most cost-effective, produce the best outcomes, and are the most feasible to implement statewide. We also believe that California's self-determination projects provide an opportunity to accomplish this and to answer several related questions regarding current system practices, including the use of RC purchase-of-service guidelines and the incorporation of life quality assessment findings into the planning process.

Accordingly, we recommend enactment of budget trailer bill legislation requiring the department, along with participating RCs and area boards, to incorporate the following issues into the self-determination pilot projects authorized by SB 1038: (1) the extent to which consumer choice should be limited, (2) how life quality assessments can be used to enhance the service planning process, (3) whether case management services can be provided outside the traditional RC model in a cost-effective manner, and (4) how to incorporate objective performance measures into a format that consumers can use to make informed choices about the services they receive. Where appropriate, the department should include its findings in the self-determination pilot project report that is required to be submitted to the Legislature by January 1, 2001.

Program Development Fund Surplus Can Offset General Fund

We recommend a reduction of $2 million in General Fund expenditures from the regional center budget and a corresponding increase in expenditures from the Program Development Fund, which contains a projected $2 million surplus. (Reduce Item 4300-101-0001 by $2,000,000 and increase Item 4300-101-0172 by $2,000,000.)

The Developmental Disabilities Program Development Fund (PDF) primarily contains fees collected from parents whose children receive services through the RCs. According to state law, the fund may be used to expand community-based programs for people with developmental disabilities and to offset General Fund costs.

The *1999-00 Governor's Budget* shows a year-end surplus of $2 million in the PDF beginning in 1997-98 and continuing through 1999-00. The department indicates that, for several years, it did not fully account for PDF revenues, and by the time the error was discovered, a reserve of nearly $2 million had accumulated. This unanticipated increase in avail-

able funds was not spent in 1997-98 and is not proposed to be spent in 1998-99 or 1999-00.

The budget proposes additional General Fund expenditures for numerous programs that fit the intended purpose of the PDF. Given that the budget fully funds caseload and cost increases, we recommend that the Legislature reduce the General Fund allocation for RCs by $2 million on a one-time basis, and increase PDF expenditures by the same amount.

DEVELOPMENTAL CENTERS PROGRAM

The budget proposes $490 million from all funds ($39 million from the General Fund) for support of the DCs in 1999-00.

Budget Does Not Reflect Full Savings From Napa Program Closure

We recommend a technical adjustment to reflect the full budget-year savings from closing the program for patients with developmental disabilities at Napa State Hospital, for a General Fund savings of $116,000. (Reduce Item 4300-003-0001 by $14,000, Item 4260-101-0001 by $102,000, and Item 4260-101-0890 by $109,000.)

Prior to its closure in February 1996, the Stockton Developmental Center housed a number of developmentally disabled residents who required an increased level of security. At the end of 1995, 178 of these residents were moved to Napa State Hospital, one of the four mental hospitals operated by the Department of Mental Health (DMH), which had bed space available at the time. The two departments entered into an interagency agreement requiring DDS to reimburse DMH for the costs of housing and treating DDS clients. Since 1995, the number of DDS-funded beds at Napa has declined steadily. In 1998-99, 115 beds are dedicated to DDS clients at a cost of $18 million ($10 million from the General Fund).

The DDS clients at Napa live in buildings that are located behind the newly constructed security fence. However, DMH indicates that it needs these buildings in order to accommodate projected increases in the number of its patients who require secured facilities. The two departments have agreed to phase out the DDS program by March 30, 2000. By that time, all of the DDS clients at Napa will be transferred to the developmental centers at Porterville and Lanterman, where secured units have been built since Stockton DC was closed.

The DMH budget includes a net decrease of $5.3 million in reimbursements from DDS, reflecting the planned phase-out of the program. How-

ever, the DDS budget was reduced by only $5.1 million (total funds), which the department indicates is an error. Accordingly, we recommend a technical adjustment to the DDS budget to reflect the full savings that will result from the program closure in 1999-00, for a General Fund savings of $116,000 ($14,000 in the DDS budget and $102,000 in the Department of Health Services.).

Budget-Year Projections of Federal Funding May Be Overly Optimistic

We recommend that the department report at budget hearings on (1) the status of its negotiations with the Health Care Financing Administration regarding the continuing freeze on new admissions to the state's Home and Community Based Services federal waiver program, (2) its plan for enabling regional centers to enroll new clients in the program, and (3) the projected loss of federal reimbursements in 1999-00 if the admissions freeze is not completely lifted by July 1, 1999, as assumed in the budget.

The Home and Community Based Services (HCBS) waiver program enables states to receive federal Medicaid funding for services provided to developmentally disabled persons in community settings. Recipients are Medicaid beneficiaries who have conditions that would require institutional care in the absence of community-based services. The waiver is based on the belief that community care is preferable to institutional care because it enables recipients to live in the least restrictive environment possible and is, on average, less expensive than institutionalization. In California, the HCBS waiver program is used to fund services for about one quarter of the developmentally disabled clients (an average caseload of 31,000 in 1998-99) served by RCs, with total annual expenditures of over $400 million (about half of which comes from the General Fund).

State Cited For Poor Service Quality. States must seek periodic reauthorization of their waiver programs from the federal Health Care Financing Administration (HCFA), an agency within the U.S. Department of Health and Human Services. In 1997, after California had requested a renewal of its HCBS waiver, HCFA officials visited several regional centers and community programs to gauge the quality of services being provided. In December 1997, HCFA released a report citing the state for numerous deficiencies, refused to renew California's waiver program, and required the state to submit a new waiver application containing quality assurance measures that addressed HCFA's findings. As a result of these findings and other concerns regarding the quality of community-based care, the *1998-99 Budget Act* appropriated about $130 million

($90 million from the General Fund) for provider rate increases, direct-care staff training, and improved RC case management services.

While California prepared its application for a new waiver program, the state was allowed to continue billing for services under the old waiver program. However, RCs were barred from enrolling new participants in the new waiver program. As a result of this ban on new admissions, the number of people receiving waiver services decreased, as did the amount of federal funding the state could collect. We note that developmentally disabled Californians entitled to receive services under the Lanterman Act continued to do so during this period of time. In effect, the admissions ban resulted in lost federal revenue and an increase in General Fund costs.

New Waiver Approved, But Admissions Still Frozen. California's new waiver program was approved effective October 1, 1998. Although DDS had assumed that the admissions ban would be lifted when the new waiver was approved, HCFA kept the ban in place. According to HCFA, the state must prove that each RC has implemented appropriate quality assurance measures before the center will be allowed to enroll new waiver participants. The federal government's decision to maintain the admissions freeze will cost the state an estimated $25 million in lost federal revenue in 1998-99, which must be made up using General Fund monies. The administration submitted a deficiency request to the Legislature for this amount in January 1999.

Optimistic Budget Projections. Although the budget assumes that *no* RCs will be certified prior to June 30, 1999, it also assumes that *all 21* centers will be certified as of July 1, 1999—just one day later. As a result, the budget projects the collection of all possible federal funding for waiver-eligible services in 1999-00. Although this could occur, it would require HCFA to reverse its position and allow the state to enroll new waiver participants at all of the RCs, without requiring them to be certified first. Alternatively, if HCFA maintains its position that each RC be certified before being allowed to enroll new waiver participants, this will have to be accomplished on a center-by-center basis. This would result in lower federal revenues than estimated in the budget, and could lead to another deficiency request in 1999-00.

At the time that this analysis was written, the department was unable to provide a plan or timeline for certifying RC compliance with the new quality assurance measures. The department indicated that DDS and HCFA had not established a method for certifying RCs at that point, and that state officials were still determining whether HCFA was willing to

lift the ban on new admissions without requiring all RCs to be certified first.

Analyst's Recommendation. As noted above, the ban on new admissions resulted in lost federal funds and increased state costs in 1997-98 and 1998-99. Although the budget assumes that the ban will be lifted as of July 1, 1999, this may be overly optimistic given HCFA's requirement that RCs be certified before they may enroll new participants. Accordingly, we recommend that the department report at budget hearings on (1) the status of its negotiations with HCFA regarding the continuing freeze on new admissions to the state's HCBS federal waiver program, (2) its plan for enabling RCs to enroll new participants in the program, and (3) the potential loss of federal reimbursements in 1999-00 if the admissions freeze is not completely lifted by July 1, 1999, as assumed in the 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 the delivery of mental health services through a state-county partnership and for involuntary treatment of the mentally disabled, (2) operate four state hospitals, (3) manage treatment services at the California Medical Facility at Vacaville (a state prison), and (4) administer nine community programs directed at specific populations.

The state hospitals provide inpatient treatment services for mentally disabled county clients, judicially committed clients, clients civilly committed as Sexually Violent Predators (SVPs), and mentally disordered offenders and mentally disabled clients transferred from the California Department of Corrections.

The budget proposes $1.5 billion from all funds for support of DMH programs in 1999-00, which is an increase of less than 1 percent over estimated current-year expenditures. The budget proposes $646 million from the General Fund, which is an increase of $8.9 million, or 1.4 percent, above estimated current-year expenditures. The increase is primarily due to (1) increases in the judicially committed and SVP populations in the state hospitals and (2) an increase in the cost of drugs used to treat state hospital patients.

Overbudgeting for SVP Evaluations

We recommend that the Legislature reduce the amount proposed for evaluations of potential Sexually Violent Predators by $1.2 million from the General Fund because the budget exceeds the amount needed on a workload basis. (Reduce Item 4440-001-0001 by $1,236,000.)

Background. In 1995, California followed the lead of several other states by enacting legislation (Chapters 762 and 763, Statutes of 1995 [AB 888, Rogan and SB 1143, Mountjoy]) enabling courts to civilly commit offenders determined to be "SVPs" to state mental hospitals. The commitments are sought for state prison inmates as they approach their scheduled parole dates. When the California Department of Corrections (CDC) identifies an inmate as a potential SVP, it refers the case to DMH for a more in-depth review. The SVP evaluation unit at DMH determines whether referred inmates meet the basic criteria for commitment and schedules psychological evaluations for those who do. The evaluations are conducted by department staff or one of 35 private clinicians who contract with DMH.

The budget includes $3.4 million for SVP evaluations and related costs, such as the time evaluators spend testifying in court, giving depositions, and updating their evaluations when court hearings are delayed. This amount is not based on an estimate of caseload and costs for the budget year, but is the amount that has historically been budgeted for SVP evaluations. However, actual expenditures for evaluations and related costs during 1997-98 were $1.9 million, and the department spent $1.1 million during the first half of 1998-99. Based on this trend, we would expect costs of $2.5 million in 1999-00, but we estimate somewhat lower costs due to a declining rate of referrals from CDC.

Slower Referral Rate Leads to Fewer Evaluations. From July through December of 1998, DMH conducted fewer evaluations than in previous years due to (1) a slower rate of referrals from CDC and (2) an increasing number of "recycled" cases—prisoners who are referred to DMH despite having been rejected from the SVP system previously and, therefore, do not require an evaluation. During this time period, DMH received an average of 52 referrals per month, 38 percent of which met the basic criteria and were scheduled for an evaluation. Based on data provided by DMH, we project a continuing decline in the referral rate and an average of 36 referrals per month during 1999-00, about 150 fewer than in 1998-99. However, we believe that any savings realized from this decrease in referrals will be offset by the following factors, so that costs in the budget year will be the same as in the current year:

- ***Recommitment Hearings.*** When SVPs reach the end of their two-year commitment term, the department can file a petition to recommit them for another two years. About 70 SVPs will reach the end of their two-year terms during 1999-00. Based on recent practice, we assume that DMH will attempt to recommit all of them, requiring additional expenditures for evaluations and court time.

- ***Supreme Court Opinion.*** In January 1999, the California Supreme Court decided that the SVP law is constitutional. The department anticipates that this ruling will spur county courts to schedule hearings for the 222 SVP cases awaiting adjudication as of January 19, 1999. Many of the pending cases have been delayed for a significant length of time, and the SVP unit expects district attorneys to request updated evaluations for a number of these patients.

Recommend Budget Reduction. In summary, we project that expenditures for evaluations will be $2.2 million in the budget year, or $1.2 million less than the budget proposes. This is about the same as projected current-year expenditures due to the net effect of the factors discussed above. Accordingly, we recommend that the Legislature reduce the DMH state operations budget by $1.2 million from the General Fund.

Medi-Cal Expenditures Out of State's Control

We recommend that (1) the department report at budget hearings on projected 1999-00 expenditures in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program and (2) the Legislature transfer $89 million in General Fund monies from the Department of Health Services budget to the Department of Mental Health for EPSDT mental health services, to be distributed to counties as part of their managed care allocations. This should help control program spending by establishing a link between program and funding responsibility. (Reduce Item 4260-101-0001 by $88,916,515 and increase Item 4440-101-0001 by $88,916,515.)

Background. The EPSDT program was established as a mandatory Medicaid service in 1967 and expanded by the Omnibus Budget Reconciliation Act of 1989. Under EPSDT, states are required to provide a broad range of screening, diagnostic, and medically necessary treatment services to Medi-Cal beneficiaries under age 21, even if the treatment is an optional service not otherwise covered in the state's Medicaid plan. The requirements apply to mental as well as physical health care and are intended to correct or improve conditions that could be more expensive to treat later in life. In this analysis, we focus exclusively on EPSDT mental health services.

