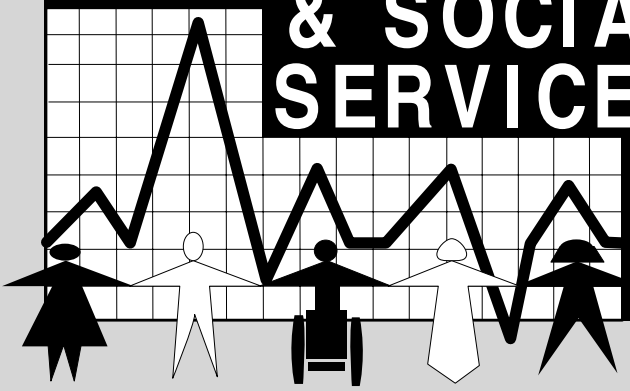
HEALTH & SOCIAL SERVICES



LAO
55 Years of Service

2001-02 Analysis

MAJOR ISSUES

Health and Social Services

☑ **Adult Health Coverage Plan Misses Some Opportunities**

- The budget proposes to expand the Healthy Families Program to provide health coverage for the parents of enrolled children. We find that the proposal misses some opportunities to further reduce the ranks of the uninsured and to conform and simplify the Healthy Families and Medi-Cal Programs. We recommend that the Legislature consider (1) further expansion of parental coverage and (2) elimination of the Medi-Cal asset test (see page C-134).

☑ **Legislation Needed to Guide HIPAA Implementation**

- We recommend legislation be enacted to improve the oversight of state implementation of recent federal legislation—the Health Insurance Portability and Accountability Act (HIPAA)—which requires significant changes in the state's health data systems and operations. In addition, we recommend consolidating all appropriations for HIPAA activities into one central funding mechanism (see page C-19).

☑ **State Could Assist with Proposition 36 Implementation**

- Because the state has a stake in the potential success of Proposition 36, which sends certain adult drug offenders to drug treatment and community supervision instead of prison or jail, we offer the Legislature a number of options for legislative changes and state budget adjustments that could assist counties with their implementation of the measure (see page C-36).

☑ Long-Term Care Services—A Fragmented System

- Our analysis of California's long-term care programs finds that they comprise a fragmented service system, although current efforts are under way to improve coordination. We recommend modifying budget proposals for pilot projects for new approaches to long-term care to take advantage of available federal grant funding (see page C-50).

☑ Reduce Children's Length of Stay in Foster Care

- Research indicates that (1) children stay longer in foster family agency (FFA) homes than in regular foster family homes, and (2) the needs of the children do not explain the longer stay. The higher payments made to FFAs may create a fiscal incentive for these agencies to keep children longer in foster care. We recommend enactment of legislation to conduct a three-year pilot project in which FFA treatment rates would incrementally decrease to a specified level (see page C-200).

☑ Current-Year CalWORKs Savings Proposal Should Be Considered With 2001-02 Budget

- The Governor's budget proposes a one-time, current-year reduction in the state's maintenance-of-effort level for the California Work Opportunity and Responsibility to Kids (CalWORKs) program for a General Fund savings of about $150 million. In order to hold the program's overall funding level harmless, the budget proposes urgency legislation to backfill this reduction with funds taken from county performance incentive payments.

- This proposal raises several policy issues for the Legislature which we recommend be considered in the 2001-02 budget process (see page C-186).

☑ Federal Law Could Strengthen Women's Cancer Programs

- A new federal law allows the state to build on the limited services now available for low-income women who are diagnosed with breast or cervical cancer. We offer several options that could better coordinate cancer screening and treatment programs for women (see page C-121).

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Health and Social Services

OVERVIEW

Health and Social Services

General Fund expenditures for health and social services programs are proposed to increase by 6.3 percent in the budget year. This increase is due primarily to a variety of caseload and cost increases and the Governor's initiatives to expand the Healthy Families Program and other public health programs. The budget also proposes to replace some California Work Opportunity and Responsibility to Kids General Fund spending with federal Temporary Assistance for Needy Families (TANF) funds in the current year, which reduces the TANF reserve in 2001-02.

EXPENDITURE PROPOSAL AND TRENDS

The budget proposes General Fund expenditures of $21.6 billion for health and social services programs in 2001-02, which is 26 percent of total proposed General Fund expenditures. As shown in Figure 1, the health and social services share of the budget generally has been declining since 1994-95, but would increase slightly compared to the prior year under the Governor's 2001-02 budget plan. The budget proposal represents an increase of $1.3 billion, or 6.3 percent, over estimated expenditures in the current year.

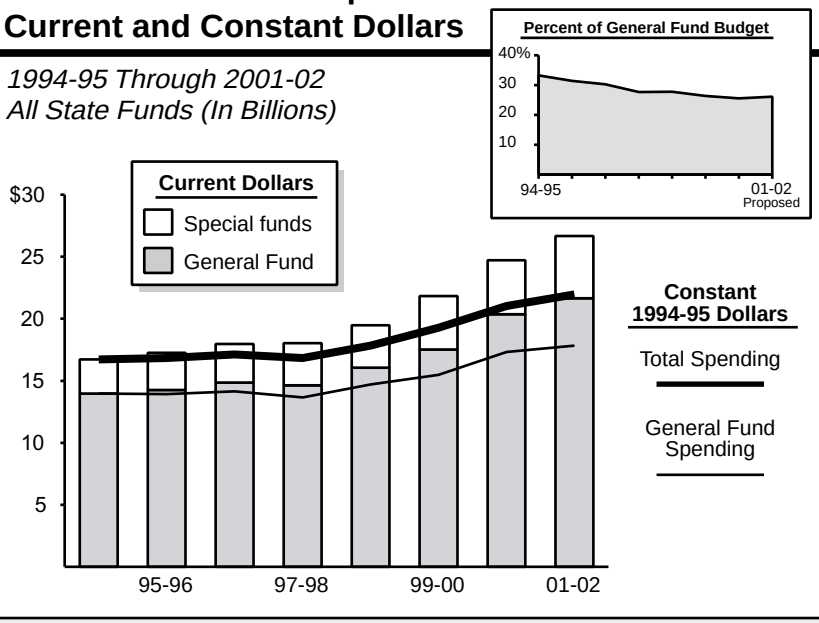
Figure 1 (see next page) shows that General Fund expenditures (current dollars) for health and social services programs are projected to increase by $7.7 billion, or 55 percent, from 1994-95 through 2001-02. This represents an average annual increase of 6.5 percent.

The figure also shows that General Fund spending (in current dollars) has increased each year since 1994-95, 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.

Figure 1

Health and Welfare Expenditures
Current and Constant Dollars

1994-95 Through 2001-02
All State Funds (In Billions)



Special funds expenditures are estimated to increase significantly in the budget year, primarily because of the creation of a special new trust fund for health services programs comprised of monies received by the state from the settlement of tobacco litigation. The budget estimates that spending from the new trust fund will amount to $445 million in 2001-02.

Combined General Fund and special funds spending is projected to increase by about $10 billion, or almost 60 percent, from 1994-95 through 2001-02. This represents an average annual increase of 6.9 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 28 percent from 1994-95 through 2001-02, an average annual rate of 3.6 percent. Combined General Fund and special funds expenditures are estimated to increase by 31 percent during the same period. This is an average annual increase of 4 percent.

CASELOAD TRENDS

Figures 2 and 3 illustrate the caseload trends for the largest health and welfare programs. Figure 2 shows Medi-Cal caseload trends over the

Figure 2

Budget Forecasts Upturn in Medi-Cal Caseloads

1990-91 Through 2001-02

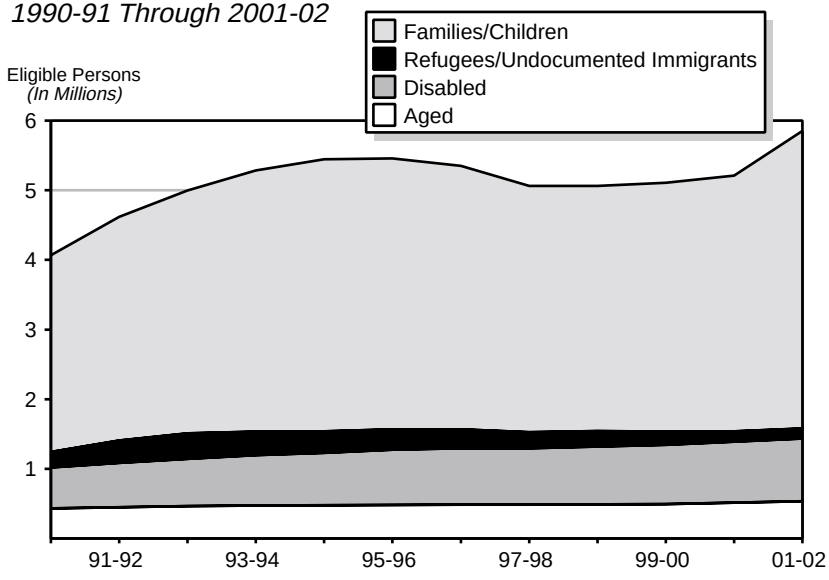
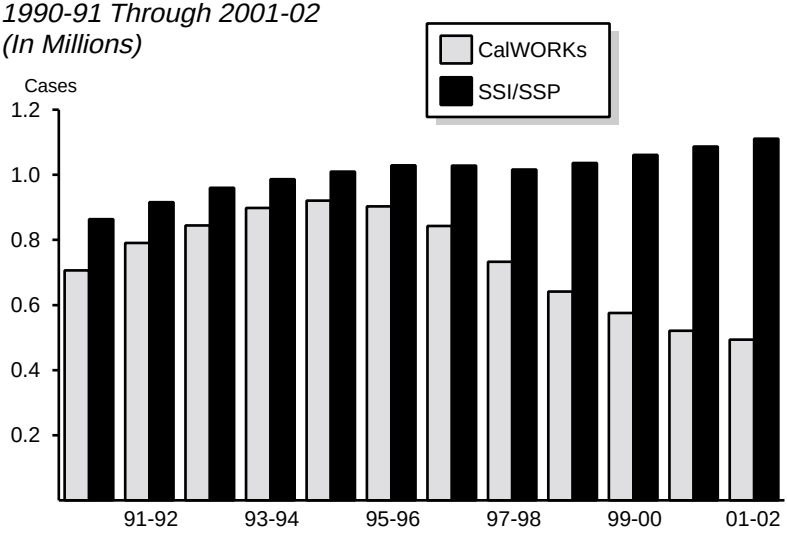


Figure 3

CalWorks Caseloads Declining; SSI/SSP Caseloads Increasing Slightly

1990-91 Through 2001-02
(In Millions)



last decade, divided into three groups: families and children (primarily recipients of CalWORKs—formerly AFDC), refugees and undocumented persons, and disabled and aged persons (who are primarily recipients of Supplemental Security Income/State Supplementary Program [SSI/SSP]). Figure 3 shows the caseloads for CalWORKs and SSI/SSP.

Medi-Cal Caseloads. As shown in Figure 2, the Governor's budget plan assumes that significant caseload growth will occur during the budget year in the Medi-Cal program. Specifically, the overall caseload is anticipated to increase by about 640,000, or 12 percent, during 2001-02 compared to the estimated current-year caseload.

This projection of strong growth follows a period of several years in which the overall size of the Medi-Cal caseload experienced relatively small changes from year to year. This projected trend reflects the estimated impact of a number of policy changes to the Medi-Cal program approved during the past two years. The changes resulting in the largest projected caseload increases are (1) the expansion of health coverage for two-parent families earning up to 100 percent of the federal poverty level (FPL) and (2) changes in program rules intended to make it more likely that families and children remain eligible for Medi-Cal coverage following their enrollment in the program.

These increases in caseload would be partly offset by a projected decline in the number of CalWORKs families who are eligible for Medi-Cal benefits. Following the enactment of welfare reform laws, the number of CalWORKs families and children has declined, along with the number of persons who are on Medi-Cal caseloads due to their receipt of CalWORKs public assistance. While this decrease in the CalWORKs-related caseload would continue to be significant, the Governor's budget proposal assumes it will not be sufficient to offset the other factors discussed above that are increasing the Medi-Cal caseload.

Healthy Families Caseload. The Governor's budget plan assumes that the caseload for the Healthy Families Program will continue the rapid growth experienced since it began enrolling children in July 1998. The budget provides for the enrollment of 106,000 additional children by the end of 2001-02 as a result of ongoing outreach efforts to increase program participation and several changes in eligibility rules. The Governor's budget plan also proposes to make parents in families earning up to 200 percent of the FPL eligible for Healthy Families coverage and enroll 174,000 of them in the program by the end of the budget year. Taken together, these proposals would increase Health Families participation by about 62 percent to 735,000 children and parents by the end of the budget year.

CalWORKs and SSI/SSP Caseloads. Figure 3 shows the caseload trend for CalWORKs and SSI/SSP. While the number of *cases* in SSI/SSP is

greater than in the CalWORKs program, there are more *persons* in the CalWORKs program—about 1.4 million compared to about 1.1 million for SSI/SSP. (The SSI/SSP cases are reported as individual persons, while CalWORKs cases are primarily families.)

To the extent that caseloads increased in these two programs, it has been due, in part, to the growth of the eligible target populations. The increase in the rate of growth in the CalWORKs caseloads in 1990-91 and 1991-92 was 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 discussed in our annual *California's Fiscal Outlook* reports, this trend is due to various factors, including the improving economy, lower birth rates for young women, a decline in legal immigration to California, changes in grant levels, behavioral changes in anticipation of federal and state welfare reform, and, since 1999-00, the impact of the CalWORKs program interventions (including additional employment services). We note, however, that contrary to this overall downward trend, the number of child-only cases has been increasing slightly in recent years. This category of the caseload includes children whose parents are undocumented, children with nonneedy relative caretakers, and children whose parents are removed from the assistance unit because of sanctions for nonparticipation in the CalWORKs employment services program.

The SSI/SSP caseload can be divided into two major components—the aged and the disabled. The aged caseload generally increases in proportion to increases in the eligible population—age 65 or older. This component accounts for about one-third of the total caseload. The larger component—the disabled caseload—grew significantly faster than the rate of increase in the eligible population group (primarily ages 18 to 64) in the early 1990s. This was due to several factors, including (1) the increasing incidence of AIDS-related disabilities, (2) changes in federal policy that broadened the criteria for establishing a disability, (3) a decline in the rate at which recipients leave the program (perhaps due to increases in life expectancy), and (4) expanded state and federal outreach efforts in the program. In recent years, however, the growth of the disabled caseload has slowed.

In the mid-to-late 1990s, the total SSI/SSP caseload leveled off and actually declined in 1997-98, in part, because of federal changes that re-

stricted eligibility. Since March 1998, however, the caseload has been growing moderately, about 2.3 percent each year.

SPENDING BY MAJOR PROGRAM

Figure 4 shows expenditures for the major health and social services programs in 1999-00 and 2000-01, and as proposed for 2001-02. 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.

As the figure shows, General Fund expenditures on Medi-Cal benefits would decline 1.4 percent under the Governor's budget plan compared with projected General Fund spending in the current year. However, this is not an accurate reflection of expenditure growth in this program. Some General Fund support for the program was replaced with support from the new tobacco settlement fund, and other General Fund support for Medi-Cal was shifted to the Department of Developmental Services (DDS) budget in a purely technical change. If these amounts were added back to the Medi-Cal budget, Medi-Cal General Fund growth would be 6.7 percent.

The technical shift of Medi-Cal General Fund support to the DDS budget results in nominal increases in the budget year of about 52 percent for regional centers and about 82 percent for developmental centers. But these nominal increases also do not accurately reflect actual program expenditure growth in these DDS programs. If the technical shift had not been made, the General Fund budget would reflect about a 17 percent increase in expenditures for regional centers and about a 62 percent decrease for developmental centers compared to current-year spending. Developmental center expenditures are proposed to decrease significantly because of (1) a reduction in caseload and (2) significant augmentations that were made to the current-year budget for special repairs and other purposes that were one-time appropriations.

The figure indicates that expenditures for the Healthy Families Program would decline about 14 percent in the budget year. However, this reflects a shift of some program support to the new tobacco settlement fund as well as significant increases in expenditures of federal funds. Thus, as the figure indicates, overall spending on the Healthy Families Program would increase 83 percent under the Governor's spending plan.

Figure 4

Major Health and Social Services Program Budget Summary[a]

1999-00 Through 2001-02
(Dollars in Millions)

	Actual 1999-00	Estimated 2000-01	Proposed 2001-02	Change from 2000-01	
				Amount	Percent
Medi-Cal					
General Fund[b]	$8,064.9	$9,457.6	$9,325.0	-$132.6	-1.4%
All funds	20,128.8	22,990.3	23,523.4	533.1	2.3
CalWORKs					
General Fund	$1,991.3	$1,935.3	$2,128.0	$192.7	10.0%
All funds	5,437.7	5,582.2	5,456.4	-125.8	-2.3
AFDC-Foster Care					
General Fund	$405.8	$387.7	$413.0	$25.3	6.5%
All funds	1,387.7	1,458.6	1,550.4	91.8	6.3
SSI/SSP					
General Fund	$2,501.0	$2,626.0	$2,870.2	$244.2	9.3%
All funds	6,494.8	6,827.0	7,293.0	466.0	6.8
In-Home Supportive Services					
General Fund	$596.5	$746.0	$843.3	$97.3	13.0%
All funds	1,610.3	1,971.7	2,260.5	288.8	14.6
Regional Centers/Community Services					
General Fund[b]	$788.2	$972.6	$1,479.9	$507.3	52.2%
All funds[c]	1,623.0	1,878.2	2,037.7	159.5	8.5
Developmental Centers					
General Fund[b]	$95.2	$177.4	$322.3	$144.9	81.7%
All funds[c]	555.4	641.7	601.0	-40.7	-6.3
Child Welfare Services					
General Fund	$486.3	$533.0	$565.1	$32.1	6.0%
All funds	1,532.9	1,697.8	1,774.5	76.7	4.5
Healthy Families					
General Fund	$76.2	$145.6	$125.2	-$20.4	-14.0%
All funds	211.8	400.1	733.1	333.0	83.2
Children and Families First Commissions[d]					
General Fund	—	—	—	—	—
All funds	$784.3	$622.2	$656.7	$34.5	5.5%
Child Support Services					
General Fund	—[e]	$370.7	$455.1	$84.4	22.8%
All funds	—[e]	840.6	998.7	158.1	18.8

[a] Excludes departmental support.

[b] Beginning in 2001-02, some General Fund spending for Medi-Cal services is displayed in the Department of Developmental Services budget instead of the Department of Health Services budget.

[c] Includes General Fund share of Medicaid reimbursements (costs budgeted in Medi-Cal).

[d] Includes state and county commissions.

[e] Child Support Services were included in the Department of Social Services in 1999-00.

MAJOR BUDGET CHANGES

Figures 5 and 6 (see page 16) illustrate the major budget changes proposed for health and social services programs in 2001-02. (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 Caseload Growth in SSI/SSP, Medi-Cal, and the Healthy Families Program, Reflects Savings From Caseload Reductions in CalWORKs and Funds Other Workload Cost Increases.*** The budget includes a projected caseload reduction of 5.2 percent in the CalWORKs program and increases of 12 percent in the Medi-Cal program, 2.2 percent in SSI/SSP, and 62 percent in the Healthy Families Program.

2. ***The Budget Proposes to Fund Statutory Cost-of-Living Adjustments (COLAs) for CalWORKs and SSI/SSP as Well as Discretionary COLAs for Foster Care.*** The budget includes a 4.85 percent COLA for CalWORKs and SSI/SSP in 2001-02. We note that the budget proposes to fund COLAs for *all* types of foster care placements—foster family agencies (FFAs), non-FFA foster family homes, and group homes. Current law provides for these COLAs, but makes them "subject to the availability of funds."

3. ***The Budget Proposes to Keep General Fund Spending for CalWORKs in 2001-02 at the Federally Required Maintenance-of-Effort (MOE) Level and Achieves General Fund Savings of $154 Million in 2000-01 Due to a Retroactive One-Time Reduction in the MOE.*** California successfully appealed a federal finding that the state failed to comply with federal work participation requirements in 1997. Based on this successful appeal, the budget assumes that California's MOE requirement is reduced by $154 million retroactively on a one-time basis. The budget reflects a General Fund savings of $154 million in the current year by replacing General Fund monies with federal TANF funds, thus reducing the TANF reserve by an identical amount.

4. ***The Budget Includes Various Significant Changes, Including the Following:***

- The budget provides an additional $272 million during 2001-02 above projected current-year General Fund expenditure levels due to increases in the cost of prescription drugs for Medi-Cal beneficiaries. These additional costs would be partly offset by a projected $69 million increase in the rebates the state receives on drugs for Medi-Cal patients.
- The budget plan provides Medi-Cal funding for a one-time payment of $175 million from the General Fund in the current year

Figure 5

Health Services Programs
Proposed Major Changes for 2001-02
General Fund

Medi-Cal	**Requested: $9.3 billion** **Decrease: $133 million (-1.4%)**

+ $272 million due to higher costs for prescription drugs, partly offset by a $69 million increase in rebates the state receives on drug purchases
+ $259 million for the costs of major changes to Medi-Cal eligibility rules, including eliminating quarterly status reports for beneficiaries and providing 12-month continuous coverage for children
+ $117 million for growth in the Early Periodic Screening, Diagnosis, and Treatment Program which provides mental health services for children
+ $64 million for ongoing hospital rate increases for settlement of the *Orthopaedic Hospital v. Belshé* lawsuit, following a related one-time payment of $175 million in the current year
+ $20 million to provide expanded services to residents of Institutions for Mental Diseases
+ $10 million to help Medi-Cal beneficiaries pay for new or increased insurance premiums to stay enrolled in Medicare HMOs

– $601 million due to a technical change shifting the display of Medi-Cal General Fund expenditures to the budget of the Department of Developmental Services
– $170 million due to shift from General Fund to new tobacco settlement trust fund
– $21 million due to an increase in the federal matching rate

Healthy Families	**Requested: $125 million** **Decrease: $20 million (-14%)**

– $20 million General Fund due to shift in some program costs from General Fund to new tobacco settlement trust fund. (Overall Healthy Families budget [all funds] would increase by $333 million due to additional federal funds and allocation of tobacco settlement funds)

Figure 6

Social Services Programs
Proposed Major Changes for 2001-02
General Fund

CalWORKs	**Requested:**	**$2.1 billion**	
	Increase:	**$193 million**	**(+10%)**

+ $154 million due to the maintenance-of-effort requirement returning to $2.7 billion following a one-time reduction in 2000-01
+ $128 million for a 4.85 percent cost-of-living adjustment (COLA)
+ $40 million for an increase in state matching fund expenditures for federal Department of Labor Welfare-to-Work funds

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– $148 million due to caseload reduction
– $97 million due to no funding for county performance incentives

SSI/SSP	**Requested:**	**$2.9 billion**	
	Increase:	**$244 million**	**(+9.3%)**

+ $156 million for a 4.85 percent COLA
+ $55 million due to a caseload increase

In-Home Supportive Services	**Requested:**	**$843 million**	
	Increase:	**$97 million**	**(+13%)**

+ $55 million due to increases in the minimum wage
+ $38 million due to a caseload increase

to settle the case of *Orthopaedic Hospital v. Belshé* related to hospital reimbursement rates. In fulfillment of the settlement agreement, an additional General Fund expenditure of $64 million is budgeted for 2001-02 for an ongoing hospital rate increase. (The Medi-Cal budget also includes an additional $60 million from the General Fund in the current year for negotiated increases in hospital rates unrelated to the court case.)

- About $80 million from the General Fund, the new tobacco settlement fund, and other sources is provided for various augmentations to create or to expand various public health programs. Proposals include medical screening and treatment programs for prostate and breast cancer, as well as programs to prevent youth from using tobacco and to better track infectious diseases.
- The budget makes two proposals to reduce CalWORKs county performance incentives. First, in the current year, the budget proposes urgency legislation to reduce the incentives by $153 million compared to the appropriation. In 2001-02, the budget exercises the option, created in last year's social services budget trailer bill, to spend less for performance incentives than the amount suggested by the statutory formula. Specifically, the budget proposes no funding in 2001-02 for county performance incentives, resulting in a savings of $244 million compared to the statutory formula.