In 1994-95, counties spent approximately $97 million from all funds (county, state, and federal) on mental health services for Medi-Cal beneficiaries under age 21. (This amount includes the funds used to match federal Medicaid dollars.) In 1995-96, DMH and the Department of Health Services (DHS) entered into an interagency agreement requiring

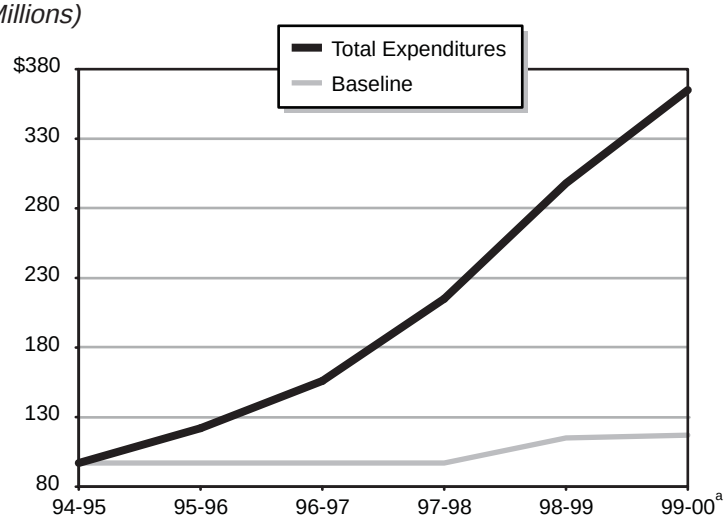
DHS to provide state General Fund support as a match for EPSDT-eligible services administered by county mental health departments, above the baseline expenditure amount of $97 million. The baseline is essentially a maintenance-of-effort (MOE) requirement for the counties. This baseline or MOE amount was not increased until 1998-99, when it was changed to $115 million to reflect (1) an inflationary adjustment of about 3 percent and (2) about $15 million in services that were not previously accounted for in the baseline. The proposed 1999-00 baseline is $117 million.

Significant Growth Since 1995-96. While DMH indicates that it originally intended to cap the state's share of costs for EPSDT services after expenditures leveled off, that has never occurred. Service costs have increased significantly every year (see Figure 1), from $25 million above the baseline in 1995-96 to an estimated $189 million above the baseline in 1998-99. If budget-year expenditures increase by the same amount as current-year expenditures, the state will spend $248 million ($120 million from the General Fund with the remainder being federal funds) above the baseline for EPSDT mental health services in 1999-00. This would be an increase of nearly 900 percent in just four years. According to DMH, the large increase in expenditures on children and adolescents include both increased services for existing clients as well as services provided to new clients.

Figure 1

Growth in EPSDT Expenditures

1994-95 Through 1999-00
(In Millions)



[a] Assumes continuation of recent growth trend.

We have identified a number of issues for the Legislature to consider with regards to the EPSDT program, which are summarized below along with our recommendations.

- ***Increases Granted Outside Budget Process.*** Substantial funding increases for 1997-98 and 1998-99 were made through budget revisions submitted to the Department of Finance, which in turn notified the Legislature of the increased spending through budget act section letters. In effect, the administration has used these methods as an alternative budget process for the EPSDT program, which has reduced the Legislature's oversight. The *1999-00 Governor's Budget* again proposes no increase in EPSDT expenditures, which we believe is unlikely given the substantial increases that have occurred historically. Therefore, we recommend that the department report at budget hearings on the projected expenditures for 1999-00 so these costs can be accounted for during the budget process.

- ***Split Between Funding and Program Responsibility Results in Lack of Cost-Control Incentives.*** With the counties responsible for program administration and the state responsible for 100 percent of the nonfederal cost increases related to EPSDT services, there is little incentive for the counties to use funds in the most cost-effective manner—for example, by implementing a rigorous utilization review process. In fact, county mental health departments have a fiscal incentive to shift costs to the EPSDT program whenever possible. In order to facilitate control over program spending, we recommend that (1) the $89 million in General Fund monies budgeted for EPSDT services in 1999-00 be shifted from DHS to DMH and incorporated into counties' mental health managed care allocations and (2) future caseload and cost adjustments be made through the annual budget process. This would treat EPSDT like other Medi-Cal mental health services, which are budgeted according to a managed care approach and administered by the counties. In this way, the counties would have to justify additional funding (which the state would have to provide) beyond caseload and inflation increases.

Summary of Recommendations. In order to address the above concerns, we recommend that (1) the department report at budget hearings on projected 1999-00 expenditures in the EPSDT program and (2) the Legislature transfer $89 million in General Fund monies from the DHS budget to DMH for EPSDT mental health services to be distributed to counties as part of their managed care allocations, with future funding increases made through the annual budget process.

Decrease Mentally Disordered Offender Evaluation Payment Rates

We recommend a reduction of $137,000 from the General Fund in the Department of Mental Health, and a reduction of $100,000 from a proposed augmentation for the Board of Prison Terms, in order to equalize the rates paid for Mentally Disordered Offender evaluations. (Reduce Item 4440-001-0001 by $137,000 and reduce Item 5440-001-0001 by $100,000.)

The Mentally Disordered Offender (MDO) program was established by Chapters 1418 and 1419, Statutes of 1985 (SB 1054, Lockyer and SB 1296, McCorquodale) to commit mentally ill prison inmates to state mental hospitals. To be deemed an MDO, an inmate must have committed one of a number of specified violent crimes, be nearing release on parole, have a severe mental disorder, and pose a substantial danger of causing physical harm to others if released into the community. In addition, the offender must have received mental health treatment in state prison for at least 90 days during the year prior to his anticipated release date.

The Board of Prison Terms (BPT) refers inmates who meet the basic commitment criteria to DMH and the CDC for psychological evaluations. If the DMH and CDC evaluators disagree about whether an inmate is eligible for an MDO commitment, BPT is required to solicit the opinions of two independent evaluators to resolve the matter. Both must concur that the inmate is eligible in order for the MDO commitment to proceed; otherwise, the inmate will likely be released on parole.

Currently, DMH conducts evaluations using three staff clinicians and about 20 contractors across the state, who are paid a flat rate of $525 per evaluation, plus travel expenses and time spent in court, for a total of $614 per evaluation. The department has $398,000 budgeted for 648 contract evaluations and $408,000 for five positions (one staff psychiatrist, two consulting psychologists, and two clerical staff) in 1998-99.

Governor's Budget Proposal. The budget proposes an augmentation of $362,000 in DMH ($280,000 for contracted evaluations and $82,000 for an additional staff position) to help address about a 25 percent increase in the projected MDO workload—from 1,272 evaluations in 1998-99 to 1,572 in 1999-00. In response to recent court decisions, many more inmates are now receiving mental health treatment at CDC institutions, resulting in a significantly higher number of offenders who are potentially eligible for MDO commitment. Accordingly, BPT and CDC also propose to increase their efforts to commit more offenders to state mental hospitals as MDOs. For BPT, the budget proposes to fund a rate increase because the board pays its evaluators a significantly lower rate than DMH. Specifically, the budget

proposes $318,000 to increase the BPT rate from $320 to the $568 base rate paid by DMH. We note that prior to 1993, when the rate was reduced as a way of cutting costs, BPT paid $400 per evaluation. Unlike DMH, BPT does not currently reimburse evaluators for travel or court time.

No Reason for Rate Differential. According to BPT, its lower pay rate has caused a number of clinicians to stop contracting with the board and instead work for DMH. While we agree that there is no reason for two departments to pay different rates for the same work, we do not believe that increasing the BPT rate to $568—a 78 percent increase—is justified. At the same time, dropping the DMH base rate from $568 to $320 may be overly drastic, possibly leading to recruiting problems. Instead, we propose a statewide rate of $400 per evaluation—the original BPT rate—plus $90 for travel reimbursement and court time, for both DMH and BPT. (Please see our analysis of BPT in the "Criminal Justice" chapter of this *Analysis*.) This would result in a savings of $137,000 in DMH from the General Fund and savings of $100,000 in BPT in 1999-00. Although DMH indicates that paying a lower rate could lead to lower-quality evaluations, we note that the department has hired a number of the same clinicians who had contracted with BPT, with no apparent difference in the quality of their work.

State Hospital Budget Underestimates MDO Commitments

The state hospital budget appears to underestimate growth in the Mentally Disordered Offender (MDO) population, given current trends in the referral and evaluation of prison inmates who are potential MDOs. We recommend that the department report at budget hearings on its MDO caseload estimates along with the projected support and capital outlay costs associated with an increasing number of MDO referrals and state hospital commitments in 1999-00 and beyond.

To be deemed an MDO, an inmate must have committed one of a number of specified violent crimes, be nearing release on parole, have a severe mental disorder, and pose a substantial danger of causing physical harm to others if released into the community. In addition, the offender must have received mental health treatment in state prison for at least 90 days during the year prior to his release date. Those who are committed as MDOs are housed and treated at Patton and Atascadero state hospitals, the highest-security institutions operated by DMH. Since the MDO statute was enacted in 1985, nearly all of the state's prisons have begun referring inmates to be evaluated for commitment under the law.

The Board of Prison Terms (BPT) refers inmates identified as potential MDOs to DMH and the California Department of Corrections (CDC) for

psychological evaluations. As discussed in the preceding issue, the budget proposes augmentations to DMH in 1999-00 to account for an increasing number of referrals, due primarily to (1) more prisons making referrals and (2) a growing number of inmates receiving mental health treatment during their prison sentences, thus making them eligible for commitment if they meet the other criteria. The department evaluates about three-quarters of the referrals it receives.

The MDO Population Outpacing Budget Projection. As the number of referrals and evaluations has grown in recent years, so has the total MDO caseload. As of June 30, 1998, the hospitals were housing 564 MDO commitments. The *1998-99 Budget Act* appropriated funds for 645 MDO commitments by June 30, 1999, which reflects a net population increase of 81 over the prior year. As of December 31, 1998, however, the MDO population had already increased to 635. If commitments continue at the same pace, the population will be over 700 by the end of June 1999.

The budget proposes an increase of $3.7 million to house and treat additional MDO commitments to the state hospitals. This is based on a projected net increase of 70 MDO patients during the budget year, thereby ending the year (June 2000) with a total of 715 patients. In light of current trends, this projection appears to significantly underestimate the 1999-00 population growth and, as a result, significantly underfunds the MDO caseload. We estimate that, based on these trends, the budget proposal would need to be increased by roughly $2 million. The department should be able to provide a more precise estimate during budget hearings.

Of additional concern is the need for appropriate security for these offenders. The 1999-00 population projections show both Patton and Atascadero state hospitals at capacity by June 30, 2000. It is unclear whether the department will be able to shift patients from Patton and Atascadero to the secured units at Metropolitan and Napa state hospitals, given legislatively mandated constraints on the number and type of judicially committed patients at both of those institutions.

Department Should Update Legislature on MDO Growth. Because the MDO caseload is growing so quickly, the state may incur a substantial increase in General Fund expenditures to support these patients in both the current and budget year. In addition, the department needs to formulate a plan for housing MDOs that takes into account the available secured beds at its four hospitals. Accordingly, we recommend that the department report at budget hearings on its caseload estimates for MDOs, along with the projected support and potential capital outlay costs associated with an increasing number of MDO evaluations and state hospital commitments in 1999-00 and beyond.

State Hospital Budget Methodology Needs Revision

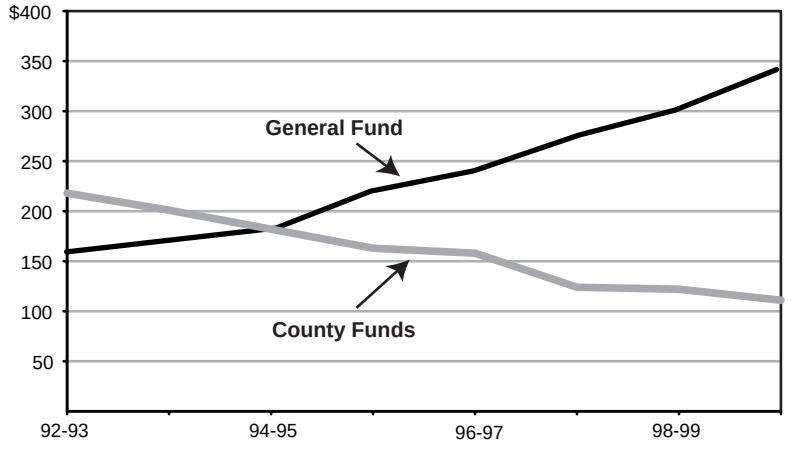
We recommend the adoption of budget bill language requiring the Department of Mental Health to develop a marginal cost methodology for funding annual caseload changes at the state hospitals, rather than the current average cost methodology, in order to more accurately reflect the costs of supporting additional patients.

State hospital funding adjustments for caseloads are made annually according to anticipated changes in the number and types of patients who will be admitted to the four institutions. The department's budget proposals for caseload changes not only include increases or decreases in overall funding, but also reflect changes in the sources of funding for different types of patients. In recent years, for example, the hospitals have housed a growing number of patients who are judicially committed under various sections of the Penal Code or civilly committed as Sexually Violent Predators. These patients are funded using General Fund monies. At the same time, there has been a decline in the number of patients placed and funded in hospitals by county mental health departments. As a result, General Fund expenditures have increased while reimbursements from the counties have declined significantly (see Figure 2).

Figure 2

State Hospitals: General Fund Costs Increasing While County Costs Decreasing

1992-93 Through 1999-00[a]
(In Millions)



[a] 1998-99 and 1999-00 are estimated.

Funding needs that are not caseload-driven or that constitute program enhancements are typically requested through separate budget change proposals. For example, the *1999-00 Governor's Budget* proposes a $6.4 million augmentation ($4.4 million from the General Fund) to reflect growing medication expenditures at the hospitals.

Current Budget Methodology. The state hospital budget consists of three main components: staff who work directly with patients, such as psychiatrists and nurses; staff who provide indirect services, such as human resources managers and groundskeepers; and operating expenses such as food, medicine, and equipment. Since 1996-97, caseload-driven budget changes have been calculated using an average cost per patient. The average cost in 1997-98 for the three components was $107,000 per patient.

In order to calculate the total amount of funding needed due to caseload increases, the department multiplies the average cost by the number of new patients, then uses a staffing formula to determine the number of new direct-care positions to request. This formula allows the department to indicate how much of its total funding will be spent on direct-care staff, while the remainder is assumed to be used for indirect-care staff and operating expenses.

Average Cost Method Overstates Amount Needed. Budgeting caseload costs according to average costs tends to overstate the amount needed to cover the incremental costs that are incurred due to an increase in the number of state hospital patients. This is because the department's calculation of average expenditures includes items such as administration, building maintenance, and groundskeeping. Unlike direct-care staffing needs, these expenditures are relatively fixed. For example, each hospital has a single director; this does not change when additional patients are admitted.

While the average cost is important to know for planning purposes, funding for new patients should be based on the variable costs that are directly related to caseload changes—such as staffing, food costs, and the purchase of additional furniture or equipment to accommodate an increased number of patients—rather than the average cost per patient.

Instead of using an average cost approach, we believe the department should develop a marginal cost methodology to budget for additional state hospital patients. This methodology can be based on variable operating expenses as well as staffing formulas for both direct- and indirect-care staff, with increases for inflation. The CDC and the two state university

systems, for example, follow a marginal-cost approach when budgeting for caseload or enrollment increases.

Summary and Recommendation. Using the average cost to budget for new state hospital patients will result in overbudgeting (and the converse is true if the same methodology were used to decrease costs as a result of caseload reductions). This is because average costs tend to be higher than marginal costs. In contrast, the marginal cost budgeting approach is commonly accepted and widely used in state government. The DMH could develop such a methodology by applying staffing ratios and associated operating expenses for both direct- and indirect-care staff.

Accordingly, we recommend the adoption of budget bill language requiring the department to develop, and submit to the Legislature, a marginal cost methodology for budgeting state hospital costs, to take effect for the 2000-01 budget. The methodology would replace the average cost approach and is not intended to preclude the department from submitting budget change proposals for specific needs or special factors.

Our recommendation can be implemented by adoption of the following language in Item 4440-011-0001:

> The Department of Mental Health shall develop a methodology for funding annual caseload changes at the state hospitals that is based on the marginal cost of supporting additional patients, to be used in 2000-01 and thereafter. The department shall submit a report on its proposed methodology to the appropriate legislative fiscal committees, the Joint Legislative Budget Committee, and the Department of Finance no later than October 1, 1999.

EMPLOYMENT DEVELOPMENT DEPARTMENT (5100)

The Employment Development Department (EDD) is responsible for administering the Employment Services (ES), the Unemployment Insurance (UI), and the Disability Insurance (DI) Programs. The ES Program (1) refers qualified applicants to potential employers; (2) places job-ready applicants in jobs; and (3) helps youths, welfare recipients, and economically disadvantaged persons find jobs or prepare themselves for employment by participating in employment and training programs.

In addition, the department collects taxes and pays benefits under the UI and DI Programs. The department collects from employers (1) their UI contributions, (2) the Employment Training Tax, and (3) employee contributions for DI. It also collects personal income tax withholdings. In addition, it pays UI and DI benefits to eligible claimants.

The budget proposes expenditures totaling $5.6 billion from all funds for support of the EDD in 1999-00. This is a decrease of $248 million, or 4.3 percent, from estimated current-year expenditures, primarily due to a decrease in projected UI and DI benefit payments and a decrease in expenditures in the Welfare-to-Work Program. The budget proposes $23 million from the General Fund in 1999-00, which is a reduction of $1.5 million (6.1 percent) compared to 1998-99.

Workforce Investment Act

The Workforce Investment Act (WIA) of 1998 replaces the Job Training Partnership Act which provides employment and training services to youths and adults. It does this by amending federal law regarding job training, adult education and literacy, and vocational rehabilitation. The goal of the legislation is to strengthen coordination among various employment, training, and education programs. We review the major provisions of the act and summarize the Governor's proposal for implementing the WIA in the state.

President Clinton signed the WIA into law on August 7, 1998. States must implement the new law by July 1, 2000, but may implement the program once the Department of Labor (DOL) completes its interim regulations, which is expected to occur in February 1999. We note that this legislation must be reauthorized in five years, which is in contrast to its predecessor—the Job Training Partnership Act (JTPA)—which was permanently authorized. Major provisions of the WIA include:

- ***State Board***. States are required to establish a state workforce investment board. The board must include the Governor, two members from each house of the Legislature (appointed by the respective leaders), and other members appointed by the Governor including representatives of business, education, labor, local government, and providers of job training. Business representatives are to hold a majority of the seats on the board. The board assists in the development of a state plan for submission to the Secretary of Labor. The board also advises the Governor on the statewide workforce investment system and the statewide labor market.

- ***State Plan***. States must submit a plan that outlines the five-year strategy for the statewide workforce investment system. The plan has many required elements, including (1) a description of the state performance accountability system, (2) identification of local service delivery areas, (3) the criteria for local officials to use when appointing members of local welfare investment boards, and (4) procedures that will assure coordination and avoid duplication among the various state and federal workforce development programs.

- ***Option for Unified State Plan***. In lieu of the single state plan, states may submit a "unified" plan to the federal government to integrate two or more of fifteen specified workforce-related programs. Individual elements of unified plans must be approved by the appropriate respective federal secretaries.

- ***Local Workforce Investment Areas and Boards***. The state is responsible for designating local workforce areas. Local governments with a population under 500,000 need state approval to be designated a WIA local area; larger local governments are entitled to automatic designation. In addition, states must approve as a local "temporary designation" area, any service delivery area (the JTPA Private Industry Councils) that (1) performed successfully under the Job Training Partnership Act and (2) has a population of at least 200,000. The chief local elected official appoints the members of the local board. Local boards must adopt five year plans

that, among other requirements, are consistent with the state plan and identify the workforce investment and job skill needs of the community.

- ***One-Stop Centers***. Each local board must establish a system whereby any citizen can search for a job and access a range of employment, training, and education programs at a one-stop center.

- ***Rewards and Sanctions***. States will be held accountable according to performance measures negotiated with the DOL. States that improve on a year-over-year basis will be eligible for incentive grants from the DOL. States that fail to meet performance standards will receive "technical assistance" for the first year of failure. Failure to meet standards for a second year *may* result in a reduction of up to 5 percent of the federal funds for the program for which the state has failed to meet these standards.

- ***Legislative Authority***. State legislatures must appropriate any federal monies or block grants for workforce-related programs governed by the WIA.

Governor's Proposal. The administration proposes a Workforce Investment Initiative that is intended to improve worker education and training for the purpose of ensuring that California has a well-trained workforce. This initiative will include the submission of a "unified" plan to consolidate and improve existing education, training, and employment programs. Because the plan must be submitted to the DOL by April 2000, the administration expects to have a draft plan developed by October 1999. The state workforce investment board will assist the administration in developing this plan.

DEPARTMENT OF SOCIAL SERVICES
CALWORKS PROGRAM
(5180)

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

The budget proposes an appropriation of $5.5 billion ($1.8 billion General Fund, $64 million county funds, $30 million from the Employment Training Panel Fund, and $3.5 billion federal funds) to the Department of Social Services (DSS) for the CalWORKs program. In total funds, this is a decrease of $681 million, or 11 percent. Similarly, General Fund spending is projected to decline by $216 million (11 percent). The budget total for CalWORKs, however, does not include funds transferred to the Department of Education to pay for Stage 2 child care or the child care reserve. When these funds are taken into account, total spending is projected to decline by $218 million, or 3.6 percent, in 1999-00.

CURRENT-YEAR UPDATE OF THE CALWORKS PROGRAM

Grants. The Legislature rejected the Governor's proposal to make permanent the previously enacted 4.9 percent grant reduction and delete the statutory cost-of-living adjustment (COLA) in 1998-99. On November 1, 1998 the temporary 4.9 percent grant reduction ended and,

pursuant to Chapter 329, Statutes of 1998 (AB 2779, Aroner), a 2.84 percent COLA was provided. These grant increases resulted in an eight-month General Fund cost of $226 million in 1998-99.

Future COLAs Tied to Future Tax Reductions. Chapter 329 provides that future COLAs will be suspended in any year where revenues are insufficient to "trigger" an additional vehicle license fee reduction, beginning in 2000-01.

Technical Corrections. Chapter 902, Statutes of 1998 (AB 2772, Aroner) primarily made technical changes to CalWORKs. Significant provisions include (1) clarifying that the 18 to 24 month time limit for employment services prior to community service begins when a client signs a welfare-to-work agreement and (2) modifying the county performance incentives, to permit the method of allocation contained in the *1998-99 Budget Act*. We discuss the issue of county performance incentives later in this section of the *Analysis*.

1999-00 BUDGET ISSUES

Impact of Maintenance-of-Effort Requirement

Because the Governor's budget proposes to expend all available federal funds and the minimum amount of General Fund monies required by federal law for the California Work Opportunity and Responsibility to Kids program, any net augmentation will result in General Fund costs and any net reductions will result in federal savings.

Maintenance-of-Effort (MOE) Requirement. To receive the annual federal Temporary Assistance for Needy Families (TANF) block grant ($3.7 billion for California), states must meet a MOE requirement that state spending on welfare for needy families be at least 80 percent of the federal fiscal year (FFY) 94 level, which is $2.9 billion for California. The MOE requirement drops to 75 percent if a state meets two specified work participation rates, but California is unlikely to meet both rates in the budget year. Although the MOE requirement is primarily met with state and county spending on CalWORKs and other programs administered by DSS, we note that $395 million in state spending in other departments is used to satisfy the requirement.

Proposed Budget Is at the MOE Floor, With Partial Match for Welfare-to-Work Program. For 1999-00, the Governor's budget for CalWORKs is at the MOE floor, with the exception of $25 million above the MOE for the purpose of providing the state match for the federal

Welfare-to-Work block grant funds. Because California is to receive $364 million in Welfare-to-Work block grant funds and the federal match rate is 2 to 1, a total of $182 million in state matching funds must be expended by September 30, 2001. When the proposed $25 million match for 1999-00 is added to the $10 million expended for the match in 1998-99, an obligation to expend $147 million in matching funds would remain.

The Governor's budget also proposes to spend all available federal TANF funds in 1999-00, including the projected carry over funds ($409 million) from 1998-99. We note that without these carry over funds, General Fund spending would be significantly above the MOE floor in 1999-00, under the budget's assumption of fully funding the program.

Technical Adjustments Raise MOE Countable Spending. As discussed below, we believe that the budget needs to be increased by $27.5 million in order to fully fund the cost of providing the statutory COLA as proposed in the Governor's budget. In addition, we believe that $4.8 million in General Fund spending on women offenders and parolees should be counted toward meeting the MOE requirement. (These issues are discussed later in our analysis of the program.) Taken together, these two technical changes would raise spending an additional $32.3 million above the MOE requirement, absent other changes to the budget that would free up federal TANF funds for these expenditure increases.

Budget Underestimates Cost of Providing the Statutory COLA

The General Fund cost of providing the statutory cost-of-living adjustment will be $27.5 million above the amount included in the budget, due to an upward revision in the California Necessities Index. These costs should be reflected in the May Revision of the budget.

Pursuant to current law, the Governor's budget proposes to provide the statutory COLA in 1999-00, at a General Fund/TANF cost of $209.4 million. The COLA is based on the change in the California Necessities Index (CNI) from December 1997 to December 1998. The Governor's budget, which is prepared prior to the release of the December CNI figures, estimates that the CNI will be 2.08 percent, based on partial data. Our review of the actual data, however, indicates that the CNI will be 2.36 percent. Applying the actual CNI of 2.36 percent raises the cost of providing the COLA to $236.9 million, or $27.5 million above the amount proposed in the budget. The administration should address this issue in the May Revision of the budget.

We note that these additional costs could be funded with federal TANF funds if the Legislature frees up these funds by budget reductions

(such as those we recommend later in this analysis). Alternatively, the General Fund could be used as a funding source. This would bring the budget above the MOE. In that case, these expenditures could count toward meeting the state's $147 million state match obligation for the federal Welfare-to-Work block grant.

The CalWORKs Grant Levels

Figure 1 shows the maximum CalWORKs grant and food stamps benefits effective July 1999, as displayed in the Governor's budget and adjusted to reflect the actual CNI. As the figure shows, grants in high-cost counties will increase by $15 to a total of $626 and grants in low-cost counties will increase by $14 to a total of $596.

As a point of reference, we note that the federal poverty guideline for *1998* (the latest reported figure) for a family of three is $1,138 per month. When the grant is combined with the maximum food stamps benefit, total resources in high-cost counties will be $874 per month (77 percent of the poverty guideline). Combined grant and food stamps benefits in low-cost counties will be $857 per month (75 percent of the poverty guideline). We note that the poverty guidelines are adjusted for inflation annually.

Figure 1

CalWORKs Maximum Monthly Grant and Food Stamps
Governor's Budget and LAO Projection
Family of Three

1998-99 and 1999-00

		1999-00		Change from 1998-99	
Recipient Category	1998-99[a]	Governor's Budget	LAO Projection[b]	Amount	Percent
Region 1: High-cost counties					
CalWORKs grant	$611	$624	$626	$15	2.5%
Food Stamps	254	249	248	-6	-2.4
Totals	**$865**	**$873**	**$874**	**$9**	**1.0%**
Region 2: Low-cost counties					
CalWORKs Grant	$582	$595	$596	$14	2.4%
Food Stamps	267	262	261	-6	-2.3
Totals	**$849**	**$857**	**$857**	**$8**	**0.9%**

[a] Effective November 1998.

[b] Based on California Necessities Index at 2.36 percent (revised pursuant to final data) rather than Governor's budget estimate of 2.08 percent.

Count Spending on Programs for Women Offenders And Parolees Toward MOE Requirement

We recommend that the department count toward the California Work Opportunity and Responsibility to Kids maintenance-of-effort requirement $4.8 million in General Fund expenditures in the Department of Corrections on programs for women offenders and parolees.