CROSSCUTTING ISSUES

Health and Social Services

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

THE GOVERNOR'S BUDGET PROVIDES FUNDING FOR COMPLIANCE WITH FEDERAL LAW

The* 2001-02 Governor's Budget *requests a total of $92 million ($23.6 million General Fund) for statewide planning and implementation of the federal Health Insurance Portability and Accountability Act. This includes $70 million ($20 million General Fund) to be allocated to state departments and agencies that apply for funding. In addition, the budget provides about $22 million ($3.6 million General Fund) and 28 positions in four departments. In the following pages, we summarize the requirements of the act, analyze the potential effects on state and county governments, evaluate the approach taken to date by state agencies to comply with the law, and recommend further legislative actions that would improve the state's compliance.

Background

What Is HIPAA? The HIPAA was enacted in 1996 and set many goals for the health care industry. The law's primary purpose was to protect health insurance coverage for workers and their families when they change

or lose jobs. This new protection will impose additional administrative requirements on the health care industry. However, a section of the law requiring administrative simplification is designed to reduce these burdens. The general approach is to accelerate the move from paper-based to electronic transactions through the establishment of national standards and requirements for the transmission, storage, and handling of certain electronic health care data.

Many experts believe that HIPAA is the most sweeping government action affecting the health care industry since the introduction of Medicare. They predict that HIPAA will affect nearly every business process of the health insurance industry and result in significant systems changes. Like efforts to address the Year 2000 (Y2K) technology problem, HIPAA does require changes in information technology (IT) systems, but HIPAA involves much more than IT projects. It will also affect administrative policies and regulations, operational processes, education, and training and these in turn will result in significant costs.

Who Must Comply? Both private and public sector organizations that provide health care services and use patient or other health care data must comply with HIPAA. Thus, the list of affected organizations includes not only health care providers, but also employers, insurers, and health plans. Health plans include Medicaid programs, Medicare, and most government-funded health care programs. The HIPAA will also affect state departments that are not considered to be health-related departments, but departments that may indirectly handle health care data such as the California Department of Veterans Affairs or the Public Employees' Retirement System. While HIPAA will affect both private and public organizations, our analysis focuses on the potential effects on state and county government.

In California, a number of state departments have recognized the potential impact of HIPAA's requirements and are participating in statewide compliance efforts. However, few departments have begun actual implementation work, such as developing a work plan. Some departments that may be affected do not appear to be participating in any compliance efforts. Figure 1 provides an overview of some departments which reported progress on HIPAA implementation as of October 2000. At this time, the state does not have a comprehensive list of all the departments that will be affected by HIPAA.

One of the departments that will be most significantly affected is the Department of Health Services (DHS). The DHS programs that have already been determined to be affected include Medi-Cal, Primary Care and Family Health, the Cancer Detection Section, the Information Technology Services Division, the Genetic Disease Branch, Children's Medical Services, and the Cancer Control Branch. Other departments that may

be affected, but have not yet reported progress on HIPAA, include the Public Employees' Retirement System, the Department of Rehabilitation, the State Teachers' Retirement System, the Department of Managed Health Care, and the Managed Risk Medical Insurance Board.

Figure 1

Departments Reporting Progress on HIPAA Implementation as of October 2000

(In Thousands)

Departments	Developed a Work Plan	Inventory Assessment	Impact Analysis	Estimate of Total Cost[a]
Alcohol and Drug Programs	In development	No	No	$12,413
Board of Equalization	Started	Started	—	356
Aging	—[b]	—	—	364
Corrections	No	No	No	—
Highway Patrol	No	No	No	—
Youth Authority	No	No	No	—
Developmental Services	Yes	Yes	Yes	5,516
Health Services	Yes	Yes	Yes	100,000
Mental Health	Yes	Yes	Yes	23,936
Motor Vehicles	No	No	No	—
Rehabilitation	No	No	No	—
Emergency Medical Services Authority	No	Yes	Yes	421
Office of Statewide Health Planning and Development	In development	Yes	Yes	927
Total				**$143,933**

[a] Cost includes multiyear amounts.
[b] No information provided.

In addition to state departments, county health-related programs, including county medical services and county hospital and health systems that serve in the role as health care providers, have compliance obligations. Some of the county program areas known to be affected include mental health, Medi-Cal and Healthy Families eligibility, and California Children's Services.

Benefits of Administrative Simplification. The administrative simplification component of HIPAA requires that all organizations that engage in the electronic transmission of administrative and financial health care information shall use a single set of electronic standards to submit and receive claims, authorize referrals for medical services, enroll benefi-

ciaries, and receive payments. Some of the benefits that may result from administrative simplification include:

- ***Increased Efficiency and Reduced Administrative Costs.*** The federal Health Care Financing Administration (HCFA) predicts that the health care industry will save about $1 billion during the first five years of HIPAA implementation. Others have estimated that billions of dollars will be saved each year by switching from paper claims to uniform electronic claims submission and using uniform billing requirements. We have not conducted our own analysis of the accuracy of these savings projections.

- ***Improved Effectiveness of the Health Care Industry.*** The standardization of information will enable the health care industry to take advantage of technical solutions to improve the overall effectiveness of the health care delivery system. For example, health care providers may be able to improve the management of their medical practices because they will be able to verify patient eligibility for medical services more quickly.

- ***Compare and Analyze Data.*** Currently, due to the pervasive use of local codes used to support special state health care programs, state Medicaid programs cannot compare data. With standardized codes, programs could analyze data that may allow them to identify relatively high-cost areas and more accurately evaluate which services and programs are most effective.

- ***Better Health Care for Beneficiaries.*** With the implementation of HIPAA, health care beneficiaries will find it easier for them, and their health records, to move to a new provider or health care plan (this is called "portability"). They will potentially benefit from improved continuity of health insurance coverage in groups and individual markets and greater coordination of care.

- ***Reduced Fraud and Abuse.*** Having a single set of unique identification numbers for specific providers, insurers, and patients should make it easier for authorities to detect medical fraud, waste, and abuse by eliminating situations where providers and individuals have multiple identifiers. These multiple identifiers make it difficult to match and track claims to both providers and individuals, particularly where fraud is intended.

What Are the Administrative Simplification Standards? To achieve administrative simplification the federal Department of Health and Human Services (HHS) as directed by the Act is developing standards that involve the following:

- ***Transaction Standards.*** The HHS has developed national standards designed to allow the electronic exchange of specific health care transactions. This includes standards for the transmission of claims for payment of medical services, enrollment in health plans, inquiries about patients' eligibility for services, and other critical health-related business transactions.

- ***Code Sets.*** These codes will standardize certain types of health care information such as diseases, injuries, impairments, and procedures on a national level.

- ***Unique Identifiers***. The HIPAA requires the adoption of unique identifier codes for health care plans, health care providers, and employers. For example, the identification number being proposed for employers is the Employer Identification Number which is issued and maintained by the Internal Revenue Service. Currently, employers may use different identification numbers when they conduct business which slows activities such as health plan enrollments and premium payments, and increases costs.

- ***System and Patient Data Security.*** Under HIPAA, security standards must be adopted that carry out "reasonable and appropriate" administrative procedures and safeguards to ensure the integrity and confidentiality of information. These rules require that certain entities enter into agreements that ensure that when an individual's information is transferred the information is protected in accordance with HIPAA's privacy and security rules.

- ***Privacy Standards.*** The privacy standards are intended to protect and enhance the rights of consumers, ensure the integrity of the health care system, and create a national framework for health privacy protection. The rule provides standards for covered information, entities, and disclosures.

When Must Organizations Comply? The HHS is planning on issuing rules for implementing HIPAA in stages or "waves." Under this approach, HHS will publish the proposed rules, receive and review comments on the rules and then will issue the finalized rules. This will allow HHS to respond to the large number of comments received. For example, more than 17,000 public comments were received on the proposed rules for transaction standards and code sets.

The first set of final standards, relating to transactions and code sets, published in August 2000, provide the health care industry until October 16, 2002, or about two years, to comply. The second set of standards released relate to privacy and the expected date of compliance for these rules is February 26, 2003. It is anticipated that the states can expect

at least seven more waves of HIPAA regulations which will be issued during the next two years, with each allowing roughly 24 months for implementation. These seven standards include national provider identifiers, national employer identifiers, security, national health plan identifiers, claims attachments, enforcement, and the national individual identifiers.

Organizational Challenges Posed by HIPAA

Government organizations will encounter many challenges to comply with Health Insurance Portability and Accountability Act standards. This will require organizations to make programmatic changes such as altering business processes, adapting to the loss of "local codes" that track the health care needs of specific groups, and modifying practices to ensure patient privacy.

The HIPAA Will Affect State and County Business Processes. The administrative simplification requirements of HIPAA will have a significant effect on the health care-related business processes of most state and local agencies because they do not currently conform with the majority of the proposed standards. Specific business processes that will be affected include billing and payment for health care services; the exchange of eligibility and enrollment information among health care providers, plans, and insurers; and referral and authorization processes for medical services. In addition, all government rules and regulations related to privacy and security policies, processes, and procedures will need to be changed significantly in order to achieve compliance.

The Loss of Local Codes Will Have a Significant Effect. The health coverage provided under state Medicaid programs can vary significantly in scope from coverage offered by other public- and private-sector health plans. Thus, some services provided under Medicaid may not generally be recognized by other health care payers and providers. Most state Medicaid agencies have created local codes (unique state and local identifiers) for identifying and tracking procedures, drugs, provider types, and categories of service. These codes enable Medicaid agencies to process claims for health care services that they provide to specific local populations of beneficiaries. Nationally, more than 22 categories of codes with additional individual codes have been identified for services including private nursing, mental health, and free immunizations for children.

Under HIPAA, a code set is any set of codes used for encoding data, such as medical diagnosis codes or medical procedure codes. The HHS-approved HIPAA code sets cover a range of medical conditions, such as diseases and injuries, or drugs and medical procedures. The HIPAA administrative simplification standards eliminate the use of local codes and require a switch to the HHS-approved code sets.

The elimination of local codes has programmatic implications that will affect information services, administrative policies and regulations, provider reimbursement levels, and oversight activities. The more local codes a state uses, the more policy and business decisions that will have to be made to address such issues. Each of the nearly 1,100 local codes that are used to administratively support many special programs in California are written into state regulations and will need to be changed to eliminate the use of these nonstandard codes.

Reimbursement levels for services could also be affected by the loss of local codes. In order to comply with HIPAA, the state may have to "roll up" services to a level that could be more costly to the state and may result in California having to pay higher reimbursement rates. For example, a local code used to provide a specific type of mental health service to disabled children under age five may not be recognized by the national code system. Under HIPAA, the local code for those services may have to be rolled up to a code that generally covers mental health services for all children ages 1 through 18 and the reimbursement level for that code may be greater or less than the reimbursement rate for the local code.

Complying With Privacy Requirements. The recently released privacy requirements have the potential to significantly change business practices for both health care providers and insurers. The new privacy rules mandate that entities that collect health care information advise patients of their right to privacy and advise them about how their personal medical information might be used by entities that have access to the information. The rules also establish policies that allow patients to review, copy, and make corrections to their personal health information. Organizations may require extensive training to meet these requirements.

The State Will Have to Develop Comprehensive Policies to Satisfy Security Requirements. Every entity that handles health care information will be required by HIPAA to develop comprehensive policies for the security of that data. This involves nontechnological issues such as employee training, disaster-recovery planning, internal audits, and provider contracting, in addition to the technical security issues such as encryption of data.

Major Fiscal Issues

The Health Insurance Portability and Accountability Act compliance is expected to have a significant fiscal impact nationwide. Estimates of compliance costs vary widely and the state has made an early estimate that compliance for just departments within the Health and Human Services Agency may cost more than $100 million over many years.

Complying With HIPAA Will Be Expensive. The HIPAA planning and implementation is expected to have a major fiscal impact on the state because of the additional staff and funding necessary to analyze and change current operations, policies, and systems. Estimates of the cost to implement HIPAA vary widely, however. The U.S. Office of Management and Budget has estimated HIPAA implementation will cost the entire health care industry (both public and private sectors) approximately $3.8 billion over five years. Others have reported that industry-wide costs could go as high as $43 billion for the same time period. Rough estimates for an organization's costs range from one and one-half times to twice the cost of Y2K.

Several state Medicaid agencies have estimated the cost of complying with HIPAA. Their estimates range from $105 million in Texas (with annual Medicaid expenditures of $6 billion) to $18 million in Florida (with annual Medicaid expenditures of $7.5 billion). By way of comparison, California has annual Medicaid expenditures through the Medi-Cal program of $24.6 billion in the current fiscal year.

The cost of HIPAA will depend on the strategy taken for achieving compliance. For example, many state Medicaid agencies are reporting that they plan to replace their information systems as part of their implementation of HIPAA, thereby significantly increasing costs. Other factors affecting costs are the start-up costs of automation, training and process reengineering, and any costs associated with addressing implementation problems. Finally, we would note that much of the cost of implementing the new standards is likely to involve one-time expenditures.

Early Estimates of State Costs. In California, several state departments have begun estimating the cost of implementing HIPAA and have requested funding for the budget year totaling $22 million ($3.6 million General Fund). Other departments that may be impacted by HIPAA either have not requested funding or may not have estimated the cost of compliance.

Representatives of the state Health and Human Services Agency estimate that, agency-wide, compliance with HIPAA may cost more than $100 million over many years. This is an early estimate and most likely will change significantly because some departments and program areas have not been thoroughly assessed. Figure 1 (shown earlier) shows the steps that some departments have taken towards complying with HIPAA and preliminary cost estimates.

Federal Funding Is Available for Medi-Cal Compliance. Compliance with HIPAA standards is a federal mandate and, as such, HCFA has authorized the use of enhanced federal funds at the 90 percent match

rate. These funds can be used for costs associated with the planning, design, development, and implementation of HIPAA requirements for the California Medicaid Management Information System (CA-MMIS) and related computer systems. The CA-MMIS is the medical and dental claims processing system used by DHS for various programs, including the Medi-Cal Program. Other information systems not related to the CA-MMIS are eligible for claiming the normal federal Medi-Cal match of about 51 percent. The availability of federal funding means that state compliance costs will be much lower than would otherwise be the case.

Federal Funds Not Available for Non-Medicaid Programs. While HIPAA is a federal mandate, federal funds are not available for non-Medicaid-related programs. Costs associated with HIPAA project planning, assessment, and remediation for nonmedical programs (for example, the Department of Motor Vehicles) must be funded by the applicable funding source for the affected program.

Similarly, federal funding is not available for counties' compliance with HIPAA, even though counties may also incur significant costs due to the required conversion of local health service codes to national codes. Because local coding is largely related to the Medi-Cal program, the state will need to make decisions as to whether it will pay for any of the counties' cost of compliance. If the state decides to pay for some of the cost, this will increase the state's overall costs for HIPAA compliance.

Health care providers that the state contracts with for health care services must also comply with HIPAA. The state must determine if it will share in the cost of changes required by the 90,000 providers.

Risks From Failure to Meet HIPAA Requirements. Failure to comply with HIPAA could result in inefficiencies in the health care delivery system and have a significant fiscal impact on the state. Specifically, the state's failure to adopt the national standards would mean that the state could risk service interruptions of its major health programs, such as delays or an inability to process provider claims for payment. The state's ability to interact with business partners could also be hindered and leave the state unprepared for future transaction standards.

Failure to meet HIPAA requirements poses other fiscal risks as well. For example, it could result in the imposition of significant federal monetary penalties against the state and potentially even the loss of billions of dollars in federal reimbursements for its health programs. At the time this analysis was prepared, HCFA had proposed noncompliance fines of $25,000 a day, per data element, per transaction. The state might also be subject to costly litigation by not complying with HIPAA standards.

What Is the State Currently Doing?

The 2001-02 spending plan provides about $92 million ($23.6 million General Fund) in various budget items for the Health Insurance Portability and Accountability Act (HIPAA) compliance activities. The Department of Health Services has established a HIPAA Project Office to act as a resource to guide and monitor compliance efforts. Other health-related departments have also begun compliance work and a separate budget item has been proposed to provide allocations of funding to other departments for HIPAA-related activities.

The *2001-02 Governor's Budget* provides $23.6 million from the General Fund and about $69 million from other funds—roughly $92 million in all—for HIPAA compliance activities in the budget year. A number of compliance efforts are already under way. We discuss these activities in more detail below.

The DHS Has Leading State Role. As the agency overseeing the Medi-Cal and Healthy Families programs, DHS is the largest purchaser of health care services within the state. For many "safety-net" providers such as County Organized Health Systems, DHS is the primary source of revenue. As the largest purchaser, DHS could greatly influence the rest of the California health care industry's compliance with HIPAA requirements.

The DHS received seven two-year limited-term positions in the *2000-01 Budget Act* to form a project work group to review and analyze final regulations, specify the effect on DHS programs, and develop a work plan for HIPAA compliance. In May 2000, DHS established the HIPAA Project Office and began performing initial HIPAA assessments of DHS programs, forming workgroups and participating in national groups focusing on standards, implementation, and legislation.

The Governor's budget requests, for the current fiscal year, to (1) administratively establish 11 additional positions beyond the seven authorized in the *2000-01 Budget Act* to conduct rate studies, perform impact assessments, and participate in project planning and (2) increase federal funds by $1.2 million. As shown in Figure 2, for the budget year, the DHS budget requests $2 million from the General Fund for continuation of these 11 positions, four additional positions that would first be established in 2001-02, and consulting services. The DHS indicates that it may request during spring 2001, additional funding for the budget year based on impact assessments and the release of the final HIPAA rules.

So far, the HIPAA Project Office has completed initial assessments in nine program areas and remediation has started on the Medi-Cal and Denti-Cal claims processing systems. The office has also begun to match local codes to national standards. Acting as a lead organization, DHS has

given presentations and provided training in the past year to state departments, county organizations, and managed care groups and plans to present its approach to HIPAA as a model for other departments. However, the Project Office has emphasized that DHS program areas, other departments, and individual providers are responsible for their own HIPAA-related activities.

Figure 2

Budget Requests for HIPAA-Related Activities

(Dollars in Thousands)

	2001-02			
	Personnel Years	General Fund	Other Funds	Total Funds
Department of Health Services	15[a]	$2,000	$17,000	$19,000
Department of Mental Health	9	1,200	1,200	$2,400
Department of Developmental Services	3	425	425	$850
Office of Statewide Health Planning and Development	1	—	80	80
Health Insurance Portability and Accountability Act Fund (Item 9909)	—	20,000	50,000	70,000
Totals	**28**	**$23,625**	**$68,705**	**$92,330**

[a] Health Services received seven two-year limited-term positions and $585,000 ($260,000 General Fund) in the *2000-01 Budget Act* for HIPAA activities.

Department of Developmental Services (DDS). The DDS received a 2000-01 appropriation of $205,000 from the General Fund and three limited-term positions for the purpose of determining the impact of HIPAA. The budget for 2001-02 requests $850,000 ($425,000 General Fund and $425,000 in reimbursements) to comply with HIPAA's transactions and code sets requirements. The DDS is completing an initial analysis of the impact of these requirements on the department's Cost Recovery System (CRS) and on other IT systems. The CRS processes electronic billings to private insurance companies and claims to Medicare and Medicaid. The department plans to submit a feasibility study report this spring along with a Department of Finance letter requesting additional funds once these initial assessments are completed. Later this spring, the department plans to address the impact of HIPAA on the business processes of the department, the developmental centers, the regional centers, and service providers.

Department of Mental Health. The Department of Mental Health (DMH) has completed a FSR for compliance with the first wave of HIPAA

regulations. The 2001-02 budget requests $2.4 million ($1.2 million General Fund and $1.2 million in reimbursements) and nine positions. The DMH is also establishing a special internal team to manage compliance activities in all four of its divisions and anticipates that the compliance effort will take five and one-half years.

Office of Statewide Health Planning and Development (OSHPD). The OSHPD 2001-02 budget requests one permanent full-time program position to evaluate the new HIPAA provisions and implement measures to comply with the data transaction and privacy standards. It is anticipated that by taking these steps the office will be able to protect the identity of individual patients.

The HIPAA Fund. The administration's 2001-02 budget proposal would establish a HIPAA fund—a separate budget item with a total of $70 million ($20 million General Fund, $10 million special funds, and $40 million nongovernmental cost funds)—to provide allocations to other departments for HIPAA compliance activities. To obtain funding, a department would submit a request to the Department of Finance (DOF) for HIPAA-related activities that the department could not fund with existing resources. The DOF would review the funding request, and, if it agreed, would provide a 30-day notification to the Legislature that it intended to make an allocation from the HIPAA fund. If a HIPAA compliance activity included changes to an information technology system, departments would also need approval from the Department of Information Technology (DOIT) prior to DOF notifying the Legislature of the allocation of funds.

Weaknesses in the Administration's Approach

The state has initiated significant efforts to comply with the Health Insurance Portability and Accountability Act. However, based upon the lessons learned during the state's Year 2000 compliance efforts, we believe that the administration's approach has a number of weaknesses that we discuss below.

Our analysis indicates that the efforts initiated to date by state agencies to comply with the requirements of HIPAA are warranted and generally appropriate. However, based on lessons learned in previous efforts to address the Y2K problem, we believe there are several weaknesses in the state's current approach to addressing the challenges posed by HIPAA. We discuss several such concerns below.

Lack of Lead Agency. When a statewide program implementation effort is necessary, the state has sometimes designated a lead agency that is responsible for overseeing all related activities and ensuring that all

departments that may be affected are participating in compliance activities. For example, the state's Y2K efforts were led by DOIT, which monitored all Y2K activities and reported to the Governor and Legislature on the state's overall progress. We believe this organizational strategy especially makes sense in situations when the task is complex and involves many different state agencies.

The HIPAA appears to be just such a situation. While DHS has established the HIPAA Project Office to oversee and coordinate its own internal department efforts, the administration had not designated a lead agency for statewide HIPAA compliance activities at the time this analysis was prepared. Unless statewide project oversight responsibility is established, it may be difficult later to hold departments (including nonhealth departments) accountable for their efforts to comply with HIPAA.

Absence of a Statewide Plan. Comprehensive planning is another critical element for complex statewide projects. For example, in managing its Y2K efforts, the state developed a statewide Y2K plan which included the following components:

- A strategy for addressing the Y2K issue.
- Y2K remediation activities required for each department.
- Y2K oversight activities to be provided by DOIT.
- A common definition that the administration and the Legislature could use to determine when the state remediation activities were "complete."

At the time that this analysis was prepared, however, the administration had not yet developed a statewide plan for addressing HIPAA compliance. Lacking such a statewide plan, HIPAA efforts may not be well-coordinated, consistent, and complete.

Lack of HIPAA Impact Assessments. Another important lesson the state learned from Y2K was the need for all departments to assess which IT systems would require Y2K remediation. These assessments formed the basis for department work plans and funding requests. Conducting assessments is an important planning component because it defines the scope of the effort, determines funding needs, and establishes time frames for completion of tasks.

At the time that this analysis was prepared, however, few departments within the Health and Human Services Agency (HHSA) had begun assessments. Because of this lack of completed assessments, it is likely that departments do not have a full understanding of:

- The scope of their individual HIPAA compliance efforts.

- Their overall funding needs.
- The time frames needed to complete compliance activities.

Difficult to Administer Fund. The state encountered some difficulties in the administration of the Y2K fund. For example, DOIT and DOF sometimes took up to six months to review and approve requests for fund allocations. This caused some departments to have to delay starting Y2K remediation tasks and, as a result, these departments later had to devote *more* resources to compliance activities to make up for the lost time.

Another difficulty was the confusion between the role of DOIT and DOF in determining what constituted an appropriate expenditure from the Y2K Fund. On some occasions DOIT and DOF disagreed over what activities *should* and *should not* be funded through the Y2K Fund. We are concerned that this same problem could affect the administration of the HIPAA fund, given budget language that again splits the approval authority for information technology activities between DOIT and DOF.