Pursuant to the federal welfare reform legislation, California may count all state spending on families eligible for CalWORKs, even if they are not in the CalWORKs program, for purposes of meeting the MOE requirement. To be countable, such spending must be consistent with the broad purposes of federal welfare reform—providing assistance to families so that they can become self sufficient.

The California Department of Corrections (CDC) operates three programs for women offenders and parolees with children. These programs provide services (such as drug treatment, child care, and education) to assist women in reintegrating into society. Because these programs provide services that are consistent with the intent of the federal welfare reform legislation, they can be counted toward meeting the federal MOE requirement.

Total spending for these program in 1999-00 is projected to be about $11 million. We note that about 45 percent of the women in the programs are likely to have had a drug-related felony conviction. Because current state law makes drug felons ineligible for CalWORKs, the spending on program services that go to drug felons would not count toward the federal MOE requirement. After reducing total spending by 45 percent to account for women who are likely to have drug-related felony convictions, and reducing the remaining amount by an additional 20 percent to account for other spending (such as health care) that may not meet the federal requirements, we estimate that at least $4.8 million of spending in the budget year for these programs operated by CDC (and $4.2 million in the current year) would count toward the MOE requirement. The administration, however, has not included these expenditures in its MOE calculations. Consequently, we recommend that the department make this adjustment, which would bring estimated current-year expenditures $4.2 million above the MOE and the budget proposal $4.8 million above the requirement. This action would create options for the Legislature, which we discuss below.

We note that these General Fund expenditures above the MOE could be counted toward the state match for the federal Welfare-to-Work block grant. Alternatively, any federal TANF savings identified by the Legislature could be used to replace General Fund monies to bring the budget down to the MOE level.

Budget Underestimates Savings From Maximum Family Grant Policy

We recommend that proposed spending for California Work Opportunity and Responsibility to Kids grants be reduced by $20.4 million (federal Temporary Assistance for Needy Families funds) to reflect the incremental savings that will occur in 1999-00 due to the continuation of the Maximum Family Grant policy. (Reduce Item 5180-101-0890 by $20,400,000.)

Chapter 196, Statutes of 1994 (AB 473, Brulte) enacted the Maximum Family Grant program. This program prohibits increases in any family's grant due to children conceived while on aid, except in cases of rape, incest, or failure of certain contraceptives, unless there has been a break in aid of at least 24 consecutive months. This policy became effective in December 1996.

In May 1998, DSS estimated that this policy would save $22.4 million in 1997-98 and $68.9 million in 1998-99. Previous multiyear estimates for this policy prepared by DSS indicated the annual baseline savings were likely to grow to nearly $200 million after five years of implementation. We note, however, that for 1999-00, the budget does not reflect any increase in savings from additional children who will not qualify for a grant because of this policy. We estimate these additional savings to be approximately $20.4 million in 1999-00. Accordingly, we recommend that the budget be reduced to reflect these savings.

We note that DSS is in the process of reestimating the actual savings attributable to the Maximum Family Grant policy during 1998. Based on the department's quality control data, a better estimate of actual and projected savings should be available in the May Revision of the budget. If appropriate, we will modify our estimate of the additional savings in 1999-00 based on this information.

Budget for Services and Child Care Should Reflect Impact of Nonparticipation

Although the budget for grants includes a reduction of 13 percent to account for adults who will be sanctioned for failing to comply with program participation requirements, the budget for employment services and child care includes no such reduction. We recommend reducing the budget for employment services and child care to account for nonparticipation, for a savings of $150.8 million (federal Temporary Assistance for Needy Families funds). (Reduce Item 5180-101-0890 by $150,775,000.)

Based on data from the Greater Avenues for Independence (GAIN) program (which provided employment services to AFDC recipients prior

to CalWORKs), the budget for CalWORKs *grants* reflects savings of $95 million to account for sanctions on adults who fail to meet various program participation requirements. Specifically, the budget estimates that during 1999-00 an average of almost 53,000 adults per month (13 percent of all cases with adults) will be sanctioned. The budget for welfare-to-work services and child care, however, has not been adjusted to reflect this nonparticipation. Since adults who are sanctioned will not receive welfare-to-work services, we recommend that the budget for services and child care be reduced to reflect the anticipated savings from nonparticipation. Based on an overall 13 percent nonparticipation rate, we estimate these savings to be $150.8 million in the budget year.

Incentive Payments Should Be Related to Improved County Performance

Of the $479 million proposed for county performance incentive payments, $287 million (60 percent) is the result of the baseline level of recipient earnings, rather than savings attributable to improved county performance in California Work Opportunity and Responsibility to Kids (CalWORKs). We recommend enactment of legislation to modify the methodology for calculating the incentive payments so that counties retain 50 percent of savings attributable to earnings (rather than the 100 percent included in the budget) because the rest of the savings would have occurred in the absence of CalWORKs. This change will result in budget savings of $193 million (federal Temporary Assistance for Needy Families funds) in 1999-00 . (Reduce Item 5180-101-0890 by $192,573,000.)

Background. The CalWORKs legislation requires that savings resulting from (1) exits due to employment, (2) increased earnings, and (3) diverting clients from aid with one-time payments, be paid by the state to the counties as performance incentives. Current law also requires that DSS, in consultation with the welfare reform steering committee, determine the method of calculating these savings.

Savings from Exits Due to Employment. For 1998-99, the steering committee recommended that county performance incentive payments attributable to savings from exits due to employment be based on the *increase* in exits compared to the average number of exits during 1994-95, 1995-96, and 1996-97. By estimating the savings from exits due to employment in comparison to a baseline, the incentive payments for exits are directly related to improved county performance.

Savings From Increased Earnings. In contrast to its approach with respect to exits, the steering committee did not incorporate a baseline for

savings due to increased earnings. Specifically, the steering committee recommended that *all* savings attributable to earnings—regardless of whether they resulted from CalWORKs interventions or would have occurred absent any change in program implementation—be paid as fiscal incentives. We note that prior to implementation of CalWORKs, 17 percent of the caseload had sufficient earnings to result in reduced grants. For 1999-00, the DSS estimates that of the $385 million in savings resulting from increased earnings, $287 million (about 75 percent) would have occurred without CalWORKs. Thus, the steering committee approach provides counties with $287 million in "performance incentives" that they would "earn" even if CalWORKs recipients show no improvements in earnings from county implementation of the program.

Savings From Diversion. The Governor's budget proposes to provide all net savings that are attributable to diversion as county performance incentives. Specifically, the budget estimates that cases diverted by the counties would have been on aid for an average of six months, and that the average one-time diversion payment would be $1,175. Based on these assumptions, DSS estimates that fiscal incentive payments based on net savings from diversion will be $18.7 million in 1999-00. We note that the diversion payment is a new program component, so any savings should be attributable to CalWORKs.

Summary of Incentive Payments. Figure 2 summarizes the sources of the fiscal incentives. As the figure shows, $287 million, or almost 60 percent of the proposed budget for performance incentives, is based on savings that would have occurred in the absence of CalWORKs, rather than from improved county performance in implementing the new program.

Tying Incentives to Improved County Performance. One approach to bringing incentives in line with performance would be to limit incentive payments based on increased earnings to the $99 million in savings from earnings that are actually attributable to CalWORKs. This approach would reduce fiscal incentives by $287 million, down to a total of $192 million.

We note that even though DSS has estimated that only $99 million in statewide savings from earnings can be attributed to CalWORKs, it is administratively difficult to separate baseline savings from CalWORKs savings at the individual county level. This technical estimating problem is one reason why the steering committee did not limit the fiscal incentive payments in this way.

To address this problem, we recommend providing counties with 50 percent of *all* savings attributable to earnings. Under this approach, fiscal incentives would be reduced by $193 million, to a total of $286 million. Al-

though this approach leaves counties with more in incentives than can be strictly justified on the basis of improved performance, it does not rely on a county-level estimate of the baseline and still provides counties with a significant fiscal incentive to assist recipients in obtaining employment. At the same time, it will result in savings to the state which, in years when CalWORKs spending is above the MOE level, will accrue to the General Fund, and in other years will be in federal TANF funds that can be used according to the Legislature's priorities for the CalWORKs program.

Figure 2

Governor's Budget for County Performance Incentive Payments

1999-00
(In Millions)

Reason for Incentive Payment	Amount	Percent
Incentives based on improved county performance		
Exits due to employment	$75	15.7%
Diversion	19	3.9
Increased earnings attributable to CalWORKs	99	34.4
Subtotal	**$192**	**40.2%**
Incentives unrelated to improved county performance		
Increased earnings attributable to pre-CalWORKs program (baseline)	**$287**	**59.8%**
Total performance incentive payments	**$479**	**100.0%**

Analyst's Recommendation. In summary, we recommend enactment of legislation to limit performance incentive payments that are based on earnings to 50 percent of total savings from earnings. Based on this recommendation, the budget for fiscal incentive payments should be reduced by $192.6 million (federal TANF funds).

Options for Using Identified Savings

Federal savings could be (1) redirected to other priorities in the California Work Opportunity and Responsibility to Kids program, (2) placed into a reserve for future years, and/or (3) transferred to the Social Services Block Grant (Title XX), where the funds could be used to offset General Fund spending in other departments. Among these options, we recommend that the Legislature place at least 50 percent ($166 million) of our identified savings into a reserve for expenditure in future years.

Options for Using Identified Savings. If adopted, the above recommendations would result in savings of $332 million. With the exception of the General Fund proposal of $25 million for the Welfare-to-Work match and the other adjustments noted previously ($27.5 million to fund the cost of the COLA and $4.8 million in Department of Corrections spending that should be counted toward the MOE requirement), the proposed budget is at the MOE floor. Thus, if the Legislature makes any budget reductions (beyond the $32.3 million discussed above), the resulting savings would be in federal funds. Such savings would be retained by the state because they are TANF block grant funds that can be carried over indefinitely.

The Legislature has three options with respect to any such federal savings: (1) redirect the savings into other priorities in the CalWORKs program, (2) place the federal savings in a reserve for expenditure in future years, and/or (3) transfer the federal funds (up to roughly $100 million) into the Social Services Block Grant (SSBG), where the funds could be used to replace General Fund spending in certain other departments. This last option requires some explanation.

In accordance with the federal TANF block grant provisions, as amended by the Balanced Budget Act of 1997, California may transfer up to $370 million of federal TANF funds into the SSBG, also known as Title XX funds. Once transferred, the funds become subject to the rules of the SSBG, including the condition that SSBG spending of transferred TANF funds must be for children or their families with incomes under 200 percent of poverty. For 1999-00, the budget proposes to use $176 million in SSBG funds to offset General Fund costs, mostly in the In-Home Supportive Services (IHSS) program and in the community-based programs of the Department of Developmental Services. We estimate that additional SSBG funds (from a TANF transfer) could be used to supplant approximately $100 million in General Fund spending for low-income children and families in these programs.

Analyst's Recommendation. Of the three options for using identified savings, we recommend that the Legislature place at least 50 percent ($166 million) of such savings into a reserve for future years. There are two advantages to this approach. First, we note that in the event of a recession, the state will be responsible for 100 percent of any increased costs for CalWORKs grants or services that would result from an increase in the caseload. Establishing a TANF reserve would help mitigate the fiscal impact of a recession. Second, creating a TANF reserve increases legislative flexibility. If counties need more funds for CalWORKs services,

they could request them during the budget year and the Legislature could authorize additional funding.

Budget Proposes to Use County Carry-Over Balances as a Funding Source

In contrast to 1998-99, the Governor's budget proposes to use $251 million in projected county carry over funds as a source of funding for the estimated need for California Work Opportunity and Responsibility to Kids employment services in 1999-00.

Background. The *1998-99 Budget Act* appropriated funds to the counties in the amount estimated to meet the need for employment services and child care for the CalWORKs program in 1998-99. In addition, $175 million in prior-year unexpended child care funds and $25 million in unexpended county administration funds were reappropriated for use by the counties in 1998-99 even though the estimated need for these services was fully funded. This approach is consistent with the CalWORKs legislation which provides that counties shall retain unexpended county block grant funds through June of 2000.

Budget Proposes to Use Unspent County Funds as Funding Source. For 1999-00, the estimated need for employment services (including county fiscal incentives) is $1,258 million. The Governor's budget, however, proposes to use $251 million in estimated unexpended county block grant funds from 1998-99 as a funding source in 1990-00. Pursuant to this policy change, the Governor's budget proposes $1,007 million in new funding for employment services in the budget year. We believe that this is a reasonable policy change. It would treat the state and federal funds in a manner that is similar to how most programs are budgeted. In other words, unspent General Funds revert back to the General Fund.

Transfer Extra Child Care Funds to Child Care Reserve

In addition to funding the estimated need for child care in 1999-00, the Governor's budget proposes to allow counties to retain $88 million in unexpended child care funds carried over from 1998-99. To ensure that child care funds are available to recipients who need them and used for their designated purpose, we recommend transferring $88 million from the county block grant allocation to the child care reserve.

Inconsistent Approach to Unexpended County Block Grant Funds. As described in the previous issue, the budget proposes to use 1998-99 unex-

pended county employment service funds as a funding source for 1999-00. Thus, the proposed appropriation for employment services has been reduced by the estimated $251 million in unexpended county block grant funds. The budget also estimates there will be $88 million in unexpended child care funds, but proposes to reappropriate these funds to the counties in *addition* to providing enough new funding to cover the entire estimated need for child care in 1999-00.

Analyst's Recommendation. The Governor's budget leaves counties with $88 million more than the estimated need for child care. We note that there is significant uncertainty in estimating the budget for child care because there is limited data upon which to estimate the child care utilization rate. Accordingly, rather than reducing the proposed budget for child care by $88 million, we recommend transferring $88 million from the county block grant allocation to the child care reserve. In this way, the funds would be restricted to child care, if needed, rather than placed within the county block grant allocation where the funds could be redirected to employment services or administration. Thus, our recommendation will ensure that sufficient funding is available for counties that have unanticipated needs for child care, while also providing assurance that these funds will be used for their designated purpose.

Penalty for Failure to Meet Federal Work Participation Rate

The federal Department of Health and Human Services has indicated that (1) California failed to meet the work participation rate for two-parent families during the final quarter of federal fiscal year 1997 and (2) the state is subject to a penalty of $6,964,000. We review California's status with respect to federal work participation rates, and estimate the cost of potential future penalties.

Background. The federal welfare reform legislation of 1996 penalizes states that fail to have specified percentages of their caseload engaged in work or some other type of work-related education, job training, or job search activity. The required participation rate for the overall CalWORKs caseload is 25 percent in federal fiscal year (FFY) 97, rising to 50 percent by FFY 02. For two-parent CalWORKs families, the participation rate is 75 percent in FFY 97 and FFY 98, increasing to 90 percent in FFY 99. These rates are adjusted downward to reflect the percentage reduction in the caseload since federal welfare reform was enacted in August 1996.

The penalty for failing to meet the specified work participation rates is up to 5 percent of the federal block grant, increasing 2 percent for each year of successive failure, to a maximum of 21 percent. California's block

grant is $3.7 billion, so a 1 percent penalty is equal to $37 million. A federal penalty results in a reduction in TANF funds and a corresponding increase in a state's MOE requirement.

Department of Health and Human Services (DHSS) Notification. In December 1998, the DHHS notified California that the state had met the participation rate for all families but had failed to meet the higher rate for two-parent families. Specifically, after accounting for the caseload reduction factor, DHHS determined that California needed to have 19.5 percent of the overall caseload, and 68 percent of the two-parent caseload, engaged in work or some other work-related activity. For the overall caseload, California achieved a 20.6 percent participation rate (therefore exceeding the penalty threshold). For the two-parent caseload, California achieved a 24.5 percent participation—well below the required rate of 68 percent. Based on this finding, California is subject to a penalty of $6,964,321. We note that, according to DHHS, 16 other states and the District of Columbia failed to meet the participation rate for two-parent families.

Determining the Amount of the Penalty. According to federal law, California became subject to the work participation requirement effective July 1, 1997. So, with respect to FFY 1997 (October 1996 through September 1997), California was subject to the requirement for just one quarter of the year. The DHHS calculated the penalty by applying the penalty rate of 5 percent to one quarter of the state's block grant. The DHHS then used its discretionary authority to *reduce* the penalty based on the "degree of noncompliance" by multiplying the gross penalty by 17.7 percent (the proportion of two-parent cases in our caseload).

State Options. The state has four options in responding to DHHS. The state can (1) accept the penalty, (2) appeal the penalty by claiming California had "reasonable cause" for not meeting the participation rate, (3) enter into a corrective compliance plan, or (4) ask for a penalty reduction based on extraordinary circumstances such as a natural disaster. Currently DSS is reviewing these options and, at the time this analysis was prepared, had made no formal response to DHHS.

Impact of Penalty. The potential penalty of approximately $7 million has not been included in the Governor's budget. We note that if California were found to be out of compliance in FFY 1998, the penalty could increase to about $45 million (based on the DHHS methodology) because the maximum penalty increases to 7 percent and the penalty would be based on a full-year of the block grant, rather than just one quarter of FFY 1997. Because any penalties result in a loss in federal TANF funds and a

corresponding increase in the state's MOE requirement, a penalty represents a potential state cost.

Withhold Recommendation on Savings Attributable to Diversion

We withhold recommendation on $15 million in projected net savings attributable to counties diverting clients from assistance with one-time diversion payments.

Current law allows counties to offer clients one-time "diversion" payments if the county believes that such payments will enable the client to remain self-sufficient and therefore off welfare. The DSS estimates that this diversion policy will reduce the CalWORKs caseload by approximately 2,700 cases during 1999-00, resulting in net savings of $15 million. In November 1998, we surveyed counties on their diversion programs. Based on the results of our survey, we believe that counties will divert significantly fewer clients than DSS estimates. Because better data reflecting actual experience with diversion will be available by the time of the May Revision of the budget, we withhold recommendation on the $15 million in estimated grant savings attributable to diversion.

Withhold Recommendation on Budget for CalWORKs Community Service

We withhold recommendation on the proposed budget for community service employment pending revised estimates of caseload and costs from the Department of Social Services and the counties.

The Governor's budget for 1999-00 is based on the workfare approach to community service employment, whereby recipients will participate in community service employment in exchange for their grant. The budget proposal for recipients who transition into community service after 24 months on aid is about $20 million (the specific amount is not separately identified in the budget). This estimate assumes that one hour of case management per month, with half of this time dedicated to creating the job slot, is sufficient funding for counties to provide community service positions to all participants. The budget assumes that employers will absorb all supervisory costs.

The DSS is currently revising its caseload estimate for community service to reflect the phase-in of recipients into CalWORKs. We also note that the cost for creating job slots in the New Hope Project (a community service employment program based in Milwaukee, Wisconsin) was sig-

nificantly higher than the amount assumed in the budget. Given the uncertainty in the budget for community service, we withhold recommendation pending receipt of updated caseload and unit cost information from DSS and the county welfare departments.

Below, we discuss different approaches to budgeting for the incremental costs of the wage-based (the recipient's grant is converted into wages) approach to community service employment.

Options for Budgeting Community Service Employment

The Governor's budget for 1999-00 assumes the workfare approach to community service, with no funding for the incremental cost of the wage-based approach. We present two alternative approaches to budgeting these incremental costs.

Under current law, the state pays for all CalWORKs employment service costs above the 1996-97 level. The Legislature, however, has not established a budgeting approach for community service.

There are two broad approaches to community service: workfare and wage-based. Under workfare, recipients are required to participate in community service as a condition of receiving their grant. Under wage-based community service, the recipient's grant is "diverted" to an employer and paid as wages to the recipient.

The decision to provide either wage-based community service or workfare is made by the counties. As noted above however, the *1999-00 Governor's Budget* assumes the workfare approach to community service employment, with the state/federal block grant funding 100 percent of the associated costs and the counties having no share of costs. On the other hand, the budget provides no state/federal block grant funds to cover the incremental cost of the wage-based approach to community service for counties that choose this option. As a result, incremental costs would be borne exclusively by the counties. Below, we describe three approaches that the Legislature could follow in budgeting the incremental cost of wage-based community service.

- ***Local Funding (Governor's Budget)***. The incremental cost of wage-based community service could be viewed as a program "enhancement," which counties could elect to fund with (1) the CalWORKs performance incentive payments that the counties receive from the state, (2) a redirection of resources from within the CalWORKs county block grant allocation, or (3) other local funds such as Welfare-to-Work grants allocated to private industry

councils. We note that the Governor's budget includes about $500 million in performance incentives in both 1998-99 and 1999-00 that the counties must expend within the CalWORKs program.

- ***State Funding: Include the Incremental Cost in County Block Grants***. The incremental cost of wage-based community service could be viewed as a base program cost for CalWORKs employment services and incorporated into the funding model for the program. Under this approach, the incremental costs would be budgeted as part of the single allocation of state/federal block grant funds to counties for employment services. The total amount available would be based on an estimate of the caseload in counties that choose the wage-based option. This would help to ensure that the counties have sufficient funds to pay for wage-based community service, but it would result in General Fund costs of up to $20 million in 1999-00 (if all counties were to choose this approach).

- ***Matching Program***. Another approach would be a middle ground, whereby the incremental costs are viewed as a program enhancement, but one that potentially promises sufficient benefits to warrant 50 percent state participation. Under this approach, the state would match dollar-for-dollar any investment by the counties in wage-based community service. To control costs, total available matching funds could be budgeted as a separate allocation and capped by the budget act appropriation. Individual county match limits, moreover, could be established whereby the total amount of matching funds a county may draw down is limited to a fixed percentage of its community service caseload.

Conclusion. Although all of the approaches to budgeting the incremental costs of wage-based community service discussed above have merit, we prefer option two—state/federal block grant funding of the incremental costs. The wage-based approach is specifically authorized by current law, provides substantial benefits to the recipient in the form of the federal Earned Income Tax Credit (EITC), and may provide a better bridge to nonsubsidized employment and self-sufficiency. Accordingly, we believe it should be considered a base program cost and be fully funded in the budget for any county that elects this option.

For a complete discussion of the fiscal and policy issues pertaining to CalWORKs community service employment, please see our report *CalWORKs Community Service: What Does it Mean For California?*

Rethinking the Budget for CalWORKs Services and Administration

Current law requires the welfare reform steering committee to report to the Legislature on alternative ways of budgeting and allocating funds for California Work Opportunity and Responsibility to Kids services and administration. We review the current budget practices and present different approaches for consideration by the steering committee and the Legislature.

Currently, the budget process for CalWORKs services and administration combines past practices with certain new program features. Key features of the CalWORKs budget process are:

- ***County Block Grant.*** Funds for administration, welfare-to-work services, and child care are provided to counties in the form of a block grant, known as the single allocation. The counties may transfer funds within these program components.

- ***County Share Fixed at 1996-97 Level***. Under prior law, the counties generally paid for 15 percent of the total costs of AFDC and Food Stamps Program administration and services. Under CalWORKs the county share of these costs is fixed at the 1996-97 level. Thus, as the budget for these components increases, the state bears 100 percent of the marginal cost.

- ***Budget for County Administration of Welfare and Food Stamps Based on County Plans.*** As with the former AFDC program, the Department of Social Services reviews individual county plans for program administration and recommends a budget based upon this review.

- ***Budget for Employment and Support Services Based on Statewide Model***. Although counties are required to submit individualized plans stating how they will implement CalWORKs, the budget for CalWORKs employment services and child care is based on a statewide model. The model uses assumptions based primarily on the former GAIN program.

- ***Allocation of Funds Among Counties Based Largely on Historical Budget Allocations Rather Than Caseload***. Counties receive employment service and child care funds based largely on the share of funds that they received under the former GAIN program. Although current law directed that some of the increased funding for employment services and child care (over the 1996-97 GAIN amount) be allocated in a manner that helps to equalize funding

among the counties, funding on a per-case basis remains inequitable. For 1998-99, the total single allocation for employment services, child care, and administration was $1.4 billion, or an average of $2,500 per aided adult. Excluding the 20 smallest counties (all of which had allocations substantially above the state average), the remaining 38 counties had allocations per aided adult ranging from $2,000 to $7,000.

- ***County Carry Over Authority***. The CalWORKs legislation provides that unexpended block grant funds would remain available to each county until July 2000. In 1998-99, counties were provided with new budget authority (that is, excluding the carry over funds) to cover the estimated need for services while retaining an additional $175 million in unexpended funds from the prior year. As discussed previously, the Governor's budget proposes to use $251 million in estimated unexpended funds from 1998-99 as a source for funding the estimated need in 1999-00. We note however, that the budget bill includes a proposed provision to extend county roll-over authority until 2000-01.

Issues for Legislative Consideration. Developing a budget system that addresses the needs of county administrators and CalWORKs recipients, while controlling public costs, is difficult. Below we present alternatives for improving (1) the development of the total budget for employment and services and (2) the method of allocating funds to the counties.

- ***Determining the Total Budget for Employment Services and Child Care***. To estimate the total budget, the state has three broad options: (1) the current practices, whereby the single statewide model for projecting costs is applied to the statewide caseload, (2) basing the budget on individual county budget plans (the current process for budgeting administrative costs), and (3) a hybrid approach, whereby the statewide model is adjusted to reflect updated county cost estimates as well as new program components and changes developed by the counties.

  The current model does not reflect county variation in program implementation. Given that counties have the broad authority to design their own CalWORKs programs, basing the budget on individual county plans has some merit. The problem with this approach is that counties have no share of marginal program costs, so there are no built-in incentives for counties to control costs. Any cost control would have to come from the DSS review of the county plans, which is administratively cumbersome. For these reasons, we prefer the hybrid approach, whereby the budget is

based on a statewide model that could incorporate new cost and program assumptions. This could be facilitated by a work group consisting of county representatives and DSS staff that would annually recommend changes to the existing model.

- ***Achieving More Equity in the Allocation of Funds to Counties***. As noted above, the single allocation of employment services, administration, and child care per aided adult varies significantly among the counties. Compared to the statewide average allocation per aided adult ($2,500), 12 counties had allocations at least $200 below the state average, and 14 counties (in addition to the 20 smallest counties) had allocations more than $500 above the average.

  These differences mean that where a recipient resides will affect the level of resources that are available for that recipient for employment services and child care, and presumably their ability to obtain employment. We note that counties have different local economic conditions and face different cost structures. Accordingly, it is not unreasonable that the allocation per aided adult vary to some degree. Nevertheless, we believe that except for the 20 smallest counties (which are unlikely to achieve economies of scale) the allocation per aided adult should not vary by more than what would be warranted by local cost differentials and economic conditions.

  To make county allocations more equitable, the Legislature could follow one of the following basic approaches: it could reduce funding to counties with high allocations and use these savings to increase the allocation to counties with low allocations. This approach is budget neutral, but results in significant reductions for high-allocation counties. Alternatively, the Legislature could increase funding for low-allocation counties and "hold harmless" counties above the average. This approach however, increases state costs and tends to work slowly towards equalization. We suggest consideration of a hybrid strategy—the first approach, with a limit on the annual reduction that any county will incur.

Accordingly, we recommend that the welfare reform steering committee consider these issues and options in developing its report to the Legislature.

FOSTER CARE

Children are eligible for grants under the Aid to Families with Dependent Children-Foster Care (AFDC-FC) program if they are living with a foster care provider under (1) a court order or (2) a voluntary agreement between the child's parent and a county welfare or probation department. Children in the foster care system can be placed in either a foster family home (FFH) or a foster care group home (GH). Both types of foster care provide 24-hour residential care. Foster family homes must be located in the residence of the foster parent(s), provide services to no more than six children, and be either licensed by the Department of Social Services (DSS) or certified by a foster family agency. Foster care group homes are licensed by the DSS to provide services to seven or more children.