Weaknesses in Funding Mechanism Oversight. During the nine months leading up to the December 1999 deadline for Y2K compliance, a number of funding notifications received by the Legislature were to backfill for funds that had already been spent for Y2K efforts without prior legislative authorization. We are concerned that the notification mechanism proposed for the HIPAA fund would also result in broad administrative control over monies with limited opportunity for legislative review and oversight.

In addition, a number of the HIPAA requests propose to establish permanent positions. Establishing permanent positions for a time-limited task will limit the Legislature's ability to determine if the positions are still needed once HIPAA activities are complete.

Fragmented Funding Processes. The budget proposes to fund specific HIPAA-related activities in four separate departmental budget items. In addition, it provides funding for unspecified activities through the HIPAA fund. In effect, the administration is using two processes to fund similar activities. Over time, this approach could become a problem when the Legislature tries to determine the total cost for HIPAA compliance. This problem occurred with Y2K remediation when the administration allocated funds to individual departments through the annual budget process in addition to funding the Y2K fund. The Legislature was not able to determine the state's total spending on Y2K remediation.

Lack of Statutory Framework. The state's Y2K remediation activities, unlike those for HIPAA, were limited to a single set of activities that were well-defined beforehand, consistent throughout government and private industry, and focused exclusively on IT systems. The HIPAA com-

pliance activities, on the other hand, are much broader in scope—encompassing mainly changes in administrative policies and regulation as well as some changes to IT systems. The Governor's budget plan does not offer a statutory framework for the HIPAA statutory compliance program except for (1) budget bill provisions outlining the process for allocations from the HIPAA fund and (2) a proposed budget trailer bill permitting DHS to adopt unspecified emergency regulations to implement HIPAA.

Our analysis indicates that a statutory framework is warranted to guide a statewide project with the formidable size, scope, and complexity of HIPAA compliance. As we have noted earlier, many significant policy issues will arise from compliance efforts. Except for budgetary decisions, the administration's approach in effect largely excludes the Legislature from key policy decisions regarding the use of HIPAA funds and the governance, oversight, and administration of these activities.

Recommendations to Improve Legislative Oversight of HIPAA Activities

We recommend that the Legislature approve the funding included in the budget to support state Health Insurance Portability and Accountability Act (HIPAA) compliance activities, but schedule all requested funds in the proposed new budget item (9909) for such activities. We further recommend the enactment of legislation to govern HIPAA compliance activities, limit the term of proposed HIPAA compliance positions, and replace the administration's proposed budget bill language with language that makes HIPAA allocations subject to state legislative requirements.

Fund All Activities Through HIPAA Fund. To adequately track all HIPAA allocations and expenditures beginning in the budget year, we recommend that the Legislature delete all HIPAA proposals from the separate department budget items and instead schedule these allocations in the HIPAA fund budget item (Item 9909). Allocations of reimbursements would be budgeted for the affected departments. The specific budget requests would be revised as follows:

- The DDS, $425,000 General Fund and $425,000 reimbursements.
- The DMH, $1.2 million General Fund and $1.2 million reimbursements.
- The DHS, $2 million General Fund, about $17 million reimbursements.
- The OSHPD, $79,600 federal funds.

Approve Positions for Two-Year Limited Terms. We also recommend that any positions requested by departments for HIPAA compliance ac-

tivities be approved for two-year limited terms. Specifically, we recommend the following:

- The DMH, nine positions.
- The DHS, 15 positions.
- The OSHPD, one position.

Enact Legislation to Govern HIPAA Activities. We recommend the enactment of legislation to govern state HIPAA compliance activities that establishes a strong statutory framework appropriate for such a broad and complex statewide project. We recommend that the legislation include specific provisions that:

- Designate HHSA as the lead agency for state HIPAA compliance activities. We recommend HHSA for this role because the agency has the broad health policy and program expertise needed to direct and assist other departments in HIPAA compliance activities. Since non-HHSA departments will also be affected by HIPAA, the legislation should authorize HHSA to direct and monitor HIPAA compliance activities in those other departments.
- Direct HHSA to develop a statewide HIPAA compliance plan.
- Require departments to complete HIPAA assessments to determine the impact of HIPAA compliance on department operations.
- Establish appropriate time frames within which control agencies must complete reviews of departmental fund requests.
- Establish clear lines of authority over the administration of the HIPAA fund.
- Specify how funds will then be transferred and allocated from the HIPAA fund.
- Provide 30-day notification to the Legislature upon allocation from the HIPAA fund.

The legislation should be modeled on Chapter 608, Statutes of 2000 (AB 2817, Honda), which established oversight and other procedures for allocation of funding from the state's Information Technology Innovation Fund. Like Chapter 608, the HIPAA legislation would establish criteria for project funding, assignment of responsibility for approving proposals, guidelines for funding requests, and procedures for notifying the Legislature regarding funding allocations.

Reject Proposed Budget Bill Language; Adopt New Budget Bill Language. We recommend that the Legislature reject proposed budget bill language for Item 9909-001-0001 relating to the allocation of the HIPAA

fund. We recommend that the Legislature replace this language with budget bill language that ensures fund allocations are consistent with the proposed legislation. Specifically, we recommend the following budget bill language:

> Provision X. The funding provided in this item shall be available for expenditure contingent upon enactment of legislation in the 2001-02 legislative session specifying procedures for allocations from this item. Funding shall be expended consistent with any requirements of that legislation.

IMPLEMENTATION OF PROPOSITION 36

In November, California voters approved Proposition 36, the "Substance Abuse and Crime Prevention Act of 2000," a measure that makes significant changes to the state's criminal justice and drug treatment systems. Implementing Proposition 36 will pose challenges to the state and counties. In this analysis, we summarize the provisions of Proposition 36, its key organizational, implementation, and funding issues, and the steps taken so far by the administration to carry out its provisions. We also offer a number of options for legislative changes and state budget adjustments the Legislature may wish to consider that could assist counties in the successful implementation of the measure.

BACKGROUND

Proposition 36 changes state law so that certain adult offenders who use or possess illegal drugs would receive drug treatment and supervision in the community rather than be sent to state prison, county jail, or supervised in the community without treatment. The measure also provides state funds ($60 million General Fund in the current fiscal year and then $120 million annually thereafter through 2005-06) to counties to pay for the treatment programs and related costs. In addition to substance abuse treatment, the measure authorizes the use of the funds appropriated under Proposition 36 for vocational training, family counseling, literacy training, probation supervision, and court monitoring of offenders subject to the provisions of the measure. Figure 1 summarizes the provisions of the new law.

Key State and Local Agencies Involved. The key players involved in the implementation of the proposition include several state agencies—specifically, the Department of Alcohol and Drug Programs (DADP), the Board of Prison Terms, and the California Department of Corrections (CDC). The key local government entities involved include county alcohol and drug treatment agencies, trial courts, county probation departments, and educational, social, and health services agencies. The specific

implementation activities in which they are involved in regard to Proposition 36 are summarized in Figure 2 (see next page).

Figure 1

Major Provisions of Proposition 36

- ***Changes sentencing laws,*** effective July 1, 2001, to require offenders convicted of "nonviolent drug possession," as defined, to be sentenced to probation and drug treatment instead of prison, jail, or probation without treatment. Excludes some offenders, including those who refuse treatment and those found by courts to be "unamenable" to treatment.
- ***Changes parole violation laws,*** effective July 1, 2001, to require that parole violators who commit nonviolent drug possession offenses or who violate drug-related conditions of parole complete drug treatment in the community, rather than being returned to state prison.
- Requires that eligible offenders receive up to ***one year of drug treatment*** in the community and up to six months of additional follow-up care.
- Establishes certain ***sanctions for offenders*** found unamenable for treatment or who violate the conditions of probation or parole.
- Permits courts (for probationers) and Board of Prison Terms (for parole violators) to require ***offenders to participate in training, counseling, literacy, or community service.***
- Requires that treatment programs be ***licensed or certified*** by the state Department of Alcohol and Drug Programs (DADP).
- Requires ***offenders to pay*** for their treatment, if they are reasonably able to do so.
- ***Appropriates state funds for distribution to counties*** to operate drug treatment programs and provide related services.
- Requires DADP to ***study the effectiveness*** of the measure and to ***audit county expenditures.***

ISSUES, CHALLENGES, AND OPPORTUNITIES

Based upon our analysis of the measure and discussions with many of these key players, we issued a report in December entitled, *Implementing Proposition 36: Issues, Challenges, and Opportunities.* We found that the state and counties will face organizational, implementation, and funding issues, including:

Figure 2

Key Players in Proposition 36 Implementation

State

Department of Alcohol and Drug Programs

- Distribute funds to counties.
- License or certify drug treatment programs.
- Collect data from counties.
- Audit county expenditures.
- Evaluate measure's effectiveness.

Board of Prison Terms (BPT)

- Set revocation criteria for parole violators directed into treatment.
- Decide when to modify or intensify treatment program and revoke parole.

California Department of Corrections

- Supervise and monitor parole violators directed into treatment by BPT.
- Report violations of revocation criteria to BPT.
- Provide treatment services to probationers and parolees directed into treatment within the county, either directly or through contracts with private providers.

Local

Trial Courts

- Set probation revocation criteria for probationers directed into treatment.
- Monitor probationers directed into treatment, including modifying or intensifying treatment programs and revoking probation for those who violate.

County Probation Departments

- Supervise and monitor probationers directed into treatment by the local trial courts.
- Report violations of drug treatment revocation criteria to courts.

Educational, Social, and Health Service Agencies

- Provide treatment services prescribed by the courts, such as vocational and literacy training and counseling.

- Developing methods for collaboration to ensure that all key players work closely together to increase the likelihood of successful implementation.
- Assessing drug treatment capacity within counties, the needs of offenders who will be treated under Proposition 36, the gaps in the continuum of drug treatment services, and ways to fill those gaps.
- Determining the criteria for supervising and monitoring offenders who will be in treatment, as well as when to revoke their probation and parole and return them to incarceration.

- Distributing funds provided under Proposition 36 to treat and supervise offenders in the community, as well as identifying other sources of funding.

A more detailed discussion of these challenges, and our recommended approach to addressing many of them, can be found in the report.

INITIAL IMPLEMENTATION ACTIONS

Since the issuance of our report, the administration has taken several significant initial steps to commence the implementation of Proposition 36, which we discuss further below.

County Funding Allocations. In keeping with the requirements of Proposition 36, DADP has administratively established a Substance Abuse Treatment Trust Fund into which was transferred a current-year appropriation of $60 million from the General Fund. Upon the review and approval of the state Office of Administrative Law, DADP then issued emergency regulations which establish the formula to be used for the distribution of the initial $60 million.

The adopted regulation specifies that DADP may retain a portion of the $60 million for administration of the measure, and the department has set aside $1.2 million from the trust fund for this purpose. The remainder of the $60 million is to be allocated to counties under a new distribution formula devised by DADP.

Under the DADP formula, half of the funds would be allocated using a standard existing formula for the distribution of alcohol and drug treatment funds, one-fourth would be allocated based upon the prevalence of drug arrests in each county, and one-fourth would be allocated based upon the number of individuals receiving drug treatment services in each county as of November 1, 2000 (the start of the month the initiative was enacted). To ensure that small counties have sufficient resources to comply with the law, the DADP formula further guarantees each county at least $147,000 from the initial round of funding. The rules also prohibit use of the funds for capital outlay projects.

In late December, DADP announced in a letter to counties the specific allocations that would be made available to them almost immediately upon their compliance with the new regulations.

Funding Procedures. The DADP regulation requires all counties to request funds to implement the new law. In order to receive funds, a county Board of Supervisors must adopt and submit to DADP by March 1, 2001, a board resolution designating a lead agency responsible for the adminis-

tration of all Proposition 36 funds and stating the county's agreement to comply with the various provisions of the law and the implementing regulations. Each county is further required by the regulations to establish a trust fund for all Proposition 36 funds.

In addition, the new DADP rules direct each county to submit to the state a county plan for implementation of Proposition 36, including provisions indicating how the county alcohol and drug program office, probation department, and courts will collaborate to carry out the law. A deadline for counties to submit their plan is not specified in the emergency regulation, although DADP officials anticipate that nearly all counties will comply by July 1, 2001, the date when the sentencing provisions of Proposition 36 diverting eligible offenders into treatment will go into effect.

Budget Proposal. The *2001-02 Governor's Budget* details the administration's proposals for using Proposition 36 funds for staffing and other expenditures to implement the measure in both the current fiscal year and the budget year. Under the Governor's expenditure plan, the $1.2 million allocated for the current year would be used to support an initial complement of 15 staff positions that are being established administratively. The Governor's budget plan would increase administrative funding to about $2.8 million in 2001-02 and establish through the budget process a total of 25.2 staff positions for several organizational units within DADP, including a new Office of Criminal Justice Collaboration that would oversee the development of both Proposition 36 implementation and ongoing drug court programs.

The department's staffing proposal is summarized in Figure 3. The budget request also provides for additional office space, information technology, and supplies for the additional staff, and allocates $600,000 in the budget year for a public university study of the new law as required by Proposition 36.

Under the Governor's budget proposal, the funding for staffing and other expenditures would be appropriated to DADP from the Substance Abuse Treatment Trust Fund. Proposition 36 appropriates $120 million from the General Fund to that trust fund in 2001-02 and in ensuing years through 2005-06.

Additional Administration Steps in Progress. At the time this analysis was prepared, we were advised that the administration was in the process of taking several additional significant steps to implement Proposition 36. These include:

- Review of the statutory and regulatory authority of DADP to ensure that Proposition 36 treatment providers are licensed or certified, as the measure requires. The department is also consid-

ering what new requirements, if any, should be established for the credentialing of drug treatment counselors.

Figure 3

Staffing Proposed for Implementation of Proposition 36

2001-02

DADP Unit	Positions	Key Activities
Permanent Positions		
Office of Criminal Justice Collaboration	8.0	Oversee implementation and provide technical assistance to counties.
Office of Legal Services	1.0	Research and analyze legal and regulatory issues.
Office of Applied Research and Analysis	2.0	Organize and supervise research into effects of Proposition 36.
Information Management Services Division	1.0	Identify and implement needed modifications to information systems.
Licensing and Certification Branch	7.0	Conduct site reviews of treatment facilities and seek corrective actions.
Audit Services Branch	6.2	Conduct audits of counties and treatment providers.
Total, new permanent positions	**25.2**	
Temporary Positions		
Human Resources Branch	1.0	Establishment of new positions and hiring of additional personnel.
Total, new temporary positions	**1.0**	
Total, staffing augmentation	**26.2**	

- Development of additional regulations for the distribution of funding from the Substance Abuse Treatment Trust Fund to counties in 2001-02 and in subsequent years. As we noted earlier, the formula established in the emergency regulations applies only to funding distributed in the current year.
- Creation of several panels to assist in the overall implementation of the measure. The DADP was planning to establish advisory panels to provide it with guidance from outside experts on overall implementation issues as well as specifically on the required evaluation of Proposition 36. Steps were also being taken to foster collaboration among the various state agencies involved in the implementation of the measure.

PROPOSITION 36 BUDGET ISSUES

Budget Actions in DADP and CDC

We recommend that the Legislature approve the proposed Department of Alcohol and Drug Programs budget to implement Proposition 36. We further recommend in our analysis of the California Department of Corrections' (CDC) budget (Item 5240) that CDC's budget be reduced by about $45 million to reflect the drop in the prison inmate population that is likely to occur in the budget year.

Accept DADP Budget Proposal. Our analysis indicates the DADP budget proposal is consistent with the proposition's requirements for strong state oversight of county implementation of the measure. The DADP's proposed expenditures for the administration of Proposition 36 from the Substance Abuse Treatment Trust Fund appear to be reasonable given the department's significant new workload and responsibilities. The funding allocated to DADP in 2001-02 would amount to about 2.3 percent of the total appropriation from the trust fund in 2001-02. Accordingly, we recommend approval of the budget request.

Reduce Prison Budget. As we further discuss in our analysis of the CDC, the budget does not take into account the impact of Proposition 36 on the prison and parole populations during the budget year. This is the case even though the diversion of offenders to treatment commences in July 2001. The CDC estimates that, as a result of Proposition 36, 3,770 fewer prison beds will be needed in the budget year and that parole caseloads will decrease by 1,051 offenders.

In our analysis of the CDC budget (Item 5240), we propose a $61 million net reduction in the department's General Fund expenditures. This amount includes $45 million to reflect the impact of Proposition 36 and $16 million to reflect a continuing decrease in the inmate population not taken into account by recent administration population projections. The Legislature may wish to consider further adjustments to prison spending at the time of the May Revision. At that time, the CDC budget plan will be adjusted to reflect updated population projections which are likely to take into account the effects of Proposition 36.

As we discuss later in this analysis, the Legislature may wish to redirect part of this $45 million in General Fund savings due to Proposition 36 to enhance efforts to implement the measure or to use these savings to address other legislative priorities.

Funding Options For Implementing Proposition 36

We recommend that the Legislature consider a number of options for legislative changes and state budget adjustments that could increase the odds of Proposition 36's success. The list of options involves the California Medical Assistance Program and California Work Opportunity and Responsibility to Kids program, federal funding that is available for worker training, literacy education, and drug treatment programs, private insurance coverage of treatment, low-interest loans for treatment facilities, and the redirection of state General Fund savings from the implementation of the measure.

State Has Stake in Proposition 36 Success. A number of counties have predicted that the funding provided to them from the Substance Abuse Treatment Trust Fund will be insufficient to provide the treatment and supervision services necessary under Proposition 36. As we have previously advised the Legislature, we believe it is too early to reach that conclusion until the treatment needs and methods of supervision of the proposition have been determined.

However, our December report also acknowledged that additional resources beyond those appropriated by the measure would be needed in order to implement Proposition 36 in a more intensive and comprehensive way. These implementation issues include providing for the drug-testing of offenders; addressing the mental health, education, training, and other social service needs of offenders diverted to treatment; or addressing the long-standing understaffing of probation departments that existed long before the passage of Proposition 36. The measure specifically states that additional appropriations by the Legislature to the treatment trust fund are permitted.

The Legislature may wish to consider assisting counties in addressing these issues in light of the state's own significant stake in the potential success of Proposition 36. The successful implementation of the proposition could both improve public safety and result in significant net savings for the state (and counties) on prison operation and construction costs as well as other health and social services expenditures. Academic research has shown that well-designed and well-run substance abuse treatment programs can provide cost-effective treatment of drug addiction that prevents the further involvement of offenders in the criminal justice system.

The state could assist the counties by providing some modest additional resources to implement Proposition 36. Such resources could be provided at no net cost to the state General Fund, either by (1) effectively using non-General Fund resources such as available federal funds and private insurance coverage, and (2) redirecting General Fund savings that will accrue to the state as a result of the implementation of the measure.

Accordingly, the Legislature may wish to consider the following options for legislative changes and state budget adjustments that we describe below that would result in more intensive and more comprehensive implementation of Proposition 36. As these options are considered, we recommend that the Legislature carefully weigh the potential fiscal and policy benefits to the state from a more successful implementation of Proposition 36 against the overall fiscal condition of the state and its other important spending priorities.

Federal Block Grant Funds. Federal law provides California and other states with allocations of Substance Abuse Prevention and Treatment Block Grant funds. The Governor's budget for DADP proposes to allocate about $223 million of these block grant funds for expenditure during 2001-02. About $15 million would be budgeted for state operations and the remaining $208 million for local assistance.

However, DADP was recently advised by federal authorities that there will be an additional $12 million in block grant funds allocated to California during 2001-02. These additional block grant funds are not reflected in the Governor's budget and would be available if the Legislature so determined to further efforts to implement Proposition 36.

Some or all of these funds could be transferred to the Substance Abuse Treatment Trust Fund created by the proposition. The Legislature also has the option of creating a separate state program providing grants to counties for local Proposition 36 implementation efforts. Providing these funds to counties separately of allocations from the Substance Abuse Treatment Trust Fund would permit the block grant funds to be used for drug-testing of Proposition 36 offenders, given that the proposition bars use of money from the trust fund for this purpose. Another alternative would be to increase the amount of block grant funds budgeted for DADP local assistance, allowing the counties to determine whether they wished to use their share of the grants to augment Proposition 36 programs or for some other purpose.

Eligibility for California Work Opportunity and Responsibility to Kids (CalWORKs) Services. The federal welfare reform legislation generally provides that offenders with a recent drug-related felony conviction are not eligible for cash assistance or for services, such as drug treatment, transportation, child care, or help in obtaining employment. (Their children remain eligible for welfare assistance.) However, the federal legislation does give states the option of adopting statutes permitting cash assistance and services to be provided to some or all of these offenders. So far, California has not exercised its option to do so.

According to CDC data, about 18 percent of the offenders sentenced to prison for drug possession felonies are women. Given that many of

these offenders have low incomes, and that many have custody of their children, it appears likely that several thousand offenders annually diverted to treatment programs under Proposition 36 could be eligible for CalWORKs services if they did not have a recent drug conviction on their record. (A parole violator diverted to drug treatment under Proposition 36 who did not have a recent conviction for a drug offense—for example, someone initially convicted of burglary and subsequently released to parole—could be eligible for CalWORKs cash assistance and services.)

If the Legislature were to change state law so that now-ineligible offenders were allowed to receive treatment services under the CalWORKs program, it appears likely that sufficient funding would be available to address their needs. In recent years, tens of millions of dollars of CalWORKs funds allocated to the counties for drug treatment and mental health services have gone unspent.

Under these circumstances, the Legislature may wish to consider amending the state welfare reform law to allow drug treatment and related services (but *not* cash assistance) to be provided through CalWORKs for Proposition 36 offenders who would qualify for such services were it not for a recent drug conviction. In our view, providing these treatment services would help reduce the welfare dependency of families of offenders whose involvement in crime is often associated with their addiction to illegal drugs. Counties would also be provided additional resources from CalWORKs that might otherwise go unspent to significantly enhance the treatment programs provided for offenders in compliance with Proposition 36.

Counting Welfare Spending as Matching Funds. The option of changing CalWORKs eligibility rules to allow certain Proposition 36 offenders to qualify for services could provide the state with additional fiscal flexibility. Pursuant to federal welfare reform legislation, California may count all state spending on families eligible for CalWORKs, even if they are not enrolled in the CalWORKs program, for purposes of meeting maintenance-of-effort (MOE) requirements for state matching funds. By counting appropriate Proposition 36 expenditures as MOE, the state is free to spend an equivalent amount of General Fund money for any other purpose it chooses. We estimate that the state could free up about $11 million General Fund annually for other purposes by counting appropriate Proposition 36 expenditures as MOE.

We would note that, even if the Legislature does not choose to change CalWORKs eligibility rules for offenders convicted in the courts on new drug charges, the state could count as MOE some of the Proposition 36 expenditures for parole violators who meet CalWORKs eligibility rules. This would be the case even if these offenders are not actually enrolled in the CalWORKs program.

As we discuss further, the Legislature may wish to redirect General Fund money that is no longer required as a state match for the CalWORKs program to further the implementation of Proposition 36 or to address other legislative priorities.

Funding Drug Treatment With Medi-Cal Funds. Some of the offenders diverted to treatment programs under Proposition 36 could be eligible for medical assistance under the Medi-Cal Program. Because substance abuse treatment qualifies as medical service provided under the program, Medi-Cal could, at least theoretically, provide a supplemental source of funding for implementation of Proposition 36. Medi-Cal is jointly funded by the state and federal governments on almost an even dollar-for-dollar matching basis. If the funding allocated to counties under Proposition 36 could be counted as the state share of Medi-Cal treatment for eligible offenders, additional federal funds could be obtained for treatment services at no further cost to the state.

There are legal questions about this approach, however, that would need to be addressed. For example, Medi-Cal reimbursement is limited in California for specified treatment services that are deemed to be "medically necessary." Reimbursement might not be available to pay for the treatment of an individual resulting from the legal order of a judge or the state parole board absent a clinical determination that the offender has an addiction problem. However, we believe it is possible to ensure that Medi-Cal only pays for the treatment of Proposition 36 offenders when it is determined through a clinical assessment, perhaps conducted under court order, that the offender meets the test of requiring medically necessary treatment. The Legislature may wish to seek a review of such legal issues to determine whether any changes in state law are necessary and feasible to enable counties to leverage their Proposition 36 allocations with federal Medi-Cal funding.