Are Foster Family Agencies "Too Successful"?

We recommend the adoption of supplemental report language requiring the department to (1) collect data to estimate the number of foster children placed in foster family agency homes due to a shortage of nonagency foster family homes and the net costs of these placements compared to the costs if nonagency homes were available, and (2) make recommendations, if appropriate, to reduce the incidence of placing foster children in a higher-cost placement than is warranted by the county's assessment.

County welfare departments have the responsibility of placing children in foster care homes. The homes fall into three categories: group homes, foster family agency (FFA) homes, and foster family homes. Foster family agencies are nonprofit organizations that recruit foster parents, certify them for participation in the program, and provide training and support services. There are approximately 225 FFAs in the state. As Figure 1 shows, they are reimbursed at a rate that falls between the grants paid to nonagency foster family homes and the average rate for group homes.

Figure 1

Foster Care Grants and Caseloads

1998-99

Type of Placement	Caseload[a]	Grant Level
Foster family home	79,000	Basic grant: $375 - $528[b] Specialized care increment: $0 - $1,872[c]
Foster family agency	17,800	$1,362 - $1,607[b]
Group home	6,700	$1,254 - $5,314[d]

[a] Excludes approximately 4,800 foster children supervised by county probation departments (primarily in group homes) and approximately 4,100 foster children placed in county shelters, medical facilities, specially licensed small family homes, and specialized pilot projects.

[b] Varies with age of child. Amount includes grant to parent and FFA support services.

[c] Varies within and among the counties.

[d] Varies with "rate classification levels," which generally reflect levels of service.

We note that in comparing these rates, it is important to recognize that most counties provide "specialized care increments" that supplement the grants to foster family homes in cases where the child needs special support services. Thus, for such children, the cost difference between an FFA and the nonagency home may be much smaller than the differences in the basic rate. (Currently, the department does not have sufficient data to estimate the average amount provided for specialized care increments.) We also note that funding for administrative support is included in the FFA reimbursement rate but is provided to counties separately from the basic cash grant.

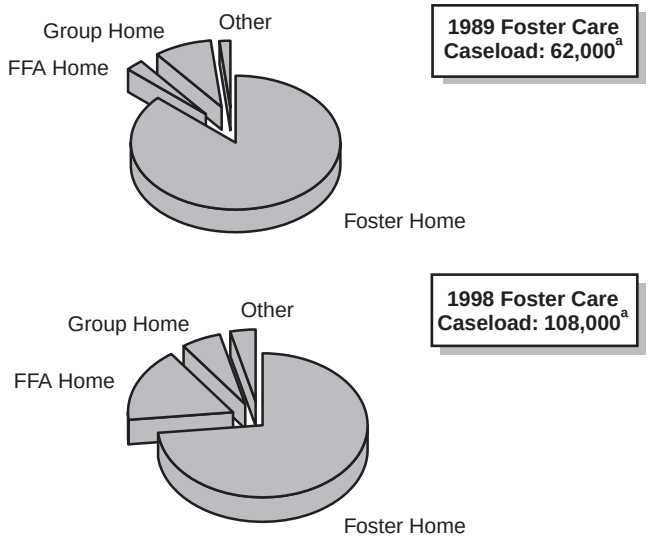
Foster family agencies were established to serve as alternatives to group home placement. In the course of our review of the foster care program, however, several county administrators indicated that frequently they must resort to an FFA placement for children who, according to the county's assessment, should be placed in a nonagency home at a lower cost. This occurs because the FFAs compete with the counties in recruiting foster parents, and in some areas the county has a shortage of parents and the FFA has a surplus. The county administrators indicate that by offering support services and the potential for higher payments, the FFAs have attracted a sufficient number of potential parents to the point that county social workers have little choice but to place a child with the FFA even where a county foster family home would be the more appropriate choice.

Figure 2 (see next page), while not conclusive, provides some evidence that FFAs have been serving as an alternative to nonagency foster family

homes as well as group homes. It shows that between 1989 and 1998, the growth of FFAs in the state has been accompanied by a decrease in the proportion of both nonagency homes and group homes. Unfortunately, there are no data that directly document the extent to which the counties are placing foster children in FFA homes at a higher cost than is warranted by the county assessment. We believe that such a determination is feasible, however, through a survey of the county welfare/children's services departments. (We note that such an assessment should take into account the specialized care increments, where applicable.) Consequently, we recommend the adoption of supplemental report language requiring the department to conduct such an analysis.

Figure 2

Use of Foster Family Agency Homes Increasing



[a] Excludes children supervised by county probation departments.

We further recommend that if the analysis documents the problem discussed above, the department make recommendations to address it. In doing so, the department could consider a variety of alternatives. These include increasing the recruitment allowance provided to the counties, establishing FFA rates above and below the existing rates to provide more flexibility in matching services to the assessments, and requiring all potential foster parents to register with the county in order to establish a closer link between the parents and the agency that conducts the assessments.

We also suggest that the department investigate the option, available to counties under current law, whereby the counties themselves can apply to act as licensed FFAs. This is an action recently taken by San Mateo County. The department should attempt to determine the impact of this policy in order to assess to what degree it has affected the county's ability to recruit potential foster parents and to make appropriate placements of foster children.

Our recommendation can be implemented by adoption of the following supplemental report language in Item 5180-001-0001:

> The department shall (1) collect data to estimate the number of foster children placed in foster family agency homes due to a shortage of nonagency foster family homes and the net costs of these placements compared to the costs if nonagency homes were available, and (2) make recommendations, if appropriate, to reduce the incidence of placing foster children in a higher-cost placement than is warranted by the county's assessment. The department shall submit its report to the Department of Finance, the Joint Legislative Budget Committee, and the appropriate fiscal and policy committees of the Legislature by March 1, 2000.

FOOD STAMPS PROGRAM

The Food Stamps Program provides food stamps to low-income persons. With the exception of the recently-enacted state-only program (discussed below), the cost of the food stamp coupons is borne by the federal government ($1.6 billion). Administrative costs are shared between the federal government (41 percent), the state (44 percent), and the counties (15 percent).

California Food Assistance Program

Federal Restrictions on Benefits For Noncitizens. The federal welfare legislation enacted in 1996 made legal noncitizens (with certain exceptions for refugees, veterans, and those who had worked for 40 quarters) ineligible for food stamps. Subsequent federal legislation—the Agricultural Research, Extension, and Education Reform Act of 1998—restored federal benefits to certain noncitizens. Specifically, effective November 1, 1998, the new legislation restored federal eligibility to noncitizens lawfully residing in the U.S. prior to August 22, 1996 who (1) are under the age of 18 or (2) were at least 65 years of age as of August 1996.

Initial State Program for Noncitizens. The Legislature enacted a temporary state-only program to provide food stamp benefits to certain noncitizens, effective September 1997. Specifically, Chapter 287, Statutes of 1997 (AB 1576, Bustamante) created the state-only California Food Assistance Program (CFAP), which provides food stamps to noncitizens under the age of 18 or over the age of 64 who were residing in the United States prior to August 22, 1996. Under CFAP, the state purchases the food stamp coupons from the federal government and distributes them to eligible recipients. This program is to sunset on July 1, 2000.

State Program Expanded in 1998. Partially in response to the 1998 federal legislation that essentially restored federal benefits to nearly all of the noncitizens that were covered by CFAP, Chapter 329, Statutes of 1998 (AB 2779, Aroner) expanded the CFAP to cover (1) noncitizens legally residing in the U.S. prior to August 1996 between the ages of 18 and 64

and (2) certain noncitizens who arrived in the U.S. after August 1996. Adult recipients of this program are subject to a specified work requirement. Like the original program, the expanded CFAP sunsets in July 2000.

1999-00 Budget. For 1999-00, the average monthly caseload for CFAP is estimated to be about 85,000 persons. The budget proposes an appropriation of $73.6 million from the General Fund for the cost of coupon purchases and an additional $5.2 million for program administration. The total is a decrease of $13.5 million from estimated expenditures in 1998-99, mostly attributable to a lower caseload due to the full-year effect of federal restoration of benefits for children and the elderly. We note that $53 million of the proposed expenditure for 1999-00 counts towards meeting the federal maintenance-of-effort requirement for the California Work Opportunity and Responsibility to Kids program.

SUPPLEMENTAL SECURITY INCOME/ STATE SUPPLEMENTARY PROGRAM

The Supplemental Security Income/State Supplementary Program (SSI/SSP) provides cash assistance to eligible aged, blind, and disabled persons. The budget proposes an appropriation of $2.4 billion from the General Fund for the state's share of the SSI/SSP in 1999-00. This is an increase of $183 million, or 8.1 percent, over estimated current-year expenditures. This increase is due primarily to the full-year cost of grant increases provided in the current year, caseload growth, modest state costs for the cost-of-living adjustment (COLA) to be provided in January 2000, and an increase in the federal administrative fee.

In November 1998, there were 324,318 aged, 21,671 blind, and 687,655 disabled SSI/SSP recipients. In addition to these federally eligible recipients, the state-only program for immigrants (described below) is estimated to provide benefits to about 2,000 legal immigrants during November 1998.

Budget Underestimates Cost of Providing Statutory COLA

The General Fund cost of providing the statutory Supplemental Security Income/State Supplementary Program cost-of-living adjustment will be $12.5 million above the budget estimate due to an upward revision in the California Necessities Index. We also estimate an additional General Fund cost of $19.5 million because the budget overestimates the U.S. Consumer Price Index. These issues should be addressed in the May revision of the budget.

Background. Pursuant to current law, the Governor's budget proposes to provide the statutory COLA to the SSI/SSP grant in January 2000. The state COLA is based on the California Necessities Index (CNI) and is applied to the combined SSI/SSP grant. It is funded by both the federal and state governments. The federal portion is the federal COLA (based

on the U.S. Consumer Price Index, or the CPI) that is applied annually to the SSI portion of the grant. The remaining amount needed to cover the state COLA is funded with state monies. Based on its assumptions concerning both the CNI and CPI, the budget includes $8.4 million for providing the statutory COLA for six months effective January 2000.

The CNI Has Been Revised. The January 2000 COLA is based on the change in the CNI from December 1997 to December 1998. The Governor's budget, which is prepared prior to the release of the December CNI figures, estimates that the CNI will be 2.08 percent, based on partial data. Our review of the actual data, however, indicates that the CNI will be 2.36 percent.

The CPI is Overestimated. The Governor's budget estimates that the CPI will be 2.6 percent for federal fiscal year (FFY) 1999. Based on our review of the consensus economic forecasts for 1999, we estimate that the CPI will be 2.3 percent. This reduction in the CPI raises the state cost of providing the statutory COLA because it effectively reduces federal financial participation toward the cost of the state COLA, which is applied to the entire grant.

Cost of Providing COLA Underestimated. Taken together, the higher CNI and lower CPI (in relation to the Governor's budget) raise the General Fund cost of providing the statutory COLA from $8.4 million to about $40.4 million in 1999-00—an increase of $32 million ($12.5 million for the CNI revision and $19.5 million from overestimating the CPI). The administration should address these issues in the May revision of the budget.

The SSI/SSP Grant Levels

Figure 1 (see next page) shows SSI/SSP grants on January 1, 2000 for both individuals and couples as displayed in the Governor's budget and our projection based on the actual CNI and our estimate of the CPI. Based on our projection, grants for individuals will increase by $16 to a total of $692 per month and grants for couples will increase by $28 to a total of $1,229. As a point of reference we note that the federal poverty guideline for 1998 is $671 per month for an individual and $904 per month for a couple. Thus, the grant for an individual would be 3 percent above the *1998* poverty guideline and the grant for a couple would be 36 percent above the guideline. (We note that the poverty guidelines are adjusted for inflation annually.)

Figure 1

SSI/SSP Maximum Monthly Grants Governor's Budget and LAO Projection

January 1999 and January 2000

Recipient Category	January 1999	January 2000		Change From 1999	
		Governor's Budget	LAO Projection[a]	Amount	Percent
Individuals					
SSI	$500	$513	$512	$12	2.4%
SSP	176	177	180	4	2.3
Totals	**$676**	**$690**	**$692**	**$16**	**2.3%**
Couples					
SSI	$751	$770	$768	$17	2.3%
SSP	450	456	461	11	2.4
Totals	**$1,201**	**$1,226**	**$1,229**	**$28**	**2.3%**

[a] Based on actual California Necessities Index increase (2.36 percent) and projected U.S. Consumer Price Index increase (2.3 percent).

Cash Assistance Program for Aged, Blind, and Disabled Legal Immigrants

Federal welfare reform and related legislation made elderly legal noncitizens in the U.S. prior to August 1996, who are not disabled, ineligible for SSI/SSP. This legislation also made noncitizens arriving after August 1996 (with certain exceptions) ineligible for SSI/SSP. Chapter 329, Statutes of 1998 (AB 2779, Aroner) created the Cash Assistance Program for Aged, Blind, and Disabled Legal Immigrants (CAPI). This program provides state-funded benefits at the SSI/SSP grant levels, less $10 for individuals and $20 for couples, to any legal noncitizen who has been denied federal benefits solely on the basis of their immigration status. With respect to legal noncitizens arriving in the United States after August 22, 1996, CAPI benefits are restricted to individuals (1) who are sponsored by a U.S. citizen, and (2) the sponsor has died, is disabled, or is abusive to the noncitizen. The state reimburses the counties for all administrative costs incurred in making the CAPI benefit payments to individuals. The program is to sunset in July 2000.

The *1999-00 Governor's Budget* proposes an appropriation of $21.3 million from the General Fund for benefit payments and

$1.4 million for county administration of the CAPI. The average monthly caseload is projected to be about 2,900 during 1999-00.

Alternatives for the Regional 4.9 Percent Grant Reduction

Chapter 307, Statutes of 1995 (AB 908, Brulte) requires that Supplemental Security Income/State Supplementary Program (SSI/SSP) grants be reduced by 4.9 percent in the "low-cost" counties. This reduction has not been implemented because it would have brought SSP grants below the federal maintenance-of-effort level. We estimate, however, that by January 2002 the annual cost-of-living adjustments pursuant to current law will raise SSP grants to a level that will trigger the implementation of the regional 4.9 percent reduction. We present alternatives for the Legislature to consider regarding the regional grant reduction.

Background. Chapter 307 requires that grants for both California Work Opportunity and Responsibility to Kids (CalWORKs) and SSI/SSP be reduced by 4.9 percent in the "low-cost" counties (specifically, the 41 counties where the lowest quartile rent was below $400 per month in 1990.) This reduction was designed to achieve a regional grant differential between "low-cost" and "high-cost" counties. The grant reduction was implemented for the CalWORKs program in January 1997 but has never been implemented for SSI/SSP because such a reduction would violate the federal maintenance-of-effort (MOE) requirement. Specifically, federal law requires that the state SSP portion of the combined SSI/SSP grant be "maintained" at or above its 1983 level. Failure to comply with the MOE requirement would result in the loss of federal Medicaid funding.

Because of the federal MOE requirement, the monthly SSP grant for individuals must be at least $156.40. (Although there are different grant levels for couples and other persons in specific circumstances, for illustration purposes this discussion is limited to the grant levels for individuals.) Implementation of the regional grant reduction—which under state law is fixed at 4.9 percent of the combined SSI/SSP grant as of June 30, 1995—would reduce the monthly SSP grant for individuals by $30.11. Thus, in order to implement this reduction without violating federal law, SSP grants must first be at least $186.51, or $30.11 above the MOE.

As of January 1999, the total maximum SSI/SSP monthly grant for an individual is $676 ($500 SSI and $176 SSP). Under current state law, a COLA is applied to the SSI/SSP grant each January. The state COLA is based on the CNI and is applied to the combined SSI/SSP grant. It is funded by both the federal and state governments: the federal portion is the federal COLA (based on the CPI) that is applied annually to the SSI

portion of the grant. The remaining amount needed to cover the state COLA is funded with state monies and applied to the SSP portion of the grant. Based on current law, and our estimates for the CNI and CPI , we believe that application of the statutory COLA will result in the SSP grant exceeding $186.51 as of January 2002. Thus, at that time, the regional 4.9 percent grant reduction would be "triggered" because the reduction could be implemented without violating the federal MOE requirement.

Figure 2 shows the estimated SSI/SSP grants for individuals from January 1999 through January 2002, based on current law and our forecasts for the CNI and the CPI. As the figure shows, grants will increase in both low-cost and high-cost counties in January 2000 and January 2001, reaching a total of $710 in that year. Then in January 2002, the grant in the low-cost counties will be reduced to $702, which is $30 less than the amount in the high-cost counties. Compared to the preceding year (January 2001), the grant in the low-cost counties goes down by $8 rather than the $22 increase that would occur in the absence of the statutory reduction.

Figure 2

Projected Maximum Monthly SSI/SSP Grants for Individuals Based on Current Law

1999 Through 2002

	January 1999	January 2000	January 2001	January 2002
High-cost counties				
SSI	$500	$512	$527	$543
SSP	176	180	183	189
Totals	**$676**	**$692**	**$710**	**$732**
Low-cost counties				
SSI	$500	$512	$527	$543
SSP	176	180	183	159
Totals	**$676**	**$692**	**$710**	**$702**

To provide some perspective on the impact of this grant reduction in the low-cost counties, we compare grants to our projections for the federal poverty guideline. As of January 2002, the grant for an individual in the low-cost counties would be about 96 percent of the federal poverty guideline, the grant for an individual in the high-cost counties would be

just above the poverty guideline, and the grants for couples in both regions would be about 30 percent above the poverty guideline.

Alternatives. Setting the level of the SSI/SSP grant is a policy decision for the Legislature. Given that the decision to impose a 4.9 percent grant reduction in the low-cost counties was made during a period when the state was facing significant fiscal constraints, however, we anticipate that there will be interest in revisiting the issue prior to implementation of the reduction. To facilitate the debate, we present two alternatives for consideration. One alternative is to eliminate the 4.9 percent regional reduction by repealing current law. A second alternative would be to gradually phase-in the 4.9 percent grant reduction by "freezing" the SSP portion of the grant in low-cost counties until the 4.9 percent differential between the high-cost and low-cost counties is achieved. Under this alternative, the federal SSI portion would continue to increase, so grants in low-cost counties would go up each year, but not as fast as in the high-cost counties where both the SSI and SSP portion of the grant would be increasing each year.

Repeal Current Law. Compared to current law, this approach would have no fiscal impact in 1999-00 or 2000-01. In 2001-02, there would be a half-year cost of approximately $55 million. The full-year cost in 2002-03 would be approximately $115 million and would continue at about that level, adjusted each year for caseload changes. Under this approach, grants for individuals in low-cost counties would be identical to grants in high-cost counties and remain just above the federal poverty guideline. Thus, there would be no regional grant differential to compensate for differences in the cost of living.

Phase-in the 4.9 Percent Regional Reduction. Under current law, the entire 4.9 percent reduction would be implemented in January 2002. At that time a recipient's maximum benefit will drop from $710 in 2001 to $702. An alternative would be to raise SSI/SSP benefits more slowly in the low-cost counties than in the high-cost counties until a 4.9 percent differential between the high-cost and low-cost counties is achieved. To do this gradually, for example, the SSP portion of the grant could be "frozen" at its current level ($176) while continuing to "pass through" the increase in the federal SSI portion each year. Figure 3 (see next page) shows the annual SSI/SSP grant under this alternative from 1999 through 2005. As the figure shows, grants would increase each year, thus eliminating the "cliff" effect of current law. We note, however, that this approach results in *lower* combined SSI/SSP grants in low-cost counties in 1999-00 and 2000-01 than would be required by current law. Under this option,

SSI/SSP grants for individuals would be at the poverty line in January 2000, and would decline to about 97 percent of poverty in 2005.

Figure 3

Projected Maximum Monthly SSI/SSP Grants For Individuals Under Phase-in of Regional 4.9 Percent Grant Reduction

1999 Through 2005

	January 1999	January 2000	January 2001	January 2002	January 2003	January 2004	January 2005
High-cost counties							
SSI	$500	$512	$527	$543	$560	$577	$595
SSP	176	180	183	189	195	201	207
Totals	**$676**	**$692**	**$710**	**$732**	**$755**	**$778**	**$802**
Low-cost counties							
SSI	$500	$512	$527	$543	$560	$577	$595
SSP	176	176	176	176	176	176	176
Totals	**$676**	**$688**	**$703**	**$719**	**$736**	**$753**	**$771**

Compared to current law, this alternative would result in General Fund savings of about $13 million in 1999-00, and $39 million in 2000-01. During the subsequent four fiscal years, there would be annual General Fund costs that peak at approximately $55 million in 2002-03 and decline to less than $20 million in 2004-05.

Conclusion. With respect to the 4.9 percent regional grant reduction, the Legislature has three broad options. The first option would be to retain current law and implement the reduction which would probably occur in January 2002. The second option would be to repeal current law and eliminate the regional grant differential. The third option would be to gradually phase-in the regional grant differential. We present one such approach to this latter option whereby the SSP grant would be increased more slowly in the low-cost counties as compared to the high-cost counties until the 4.9 percent differential is achieved.

COUNTY ADMINISTRATION OF WELFARE PROGRAMS

The budget (Item 5180-141) appropriates funds for the state and federal share of the costs incurred by the counties for administering the following programs: (1) Food Stamps; (2) Child Support Enforcement; (3) Aid to Families with Dependent Children—Foster Care (AFDC-FC); (4) Special Adults, including emergency assistance for aged, blind, and disabled persons; (5) Refugee Cash Assistance; and (6) Adoptions Assistance. The budget also includes funding for the development, implementation, and maintenance of major welfare automation projects.

Pursuant to the reorganization of the budget, Item 5180-141 does not include the county costs for administering the California Work Opportunity and Responsibility to Kids (CalWORKs) program, because these costs are reflected in the CalWORKs program appropriation in Item 5180-101 (see our analysis of CalWORKs).

The budget proposes an appropriation of $323.9 million from the General Fund for county administration of welfare programs (excluding CalWORKs) in 1999-00. This represents a decrease of $9 million, or 2.7 percent, from estimated current-year expenditures.

Automation Projects

The budget proposes an appropriation of $36.8 million in the Department of Social Services for the state's share of the costs of four major welfare automation projects. These projects are the Statewide Automated Welfare System (SAWS), the California Child Support Automation project, the Statewide Fingerprint Identification System, and the Electronic Benefit Transfer program. The Health and Welfare Agency Data Center (HWDC) is responsible for administering these projects.

The SAWS—Los Angeles County Contract Amendment. We note that the budget does *not* reflect a request from Los Angeles County for $55.3 million for a seven-year contract amendment pertaining to the develop-

ment of the Los Angeles Eligibility Automated Determination Evaluation and Reporting (LEADER) system for automating welfare. (LEADER is one of four SAWS consortia.) This request, which includes $29.2 million for 1998-99 and $9.1 million for 1999-00, was made too late for inclusion in the budget, but is likely to be reflected in the May revision to the budget.

Child Support Automation. The budget proposes General Fund spending of $6.3 million in 1999-00 for the costs associated with child support automation. This is a reduction of $4.6 million (42 percent) from estimated expenditures for 1998-99. We note that development of the Statewide Automated Child Support System (SACSS) was terminated in November 1997. Chapter 329, Statutes of 1998 (AB 2779, Aroner) requires (1) all counties to transition into specified consortia for automation purposes and (2) the development of interim and long-term solutions for child support automation that will meet federal requirements and minimize federal penalties. The reduction in spending for 1999-00 reflects completion of county transitions to non-SACSS systems and reductions in one-time equipment purchases.

For a discussion of the major welfare automation projects, please see our review of the HWDC in the General Government Section of this *Analysis.*

Budget Proposes No State Share Of Federal Penalty on Automation

The budget estimates that federal reimbursements to California will be reduced by $37.1 million in the current year and $52.8 million in the budget year, due to the penalty on the state for not meeting the deadline for implementing a statewide child support enforcement automation system. The budget proposes to pass the full penalty on to the counties, which is not consistent with current law. We recommend adjusting the budget to reflect the state's proportional share, for a General Fund cost of $2.2 million in the current year and $3.2 million in the budget year. (Increase Item 5180-001-0001 by $2,645,000 and increase Item 5180-141-0001 by $537,000.)

Due to the failure of the state to implement a statewide automated child support system, California is subject to federal penalties in the form of a reduction in federal reimbursements for child support enforcement. Federal law allows the Secretary of Health and Human Services to waive the regular penalty and instead impose an alternative penalty if states have made good faith efforts to meet the federal automation requirements. The budget assumes that the alternative penalty will be enforced, resulting in a reduction in federal reimbursements of $37.1 million in the current year and $52.8 million in the budget year.

Current state law provides that federal penalties shall be considered a reduction in federal financial participation in county *and* state administrative costs of the child support program. The budget, however, proposes to pass the full amount of the penalty on to the counties, with the state bearing no share.

The administration has provided no explanation for this variation from the requirements of current law, with respect to allocating the penalty between the state and county governments. Consequently, to be consistent with current law, we recommend that the budget be adjusted to reflect the state's proportional share of the penalty and to backfill for the loss of federal funds. This would result in a General Fund cost of $2.2 million in the current year and $3.2 million in the budget year, and county savings of the corresponding amounts.

We also note that the budget assumes the counties will maintain the level of spending on the program to backfill for the federal reductions. Because the counties are not required to backfill for reductions in federal funds, there is no assurance that the budget assumptions for county spending will be realized. As we have discussed in previous analyses of this program, there is a strong relationship between county administrative effort and child support collections. Thus, if the counties reduce their spending below the amount assumed in the budget, collections could be affected and the associated General Fund savings (in CalWORKs grant expenditures) could be less than budgeted.

We also note, on the other hand, that the estimated amount of federal reimbursements after the penalty, when combined with state and federal incentive payments that are distributed to the counties, exceeds the budget estimates for administrative spending. This suggests that most of the counties probably have the ability to meet the budget expectations for administrative spending in spite of the federal penalty.

Budget Assumes Other Counties Will Absorb Los Angeles County "Share" of Federal Penalty

The federal government has levied penalties (in the form of reduced reimbursements) against California for failure to implement a statewide child support automation system. Current state law prohibits passing the federal penalty onto Los Angeles County because the county has implemented its component of the statewide automation system. The budget proposes to pass Los Angeles County's proportional "share" of the penalty onto the other counties rather than the state.

Los Angeles County, with the approval of the federal administration, has developed and implemented its own child support automation system as part of the required statewide system. Because of this, Chapter 404, Statutes of 1998 (SB 1410, Burton) provides that no portion of the federal penalty for delayed implementation of the statewide system shall be assessed against Los Angeles County (unless the county system fails to interface with the statewide system, which has not been implemented).

The federal government has applied penalties (in the form of reduced reimbursements) to California for failure to implement a statewide child support automation system. The reduced reimbursements mean fewer federal funds for county administration of the child support system. (Although the federal administration certified the Los Angeles County system, this did not reduce the federal penalty on the state.)

Chapter 329, Statutes of 1998 (AB 2779, Aroner) permits the Department of Social Services (DSS) to backfill with state funds "any dollar reduction to county administrative funding," subject to the availability of funds in the annual budget act. The budget, however, proposes to pass Los Angeles County's proportional "share" of the penalty (about $8 million in the current year and $11 million in the budget year) onto the other counties.