Medi-Cal-Funded Mental Health Treatment. Proposition 36 offenders who are seriously mentally ill could also be assisted under the Medi-Cal Program because mental health services are an authorized medical service. Given that more than 70 percent of seriously mentally ill offenders also have a substance abuse problem, it is likely that several thousand Proposition 36 offenders could benefit from mental health services. With some additional state help, counties might be able to make mental health services available for offenders with a "dual diagnosis" of both drug addiction and a serious mental illness.

As is the case with drug treatment services, we believe that counties could use their Proposition 36 trust fund allocations as a match for federal Medi-Cal funding if the offender meets the test of requiring medically necessary treatment. However, some of the same legal questions

about using Medi-Cal for substance abuse treatment would also apply to the provision of mental health services in this way.

We also note that Proposition 36 does not specifically authorize the use of trust fund allocations for mental health services. However, a provision permits trust funds to be spent for "any miscellaneous costs made necessary by the provisions of this act" and therefore could be interpreted to allow funding of mental health services for an offender with a dual diagnosis of drug addiction. The Legislature may wish to consider amending Proposition 36 to clarify that trust fund allocations could be used for mental health services in such cases.

Workforce Investment Act Funding. The Legislature may wish to consider furthering Proposition 36 programs by using federal funds allocated to the state and county governments under the Workforce Investment Act. Proposition 36 authorizes judges and parole officials to mandate that offenders participate in vocational training and literacy education programs, and the measure allows funds from the Substance Abuse Treatment Trust Fund to be used to provide such training. If other sources of funds were available to pay for vocational training and literacy education, though, more money would remain available for counties' substance abuse treatment programs and related services.

The *2001-02 Governor's Budget* appropriates about $800 million in funding received by the state under the Workforce Investment Act, a recent federal law that targets funds to assist adults facing serious barriers to employment. Up to 15 percent of the allocation is reserved for statewide activities, with the balance of funding allocated to counties. The Governor's proposed budget identifies few specific statewide projects, and proposes to leave most allocation decisions to the California Workforce Investment Board.

The Legislature, or the board, may wish to consider setting aside part of the state's allocation for Proposition 36 offenders, or encouraging counties to take similar actions with their Workforce Investment Act allocations. Our analysis indicates that some offenders subject to Proposition 36 may have other significant problems beside their drug addiction, such as a lack of job skills, that increase their risk of future involvement with the criminal justice system. These offenders may be less likely to commit probation or parole violations or commit new crimes if they received vocational training that made them employable using the federal funds available under the Workforce Investment Act. The federal law permits these funds to be used to provide job training and job preparation assistance for adults, as well as for literacy education provided in coordination with employment assistance services.

Private Health Insurance Coverage. Proposition 36 provides that any offender who is reasonably able to do so may be required to contribute to the cost of his or her placement in a drug treatment program. Not all offenders convicted of the nonviolent drug possession crimes subject to the provisions of Proposition 36 will be indigent, and our analysis indicates that many will face at least a nominal charge for the cost of their services. Moreover, some individuals subject to the drug treatment provisions of Proposition 36 may have health insurance that could provide substantial reimbursements of the cost of substance abuse treatment provided under the measure.

If third-party private reimbursement was available to pay for treatment services in such cases, more public money would remain available to counties to enhance their substance abuse treatment programs and to support other activities to implement Proposition 36 effectively. However, we are advised that, in such cases, some health insurers may decline to pay for such services on the grounds that they were the result of a criminal conviction rather than medical necessity. The Legislature may wish to ask Legislative Counsel whether there are any legal impediments to ensuring that third-party reimbursement is available to counties to help pay for treatment provided under Proposition 36. As in the case of Medi-Cal, we believe third-party payment for such services may reasonably be required when a clinical assessment has determined that they are medically necessary.

Capital Outlay Needs of Treatment Facilities. The DADP has predicted that Proposition 36 could result in the need for a significant expansion of residential facilities and nonresidential programs to serve offenders diverted to treatment under its provisions. We are advised by drug treatment providers that they will need new or expanded facilities for residential or outpatient treatment programs to serve Proposition 36 offenders in addition to their existing drug treatment patients. However, the DADP's emergency regulations prohibit the use of any of the first allocation of money from the trust fund for major capital outlay projects.

We believe the state could assist counties and drug treatment providers with their capital outlay needs through the existing loan program operated by the California Health Facilities Financing Authority. The authority has frequently provided 3 percent interest-rate loans for up to 15 years to drug treatment programs as well as other types of health program providers. We are advised that the authority may have up to $18 million available during the budget year for such loans. The Legislature may wish to request the authority to (1) assess whether it has sufficient funding available to meet the anticipated needs of providers participating in the implementation of Proposition 36 and (2) report at the time of budget hearings as to whether it has sufficient resources to meet the needs both

of drug treatment providers and other types of medical providers seeking financing assistance.

Redirection of State Savings. Earlier in this report, we indicated that the Legislature has the option of redirecting anticipated state savings on prison operating costs due to Proposition 36 to further efforts to implement the measure. Any General Fund resources made available by counting Proposition 36 expenditures as a match to the CalWORKs program could also be used for such purposes.

For example, the Legislature could use these additional General Fund resources to provide counties with the funding needed to pay for drug-testing of Proposition 36 offenders. While the proposition prohibits the use of the Substance Abuse Treatment Trust Fund to support drug testing, the measure does not prohibit drug testing for offenders paid for from other funding sources such as we have identified. The Legislature may also wish to consider providing additional funding for court monitoring or probation supervision of Proposition 36 offenders.

CONCLUSION

In considering the alternatives we have offered in this analysis, the Legislature should bear in mind that some of these options represent courses of action that do not work in combination with each other. For example, to the extent that Medi-Cal funding is used to provide substance abuse treatment services for Proposition 36 offenders, those expenditures may not also be counted as state MOE for the CalWORKs program.

Other options may complement each other. That is the case, for example, with the alternatives on counting MOE and the option for making certain Proposition 36 offenders eligible for CalWORKs services.

Finally, as we stated earlier, we recommend that the Legislature carefully weigh the potential fiscal and policy benefits to the state from the successful implementation of Proposition 36 against the overall fiscal condition of the state and its other important spending priorities in making such funding decisions.

CALIFORNIA SPENDING ON LONG-TERM CARE SERVICES

SUMMARY OF SPENDING AND CASELOADS

A number of diverse programs make up California's system of long-term care, and a variety of consumers use long-term care services. Our review of long-term care spending and caseloads shows that about half of the state's long-term care expenditures are for institutional care, while most long-term care consumers receive their care from home- and community-based services. Generally, long-term care spending is increasing, while caseloads are either remaining constant or growing at a much smaller rate than spending. In our review, we also note that California's long-term care programs comprise a fragmented service system, but that efforts are under way to improve coordination.

Background

Assembly Bill 452 (Mazzoni). Assembly Bill 452, the Mazzoni Long-Term Care Act of 2000 (Chapter 895, Statutes of 1999), directed the Legislative Analyst's Office to provide in our *2001-02 Analysis of the Buget Bill* a summary of spending on California's long-term care programs and, to the extent feasible, estimates of the population served by each program. In accordance with Chapter 895, in this section we provide an inventory of the state's long-term care services. We examine what is meant by long-term care, how much is spent on long-term care services, and how many clients are served by the various programs. We also report on recent patterns of growth in California's long-term care system. Later in this *Analysis*, we also provide a summary of the Governor's 2001-02 proposals to strengthen long-term care.

State's Efforts to Improve Long-Term Care. Both the Governor and the Legislature have demonstrated an interest in improving the quality and availability of long-term care services in California. The Governor's Aging With Dignity Initiative and the Legislature's subsequent budget actions in 2000 provided for enhancements in the state's long-term care

services. The Legislature also passed additional long-term care measures which were subsequently approved by the Governor. For example, in addition to mandating this report, Chapter 895 established a state Long-Term Care Council through the year 2006. Comprised of directors from selected departments within the California Health and Human Services Agency (HHSA), the council is charged with the task of developing strategies for long-term care. As an initial effort to coordinate long-term care services, the council submitted state long-term care budget proposals for the *2001-02 Governor's Budget*.

Efforts to improve long-term care in California have focused primarily upon expanding long-term care services that prevent or delay institutional care, maximize a person's independence, and offer consumer choice. Changes in long-term care services that have occurred have resulted not only from state policy initiatives, but also from federal incentives. In particular, the federal government provides matching funds for qualifying state programs that offer home- and community-based care as an alternative to institutional care. In addition, a recent U.S. Supreme Court decision, *L.C. & E.W. vs. Olmstead*, is likely to shape continued state efforts to improve long-term care. The June 1999 court ruling means that states must provide alternatives to institutions for persons with disabilities who could transition to a community setting, notwithstanding available resources and consumer preference.

Characteristics of Long-Term Care

Long-Term Care Encompasses a Wide Array of Services. In general, California law defines long-term care as a coordinated continuum of services that:

- Addresses the individual's health, social, and personal needs.
- Maximizes the individual's ability to function independently outside of an institution.

Long-term care services assist the individual in accomplishing routine daily activities, depending on an individual's level of need. For example, a long-term care service may provide a disabled person with assistive technology that allows that person to accomplish routine activities independently. In another case, an individual may receive assistance in the home with meal preparation; housework or shopping; or with eating, bathing, and dressing.

Generally, long-term care does not include medical care. Health insurance, including Medicare, provides for acute medical care, but generally does not cover nonmedical support services needed to perform daily routine activities. Supportive services, therefore, are made available by

other providers and payers of long-term care such as Medicaid; family caregivers (spouses, adult children, and relatives); and private long-term care insurance. Some long-term care services, notably skilled nursing facilities, adult day health care, and the Program for All-Inclusive Care for the Elderly (PACE) nevertheless do provide some medical care, which is incorporated into the service provider's rates for overall long-term care.

Long-Term Care Services Used by Diverse Group. Long-term care services are provided not only to the elderly (65 years and older), but also to younger persons with developmental disabilities, mental disabilities, or physical disabilities. Many elderly and disabled persons receiving long-term care are linked to the long-term care system as a result of being eligible for Medi-Cal or the Supplemental Security Income/State Supplementary Program (SSI/SSP).

Persons with developmental disabilities generally have a mental or physical impairment, which begins before their eighteenth birthday and is expected to continue indefinitely, and is due to mental retardation, cerebral palsy, epilepsy, autism, or a condition closely related to mental retardation. They receive their services in state-operated developmental centers or in the community through nonprofit regional centers. Individuals with mental disabilities include mentally ill persons, who generally receive care in state and county mental health programs, and persons with traumatic brain injuries. Persons with physical disabilities may receive services supported by the Department of Rehabilitation that maximize their ability to function independently, such as those offered by independent living centers.

Delivery of Long-Term Care Services

Where Long-Term Care Is Provided. Figure 1 (pages 53 through 55) provides a summary of state-funded long-term care programs. Programs are listed according to the setting—institutions, the community, or the home—in which the program is provided. Major programs within each setting have been identified along with the department that administers or provides funding for the program, the total amount of spending in 2000-01, the types of services provided, and the types of clients served.

Long-term care services are provided in a variety of settings and living arrangements. Institutional care includes skilled nursing facilities and intermediate care facilities, both of which are licensed health facilities. Community-based services include nonmedical residential care, adult day health care, transportation, and nutrition. The in-home category, including such programs as In-Home Supportive Services (IHSS), provides personal care services in the home and case management aimed at coordinating a variety of services that allow a person to remain in his/her own home.

Figure 1

Summary of Long-Term Care Programs

2000-01
(In Millions)

Program	Department	Total Cost	Service	Clients
Institutional Care				
Nursing Facilities—Fee-for Service	Medi-Cal/Health Services	$2,634	Private, licensed skilled nursing facilities.	Medi-Cal eligible elderly, disabled, or needy.
Nursing Facilities/Intermediate Care Facilities—Managed Care	Medi-Cal/Health Services	236	Long-term care provided by County Organized Health Systems, usually in an institutional setting.	Medi-Cal eligible elderly, disabled, or needy.
Developmental Centers	Developmental Services	656	State institutions.	Developmentally disabled.
State Hospitals-Lanterman-Petris-Short	Mental Health	110	State institutions.	Mental health patients.
State Hospitals-Forensic	Mental Health	407	State institutions.	Mental health patients.
Intermediate Care Facilities-Developmentally Disabled	Medi-Cal/ Developmental Services	326	Private, licensed health facilities.	Developmentally disabled.
Veterans' Homes-Nursing Facilities and Intermediate Care Facilities	Veterans Affairs	60	State institutions, with licensed skilled nursing and intermediate care facilities.	Elderly or disabled veterans.
Veterans' Homes-Residential	Veterans Affairs	20	State institutions, with residential and domiciliary care.	Elderly or disabled veterans.
Community-Based Care				
Regional Centers/Nonresidential	Developmental Services	$1,120	Services provided to clients residing in own home or home of a relative.	Developmentally disabled.

Continued

Program	Department	Total Cost	Service	Clients
Regional Centers/Residential	Developmental Services	$708	Services provided to clients residing in community care facilities.	Developmentally disabled.
SSI/SSP Nonmedical Out-of-Home	Social Services	456	Cash grant for residential care (generally, grants used for Residential Care Facilities).	Elderly or disabled, as eligible according to income and assets.
Adult Day Health Care	Medi-Cal/Aging	123	Licensed facilities offering health, therapeutic, and social services.	Elderly, disabled adults.
Nutrition	Aging	68	Congregate or home-delivered nutritional meals.	Elderly.
Program of All-Inclusive Care for the Elderly	Health Services	66	Full range of care, including adult day health, case management, personal care, provided on a capitated basis.	Elderly.
Supportive Services	Aging	36	Programs authorized by the Older Americans Act, including case management and transportation.	Elderly.
Conditional Release Program	Mental Health	17	Assessment, treatment, and supervision.	Judicially committed.
Independent Living Centers	Rehabilitation	13	Grants provided to centers, which provide a full range of services.	Disabled.
Caregiver Resource Centers	Mental Health	12	Nonprofit resource centers.	Caregivers of brain-impaired adults.
Ombudsman	Aging	6	State program that advocates for rights of residents in 24-hour long-term care facilities.	Elderly.
Alzheimer's Day Care Resource Centers	Aging	5	Day care.	Persons with Alzheimer's disease or other dementia and their caregivers.
Alzheimer's Disease Research Centers	Health Services	4	Diagnostic and treatment services.	Persons with Alzheimer's disease or other dementia.

Continued

Program	Department	Total Cost	Service	Clients
Senior Companion Program	Aging	$2	Companionship and transportation services.	Elderly.
Respite Care	Aging	1	Temporary or periodic services to relieve primary and unpaid caregivers.	Elderly or disabled, and their caregivers.
In-Home Care				
In-Home Supportive Services	Social Services	$1,972	Private and public services, coordinated by the county welfare departments, to allow eligible persons to remain in their homes.	Low income elderly, blind, or disabled.
Multipurpose Senior Services Program	Aging	39	Case management program provided under a federal waiver to prevent or delay premature institutional placement.	Medi-Cal eligible elderly certifiable for skilled nursing care.
Linkages	Aging	9	Case management program to prevent or delay premature institutional placement (services provided regardless of Medi-Cal eligibility).	Elderly or disabled.

Multiple State Departments Provide Long-Term Care. Within California, the Departments of Aging (CDA), Health Services (DHS), Social Services (DSS), Developmental Services, Mental Health (DMH), Rehabilitation, and Veterans Affairs directly administer programs and services that provide long-term care. In some cases, for example, mentally disabled and developmentally disabled clients, the department provides funding to county-operated entities or nonprofit organizations for long-term care services.

Many of the long-term care services in California are funded by Medi-Cal—the state's Medicaid program—which is the jointly funded state-federal health insurance program for eligible low-income and needy persons. Specifically, Medi-Cal pays for nursing home beds on a fee-for-service basis for authorized individuals. Medi-Cal also funds an in-home personal care services program as a state optional benefit, which is administered by DSS as part of the IHSS program. Medi-Cal additionally funds home- and community-based services to targeted individuals—those who might otherwise require institutional care. These services are provided under federal home- and community-based services waivers which allow payment for services not otherwise authorized by Medi-Cal. For example, the Multipurpose Senior Services Program (MSSP) provides case management to frail elderly persons so that they may continue to live in their own homes.

Other long-term care programs administered by the CDA and local Area Agencies on Aging receive federal funds under the Older Americans Act. The state provides nutrition services, as well as other home- and community-based social service programs, with these federal funds.

The state's framework for delivering long-term care services largely reflects the state's central role as an administrative entity for federal funds. The federal government requires a single state agency to be responsible for federal Medicaid funds. In California, that agency is DHS, which receives all federal Medicaid funding and disburses these funds to other departments that administer the programs providing long-term care services. Notwithstanding DHS' designation as the single state agency for federal funding, the General Fund portion of Medicaid funding is channeled through DHS only in some cases. In other cases, it is allocated directly to the department administering a particular program.

Long-Term Care Expenditures and Caseloads

Key Trends Evident in Data. Figure 2 (see pages 58 and 59) summarizes the total spending, caseloads, and cost per case for the major long-term care services provided in the state.

The data demonstrate some important points regarding California's system of long-term care:

- ***Public Spending on Long-Term Care Is Largely Concentrated on Nursing Facilities and the IHSS Program.*** About $2.6 billion will be spent during 2000-01 on nursing facilities (on a fee-for-service basis) and another $2 billion on IHSS.
- ***The State Spends Almost as Much for Institutional Care as for Home- and Community-Based Care Combined.*** California will spend $4.5 billion (all funds) for all institutional long-term care and $4.7 billion (all funds) for home- and community-based long-term care in 2000-01.
- ***More Persons Use Home- and Community-Based Services Than Reside in Institutions.*** About 250,000 individuals rely upon the IHSS program for assistance. Although spending on nursing facilities is higher than spending on IHSS, only 65,000 individuals reside in nursing homes (fee-for-service).
- ***Institutions Are the Most Costly Setting for Long-Term Care on a Per-Case Basis.*** Because institutional care generally involves higher levels of care and supervision, it costs the most—on average $50,000 per case annually. In comparison, the annual cost of providing in-home care averages no more than $8,000 per case. Although a meaningful average for community-based care cannot be computed, the average costs of the individual programs also remain well below the cost of institutional care.
- ***The General Fund Accounts for More Than Half of Long-Term Care Spending.*** The major long-term care programs, including nursing facilities, services for the developmentally disabled, and IHSS, are funded by Medi-Cal. The state receives matching federal dollars for most of the services provided under these programs. The federal government, therefore, shares a significant portion of state long-term care costs. On balance, however, the General Fund is the primary source of long-term care services, accounting for more than half of the total.

Long-Term Care Spending Is Increasing

Growth in Spending Over Three Years. As Figure 3 shows (see page 59), spending on state-funded long-term care services grew from nearly $7 billion in 1998-99 to $7.7 billion in 1999-00, and is estimated to reach $9.1 billion in 2000-01. During this period, the General Fund portion of these costs was $3.7 billion in 1998-99, $4.2 billion in 1999-00, and will be an estimated $5 billion in 2000-01.

Figure 2

State-Funded Long-Term Care Services Funding and Caseloads

2000-01
(Funding In Millions)

Program	Department[a]	Funding				Caseloads[b]	Cost Per Case
		State	Federal	Local	Total Amount		
Institutional Care							
Nursing Facilities—Fee-for-Service	Medi-Cal/DHS	$1,308	$1,326	—	$2,634	65,050	$40,487
Nursing Facilities/ICFs—Managed Care	Medi-Cal/DHS	117	119	—	236	8,704	27,130
Developmental Centers	Medi-Cal/DDS	417	240	—	656	3,844	170,751
State Hospitals-LPS	DMH	9	4	$97	110	857	128,636
State Hospitals-Forensic	DMH	407	—	—	407	2,717	149,835
ICF-DDs	Medi-Cal/DDS	160	166	—	326	7,075	46,062
Veterans' Homes-SNF&ICF	DVA	45	15	—	60	460	131,087
Veterans' Homes-Residential	DVA	15	5	—	20	965	20,478
Institution Totals		**$2,479**	**$1,873**	**$97**	**$4,450**	**89,672**	**$49,620**
Community-Based Care							
Regional Centers/Nonresidential	DDS	$806	$314	—	$1,120	133,092	$8,415
Regional Centers/Residential	DDS	510	198	—	708	22,803	31,061
SSI/SSP Nonmedical Out-of-Home	DSS	238	218	—	456	63,850	7,141
Adult Day Health Care	Medi-Cal/CDA	60	63	—	123	18,930	6,492
Nutrition	CDA	9	59	—	68	224,698	305
Program of All-Inclusive Care For the Elderly[c]	Medi-Cal/DHS	33	33	—	66	3,711	17,785
Supportive Services	CDA	5	31	—	36[d]	908,836	40
Conditional Release Program	DMH	17	—	—	17	749	23,028
Independent Living Centers	DR	6	7	—	13	33,736	$371
Caregiver Resource Centers	DMH	12	—	—	12	13,583	902
Ombudsman	CDA	4	2	—	6	180,451	32
Alzheimer's Day Care Resource Center	CDA	4	—	—	5	2,639	1,768
Alzheimer's Disease Research Centers	DHS	4	—	—	4	2,000	2,000
Senior Companion Program	CDA	2	—	—	2	425	4,388
Respite Care	CDA	1	—	—	1	1,068	604
Community Totals[e]		**$1,710**	**$926**	**—**	**$2,637**	**1,610,571**	**N/A[f]**

Program	Department[a]	Funding				Caseloads[b]	Cost Per Case
		State	Federal	Local	Total Amount		
In-Home Care							
IHSS	Medi-Cal/DSS	$746	$807	$418	$1,972	248,999	$7,919
MSSP	Medi-Cal/CDA	22	17	—	39	13,847	2,800
Linkages	CDA	9	—	—	9	5,643	1,547
In-Home Totals[e]		**$777**	**$825**	**$418**	**$2,019**	**268,489**	**N/A[f]**
Grand Totals		**$4,966**	**$3,624**	**$515**	**$9,106**	**N/A[f]**	**N/A[f]**
Percentage of Totals		55%	40%	6%	100%[g]	N/A[f]	N/A[f]

a Department of Health Services (DHS), Department of Developmental Services (DDS), Department of Mental Health (DMH), Department of Veteran Affairs (DVA), Department of Social Services (DSS), California Department of Aging (CDA), and Department of Rehabilitation (DR).

b Some caseload data represent an annual estimate based on an average monthly caseload, and therefore does not represent the number of persons served on an annual basis.

c Includes Senior Care Action Network.

d In addition to total spending shown for supportive services, $14 million (General Fund) was appropriated for long-term care innovation grants in FY 2000-01.

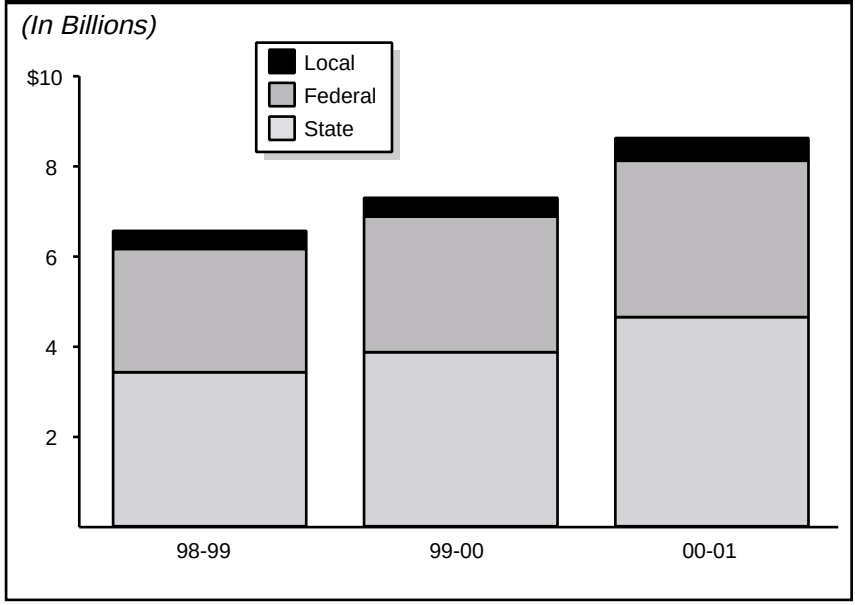
e Caseload summation does not provide an unduplicated count of total users. Many individuals use more than one service.

f Caseload summation does not provide an unduplicated count of total users.

g Percentages may not total due to rounding.