We do not believe that it is reasonable to expect the other counties (rather than the state) to backfill for the reduction in federal reimbursements attributable to Los Angeles County's share of those reimbursements. Furthermore, it is not clear whether this was the Legislature's intent in enacting SB 1410, even though separate legislation governing the allocation of the federal penalty, in general, gives the department this discretion. Consequently, we recommend that the Legislature address this issue in the budget hearings.

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 CWS Program provides:

- Immediate social worker response to allegations of child abuse and neglect.
- Ongoing services to children and their families who have been identified as victims, or potential victims, of abuse and neglect.
- Services to children in foster care who have been temporarily or permanently removed from their families because of abuse or neglect.

Child Welfare Caseload Forecast Should Be Revised

Data collection problems make it difficult to forecast Child Welfare Services caseloads, but we believe the budget forecast overstates current-year caseload and understates the budget year. Additional data should permit a better estimate in the May revision of the budget.

The budget forecasts that CWS caseloads will increase by 7.2 percent in 1998-99, which is somewhat higher than the annual growth rate in recent years. Because of data collection problems associated with the implementation of the new statewide automation system—the Child Welfare Services/Case Management System—the department indicates that only two complete months of current-year data are available, making forecasting more difficult than in the past. As a result, the decision was made to (1) base the current-year estimate on last year's May revision estimate for the current year and (2) assume no caseload growth in the budget year.

The CWS caseload generally has been characterized by annual growth rates of roughly 4 percent since 1992-93. Based on this trend, we believe that it is unrealistic to assume no caseload growth in the budget year. On

the other hand, the department indicates that based on a few months of data, caseloads for the current year are running below the budget forecast (a 7.2 percent increase over the prior year).

Because additional monthly data will be available for the May revision of the budget, the department will be able to provide a better forecast at that time. Consequently, we suggest that the budget subcommittees wait until the May revision to consider the appropriation for CWS basic caseloads.

Independent Living Program Is Overbudgeted

We recommend reducing General Fund support for the Independent Living Program by $4.9 million in 1998-99 and $5.7 million in 1999-00 because the budget exceeds the amount needed to fully fund the program. (Reduce Item 5180-151-0001 by $ 5,733,000.)

The Independent Living Program (ILP) provides training designed to prepare youths for emancipation from foster care. Chapter 311, Statutes of 1998 (SB 933, Thompson) extended eligibility for the program from ages 16 through 18 to ages 16 through 21. The *1998-99 Budget Act* augmented funding for the program in order to serve all eligible foster care participants.

The budget proposes $24.9 million ($11.4 million General Fund) to support the ILP in 1998-99 and $28.7 million ($15.2 million General Fund) in the budget year. The proposal is the estimated amount needed to fully fund the program.

We believe that the budget proposal goes beyond the amount needed to fully fund the program for two reasons. First, it is based on an assumption that *all* eligible foster care youths will choose to participate in the program, even though participation is voluntary. In our view, this assumption is unrealistic. We believe that some foster youths will choose not to attend the training program, perhaps on the basis that they have received adequate guidance from their foster parents. Secondly, the budget assumes that all individuals who participate in the program in the current year will choose to participate again in the following year if they have not emancipated from foster care. We believe that this also is an unrealistic assumption, as many of these foster youths are likely to view repeat participation as unnecessary.

Both of these factors will affect the participation rate for the ILP. Unfortunately, it is difficult to estimate the degree of voluntary participation because in past years the program was not fully funded and therefore it

is not known to what degree the lack of funding was responsible for nonparticipation. Absent such data, we believe that it would be more reasonable to assume an overall participation rate of 80 percent for the budget year (as applied to the baseline and expansion components of the program) rather than the 100 percent rate assumed in the budget. Accordingly, we recommend adjusting the budget to reflect this assumption, which would result in a General Fund savings of $4.9 million in the current year and $5.7 million in 1999-00.

ADOPTIONS

The department administers a statewide program of services to parents who wish to place children for adoption and to persons who wish to adopt children. Adoptions services are provided through state district offices, 28 county adoptions agencies, and a variety of private agencies. Counties may choose to operate the Adoptions Program or turn the program over to the state for administration.

There are two components of the Adoptions Program: (1) the Relinquishment (or Agency) Adoptions Program, which provides services to facilitate the adoption of children in foster care; and (2) the Independent Adoptions Program, which provides adoption services to birth parents and adoptive parents when both agree on placement.

In addition to the Adoptions Program, the Adoptions Assistance Program (AAP) provides grants to parents who adopt "difficult to place" children. State law defines these children as those who, without assistance, would likely be unadoptable because of their age, racial or ethnic background, handicap, or because they are a member of a sibling group that should remain intact.

State Reporting Problems Could Jeopardize Receipt of Federal Adoptions Incentive Payments

Delays in implementing the statewide child welfare automation system could prevent the department from meeting the August 1999 reporting deadline to qualify for federal adoptions incentive payments. We recommend that the department (1) consult with the federal administration on possible alternative means of submitting the required data, should it become necessary, and (2) provide the budget subcommittees with a status report on this issue during the hearings.

The federal Adoptions and Safe Families Act of 1997 (PL 105-89) authorizes the Secretary of Health and Human Services to make incentive payments to states that increase the number of adoptions of children in foster care. The incentive payment amounts to $4,000 per child, plus an

additional $2,000 for each special needs adoption, although the total amount allocated to the states is capped at $20 million annually through federal fiscal year (FFY) 2003. Chapter 1056, Statutes of 1998, (AB 2773, Committee on Human Services) indicated the intent of the Legislature that incentive payments allocated to California be used for post-adoptions services.

In order to qualify for the incentive payments authorized for adoptions in FFY 1998 (October 1997-September 1998), states must report the number of finalized adoptions to the federal administration by August 1, 1999. The federal statute requires that the states report their qualifying adoptions via the federal Adoption and Foster Care Automated Reporting System (AFCARS). In California, the new statewide Child Welfare Services/Case Management System (CWS/CMS) was designed to meet the AFCARS reporting requirements.

The CWS/CMS is operating in all counties, but the department indicates that due to start-up and implementation problems, adoptions data reporting currently are incomplete and may not be accurate. Thus, at the time this analysis was prepared, the department was uncertain whether the state will be able to meet the August 1999 deadline.

We recommend that the department provide the budget subcommittees with a status report on this issue during the hearings. We further recommend that prior to the hearings, the department consult with the federal administration on the possibility of using alternative means of reporting—such as a sample of CWS/CMS counties or the use of a database separate from the new statewide automation system—in the event that the CWS/CMS problems cannot be resolved in time to meet the deadline. This would help to guard against the possibility that technical reporting problems will prevent the state from receiving funds that it otherwise would earn on the basis of its performance.

No Clear Rationale for Proposal to Eliminate New Program

In its proposal to eliminate the Substance Abuse/HIV Child Adoption Program for a General Fund savings of $1 million, the budget incorrectly states that the program is scheduled to sunset at the end of the current year. Because this is a new program established by statute in the current year and the administration has no policy rationale for eliminating it, we recommend continuing the program. We withhold recommendation on the appropriation, pending receipt of information from the department on estimated current-year expenditures for the program.

We further recommend adoption of supplemental report language requiring the department to submit reports on the program's implementation, outcomes, and effectiveness.

Background. In 1989, the Legislature established the Options for Recovery pilot project, which provided funds for the recruitment, training, and respite care for foster parents to care for children who have medical problems related to drug or alcohol exposure or to AIDS. The program was made permanent in 1997 by Chapter 606, Statutes of 1997 (AB 67, Escutia).

From 1995 to 1997, the federal Department of Health and Human Services funded a demonstration project in Los Angeles County to promote the adoption of children who were exposed prenatally to alcohol or drugs. The evaluation was based on clients' ratings—which were favorable—but no other outcome-based study was done.

New Program. In September 1998, the Legislature enacted Chapter 1014 (AB 2198, Washington) and appropriated $1 million from the General Fund to extend the Options for Recovery services to adoptive and preadoptive parents. To be eligible for the funds, counties must submit a plan for approval by the Department of Social Services. The department, however, has not implemented the program, indicating that the delay is due to higher priorities and a lack of staff resources. The department plans to prepare the required all-county letters with the goal of allocating funds by this April.

Budget Proposal. The budget proposes to eliminate the new adoptions program in 1999-00, indicating that it is scheduled to sunset at the end of the current year. In fact, however, there is no statutory sunset date for this program. While acknowledging the error, the Department of Finance indicates that the administration will continue to propose elimination of the new program because it is "discretionary" (that is, subject to annual budget act appropriations) and there was a need to achieve savings.

LAO Recommendations. The administration has provided no policy basis for eliminating the program and no rationale for distinguishing it from other existing programs supported by the General Fund or from the original Options for Recovery program. As a new program which has yet to be implemented, it is obviously too early to determine whether it will accomplish its purpose. Consequently, we recommend that the program be continued so the Legislature will have an opportunity to assess its performance. We withhold recommend on the amount of the appropriation, pending receipt of information from the department on estimated

current-year expenditures and the possibility of reappropriating unexpended current-year balances in the budget year.

In order to facilitate the Legislature's oversight of the program, we further recommend adoption of supplemental report language requiring the department to submit a report by March 1, 2000 on the program's implementation, and a subsequent report by December 30, 2000 on the program's outcomes and effectiveness, and the extent to which it has accomplished its purposes. We note that if necessary, the department can use the resources of its Research Branch to help prepare these reports.

We suggest adoption of the following supplemental report language:

> The department shall submit a report to the Legislature, by March 1, 2000, on the implementation of the Substance Abuse/HIV Adoptions program. The department shall submit a subsequent report by December 30, 2000 on the program's outcomes, and an assessment of its effectiveness and the degree to which it has accomplished its goals.

FINDINGS AND RECOMMENDATIONS

Health and Social Services

		Analysis Page
16.	**Cancer Research Fund Balance Should Be Transferred to General Fund. Increase General Fund Revenues by $1,555,000.** Recommend year-end unexpended balances in the Cancer Research Fund (projected to be $1.6 million) be transferred to the General Fund because (a) these balances will not be needed to fund the program in 1999-00 and (b) the original source of these funds is the General Fund.	C-65
17.	**Budget Does Not Maximize Federal Funds for Drinking Water Program. Increase Item 4260-111-0001 by $285,000 and Increase Item 4260-111-0890 by $1,408,000.** Recommend increasing the General Fund amount budgeted for transfer to the Safe Drinking Water State Revolving Fund by $285,000 in order to obtain all available federal funds from the federal fiscal year 1998 grant (an additional $1.4 million). We also recommend that the department report at budget hearings on the advisability of expediting the receipt of additional federal funds available for federal fiscal year 1999.	C-65

Managed Risk Medical Insurance Board

18.	**New Policies Adopted to Increase Enrollment**. To address lower-than-expected enrollment in the Healthy Families Program, the Managed Risk Medical Insurance Board and the Department of Health Services shortened the application form and prepared fact sheets on immigration status.	C-68
19.	**Monthly Enrollments Falling Behind Budget Projections for Current Year**. Actual enrollments for the Healthy Families Program in October 1998 through December 1998 are about 5 percent lower than the budget estimates. The administration will submit revised estimates for the current and budget years in the May Revision of the budget.	C-69
20.	**Budget Proposes to Apply Income Deductions for Determining Eligibility**. The budget proposes a $2.7 million General Fund set-aside to apply the Medi-Cal income deductions to the Healthy Families Program for purposes of determining eligibility. Funding the proposal is contingent on savings from another budget proposal to secure federal funding of the state-only family planning program.	C-70

Analysis Page

Department of Developmental Services

Department of Mental Health (DMH)

Employment Development Department

California Work Opportunity and Responsibility to Kids (CalWORKs)

Analysis Page

33. **Spending on Programs for Women Offenders and Parolees Toward MOE Requirement.** Recommend that the department count toward the CalWORKs MOE requirement $4.8 million in General Fund expenditures in the Department of Corrections on programs for women offenders and parolees. C-101

34. **Budget Underestimates Savings From Maximum Family Grant Policy. Reduce Item 5180-101-0890 by $20,400,000.** Recommend that proposed spending for CalWORKs grants be reduced by $20.4 million (federal Temporary Assistance for Needy Families [TANF] funds) to reflect the incremental savings that will occur in 1999-00 due to the continuation of the Maximum Family Grant policy. C-102

35. **Budget for Services and Child Care Should Reflect Impact of Nonparticipation. Reduce Item 5180-101-0890 by $150,775,000.** Recommend reducing the budget for employment services and child care by $150.8 million (federal TANF funds) to account for nonparticipation of recipients. C-102

36. **Incentive Payments Should Be Related to Improved County Performance. Reduce Item 5180-101-0890 by $192,573,000**. Recommend enactment of legislation to modify the methodology for calculating incentives so that counties retain 50 percent of savings attributable to earnings (rather than the 100 percent included in the budget). This change would more closely relate fiscal incentive payments to improved county performance and would result in savings of $193 million (federal TANF funds) in 1999-00. C-103

37. **Options for Using Identified Savings**. Federal savings could be (a) redirected to other priorities in CalWORKs, (b) placed into a reserve for future years, and/or (c) transferred to the Social Services Block Grant (Title XX), where the funds could be used to offset General Fund spending in other departments. Among these options, recommend that the Legislature place at least 50 percent ($166 million) of our identified savings into a reserve for expenditure in future years. C-105

38. **Budget Proposes to Use Carry-Over Balances as a Funding Source.** In contrast to 1998-99, the Governor's budget proposes to use $251 million in county carry over funds as a source of funding for the estimated need for CalWORKs employment services in 1999-00. C-107

Analysis Page

Foster Care

Supplemental Security Income/ State Supplementary Program (SSI/SSP)

County Administration of Welfare Programs

Child Welfare Services

Adoptions