Figure 3

Long-Term Care Spending Has Increased



An increase of $1.3 billion in General Fund spending from 1998-99 through 2000-01 may be attributed in part to the expansion of services not covered by Medi-Cal and, therefore, not eligible for federal funding support. Also, there has been a reduction in federal funding for two programs. Specifically, two developmental centers lost federal funding due to noncompliance with federal requirements, and the General Fund compensated for that loss. Efforts are under way that would allow restoration of federal funding by 2001-02.

Increases in spending occurred across all three settings for long-term care. However, the rates of increase and, therefore, the relative shares that each of these settings are of total expenditures, have changed somewhat over time. For example, the data indicate that the share of total spending for institutional care has decreased slightly from 1998-99 through 2000-01, from 51 percent to 49 percent. The share of total spending for in-home care, on the other hand, has increased slightly from 21 percent to 22 percent during the same period.

Factors Contributing to Growth. We have identified two major factors contributing to growth in long-term care spending:

- ***The Costs of Providing Services Are Increasing***. In particular, IHSS spending grew at a significant rate, largely due to wage increases approved for home-care workers in 2000-01. In addition, institutional care costs are being driven upward by rising costs for health care and are reflected in a state increase in the rates paid to nursing facilities, intermediate care facilities, and adult day health care centers beginning in August 2000. The increase in the rates includes a wage increase to be passed through to certain employees of nursing facilities and intermediate care facilities.

- ***The State Is Expanding Community-Based Long-Term Care Programs***. For example, the state increased the number of PACE programs in 1998 after the federal government permanently authorized the PACE model of care as a federally funded Medicare and Medicaid benefit. The PACE is an innovative managed care program where one rate covers a full range of both acute- and long-term care services as an alternative to institutional care. Another example is the expansion of adult day health care to for-profit services, authorized by Chapter 1121, Statutes of 1994 (SB 1492, Mello). The Linkages program and the MSSP, both case management programs intended to prevent premature institutional placement, also have been expanded in recent years.

Caseloads Not Main Cost Factor. Notably, caseloads are not significantly driving up costs for the largest long-term care programs. For example, growth in caseloads over fiscal years 1998-99, 1999-00, and 2000-01

has remained fairly flat for the services with the highest spending levels, specifically for nursing facilities and developmental centers. Expenditures for nursing facilities, on a fee-for-service basis, grew an average of 13 percent each year and expenditures for developmental centers grew an average of 15 percent each year, while caseloads show zero growth. Also, caseloads for regional centers for the developmentally disabled and caseloads for the IHSS program grew at significantly lower rates than the corresponding growth in expenditures for these programs. Caseloads for regional centers generally grew by 6 percent per year, while overall expenditures for this program grew by 15 percent. Likewise, caseloads for the IHSS program grew an average of 7 percent each year, while costs rose by 19 percent.

Coordination of Long-Term Care Services

Long-Term Care Services Are Fragmented. The state's continuum of long-term care consists of multiple programs administered by multiple entities. Administration of long-term care services in California remains fragmented with no real "system" of long-term care in place. With the exception of the regional centers, which coordinate care for persons with developmental disabilities, little formal coordination of services available to eligible individuals occurs. Nevertheless, informal coordination sometimes does take place at the local level. An adult day health care center, for example, might assist an individual in accessing other services, such as IHSS and transportation services.

Current Efforts to Coordinate Services. The Long-Term Care Council, chaired by the HHSA, was recently established as an interagency working group to seek efficiencies in long-term care programs and to recommend viable options for individuals with long-term care needs. In addition, DHS has a Long-Term Care Integration Pilot Project to develop and test a seamless service delivery system at the local level.

LONG-TERM CARE BUDGET ISSUES

Summary of the Governor's 2001-02 Proposals

The* 2001-02 Governor's Budget *proposes more than $10 million ($8 million General Fund) for various programs to expand home- and community-based long-term care services. The proposals build upon the Governor's Aging With Dignity Initiative, recently enacted legislation, and the efforts of the California Long-Term Care Council that was established last year. We raise no issues with most of the proposals at this time.

The *2001-02 Governor's Budget* proposes approximately $10 million ($8 million General Fund) to establish new and expand existing home- and community-based long-term care services. The administration proposals are explained below and summarized in Figure 4.

Figure 4

Governor's Long-Term Care Proposals

2001-02
(In Millions)

	General Fund	Other Funds	Total
New Programs			
Pilot Projects to Expand Community Long-Term Care Options	$0.5	$0.5	$1.0
Assisted Living Waiver	0.5	0.5	1.0
Nursing Home Quality of Care	1.0	0.9	1.9
Institutions for Mental Diseases Transition Pilot Project	1.0	—	1.0
Elder Abuse Awareness Campaign	2.0	—	2.0
Continued Programs			
Linkages	$1.5	—	$1.5
Adult Day Health Care	0.5	$0.5	1.0
Senior Wellness Education Campaign	1.0	—	1.0
Totals	**$8.0**	**$2.4**	**$10.4**

- ***Pilot Projects to Expand Community Options for Long-Term Care:*** $1 million ($500,000 General Fund) for a contractor to develop and evaluate a pilot project that would seek community placement for certain disabled Medi-Cal eligible persons residing in nursing homes. The pilot would include the development of an assessment tool for community placement and would run for three years at three sites. This proposal, which would be implemented by DHS, was developed in conjunction with the Long-Term Care Council.
- ***Assisted Living Waiver:*** $1 million ($508,000 General Fund) to contract out the development of a federal demonstration waiver that would allow Medi-Cal eligible persons to receive care in residential care facilities or supportive housing. This proposal would implement Chapter 557, Statutes of 2000 (AB 499, Aroner), and could offer an alternative to nursing home care for some individuals.

- ***Nursing Home Quality of Care***: $1.9 million ($1 million General Fund) to create a Centralized Complaint Intake Unit within the Licensing and Certification Division of DHS in order to implement a standard procedure for handling complaints, in accordance with Chapter 451, Statutes of 2000 (AB 1731, Shelley). The unit would input and track complaints from residents and staff in long-term health facilities and would ensure a response to serious complaints within 24 hours. The budget would establish 22.5 permanent new positions and also includes funding to study the current method of reimbursing long-term care through the Medi-Cal Program.

- ***Institutions for Mental Diseases (IMDs) Transition Pilot Project***: $1 million from the General Fund annually for three years to seek community placement for individuals in IMDs. The IMDs are institutions providing long-term nursing and psychiatric care that are operated and funded by the counties under state-local realignment. During the first year, $750,000 would be distributed to counties to assess which IMDs residents could be placed in a home- or community-based setting. This proposal would be implemented by DMH and also was developed in conjunction with the Long-Term Care Council.

- ***Elder Abuse Public Awareness Campaign***: $2 million from the General Fund for the Attorney General, in conjunction with other state and private organizations, to establish a statewide campaign to raise public awareness about elder and dependent adult abuse, as required by Chapter 559, Statutes of 2000 (AB 1819, Shelley). The Governor proposes to spend a total of $6 million over three years on this campaign.

- ***Linkages Expansion***: $1.5 million from the General Fund to add up to 900 new client slots and to increase staffing for case management and support of seniors living at home who do not qualify for similar services available to Medi-Cal beneficiaries. Authorized by the Older Californians' Act in 1989, the Linkages program is administered by the CDA. Currently, it serves more than 5,000 clients at 36 different sites. The proposal would increase the client slots at each of the sites by 25.

- ***Adult Day Health Care:*** $982,000 ($484,000 General Fund) to increase CDA oversight of the recently expanded adult day health care program. The proposal would establish 8.5 new positions (3.5 of which are two-year limited term) and convert 2 limited-term positions to permanent status in order to handle an increased workload resulting from growth in the number of adult day health care centers.

- ***Senior Wellness Education Campaign:*** $1 million from the General Fund to make permanent the Senior Wellness Education Campaign, which is an Aging With Dignity Initiative funded as a one-time cost in 2000-01. The campaign targets seniors, their families, caregivers, and community organizations for the purpose of encouraging healthier lifestyles that might prevent the need for full-time, long-term care.

Evaluating the Governor's Long-Term Care Proposals

Projects Move in Right Direction. Our analysis indicates that the Governor's budget proposals generally have merit and are consistent with the administration's and the Legislature's efforts to strengthen the long-term care system through the adoption last year of the Aging With Dignity Initiative and the establishment of the Long-Term Care Council.

Several of the projects also are consistent with the mandates of the *Olmstead* decision, which found that the unjustified institutionalization of people with disabilities constitutes discrimination under the Americans with Disabilities Act. The court's decision therefore compels states to review available alternatives to institutional care for individuals with disabilities. Two of the Governor's budget proposals seek to identify individuals currently receiving institutional care (in nursing facilities and in county-operated IMDs) for placement in a community setting. A third proposal would advance compliance with the *Olmstead* ruling by seeking to develop an assisted living Medi-Cal waiver program that also might offer an alternative to institutional care for some individuals.

At this time, we have no issues with the Governor's proposals to implement an assisted living waiver, expand the Linkages program, conduct elder abuse public awareness and senior wellness education campaigns, and expand oversight of adult day health care centers. We discuss our proposed modifications of the other budget proposals below.

State May Be Eligible for Federal Grants to Fund New Projects

We recommend that funding for the Institutions for Mental Diseases transition pilot project be reduced by $333,000 from the General Fund, with a corresponding increase in federal funds by $333,000, due to the availability of federal grant funds for such projects. We also recommend approval of the funding requested for pilot projects to expand community options for long-term care, but propose that the federal funding appropriation be increased by $833,000 because of the availability of federal grant funding for expansion of such projects. Finally, we recommend that the state Health and Human Services Agency report at

the time of budget hearings on state activities to apply for these federal grants. (Reduce Item 4440-101-0001 by $333,000, increase Item 4440-101-0890 by $333,000, and increase Item 4260-001-0890 by $833,000.)

New Federal Grant Programs. The Health Care Financing Administration (HCFA), the agency that administers the federal Medicaid program, recently announced two grant programs providing collectively more than $65 million to states for projects that would allow persons with disabilities and chronic illnesses to live in the most integrated setting appropriate to their needs. Two of the long-term care projects proposed in the *2001-02 Governor's Budget* appear to be eligible for these new federal grants.

Grants to Transition Disabled Persons From Institutions. The first federal grant program would assist states in the transition of disabled persons from nursing facilities to community-based settings. The HCFA plans to award up to $15 million in grants nationally by September 2001, with each individual grant ranging from $300,000 to $1 million for a period of three years.

One of the Governor's proposals, the IMDs transition pilot project, appears to be eligible for funding from the new federal grant program. Just as the federal grant program proposes, the Governor's pilot project aims at providing a transition for disabled persons from an institution to the community. The Governor's proposal for a three-year pilot also matches the proposed three-year term of the federal grants. Shifting the cost of the pilot program from the state to federal grant funds could result in a savings to the state General Fund of up to $333,000 annually for three years.

Grants for Expanding Community Options. The second federal grant program announced by HCFA would award $50 million to states over three years, with individual state grants ranging from $250,000 to $2.5 million for the project period. These so-called "real choice systems change" grants are to support state programs that generally create improvements in community living for people with disabilities.

Our analysis indicates that this second federal grant program could assist the Governor's budget proposal for pilot projects to expand community options for long-term care. Federal grant funds probably could not be used in place of the proposed General Fund appropriation during 2001-02. That is because the initial state funding would be used to develop an assessment tool to identify persons currently residing in nursing homes who could be placed in the community, not for actually testing any new programs to support successful community placement. However, we believe that these federal grant funds could be used as an extension of the pilot projects to begin expanding these community options. If a grant application were successful, the state could receive up to $833,000

during 2001-02, and again in the two subsequent years, to follow through on the Governor's pilot projects.

Analyst Recommendations. For these reasons, we recommend a $333,000 reduction from the General Fund and a corresponding increase in federal funds for the IMDs transition pilot project. We further recommend that the Legislature adopt budget bill language authorizing DMH to submit a Section 27.00 letter for additional General Fund resources if the state is unsuccessful in a federal grant application. These actions would give DMH federal spending authority if the state is awarded grant funding but would also ensure the availability of General Fund support in the event that federal funding is not provided.

We further recommend that $833,000 in additional federal spending authority be provided to DHS in the event it is successful in obtaining federal grant funding to expand the pilot projects to expand community options for long-term care. Finally, we recommend that HHSA report during budget hearings on efforts to apply for federal grants for these projects.

Staffing Level of New Nursing Home Complaint Unit Not Justified

We withhold recommendation on $1.4 million ($500,000 General Fund) and 22.5 positions requested for a new Department of Health Services unit that would process all complaints filed against long-term care health facilities. The department has not explained why the funding and staffing for district offices now handling the intake of these complaints cannot be redirected to help support the new centralized complaint unit. We recommend that the department report at budget hearings regarding the funding and positions currently used in district offices for complaint intake activities. If the Legislature approves the department's request for the additional 22.5 positions, we recommend that 10 of the requested new permanent positions be established instead as two-year limited term positions until the ongoing workload of this new unit can be determined.

Governor's Proposal. The Governor's budget proposes to create a Centralized Complaint Intake Unit within the Licensing and Certification Division of DHS. The unit would receive and track complaints against nursing homes, and ensure proper action is taken. This proposal would facilitate a standard complaint intake procedure that is required by Chapter 451. It would add 22.5 permanent positions to staff the unit at a cost of $1.4 million ($500,000 General Fund) in 2001-02. The Governor's budget also includes $500,000 from the General Fund within the Medi-Cal budget to study the current method of reimbursing long-term care through the Medi-Cal Program.

Proposal Creates 22.5 Headquarters' Positions. The 22.5 new permanent positions include the following: 1 health facility evaluator manager, 1 health facility evaluator specialist, 2 supervisors, 2 evaluators, 12 program technicians, 2 office technicians, and 2.5 nurses. The number of positions is based upon a projected workload of processing 13,000 complaints annually.

Currently, all complaints are received and investigated by DHS Licensing and Certification district offices. Complaints are tracked in a statewide computerized system, to which headquarters has access. Under the proposed centralized complaint intake proposal, the centralized unit would receive all complaints and then assign the complaints to the appropriate district office for inspection or investigation. The district offices, therefore, would retain the primary role in investigating complaints and updating data systems for any action taken on investigated complaints.

No District Resources Redirected. The budget proposal argues that a lack of staff resources has contributed to past failures to track and to respond promptly to complaints. However, district staff did process about 13,000 oral and written complaints in 1999-00. The district staff performed job duties that will be transferred to the proposed new staff at headquarters. The Governor proposes no redirection of these district resources to fund the new centralized complaint intake unit, and has provided an insufficient explanation for keeping staffing and funding for district offices that will see a workload decrease as a result of the creation of the new centralized complaint unit. The DHS has asserted that redirection of existing staff resources would compromise other critical functions but has not demonstrated how merely shifting the location of the DHS staff involved in complaint intake activities could create a problem.

Recent Enforcement Efforts Could Result in Fewer Complaints. According to DHS data, the number of complaints received by Licensing and Certification district offices between 1997-98 and 1999-00 increased by 9 percent to about 13,000. Although the number of complaints has risen, recent enforcement efforts could result in a future decline in the number of complaints received, especially if enforcement efforts are effective. These recent enforcement efforts include increased penalties to nursing facilities for health and safety violations, increased unannounced site inspections, and the addition of Licensing and Certification district office staff to conduct investigations of complaints.

Within two years, the effect of these new enforcement efforts on workload will be known and the Legislature can determine how many permanent positions are needed to accomplish the goals required by statute. If the number of complaints drop as a result of these activities, some of the 22.5 new DHS positions proposed in the budget may no longer be needed.

Analyst Recommendation. We have no concerns about the proposed $500,000 Medi-Cal reimbursement study. We withhold recommendation on the $1.4 million requested in the budget for the new centralized complaint unit. While we agree that a higher level of service might result from the creation of the new unit, the department has not justified the level of additional new resources requested given that existing staff in district offices are currently handling this workload. For this reason, we recommend that DHS report to the Legislature regarding the funding and positions currently used for complaint intake in district offices.

If the Legislature approves the department's request for an additional 22.5 new positions, we recommend that 10 of the positions be established as two-year limited-term positions until the ongoing workload of this unit can be determined. These positions are 1 health facility evaluator specialist, 1 supervisor, 1 evaluator, 6 program technicians, and 1 office technician.

NEW TOBACCO SETTLEMENT FUND

Tobacco Settlement Funds Earmarked for Health Programs

The Governor's budget proposes to establish a new fund—the Tobacco Settlement Fund—to be used for specific health programs. In the following pages, we summarize the initiative and discuss our findings and related recommendations.

Background. In November 1998, California and other states reached a settlement agreement on lawsuits brought by the states against the major tobacco companies. It was originally estimated that California would receive about $25 billion over 25 years, with $12.5 billion going to the counties and $12.5 billion to the state. Since that time, however, the estimated amount the state and counties would receive has decreased due to a provision in the settlement agreement that reduces payments in accordance with a decline in tobacco sales. The state's share is now projected to be approximately $10.6 billion, or about $2 billion less than its original estimated share of the settlement agreement (the counties' share has been reduced by a like amount). Figure 1 (see next page) shows the amounts the state is estimated to receive each year for the entire term of the agreement.

The basis of the state's settlement agreement was that the state incurred additional expenses for treating tobacco-related illnesses in the Medi-Cal Program and other health programs, and thus, had limited funds with which to expand health coverage to the uninsured. Accordingly, there has been significant public and legislative interest in dedicating those funds to smoking cessation programs and proposals to expand access to health care for the uninsured. Several bills have been introduced in the Legislature seeking to accomplish this funding dedication goal, including SB 673 (Escutia), although none were enacted.

The Governor's Budget Proposal. The budget assumes total tobacco settlement revenues of $468 million in fiscal year 2001-02. Under the Governor's plan, all of this revenue would be deposited in a newly established Tobacco Settlement Fund (TSF), and earmarked for specific health care initiatives. Of the total amount, $295 million would be allocated to the Department of Health Services budget and $150 million would be

allocated to the Managed Risk Medical Insurance Board. The remainder would be used to establish a 5 percent reserve for the new fund.

Figure 1

Estimated Annual Tobacco Settlement Payments to the State

(In Millions)

Year	
1998[a]	$153
1999	—
2000	409
2001	373
2002	445
2003	446
2004 through 2007[b]	386
2008 through 2017[b]	369
2018 through 2025[b]	441
Total	**$10,568**

[a] Actual.
[b] Each year.

Figure 2 shows the specific programs for which the money is budgeted.

Tobacco Settlement Fund Not A Reliable Long-Term Funding Stream

Our analysis indicates that most of the funding in the Tobacco Settlement Fund (TSF) would be used for existing, ongoing programs now supported by the General Fund. Only about 24 percent of the TSF would be allocated for new health care initiatives. The fund is not a viable long-term source of support for the proposed mix of programs since its revenues are likely to decline over time. For this reason, we recommend amending the proposed budget trailer bill to establish a 10 percent reserve for the fund, instead of the proposed 5 percent reserve.

Fund Includes Mostly Base Expenditures. During the past two years, legislation has been enacted to reduce the number of uninsured children and adults by expanding eligibility in the Medi-Cal and Healthy Families Programs. In 1999, Medi-Cal was expanded to cover working poor adults with income up to 100 percent of the federal poverty level (FPL) (referred to as 1931 [b] expansion in Figure 2). In addition, Healthy Families was

Figure 2

Allocation of Tobacco Settlement Fund Revenues

(In Millions)

Departments/Programs	
Department of Health Services (DHS)	
Medi-Cal	
1931(b) expansion	$123
Aged, blind, and disabled persons with income below 133 percent FPL [a]	47
Child Health and Disability Prevention Program	
Replacement of Proposition 99 funding	$65
Public Health	
Breast Cancer Treatment Program	$20
Prostate Cancer Screening and Treatment Program	20
Youth Smoking Prevention Program	20
Subtotal, DHS	$295
Managed Risk Medical Insurance Board (MRMIB)	
Healthy Families Program	
Children with family income between 201 percent to 250 percent FPL [a]	$74
Parents health care expansion	76
Subtotal, MRMIB	$150
Total	**$445**

[a] Federal poverty level.

expanded to include children with incomes between 201 percent and 250 percent of the FPL, as well as legal immigrant children. Last year, Medi-Cal was again expanded to provide no-cost coverage to low-income aged, blind, and disabled persons with incomes up to 133 percent of the FPL. The state support for these expansions came from the General Fund.

The *2001-02 Governor's Budget* would in effect shift the costs of these prior-year expensions to the TSF. Of the $445 million of proposed expenditures from the fund, approximately $339 million, or 76 percent, represents expenditures for existing ongoing programs that would be shifted from the General Fund to the TSF. Of that amount, more than $100 million would cover projected caseload growth in the Medi-Cal, Healthy Families, and Child Health and Disability Prevention programs. The remaining $106 million, or about 24 percent of the total funds allocated, is for new health proposals, including $76 million to expand Healthy Families to

parents, $20 million for new smoking prevention programs, and $10 million to expand the Prostate Cancer Screening and Treatment program.

Tobacco Settlement Not a Stable Source of Revenue. If the downward trend in smoking continues, tobacco settlement revenues are likely to continue to decline. During the past twelve years, the state has spent more than $781 million, an average of about $65 million a year, on antitobacco and smoking prevention programs. In addition, new state laws prohibited smoking in public places and increased taxes on tobacco products. These changes appear to have reduced the prevalence of smoking during this period. The 2001-02 budget proposes to allocate $106 million (mostly Proposition 99 funds) to continue antitobacco and smoking prevention programs, including $20 million in new spending from the TSF. If these programs and other measures continue to be effective in reducing smoking, tobacco settlement payments to the state could go even lower because its payments are linked to the volume of tobacco sales.

New Fund Not Viable in the Long Term. We believe that the Governor's plan to fund the specified programs on an ongoing basis from the TSF is not viable in the long term. As we discussed above, the tobacco settlement is likely to be a declining revenue stream. Yet, under the Governor's proposal, the fund would be heavily committed to programs with growing caseloads. Our analysis indicates that the combination of declining revenue and growing caseload makes the fund unreliable as the sole source of funding for these programs in the long term.

If the Governor's caseload projections are correct, this problem could surface as soon as 2002-03. We note that the budget plan assumes all of the expansions would reach full implementation by the end of the budget year. If this actually were to occur, the fund would likely be overextended by 2002-03 as budgets for Medi-Cal and Healthy Families would be adjusted to account for inflation in health care costs. At this point, the Legislature and Governor would need to find alternative funding sources for the additional costs. Given the magnitude of the programs included within the fund, it is possible that the 5 percent reserve would be inadequate to cover future cost adjustments.

As we discuss below, we believe the Healthy Families Program is actually overbudgeted in 2001-02. However, that would only delay the inevitable point at which expenditures for these programs will expand beyond the ability of the fund to support them.

Budget-Year Funds Available for Limited-Term Spending. Our enrollment projection for Healthy Families indicates that this program is not likely to reach full enrollment in 2001-02. We estimate there will be TSF savings of $33 million from the Healthy Families Program. (See our analysis of the Healthy Families Program for a more detailed discussion of

these caseload issues.) We would caution the Legislature against allocating these savings for other purposes, however. This is because the funds will likely be needed in fiscal year 2002-03 to support the continued phase-in of the Healthy Families expansions.

Analyst's Recommendation. For these reasons, we recommend amending the proposed budget trailer bill to establish a 10 percent reserve for the fund, instead of the proposed 5 percent reserve. This would ensure that needed funding is available when the caseload programs are fully phased in. It would also protect the noncaseload programs from reductions in the event there is a sudden surge in enrollment or lower-than-anticipated tobacco settlement revenues.

In addition, the Legislature may wish to consider whether certain programs should be shifted back to the General Fund. As we indicated above, the TSF is heavily dedicated to caseload programs, thus, placing the fund at risk of not remaining viable in the long term. An alternative approach is to replace one of the caseload programs, such as the Medi-Cal 1931 (b) expansion, for example, with a noncaseload program, such as one of the proposed Proposition 99-funded smoking cessation programs. This would relieve some of the fiscal pressure on the fund. It also would allow the noncaseload driven programs, such as the tobacco prevention programs to remain in the fund with less risk of being cut in the future because of caseload growth in the Medi-Cal and Healthy Families Programs.

CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

PROGRAM FAILS AS GATEWAY TO AFFORDABLE HEALTH CARE

Background

Purpose of the Program. The state Child Health and Disability Prevention (CHDP) program was established by Chapter 1069, Statutes of 1973 (AB 2068, Brown), to provide preventive health, vision, and dental screens to children and adolescents in low-income families who do not qualify for Medi-Cal. It is modeled after the federal Medicaid benefit called Early and Periodic Screening, Diagnosis, and Treatment services. The CHDP program currently reimburses public and private providers for completing health screens and immunizations for children and youth under 19 years of age with family incomes at or below 200 percent of the federal poverty level (FPL). The program is jointly administered by the state Department of Health Services (DHS) and county health departments. An estimated 1.9 million screens will be provided in 2001-02.

The Changing Healthcare Landscape. When CHDP was established in 1973, the availability of subsidized health care for children was very limited. The CHDP program, though limited to coverage of preventive health screens and medically necessary follow-up treatment, filled a fundamental gap in the availability of care for low-income children. Today the landscape of affordable health care is very different. The Healthy Families Program has been implemented and now provides comprehensive health insurance coverage similar to Medi-Cal for children in families with income up to 250 percent of the FPL. As a result of the income eligibility expansions in Medi-Cal and Healthy Families, there are now overlapping income eligibility standards for these three programs.

Children using CHDP are now either (1) eligible to enroll for full Medi-Cal benefits, (2) eligible to enroll in Healthy Families, or (3) undocumented immigrants and, therefore, ineligible for either of these two programs. (Undocumented immigrants qualify for no-cost Medi-Cal, but only for emergency care, including labor and delivery services.) This evolution in the health care environment resulted in the state establishing a new role for CHDP—as a "gateway" facilitating children's enrollment in the Healthy Families Program. Figure 1 summarizes the eligibility criteria for CHDP, as well as those for the Healthy Families and Medi-Cal Programs. The figure illustrates the overlap in income eligibility that exists among the three programs.

Figure 1

Income Eligibility Criteria for CHDP, Medi-Cal, and Healthy Families

Age	Family Income (As Percent of Federal Poverty Level)
CHDP	
• 0-18 years of age	• At or below 200 percent
Medi-Cal (Poverty Group)[a]	
• 0-11 months of age	• At or below 200 percent
• 1-5 years of age	• At or below 133 percent
• 6-18 years of age	• At or below 100 percent
Healthy Families	
• 0-11 months of age	• Between 200 percent and 250 percent
• 1-5 years of age	• Between 133 percent and 250 percent
• 6-18 years of age	• Between 100 percent and 250 percent

[a] Children who meet eligibility criteria for enrollment in no-cost Medi-Cal.

The Governor's Budget. The proposed 2001-02 budget includes a total of $126 million for CHDP, an increase of $11 million, or 9.5 percent, above estimated current-year expenditures. Of that amount, $65 million would be allocated from tobacco settlement funds, $49 million from the General Fund, and the remaining $12 million from various federal and special funds. The increase is driven by a number of factors, including the addition of a new vaccine to protect children against meningitis and ear infections, the full-year cost of previously enacted rate increases, and projected growth of 108,000 in the number of screens.

The LAO Findings

Based on our analysis, few children are entering the Healthy Families Program through the Child Health and Disability Prevention (CHDP) program. This has resulted in missed opportunities to provide comprehensive health coverage for low-income children, as well as a missed opportunity to use available federal funds to help support the cost of providing the care. This situation appears to be the result of a number of factors, including a lack of coordination between the two programs, failure to coordinate county administered Healthy Families outreach activities with local CHDP programs, and outdated data systems for client tracking and claims auditing.

Few Children Enter Healthy Families Through CHDP Gateway. As a gateway program, CHDP services provided to children who enrolled in Healthy Families within a 90-day period are to be reimbursed by the Healthy Families Program. This retroactive payment allows the state to maximize federal funds and save state General Fund monies for the CHDP program. When the gateway concept was adopted, DHS assumed that 50 percent of Healthy Families enrollees would enter the program shortly after using CHDP services. However, CHDP clients are not enrolling in Healthy Families at the anticipated rate.

The best available indicator of the number of children enrolling in Healthy Families through CHDP is the level of reimbursement to CHDP for services provided to children who ultimately enroll in Healthy Families. In 1999-00, the most recent year for which data are available, only 4.5 percent of the new enrollees in Healthy Families had reimbursed CHDP claims. This represents a slight increase over 1998-99, when claims were reimbursed for only 3.4 percent of new Healthy Families enrollees. Due to a recent change in the retroactive claiming period—from 30 days to 90 days—we estimate that CHDP will be reimbursed for 9.6 percent of Healthy Families' enrollees in 2000-01. However, this is still a relatively small number of CHDP clients. Figure 2 shows initial expectations for CHDP reimbursements compared to actual reimbursements.

These figures probably underestimate somewhat the number of CHDP children enrolling in the Healthy Families Program. This is because they only reflect the number of children who were admitted into the program within the retroactive claiming period. However, the Managed Risk Medical Insurance Board (MRMIB)—the state department that administers the Healthy Families Program—has indicated that the 90-day retroactive claim period would capture approximately 90 percent of Healthy Families' new enrollees.

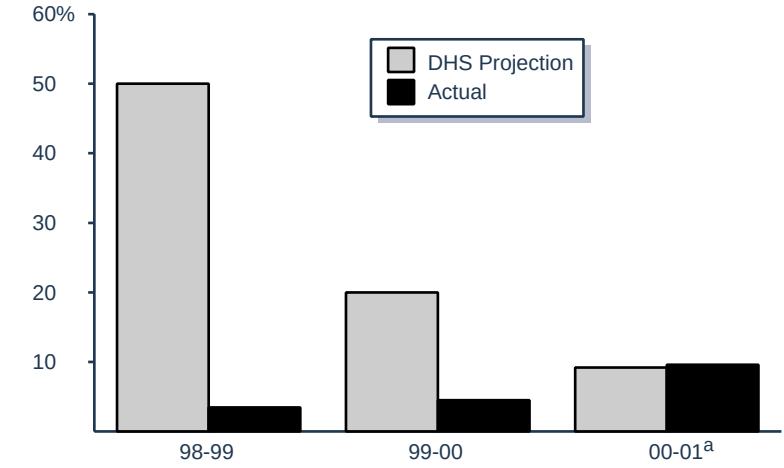
Lack of Effective Gateway Results in Missed Opportunities for Children and the State. There are several reasons why it is advantageous for CHDP clients who qualify for Medi-Cal or Heathy Families to be enrolled in the other two programs. First, Medi-Cal and Healthy Families offer

free or low-cost *comprehensive* health coverage. Although all three programs provide coverage for preventive health screens and immunizations, Medi-Cal and Healthy Families provide a full range of medical benefits, as well as dental and vision care.

Figure 2

Few CHDP Clients Enrolling in Healthy Families

Reimbursed CHDP Claims as a Percentage of Healthly Families' New Enrollees



[a] 2000-01 is an LAO estimate based on first quarter trends.

Second, Medi-Cal and Healthy Families provide a "medical home" by allowing the families to choose a health plan and regular doctor, as well as around-the-clock access to care. By contrast, in some counties, CHDP services are only available for a few hours on certain days of the week. Anecdotal evidence also indicates that CHDP clients needing follow-up care often wait months to be treated. This is especially the case for follow-up dental care.

Third, the federal government shares in the cost of the Medi-Cal and Healthy Families Programs, contributing approximately 50 percent and 67 percent, respectively. As mentioned previously, the state CHDP program is funded largely by the General Fund and tobacco settlement funds. Therefore, shifting children from the CHDP program to the other programs would produce immediate state savings. There would also be savings for counties which would otherwise have to spend county General Fund monies to supplement their Proposition 99 funds for CHDP follow-up treatment.

The DHS Has Not Developed a System of Coordination. Given data showing that large numbers of Healthy Families clients are not entering the program from CHDP, we examined the state and local efforts to incorporate CHDP into the Healthy Families Program. On the plus side, we found that DHS has distributed policy letters to CHDP health care providers encouraging them to promote enrollment in the Healthy Families Program. The DHS staff have also verbally encouraged promotion of enrollment at statewide meetings with local program officials. However, DHS has not incorporated Healthy Families enrollment activities into CHDP program procedures. For example, it has not required CHDP providers to facilitate enrollment in Healthy Families. Nor has DHS given local CHDP programs additional resources to take on new activities that would be necessary in order to effectively integrate the two programs. Additionally, DHS and MRMIB have not established any standard operating procedures for the provision of Healthy Families information or materials to local CHDP programs.

Overall, the absence of a statewide system to enroll CHDP clients in the Healthy Families and Medi-Cal Programs results in a lack of coordination at the local level. For example, we found that some county health departments receiving Medi-Cal/Healthy Families Outreach contracts—funds awarded to community-based organizations, school districts, and local governments—to provide outreach and education about Healthy Families and Medi-Cal for children failed to coordinate their outreach activities with CHDP staff.

The CHDP Information System Not Compatible With Medi-Cal and Healthy Families. The existing CHDP computer information system is not compatible with the Medi-Cal and Healthy Families information systems. The systems do not share common identifiers, such as client names, social security numbers, or other account numbers that permit records of CHDP clients to be linked to Medi-Cal or Healthy Families participants. This is because CHDP records track claims while the Medi-Cal and Healthy Families systems track individual members.

These differences limit the efficiency of CHDP as a gateway program. For example, the absence of a common identifier limits the state's ability to maximize federal funding and save General Fund monies by retroactively reimbursing CHDP when children enroll in Healthy Families. According to DHS, they are able to match clients for purposes of retroactive reimbursement only 70 percent to 80 percent of the time.

Moreover, since the state has no way of knowing if a child is enrolled in both Healthy Families and CHDP, the state is at risk of making duplicate payments for the same services. Under the current system, a child who is enrolled in Healthy Families could be seen by a CHDP provider. If the CHPD provider has no knowledge of the child's Healthy Families

status, the provider could submit a claim and be reimbursed for those services under the CHDP program.

The extent of such double billing and its cost to the state are unknown. There is evidence, however, that such double billing is occurring. We compared our estimates of the number of uninsured children with family incomes below 200 percent of the FPL (the group eligible for CHDP) against DHS's estimates of children who utilize CHDP. The comparison shows that there are more children using CHDP than there are eligible uninsured children. This strongly suggests that children with health coverage (predominantly Healthy Families and Medi-Cal) are in fact utilizing CHDP services.

Recommendations for Improving the CHDP Gateway

Our analysis suggests that the gateway concept is a sound one and that an effective Child Health and Disability Prevention (CHDP) gateway could move the state closer to its goal of providing Healthy Families and Medi-Cal coverage to every eligible child. In this section we recommend a number of actions the Legislature can take to make CHDP an effective gateway.

Figure 3 summarizes our recommendations which are discussed in detail below.

Figure 3

CHDP as a Model Gateway LAO Recommendations

- ***Health Care Providers.*** Enact legislation establishing new requirements for health care providers to encourage families to apply for Healthy Families or Medi-Cal.
- ***Local CHDP Staff.*** Encourage counties to use local CHDP staff to assist clients in applying for Healthy Families and Medi-Cal, and streamline the application process with a new on-line computer program.
- ***Centralized Determination System.*** Reconsider legislation to process all Medi-Cal family and child applications through a centralized and simplified, state-level eligibility determination system.
- ***Information System Link.*** Adopt supplemental report language directing DHS to analyze the feasibility of linking the CHDP information system with the Medi-Cal and Healthy Families information systems.
- ***Family Income Level.*** Make additional children eligible for CHDP services by increasing the maximum allowable family income to 250 percent of the federal poverty level once the gateway model has been implemented.

Encourage CHDP Clients to Apply for Medi-Cal and Healthy Families. We recommend the enactment of legislation establishing new requirements for health care providers to encourage families to apply for Medi-Cal or Healthy Families. We believe such legislation could convert the CHDP program into a true point of entry for the Healthy Families and Medi-Cal Programs.

Under this proposal, in order for a provider to receive a reimbursement from CHDP for a health screen, the client for whom reimbursement is sought must have applied for Medi-Cal or Healthy Families. The provider would record on each CHDP claim the proof that the client's family has applied for Medi-Cal or for Healthy Families coverage. The family would be assisted in completing the application.

In theory, linking payments for CHDP screens to requirements that families apply for Medi-Cal and Healthy Families could prompt some families not to utilize CHDP. Some families might believe that completing the application is too much effort. Others, namely immigrant families—both documented and undocumented—might fear that applying for a government-sponsored program will jeopardize their residence in the U.S. or will deem them a liability to their U.S. sponsor.

In order to ensure continued access to CHDP health care services, we recommend that local CHDP offices or the Healthy Families community outreach contractor ensure that each provider has an up-to-date list of certified application assistants available in the area to assist each family. The larger CHDP providers, such as community clinics, might find it beneficial to have certified application assistants on site to expedite application completion and submission. (We note that many clinics already provide this assistance.) Community-based organizations that provide certified application assistance could further collaborate with providers to station application assistants in providers' offices.

We further recommend the enactment of legislation directing DHS and MRMIB to implement a coordinated education campaign to assure CHDP families that submitting their applications to Medi-Cal and Healthy Families will not result in any action against them by the Immigration and Naturalization Service.

New Data System Could Improve Gateway. If the CHDP program is to become an effective gateway to enrollment in the Healthy Families and Medi-Cal Programs, the state's information system must be able to distinguish CHDP clients from Healthy Families and Medi-Cal clients for client-tracking purposes—both to ensure the accuracy of payments and to measure enrollment outcomes. Therefore, we recommend that DHS explore ways to improve its data system.

Specifically, we recommend the adoption of supplemental report language to the *2001-02 Budget Act* directing DHS to (1) analyze the limitations of the current CHDP data system in regard to its capacity to accurately compare client data among the CHDP, Medi-Cal, and Healthy Families Programs; (2) explore the feasibility of linking CHDP client data with Medi-Cal and Healthy Families Program data in order to accurately audit medical claims and track individuals across programs; and (3) examine technological alternatives for linking these data. These actions would prepare DHS for the procurement of an improved CHDP information system.

Single Point of Entry Needed for All Applications. Currently, there are two processes in place to determine eligibility for Medi-Cal. Under one method called the "single point of entry," the joint Medi-Cal/Healthy Families application is processed by Electronic Data Systems (EDS) under contract with the state. The EDS, as the fiscal intermediary for the Medi-Cal and Healthy Families Programs, is also responsible for making payments to providers. Under the other method, applications are processed by eligibility workers in county welfare offices.

The *2000-01 Budget Bill* passed by the Legislature provided funding to allow all applications to be processed through a single point of entry. However, the Governor vetoed that appropriation. We recommend that the Legislature and Governor reconsider establishing a single point of entry for all applications. This approach would facilitate the implementation of changes we have recommended by (1) enhancing state oversight of enrollment in Healthy Families and Med-Cal and (2) creating a centralized database with which to compare CHDP claims.

Aligning Income Eligibility. Once CHDP has become a true gateway program for comprehensive health coverage, we recommend that the Legislature enact legislation to align income eligibility in CHDP and Healthy Families. Under current program requirements, children are eligible for CHDP services if their family income is no greater than 200 percent of the FPL. At the time that CHDP was proposed as a gateway program, Healthy Families' income eligibility was also limited to 200 percent of the FPL.

Policymakers have generally found that keeping income eligibility standards the same across similar programs facilitates a "seamless delivery system" by minimizing exclusion from eligibility and simplifying the application process. Given the prior decision of the Legislature to increase Healthy Families' income eligibility to 250 percent of the FPL, it should eventually consider increasing CHDP's income eligibility to the same level. By aligning eligibility standards, CHDP could encourage enrollment in Healthy Families for all children who are eligible for Healthy Families, not just for those whose family income is at or below 200 percent of the FPL.

Expanding income eligibility for CHDP would result in an increase in the program's caseload of one-time clients. However, most children who would become eligible for CHDP under this expansion would also be eligible for enrollment in the Healthy Families Program. Even their single CHDP screen then would be retroactively reimbursed by the Healthy Families Program. Therefore, we recommend that the Legislature enact legislation increasing the income eligibility standard for CHDP to the same level as the Healthy Families Program after the gateway model has been fully implemented.

Conclusion

The CHDP program was established at a time when low-income children had few options for affordable health care. Expansions in the Medi-Cal Program and the enactment of the Healthy Families Program have created an opportunity to transform CHDP from a limited "safety net" program for children into a true point of entry to comprehensive health coverage. However, in order to accomplish this, the state must take steps to open the gateway.

We believe our recommendations move the state in this direction by (1) establishing new requirements for health care providers to encourage families to enroll in Healthy Families and Medi-Cal, (2) encouraging counties to help families apply for health coverage and streamlining the application process with a new on-line computer program, (3) centralizing and simplifying the application process for public health coverage, (4) preparing to improve CHDP's data system, and (5) raising CHDP's income eligibility level to match the income limits of Healthy Families.

Our analysis suggests that the costs of making these improvements would be offset by savings to the state in the CHDP program, as CHDP clients enrolled in Healthy Families and Medi-Cal and as duplicate medical payments were eliminated.

Shifting the CHDP caseload to Medi-Cal would increase state costs for that program, but the enrollment of more CHDP clients in Healthy Families would not result in any significant additional state costs because the state has already budgeted for Healthy Families coverage for these children.

Figure 4 summarizes the benefits of our recommended approach. We believe that reforming the CHDP program and its data system will improve the health of low-income children by extending more comprehensive free or low-cost health coverage to additional children under the Medi-Cal and Healthy Families Programs.

Figure 4

Benefits of the LAO Gateway Approach

- ***Promotes comprehensive health coverage for low-income children*** by enrolling CHDP clients in programs that offer a greater scope of services, including vision, dental, and prescription coverage, as well as visits to the doctor when the child is sick.
- ***Reduces number of uninsured children in California*** whose lack of coverage has been associated with greater utilization of emergency room visits and higher costs for hospitals, and local-state governments.
- ***Simplifies and improves for families*** receiving CHDP services the process of applying for Medi-Cal and Healthy Families coverage.
- ***Curbs General Fund costs in the CHDP program***, potentially in the tens of millions of dollars annually, by transferring the cost of health care to the Healthy Families and Medi-Cal programs for which the federal government bears a significant share of the costs.
- ***Reduces county costs*** for providing follow-up treatment for conditions diagnosed in CHDP screens, as CHDP clients enroll in Healthy Families and Medi-Cal and shift treatment costs to these programs.

DEPARTMENTAL ISSUES

Health and Social Services

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

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

At the state level, the Department of Health Services (DHS) administers the Medi-Cal Program. Other state agencies, including the California Medical Assistance Commission (CMAC), the Department of Social Services, the Department of Mental Health, the Department of Developmental Services (DDS), the California Department of Aging, and the Department of Alcohol and Drug Programs receive Medi-Cal funding from DHS for eligible services that they provide to Medi-Cal beneficiaries. At the local level, county welfare departments determine the eligibility of applicants for Medi-Cal and are reimbursed by DHS for the cost of those ac-

tivities. 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 $25.4 billion from all funds for state operations and local assistance in 2001-02. The General Fund portion of this spending ($9.4 billion) decreases by $129.6 million, or 1.4 percent, compared with estimated General Fund spending in the current year. However, this is not an accurate reflection of expenditure growth in this program. About $170 million of General Fund expenditures were replaced with Tobacco Settlement funds for specified Medi-Cal expansions and about $601 million in the Medi-Cal General Fund was shifted to the DDS budget in a purely technical change. If these amounts were added back to the Medi-Cal budget, the Medi-Cal General Fund would total $10.1 billion, an increase of $641.4 million or 6.7 percent. The remaining expenditures for the program are mostly federal funds ($14.4 billion).

The spending total for the Medi-Cal budget includes an estimated $2 billion (federal funds and local matching funds) for payments to DSH hospitals, and about $3.1 billion budgeted elsewhere for programs operated by other departments, counties, and the University of California.

MEDI-CAL BENEFITS AND ELIGIBILITY

What Benefits Does Medi-Cal Provide?

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

How Medi-Cal Works

Currently, more than half (61 percent) of the Medi-Cal caseload consists of participants in the state's two major welfare programs, which include Medi-Cal coverage in their package of benefits. These programs are (1) the California Work Opportunity and Responsibility to Kids (CalWORKs) program, which provides assistance to families with children and replaces the former Aid to Families with Dependent Children program, and (2) the Supplemental Security Income/State Supplemen-

tary Program (SSI/SSP), which assists elderly, blind, or disabled persons. Counties administer the CalWORKs program through county welfare offices which 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 provides health care through two basic types of arrangements—fee-for-service and managed care.

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

Managed Care. Prepaid health plans generally provide managed care. The plans receive monthly "capitation" payments from the Medi-Cal Program for each enrollee in return for providing all of the covered care needed by those enrollees. These plans are similar to health plans offered by many public and private employers. Currently, slightly less than half (2.6 million of the total of 5.2 million Medi-Cal eligibles) are 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 half of Medi-Cal eligibles are welfare recipients. Figure 1 (see next page) shows for each of the major Medi-Cal eligibility categories, the maximum income limit (not including earned and unearned income disregards or exemptions) in order to be eligible for health benefits and the estimated caseload and total benefit costs for 2000-01. 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

Figure 1

Major Medi-Cal Eligibility Categories

2000-01

	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)	$1,265	✔	—	1,182	$8,281
• Medically needy	934[d]	✔	✔	140	905
• Medically needy—long term care	Special limits	✔	✔	69	2,807
Families, Children, and Pregnant Women					
Families					
• Welfare (CalWORKs)	$969[e]	✔	—	1,768	$2,571
• Section 1931(b)-only[f]	1,421	✔	—	1,394	2,037
• Medically needy	1,141	✔	✔	—[g]	—[g]
Children and Pregnant Women					
Children					
• 200 percent of poverty—infants	$2,842	—	—	49	—[h]
• 133 percent of poverty—ages 1 through 5	1,890	—	—	103	$87
• 100 percent poverty—ages 6 through 18	1,421	—	—	83	67
• Medically indigent—ages 0 through 21	1,141	✔	✔	149	325
Pregnant women					
• 200 percent of poverty—pregnancy service	$2,842	—	—	123	$554
• Medically indigent—all services	1,141	✔	✔	6	82
Emergency-Only					
Undocumented immigrants who qualify in any eligibility group are limited to emergency services (including labor and delivery and long-term care).				143[i]	$433

a Amounts are for countable income or grant only for a four-person family and do not include income disregards.
b Indicates whether persons with higher incomes may receive benefits on a share-of-cost basis.
c Combined state and federal costs.
d Effective January 1, 2001, this category is expanded and would include couples with an income limit equivalent to $1,247.
e Income limit to apply for CalWORKs. After becoming eligible, the income limit increases to $1,760 (family of four) with the maximum earned income disregard.
f Includes Transitional Medi-Cal, which extends coverage for families who leave CalWORKS or 1931(b)-only for up to 12 months.
g Enrollment and costs included in amounts for Section 1931(b) family coverage.
h Costs included in amount for 200 percent of poverty pregnant women group.
i About 244,400 additional undocumented immigrants are included in other categories at a cost of $1.1 billion.

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 1.4 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—about 27 percent of the total Medi-Cal caseload. 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 (85 percent) are recipients of SSI/SSP benefits and receive Medi-Cal coverage automatically.

The other aged, blind, or disabled eligibles are in the "medically needy" category. They also have low incomes, but do not qualify for, or choose not to participate in SSI/SSP. For example, aged low-income *noncitizens* generally may not apply for SSI/SSP (although they may continue on SSI/SSP if they already were in the program as of August 22, 1996). As another example, about 19 percent of the medically needy persons in this category have incomes above the Medi-Cal limit and participate on a share-of-cost basis. Beginning January 1, 2001, as a result of no-cost Medi-Cal expansion, fewer persons will participate on a share-of-cost basis.

The number of Medi-Cal eligibles in long-term care is small—only 68,500 people, or 1.3 percent of the total caseload. Because long-term care is very expensive, benefit costs for this group total $2.8 billion, or 16 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 with Children. Medi-Cal provides coverage to families with children in three eligibility categories. The first two categories were created by Section 1931(b) of the Social Security Act, which required states to grant Medicaid eligibility to anyone who would have been eligible for cash-assistance under the welfare requirements in place on July 16, 1996. One of these categories consists of CalWORKs welfare recipients who automatically receive Medi-Cal. The second category—referred to as the 1931(b)-only group—consists of families who are eligible for CalWORKs, but who choose only to receive Medi-Cal services. The income limit for families in this second category is 100 percent of the federal poverty level (FPL). However, once enrolled in Section 1931(b) coverage, families may

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

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

About 34 percent of all Medi-Cal eligibles are CalWORKs welfare recipients. Although CalWORKs recipients constitute the largest single group of Medi-Cal eligibles by far, they account for only 14 percent of total Medi-Cal benefit costs. This is because almost all CalWORKs recipients are children or able-bodied working-age adults, who generally are relatively healthy. Similarly, 1931(b)-only and medically needy families who are Medi-Cal eligible account for 27 percent of all Medi-Cal eligibles and only 11 percent of total benefit costs.

Women and Children. Medi-Cal includes a number of additional eligibility categories for pregnant women and for children. Medi-Cal covers all health care services for poor pregnant women in the medically indigent category, which has the same income and asset limits and spend-down provisions as apply to medically needy families. However, pregnancy-related care is covered with no share of cost and no limit on assets for women with family incomes up to 200 percent of the FPL (an annual income of $34,100 for a family of four).

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

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

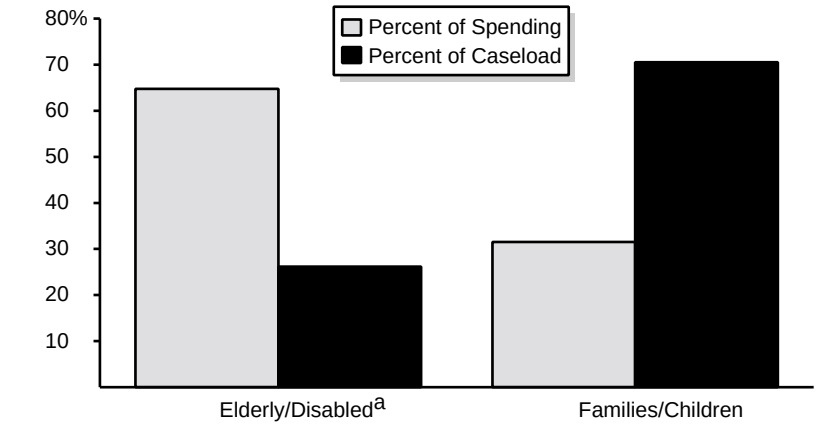
for recent *legal* immigrants, do not qualify for federal funds and are supported entirely by the General Fund.

Most Medi-Cal Spending Is For the Elderly or Disabled

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

Figure 2

Medi-Cal
Most of Caseload Is Families/Children
Most Spending Is For Elderly/Disabled



[a] Includes long-term care.

MEDI-CAL EXPENDITURES

Rapid Spending Growth in the Current Year

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

The budget e1stimates that for the current year the General Fund share of Medi-Cal local assistance costs will increase by $1.4 billion (17 per-

cent), compared with 1999-00. The bulk of this increase is for benefit costs, which will total an estimated $9 billion in 2000-01. Other local assistance costs will also increase in the current year compared with 1999-00. For example, county administration costs will go up about $23 million (5.5 percent) and costs related to claims processing by the fiscal intermediary will increase by $9.4 million or about 15 percent. The General Fund cost for hospital construction debt service will increase by $9.1 million (20 percent) during 2000-01.

Figure 3

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

1999-00 Through 2001-02
(Dollars in Millions)

	Actual 1999-00	Estimated 2000-01	Proposed 2001-02	Change From 2000-01 Amount	Change From 2000-01 Percent
Support (state operations)	$70.4	$80.4	$86.3	$5.9	7.3%
Local Assistance					
Benefits	$7,593.0	$8,953.7	$8,782.8	-$170.9[b]	-1.9%[b]
County administration (eligibility)	410.7	433.3	469.7	36.4	8.4
Fiscal intermediaries (claims processing)	61.2	70.5	72.5	2.0	2.9
Hospital construction debt service	45.9	55.0	51.4	-3.6	-6.5
Subtotals, local assistance	($8,110.8)	($9,512.6)	($9,376.5)	(-$136.1)	(-1.4%)
Totals	**$8,181.2**	**$9,593.0**	**$9,462.8**	**$-130.2[b]**	**-1.4%[b]**
Caseload (thousands of beneficiaries)	5,106	5,210	5,850	640	12.3%

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

[b] The replacement of Medi-Cal General Funds with $170 million of Tobacco Settlement funds and shifting $601 million to the Department of Developmental Services' budget causes the budget to decrease. If this had not been done, the total budget would have increased by $641 million or 6.7 percent.

Most of the $1.4 billion increase in benefit costs results from increases in the cost and utilization of health care goods and services (including provider rate increases)—about $871 million. In addition, the settlement of a ten-year-old lawsuit over Medi-Cal hospital reimbursement rates will increase expenditures by $175 million. Caseload growth adds about

$82 million of General Fund cost. A change in the way the state pays for Medicare claims accounts for $54 million, changes in the state-federal cost-sharing ratio increases state costs by $52 million, and other factors account for the remainder of the cost increase (about $127 million).

2000-01 Provider Rate Increases. About $596 million of the General Fund spending increase for benefits in the current year is for provider rate increases. Various rate increases for physicians, dentists, in-home nursing, and other medical provider services will total $230 million, most of which is to increase physician services rates by about 17 percent, including a 40 percent increase for physician services provided in emergency rooms. Increases for long-term care facilities such as nursing homes and intermediate-care facilities total $204 million including a 5 percent wage pass-through. Rate increases approved by DHS or CMAC for Medi-Cal managed care plans account for $103 million of the increase. In addition, hospitals have negotiated rate increases with CMAC resulting in a $60 million increase for inpatient costs.

Pharmacy and Certain Other Costs Growing Rapidly. The budget estimates that the General Fund cost of payments to pharmacy providers (for drugs and various types of medical supplies) will result in a net increase of $138 million in the current year. In addition, General Fund costs for adult day health services will increase by an estimated $39 million, compared with 1999-00. Both of these categories include some groups of providers that DHS has targeted for fraud prevention efforts.

Settlement of Hospital Payment Suit Results in Payout. Pending federal approval, the state has settled the *Orthopaedic Hospital v. Belshe'* litigation and other related lawsuits over the amount Medi-Cal pays for hospital outpatient services. As part of the settlement, Medi-Cal will pay hospitals a lump sum of $350 million ($175 million General Fund) in the current year. We discuss this litigation further later in this analysis.

Caseload Increase Reflects Eligibility Expansions and Simplification. The budget estimates that caseload in the current year will increase by more than 100,000 eligibles or 2 percent. The increase is primarily related to two factors. The first factor is the continued expansion of Section 1931(b) eligibility to cover both the children and parents in families with income at or below 100 percent of the FPL. While the expansion has increased total Medi-Cal caseload by approximately 75,000, the phase-in of new eligibles has been slower than originally estimated. Further caseload increases resulting from this change are expected to continue in 2001-02.

The second factor increasing caseload is two statutes enacted this year simplifying the eligibility process. Legislation provided 12-month continuing eligibility for Medi-Cal children and eliminated the quarterly status reporting requirements for families eligible for Medi-Cal. These

changes are projected to increase the monthly average caseload by about 26,000 in the current year, with significant additional caseload increases anticipated in the budget year.

$204 Million General Fund Deficiency in 2000-01

The *2000-01 Budget Act* anticipated some of the ongoing Medi-Cal cost increase and provided funding for legislatively approved rate increases and caseload increases caused by the expansion of Section 1931(b) family eligibility and simplified eligibility processes. However, the Governor's budget proposes a net increase in Medi-Cal spending of $204 million above the budget act. This is primarily because of the settlement of the hospital rate lawsuit. The major components of the additional spending are discussed below.

Settlement of Hospital Litigation—$175 Million. Most of the current-year deficiency results from the settlement reached in lawsuits pertaining to Medi-Cal payment rates for hospital outpatient services. Hospitals have been in litigation with the state over reimbursement rates since 1990 in the case known as *Orthopaedic Hospital v. Belshe'*. The DHS had set rates based on what it deemed necessary to encourage enough hospitals to participate in the Medi-Cal Program. However, the courts interpreted federal law to require reimbursement based upon a determination of "reasonable costs." The DHS expects to pay a lump sum payment of $175 million from the General Fund in the current year. In 2001-02 it will increase hospital outpatient rates by approximately 30 percent and then for each of the following three years by 3.3 percent annually.

Inpatient Costs and Managed Care Rate Increases—$95.6 Million. The budget act underestimated the rate increases that hospitals would negotiate with CMAC by $60 million. Also, managed care costs increase by $36 million because additional funding is provided to ensure the same level of provider rate increases in managed care as were provided in fee-for-service.

Los Angeles County Outpatient Services—$30 Million. Under the terms of the extension of its Medicaid Demonstration Project, Los Angeles County outpatient sites and their private partner contract clinics will receive Federally Qualified Health Center (FQHC)-like cost based reimbursement for outpatient services provided to Medi-Cal patients. These rates will be paid pending their application and approval of FQHC status. State General Fund costs are expected to be $30 million in both the current year and 2001-02.

Continuous Eligibility For Children—$5.6 Million. Effective January 1, 2001 legislation provides 12 month continuing eligibility for all Medi-Cal eligible children. This was not reflected in the 2000-01 budget

plan because the legislation was enacted at the end of the legislative session.

Medicare HMO Premiums—$5 Million. Effective January 1, 2001 Medi-Cal will pay the monthly premiums for Medi-Cal eligibles enrolled in Medicare health maintenance organizations (HMOs). By paying these premiums the Medi-Cal Program expects to avoid General Fund costs of up to $14 million in the current year and $28 million in 2001-02 that otherwise would have occurred if persons affected by the new premiums dropped their Medicare HMO coverage and Medi-Cal had to pay their drug costs.

Budget-Year Expenditure Growth Significant

The Governor's budget estimates that total General Fund spending for Medi-Cal local assistance will be $9.4 billion in 2001-02, a decrease of $136 million, or 1.4 percent from the estimated spending in the current year. This amount does not reflect true expenditure growth in the Medi-Cal Program. This is because the decrease results from the replacement of approximately $170 million of General Fund expenditures for specified Medi-Cal expansions with new Tobacco Settlement funds, as well as the shift of $601 million in Medi-Cal General Fund monies to the DDS budget in a purely technical change. Barring these changes, Medi-Cal General Fund spending for local assistance would total $10.1 billion, an increase of $638 million or 6.8 percent. The budget estimates that the Medi-Cal caseload will increase by 640,000 (about 12 percent) in 2001-02 to a total of almost 5.9 million average monthly eligibles—roughly 17 percent of the state's population.

Most of the added spending in 2001-02 is for benefit costs. Because of the switch to tobacco settlement funding and the DDS funding shift, it appears that major benefits spending decreased by $199 million when it has actually increased by $606 million. Figure 4 (see next page) shows the major components of the change in benefit costs, which we discuss below.

Increased Costs and Utilization of Services—$258.8 Million Cost. Based on the budget's projections, General Fund costs for Medi-Cal benefits appear to decrease by 1.9 percent in 2001-02. However, disregarding funding shifts, benefits spending actually increases by 6.7 percent, largely due to higher prescription drug costs, caseload expansions, and hospital rate increases. The department attributes most of the increase to spending on drugs. This includes price and utilization increases of $272 million for existing drugs and for new drugs added to the Medi-Cal formulary and rebates of about $69 million obtained through the drug-rebate program.

Medi-Cal "buy-in" payments for Medicare premiums also are increasing. Medi-Cal pays Medicare premiums for Medi-Cal enrollees who also

are eligible for Medicare (dual eligibles) in order to obtain 100 percent federal funding for those services covered by Medicare. The budget estimates that the General Fund cost of these buy-in payments will increase by $51 million in 2001-02. The budget also projects a $5 million increase in the monthly premium that the Medi-Cal Program pays to HMOs that have enrolled beneficiaries eligible for both the Medi-Cal and Medicare programs (dual eligibles).

Figure 4

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

2001-02
(In Millions)

Price and Utilization of Services	**$258.8**
Increased pharmacy costs	271.7
Increased cost for Medicare premiums	50.7
Payment of a monthly premium to HMOs that enroll beneficiaries eligible for both Medi-Cal and Medicare	5.0
Savings from drug rebate program	-68.6
Caseload	**$258.8**
Full-year impact of providing 12-month continuing eligibility to children	129.1
Elimination of the quarterly status report	68.4
Continued expansion of 1931(b) eligibility to 100 percent of poverty	37.8[a]
Expanded eligibility for aged, blind, and disabled	23.5[a]
Pass-Through Funding for Other Departments	**-$601.0**
Shift Medi-Cal costs for DDS Regional Center consumers	-346.0
Shift Medi-Cal costs for developmental center consumers	-255.0
Changes in Financing, Payments, and Recoveries	**-$115.3**
Reduce Orthopaedic Hospital settlement payment amount	-110.8
Other	-4.5
Total	**-$198.7**

[a] Approximately $170 million of expenditures for specified caseload expansions are being shifted to a new Tobacco Settlement Fund.

Caseload Increases—$258.8 Million Cost. The largest caseload-related cost increases are due to the full-year effect of simplification of the complex Medi-Cal eligibility process that took effect January 2001. The budget includes $129.1 million from the General Fund to provide continuous

eligibility to children 19 years of age and younger if federal financial participation is available. This is expected to result in a caseload increase of about 390,000 eligibles in 2001-02. Eliminating quarterly status reporting requirements for parents and providing continuous Medi-Cal eligibility for persons leaving the CalWORKs program are expected to enable 218,000 adults to retain coverage at a cost of $68.4 million from the General Fund.

The phase-in of the program to expand 1931(b) eligibility to cover both children and parents in families with income at or below 100 percent of the FPL has been slower than anticipated. As a result, the $37.8 million General Fund cost of this change has been shifted to 2001-02 to cover the anticipated cost of nearly 161,000 additional enrollees. These costs will be funded by the new Tobacco Settlement Fund under the Governor's spending plan.

Legislation enacted in 2000 expanded Medi-Cal benefits for aged, blind, and disabled persons. Effective January 2001, Medi-Cal benefits are being provided without a share of cost to all aged, blind, and disabled persons with current income equivalent to 133 percent of the FPL and below. The $23.5 million increase in the budget year is due to the full-year cost of this change. In 2001-02, this caseload expansion of about 37,000 would also be funded by the new Tobacco Settlement Fund.

Pass-Through Funding for Other Departments/Programs—$601 Million Decrease. Previously, Medi-Cal costs for services provided by DDS to Medi-Cal beneficiaries were budgeted in the DHS General Fund item and transferred to DDS as a reimbursement. According to the *Governor's Budget Summary*, these costs will be budgeted directly in the DDS budget beginning in 2001-02 to eliminate any unnecessary fund transfers between the two state agencies. The Governor's budget proposes that $346 million for the General Fund portion of Medi-Cal costs for regional center consumers and $255 million of Medi-Cal General Fund costs for the developmental centers be budgeted directly in the DDS budget.

Changes in Financing, Payments, and Recoveries—$115 Million Decrease. The bulk of the spending decrease in this category involves the one-time payment in the current fiscal year of $175 million for the settlement reached in the *Orthopaedic Hospital v. Belshe'* litigation and other related lawsuits pertaining to Medi-Cal payments for hospital outpatient services. According to the terms of the settlement, following the lump-sum $175 million payment in 2000-01, DHS expects to increase hospital outpatient rates by approximately 30 percent in 2001-02, at a cost of $64.2 million General Fund. Because funding for the one-time payment will not be carried over into the 20001-02 budget for Medi-Cal there is effectively a cost reduction of $110.8 million from the General Fund in the budget year.

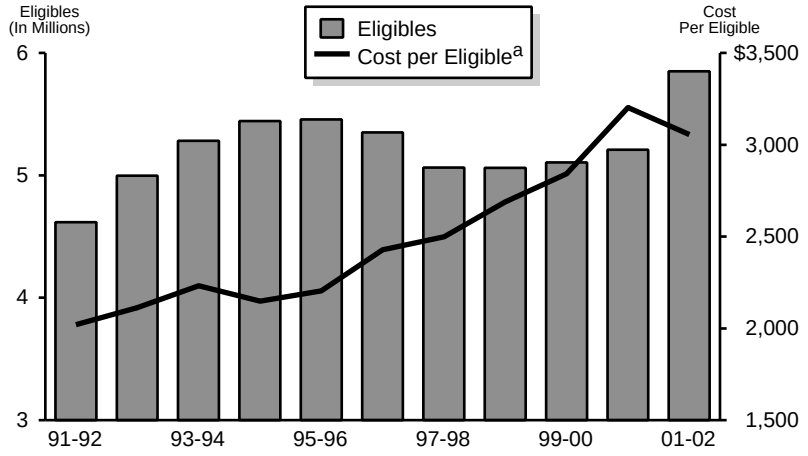
MEDI-CAL COST AND CASELOAD TRENDS

Figure 5 illustrates how Medi-Cal caseload and per-eligible costs have changed since 1991-92, along with projections of these for 2000-01 and 2001-02 based on the budget estimates.

Figure 5

Medi-Cal Caseload to Increase As Cost Per Eligible Declines

1991-92 Through 2001-02



[a] Excludes pass-through funding for programs outside of the Department of Health Services.

Budget Forecasts Growing Caseloads, But Costs Drop Slightly

The budget projects that in the current year the number of eligibles and the cost of benefits per eligible will grow. In the budget year, however, caseloads are projected to continue to grow while the cost per eligible will decline.

Caseload. The number of persons enrolled in Medi-Cal grew rapidly in the early 1990s—caseload growth in 1992-93 was almost 8 percent over the prior year. Between 1991-92 and 1995-96, the Medi-Cal average monthly caseload grew from 4.6 million eligibles to 5.5 million. The rapid growth resulted from the ongoing effects of Medicaid eligibility expansions enacted in the late 1980s and from increased welfare caseloads associated with the severe recession that California experienced at that time.

In the mid-1990s, the Medi-Cal caseload leveled off, and then dropped by almost 300,000 eligibles (5.4 percent) in 1997-98. Again, the change in the Medi-Cal caseload roughly paralleled changes in the CalWORKs welfare caseload. That caseload began a sharp drop at that time in response to the turnaround in the state's economy and greater emphasis on moving families from welfare to work in the wake of enactment of state and federal welfare reform legislation. Another factor contributing to declining welfare and Medi-Cal caseloads probably was reluctance among immigrant Californians to make use of public benefits because of concerns about whether such use might adversely affect their ability to naturalize or to sponsor the immigration of family members in the future.

From 1997-98 through 1999-00, the Medi-Cal caseload was relatively flat while the CalWORKs caseload continued to decline. The Medi-Cal caseload has not declined primarily because of the backlog of eligibility determinations for former CalWORKs recipients that resulted from the delay in implementation of Section 1931(b) Medi-Cal eligibility by DHS and the counties. In the current year and 2001-02, the budget estimates that the Medi-Cal caseload will grow once more, primarily due to a variety of eligibility expansions and simplified eligibility processes.

Cost Per Eligible. While the caseload has gone up and down, the cost trend has been almost steadily upward until 2001-02. The average annual growth rate of the estimated cost of benefits per eligible (excluding pass-through funding to other departments and local governments) is 4 percent, which is twice the rate of general inflation during this period, as measured by the Gross Domestic Product deflator.

The temporary dip in the cost per eligible that occurred in 1994-95 and 1995-96 was partly the result of a change in the caseload mix, rather than an underlying drop in health care costs. This is because the rapid increase in the number of families on welfare (whose health care costs are relatively low) temporarily reduced the *proportion* of aged and disabled persons (relatively high-cost groups) in the Medi-Cal caseload, and this change in the mix tended to reduce the average cost per eligible. As the CalWORKs welfare caseload subsequently fell, the elderly and disabled share of the Medi-Cal caseload returned to its earlier level of about 26 percent, and the cost per eligible resumed its growth in 1996-97. In 1999-00, the estimated cost per eligible increased by 5.7 percent.

Based on the Governor's budget, these costs would increase by almost 13 percent in the current year, but would depart from the pattern of the prior five years by decreasing 4.6 percent in the budget year. The projected slowing of the growth rate in 2001-02 appears to be the result of an increase in the number of healthy beneficiaries rather than a decrease in health care costs. The simplification of the eligibility process means that

the Medi-Cal Program probably will retain a greater number of children and families on its caseload who do not regularly need health care services. In the past, these individuals might not have submitted quarterly status reports because they did not need health care services at that time and, as a result, they were dropped from Medi-Cal coverage. These individuals would probably reenroll later when they needed health care services. With continuous eligibility, these individuals are much less likely to leave the program. Therefore, the Medi-Cal caseload increase will include a larger segment of the population that is healthy, resulting in fewer additional program costs compared to other beneficiaries, such as the aged, blind, and disabled.

Overall Caseload Estimate Reasonable; One Component May Be Overestimated

We find that the budget's overall estimate for the Medi-Cal caseload is reasonable, but that the projected increase in the caseload of Medi-Cal nonwelfare families may be overestimated. Accordingly, we will monitor caseload trends and recommend appropriate adjustments at the time of the May Revision.

Figure 6 shows the budget's forecast for the Medi-Cal caseload in the current year and 2001-02. The majority of the projected Medi-Cal caseload growth consists of families and children. The budget estimates that the caseload for this group will increase by 2.8 percent in the current year and about 16 percent in the budget year. Nonwelfare families account for most of the projected increase in Medi-Cal eligible families and children. The budget estimates that the caseload of Medi-Cal eligible nonwelfare families will increase by about 52 percent in the current year, then increase *again* by 49 percent in the budget year.

The projected caseload increase is primarily the result of growth in the 1931(b) program, elimination of the quarterly status reporting requirements for adults, and the implementation of new continuous eligibility rules for children.

Nonwelfare Family Growth May Be Overestimated. Our analysis indicates that the projected increase in Medi-Cal eligible nonwelfare families for the budget year may be overestimated. This is because in the current year, the caseload increase expected to result from the expansion of the nonwelfare 1931(b) program to 100 percent of FPL (effective March 2000) has been about half of what was anticipated. This is attributed to the complexity of making 1931(b) eligibility determinations. Additionally, the overall Medi-Cal caseload for the current year appears to be slightly below the estimate upon which the Governor's budget plan for

2001-02 is based. If this caseload trend continued, state Medi-Cal costs could be tens of millions of dollars below the level of spending assumed in the *2001-02 Governor's Budget*.

Figure 6

Medi-Cal Caseload
Governor's Budget Estimate

1999-00 through 2001-02
(Eligibles in Thousands)

			Change from 1999-00			Change From 2000-01	
	1999-00	2000-01	Amount	Percent	2001-02	Amount	Percent
Families/Children	**3,573**	**3,675**	**102**	**2.8%**	**4,271**	**596**	**16.2%**
CalWORKs[a]	2,033	1,768	-265	-13.0	1,652	-116	-6.6
Nonwelfare families[b]	919	1,394	475	51.7	2,071	677	48.6
Pregnant women	176	178	2	1.3	203	25	14.1
Children	446	335	-111	-24.8	345	10	3.0
Aged/Disabled	**1,311**	**1,357**	**45**	**3.5%**	**1,402**	**46**	**3.4%**
Aged	489	508	18	3.7	525	18	3.5
Disabled	823	849	27	3.3	877	28	3.3
Totals	**4,885**	**5,032**	**147**	**3.0%**	**5,674**	**642**	**12.8%**

[a] California Work Opportunity and Responsibility to Kids program.
[b] Includes former CalWORKs recipients temporarily continued in the "Edwards" category.

Uncertainties in Estimate. However, it is highly uncertain at this time whether this trend will be sustained. There are a number of factors that could result in higher caseloads as well as factors that could produce lower caseloads. On the upside, a number of significant expansions in Medi-Cal coverage and change in eligibility rules only began to take effect on January 1, 2001. It may be several months before they are fully implemented and their true effects on the Medi-Cal caseload are known.

There is downside potential for the caseload estimates as well. For example, the lag in eligibility determinations (discussed above) may carry over into the budget year and some counties may continue to encounter delays and difficulties in the Section 1931(b) eligibility process. In this event, the number of adults enrolling in the 1931(b) program would be less than anticipated. Moreover, the projected number of additional persons who would remain enrolled in Medi-Cal because they no longer have to submit a quarterly status report could also be less than estimated in the budget.

Overall Projections Appear Reasonable. Our review found that other caseload estimates appear reasonable. The overall children's monthly caseload component of the nonwelfare families category is expected to increase by about 17,000 in the current year, and nearly 370,000 in the budget year. This growth is consistent with the new rules providing these children with continuous eligibility. Caseloads for the aged and disabled are expected to grow by about 45,000 in both the current year and in the budget year. This budget forecast also appears reasonable, given the recent expansions of eligibility for this group and recent caseload trends. In summary, while we believe that some caseload savings in the budget year are possible, we do not recommend a specific budget adjustment at this time. That is because it is not yet clear whether the delays associated with 1931(b) determinations will continue. Accordingly, we will continue to monitor the Medi-Cal caseload trends and recommend appropriate adjustments at the time of the May Revision.

Potential Risks to Accuracy of Caseload Projections and Cost Estimates. The accuracy of the department's caseload projections and cost estimates are dependent upon a number of other more general factors not discussed above. Among the factors that could cause the Medi-Cal program's caseload and cost to vary from the projections are:

- ***Federal actions*** such as a minimum wage rate increase or the enactment of laws expanding Medi-Cal eligibility.
- ***Further changes in state laws and regulations*** adopted by the Legislature and the Governor or through the initiative process. For example, pursuant to legislation, regulations setting new minimum nurse-to-patient staffing ratios are likely to be implemented this year that could affect hospital and managed care rates.
- ***Changes in the economy and general inflation*** could affect the number of people eligible for Medi-Cal. Economic changes could also result in further provider rate increases which would cause an increase in Medi-Cal expenditures.

Significant changes in any of these areas could easily result in a caseload growth higher or lower that the one contained in DHS's Medi-Cal estimate.

SETTING MEDI-CAL PHYSICIAN RATES— A MORE RATIONAL APPROACH

Background

For 2001-02, the Medi-Cal Program will spend an estimated $1 billion ($500 million General Fund) for physician services in the tradi-

tional "fee-for-service" portion of the program in which providers are paid for each examination, procedure, or other service that they furnish. In addition, a significant portion of the estimated $4.2 billion ($2 billion General Fund) in premiums that Medi-Cal provides to health plans for beneficiaries in managed care indirectly pays for physician services.

About half of the persons eligible for Medi-Cal are enrolled in managed care organizations while the remainder receive services under the fee-for-service portion of the program. Although we believe a review is warranted of the managed care plan rate system, this analysis focuses primarily upon the mechanism for establishing physician rates for fee-for-service Medi-Cal services.

The Current Rate-Setting System

Our analysis indicates that the rates paid to physicians for services provided under the Medi-Cal Program are relatively low compared to the rates paid by the federal Medicare program and other health care purchasers. Despite state and federal requirements, the Department of Health Services has not conducted annual rate reviews or made periodic adjustments to Medi-Cal rates to ensure reasonable access to health care services. Rate adjustments have generally been adopted in the budget process on an ad hoc basis, usually in response to complaints about limited access to specific services and to provider requests for rate increases. Thus, there is not a rational underlying basis for the state's complex system of setting Medi-Cal rates. In comparison, Medicare uses a comprehensive, annually updated, rate-setting system that is available for use by other government programs and the public generally. Our key findings, which we discuss below, are summarized in Figure 7 (see next page).

Studies Show Medi-Cal Rates Are Low. Studies show that the rates that Medi-Cal pays for physician services are relatively low compared to rates paid by other major purchasers of health care. For example, a May 1999 study conducted by Pricewaterhouse Coopers LLP for the Medi-Cal Policy Institute found that Medi-Cal physician rates for some common procedures were substantially less than those paid by the federal Medicare program, which provides health care benefits for the elderly and some disabled persons, or by private health plans. Medi-Cal rates for certain medical services were often less than half the rates paid by other health care purchasers.

A national study of physician rates in state Medicaid programs by The Urban Institute found that these states, on average, paid physicians at rates equal to about 64 percent of Medicare rates. However, the study

found that California's Medi-Cal rates were comparatively lower, amounting to an average of 47 percent of the Medicare rates in 1998.

Figure 7

Current Physician Rate-Setting System

Key Findings

- Medi-Cal rates are low compared to Medicare and other health care purchasers.
- The Medi-Cal Program has not met state and federal requirements for setting rates, ensuring reasonable access to health care.
- Research indicates physician rates can affect access to care and health care quality.
- Medi-Cal physician rates are not based upon an assessment of relative access of Medi-Cal beneficiaries to quality health care or any measure of the actual costs of providing medical services.
- Medicare has a rational, comprehensive rate-setting system that adjusts physician rates annually.
- Medi-Cal physician rates now average about 60 percent of Medicare rates.

Budget Problems Held Down Rates. These low rates resulted in part from the state's budget problems during the recession of the early 1990s. Most Medi-Cal physician rates were frozen and some rates were actually reduced to hold down state costs. As the state economy and state budget situation improved, rates were increased in the 1998-99 and 1999-00 state budgets for specific services, such as primary care and emergency room services. But no general increase affecting Medi-Cal physician rates across the board had been implemented since 1985-86 until the enactment of the *2000-01 Budget Act*.

As shown in Figure 8, the 2000-01 budget provided about $133 million from the General Fund (plus matching federal funds) for (1) targeted rate increases and (2) a general physician rate increase (identified as "other physician services" in Figure 8). The recent rate increases, however, do not put into place any ongoing process for evaluating physician rates or for periodically adjusting them when appropriate.

Requirements for Regular Rate Reviews Have Not Been Met. State law establishes the following two general criteria for Medi-Cal physician rates: (1) rates must be sufficient to provide Medi-Cal recipients with reasonable access to medical care services and especially to primary and maternity care services; and (2) rates must apply statewide, except that higher rates may be paid if necessary to provide access to care in spe-

cific areas. The state provision for reasonable access to care is consistent with the requirement of federal Medicaid law that rates be sufficient to enlist enough providers so that care and services are available to Medicaid participants to at least the same extent that they are available to the general population in the geographic area. State law also requires the Department of Health Services (DHS) to annually review and periodically revise Medi-Cal physician and dental rates "to ensure the reasonable access of Medi-Cal beneficiaries to physician and dental services."

Figure 8

Physician Rate Increases for Medi-Cal and Related Health Programs—General Fund

2000-01
(Dollars in Millions)

	Amount	Percent Increase
Child Health and Disability Prevention Program—health screening exams	$19.2	20.0%
California Children's Services	9.2	20.0
Emergency-room and on-call physicians	10.5	40.0
Neonatal intensive care	5.4	30.0
Comprehensive perinatal services	2.6	11.0
Other physician services	84.9	15.6
Total	**$132.9**	

Despite these statutory provisions, DHS has not performed the required annual rate reviews or proposed revisions to physician rates for many years. The rate increase included in the 2000-01 budget was not based upon any objective analysis of the adequacy of physician rates.

The Legislature approved a bill in 1999 (AB 461, Hertzberg) to require DHS to conduct a rate review by April 1, 2000, including a comparison of Medi-Cal physician rates with those of Medicaid programs in five comparable states. The Governor vetoed this legislation, stating that DHS lacked the administrative resources to conduct such a rate review.

Studies Show Relationship Between Rates and Health Care. A recent national analysis of Medicaid physician rates by The Urban Institute concluded that "physician fee levels affect both access and outcomes for Med-

icaid patients." One study cited by The Urban Institute report found that higher rates were "associated with a small, but significant, decline in the infant mortality rate." Another study found that children enrolled in Medicaid programs that paid relatively higher physician fees were more likely to obtain care at a doctor's office.

The findings of this national study are consistent with a recent survey of Medi-Cal beneficiaries. Specifically, in a recent survey of Medi-Cal beneficiaries, the Medi-Cal Policy Institute reported that 80 percent of program participants believe that they are receiving high-quality medical services. However, 56 percent reported difficulty finding doctors who would provide them treatment, and 78 percent said it is very important that more doctors participate in the program.

No Rational Basis for Rate System. There are three basic steps in the methodology for calculating most Medi-Cal physician rates. First, physician procedures are classified according to a *coding structure*. Second, each procedure is assigned a *relative unit value*. Third, the payment amount is determined by multiplying the relative unit value by a *dollar conversion factor*. (We explain this process in more detail in our February 2001 report entitled, *A More Rational Approach to Setting Medi-Cal Physician Rates*.)

The structure of Medi-Cal rates is complex with thousands of possible combinations of procedure codes, relative unit values, conversion factors, and other rate modifications. Nevertheless, DHS has no regular process in place for the periodic evaluation of the adequacy of physician rates or for periodically adjusting them. Physician rates are no longer tied to a 1969 relative unit value system developed by the California Medical Association. Thus, the rate adjustments approved in recent years in the budget process have generally been adopted on an ad hoc basis, usually in response to complaints about limited access to specific services and to provider requests for rate increases.

The rate increases included in the 2000-01 budget, for example, were based upon general legislative concerns about the adequacy of rates and overall budget priorities; they were not based on any specific objective measures of the adequacy of those rates in ensuring patient access to care or quality of care. While DHS has used additional funding received through the budget to adjust Medi-Cal physician rates to reduce some of the disparities with Medicare, large differences still exist for some medical procedures.

The lack of a rational system for physician rate setting has significant potential ramifications for the provision of health care for Medi-Cal beneficiaries and the administration of the program: (1) the state will not ensure reasonable access to quality health care services; (2) physician ser-

vices will be used less efficiently, with overpayments for some medical procedures and underpayments for others, providing an incentive for the overuse of some services and the under use of others; (3) some medical providers may not be fairly compensated for certain medical procedures; and (4) the Medi-Cal rate system will remain complex and difficult to administer for DHS and participating physicians.

Medicare Is a Useful Benchmark. Our analysis indicates that Medicare provides the state with a useful benchmark for rate setting, for several reasons. Similar to the Medi-Cal Program, Medicare uses a three-step rate-setting process involving a coding structure, relative unit values, and a dollar conversion factor. The key differences in Medicare which we believe make it a useful benchmark are that (1) the relative values and conversion factor the Medicare rate system assigns to medical procedures are updated regularly, and (2) Medicare rates fairly accurately reflect the current costs of providing physician services. Medicare has the most comprehensive, annually updated, rate system in the nation, and it is publicly available for use by anyone, including other public agencies such as the Medi-Cal Program. Many purchasers of health care, including both private health plans and about 19 state Medicaid programs, use the relative value-based rate system developed by Medicare when adjusting physician rates.

Using Medicare rates as the basis for Medi-Cal rate setting would allow DHS to avoid the expensive and unnecessary process of developing its own separate physician rate structure. This approach also should not be difficult for health care providers to accept, given that four out of five California physicians participate in Medicare.

Medi-Cal Rates Now 60 Percent of Medicare. The 2000-01 budget included about $85 million from the General Fund (plus an equivalent amount of federal matching funds) for a general increase in physician rates averaging 15.6 percent. Because the intent of the budget action was to reduce disparities with Medicare, larger rate increases were provided for some procedures than for others. State payments to managed care health plans will also be increased proportionally to allow those plans to provide higher compensation for physicians.

Based upon data provided by DHS, we estimate that the overall level of Medi-Cal physician payments has increased to roughly 60 percent of the Medicare rates allowed for nonhospital settings as a result of the recent physician rate increases. We estimate that Medi-Cal physician payments averaged about 50 percent of the Medicare rates before the recent rate increases were implemented.

Reforming the Way Physician Rates Are Set

We recommend that the Legislature establish a more rational process for establishing Medi-Cal rates and for periodically reviewing and adjusting those rates. In the short term, if the Legislature wishes to continue to narrow the significant gap between Medi-Cal physician rates and the rates paid under other health programs, Medicare rates should be used as a benchmark. In order to provide a long-term solution, the Legislature should direct the Department of Health Services to perform a comprehensive analysis of access to physician services and the quality of care provided to Medi-Cal beneficiaries, and offer proposals commencing in 2002-03 for periodic future adjustments to physician rates based upon that analysis. Figure 9 summarizes our recommendations.

Interim Approach—Base Medi-Cal Rates Upon the Medicare Program. Due to the lack of objective data at this time about health care access or quality of care for Medi-Cal beneficiaries, we have no basis for recommending any further change now in Medi-Cal physician rates. However, as we have noted in this analysis, Medi-Cal rates in many cases are well below the rates paid by other health care purchasers, including Medicare.

Accordingly, we recommend that any rate adjustments the Legislature does choose to provide in the interim for the Medi-Cal Program in the state budget process be made in a way that further narrows the program's differences with Medicare rates. We also propose that DHS report each year to the Legislature regarding how Medi-Cal and Medicare rates compare, and the cost of keeping Medi-Cal rates in alignment with Medicare and other major purchasers of health care.

We further recommend that any specific rate increases generally be limited to 80 percent of the Medicare level. This is due to the way Medicare and Medi-Cal provide coverage to persons eligible for both programs. The Medi-Cal Program pays the Medicare premiums and deductibles and any required copayments for medical services on behalf of these persons. Participating physicians generally agree to accept the Medicare rates for services to Medicare beneficiaries. However, the Medicare *payment* is only 80 percent of the Medicare *rate*—with copayments by beneficiaries making up the remaining 20 percent of the payment due to the physician.

Federal law allows state Medicaid programs to limit the amount they pay for Medicare copayments on behalf of dual eligibles, and California has chosen to exercise this option under state law. If the Medicare payment is greater than the Medi-Cal rate, then Medi-Cal pays nothing, and the provider receives only the Medicare payment. If the Medi-Cal rate is greater than the Medicare payment, then Medi-Cal pays the difference between the higher Medi-Cal rate and the lower Medicare payment.

Figure 9

LAO Recommendations for Setting Medi-Cal Physician Rates

Establish a More Rational Process

- ***Interim Rate Adjustments***. We have no basis at this time for recommending Medi-Cal physician rate increases. If the Legislature wishes to increase rates, we recommend that those rate increases be made in a way that narrows the gap but does not exceed 80 percent of Medicare rates.
- ***Reporting of Rate Comparisons***. We recommend that the Department of Health Services (DHS) report each year to the Legislature regarding how Medi-Cal rates compare to Medicare rates and the cost of keeping those rates in alignment with Medicare and other major purchasers of health care.
- ***Future Rate Adjustments***. We recommend that DHS perform a comprehensive analysis of access to physician services and quality of care provided to Medi-Cal beneficiaries and the actual cost of providing medical services. Thereafter, DHS should base future rate adjustments upon that analysis. All rates would thereafter be reviewed at least once every five years.

For most procedures and services, the Medi-Cal rate is less than the Medicare payment amount. As a result, the state avoids substantial medical costs.

We estimate that if Medi-Cal rates were generally increased to the maximum recommended level of 80 percent of Medicare rates, the annual General Fund cost would be roughly $237 million. If the interim 80 percent limit we propose were exceeded so that Medi-Cal and Medicare physician rates were equal, we estimate that annual General Fund costs would increase much more—about $540 million—for the reasons we have discussed above.

Long Term—Base Rates on Comprehensive Review. We recommend the enactment of legislation directing DHS to perform a comprehensive analysis of the access to physician services and quality of care provided to Medi-Cal beneficiaries. The DHS would recommend periodic adjustments to physician rates based upon the results of that analysis. The Legislature would then determine whether to appropriate funding for such rate adjustments.

This analysis would involve regular measurement and evaluation of both patient access to health care and the quality of that care. While the department now contracts for such reviews for Medi-Cal managed care plans, it does not comprehensively or regularly do so for fee-for-service Medi-Cal services.

The long-term fiscal impact of the proposed new rate-setting mechanism is uncertain and would largely depend upon the extent to which the Legislature appropriated funding for any periodic rate increases recommended by DHS.

The Benefits of the LAO Approach

We believe that our proposal to establish a rational process for setting Medi-Cal rates, and for periodically reviewing and adjusting those rates, offers some significant potential benefits. For example, it would ensure that the Medi-Cal Program remains in compliance with state and federal statutory requirements for the payment of rates sufficient to ensure the participation of medical providers and regular review and adjustment of physician rates. Our approach is likely in the long term to foster reasonable access to health care for Medi-Cal beneficiaries and a better quality of care. This is because our proposal would ensure that rates are reviewed and adjusted with these factors in mind. Physician services are likely to be used more efficiently under our proposal since rates would be more in line with current costs, thus avoiding overuse of some medical procedures and under use of others. Medi-Cal rates would keep pace with changes in medical practices and technology.

Our proposal would also simplify administration of the Medi-Cal Program by doing away with an extremely complex rate structure. For example, the 20 different dollar conversion factors used to determine payments for physician services would be consolidated into one such factor, and many special modifications of rates would no longer have to be calculated.

OTHER ISSUES

Los Angeles County Section 1115 Medicaid Demonstration Project

We recommend approval of $30 million from the General Fund requested for the extension of a Medicaid demonstration project providing state and federal funds to enable Los Angeles County to reduce its inpatient, and expand its outpatient, health care system.

In order to strengthen the Legislature's oversight of this project, we recommend the adoption of supplemental report language requiring that the state Department of Health Services report on the county's progress toward restructuring the local health system and its assessment of county plans to address significant health program budget shortfalls projected to begin in 2003-04.

We further recommend that the 2001-02 budget request for funding to monitor the demonstration project be reduced by $6.8 million (about $3.4 million General Fund and $3.4 million federal funds), because the monitoring contract is unlikely to be awarded until 2002-03. In addition, the Legislature may wish to consider using available federal funds instead of the General Fund to pay for workforce training related to the demonstration project, thereby saving about $27 million from the General Fund over a five-year period. (Reduce Item 4260-101-0001 by $3.4 million and Item 4260-101-0890 by $3.4 million.)

Background. At the start of the 1995-96 fiscal year, Los Angeles County faced a $655 million budget deficit in health services operations and the potential collapse of its medical "safety net" programs. State, federal, and county officials collaborated to develop a five-year plan to address the crisis by financially stabilizing the county health system, and, over time, moving it away from expensive hospital services toward community-based primary care and preventive services. In April 1996, HCFA approved the plan as a Medicaid demonstration project that was to end during 1999-00.

Since that time, Los Angeles County has made some progress toward achieving the project's goals, including increasing ambulatory (community based) sites throughout the county from 45 to 156 and decreasing emergency room visits by 27 percent. However, the fundamental restructuring goals of reducing inpatient care and expanding outpatient care were not achieved by the end of the project's term. Access to community-based care was to have been increased by 900,000 additional visits, but it was increased by 600,000 visits, and other goals for reducing operating costs were not achieved. As a result, the county requested an extension of the program to provide it additional time and funding to institute reforms and restructure its health system.

On June 27, 2000, HCFA approved a five-year extension to the demonstration project (for 2000-01 through 2004-05). The extension provides $900 million in federal funds that would be phased out over the five-year extension of the project. The total amount of supplemental funding available to Los Angeles County as a result of the demonstration project is $1.5 billion, including federal ($900 million), state ($150 million), and county ($400 million) funds.

Provisions of the Project Extension. The project's extension is contingent upon the state and county meeting a number of specific requirements that include:

- ***Further Increasing Access Through Outpatient Services.*** To advance the restructuring process, the county has committed to continuing expansion of outpatient services. For example, the county must provide a minimum of three million outpatient visits annu-

ally in public and private clinics. As part of this effort, the state must ensure that participating clinics are reimbursed at adequate rates. The county will also expand speciality care services and enhance the mix of services that are available to the uninsured.

- ***Improve Screening and Enrollment Processes.*** The state and the county must take steps to eliminate or reduce barriers to Medi-Cal and Healthy Families enrollment and must specifically ensure that the total number of Medi-Cal eligibles in the county is increased. Some of these steps include ensuring timely processing of applications and providing enrollment materials in languages other than English. Also, through a pilot project, the county must simplify the annual redetermination process by allowing the beneficiary to complete a form and sign to self-declare the information needed for redetermination.
- ***County Workforce Training.*** The state and county must develop a plan and commit funds for workforce training and restructuring activities in the county's health care system to enable county health care workers to be better prepared for new responsibilities.
- ***State Monitoring Plan.*** The state must submit a detailed monitoring plan that includes specific requirements and measurable milestones of county progress towards reform of health care operations. The plan also enables the state to issue sanctions that could amount to tens of millions of dollars if these goals are not met.
- ***State Administrative and Reporting Requirements.*** The state must perform various administrative activities related to the demonstration project and submit quarterly and annual progress reports to HCFA.

Commitment of State and County Funds. Unlike the initial waiver, which did not require a significant state General Fund contribution, the extension agreement requires the state to provide $30 million annually from the General Fund for five years beginning in the current fiscal year. This funding is in addition to the normal reimbursements the state provides the county through programs such as Medi-Cal. The funding would be used to provide cost-based reimbursement for services provided at eligible county-affiliated clinics.

In addition to these state funds, the county has committed $300 million of tobacco litigation settlement funds and an additional $100 million of the county General Fund during the extension period for demonstration-related services.

State Investment Has Risks. The terms and conditions under which HCFA approved an extension to the demonstration project outline spe-

cific goals that Los County must achieve. Given that many of these goals were not fully achieved in the first five years of the project, there is uncertainty about whether they will be met in the next five years. The extension requirement that the state contribute $150 million during this five-year period gives it a vested interest in the county's success in meeting these goals and establishing a more cost-effective and efficient health care system.

However, the county's own fiscal estimates show that, even with the state and federal financial help provided for the demonstration project, the county DHS will face a budget shortfall beginning in the third year (2003-04) of the extension. The shortfall is projected to continue through the end of the project and beyond. The shortfall is projected to amount to $333 million in 2003-04 and grow to $534 by 2005-06, the year after the extension expires. The threat of continued deficits in 2005-06 and subsequent years, and the projected decline in federal funds, leaves the state at risk of being called upon to provide hundreds of millions of dollars annually for Los Angeles County health services beyond the extension period.

The county has not yet determined how it will address these shortfalls. Currently, it is considering options, including consolidations and reductions of health operations, to eliminate shortfalls during the five-year demonstration project period. To plan for the shortfall expected after the five-year period, beginning in 2005-06, the county DHS will submit a report to the county Board of Supervisors in December 2002 that provides options for changes in facilities and services in line with requirements to balance the budget.

Monitoring Funding Apparently Not Yet Needed. In addition to the $30 million General Fund augmentation in both 2000-01 and 2001-02, the Governor's budget requests $7.7 million ($3.8 million from the General Fund) and nine positions to fulfill the monitoring and auditing responsibilities mandated in the terms and conditions of the waiver extension. Of this amount, $6.8 million (about $3.4 million from the General Fund and an equal amount of federal funds) would be used to hire a contractor that would conduct the overall program monitoring activities.

The timetable for hiring the contractor involves recruiting, hiring, and training staff to develop a request for proposal; soliciting and reviewing bids; interviewing applicants; and hiring the contractor. The DHS' own timetable provides for the interviewing and hiring of the contractor to occur at the earliest between May 1, 2002 and June 30, 2002. Yet, we are advised that the contractor hiring process has already fallen behind schedule. Given this situation, we believe it is very unlikely that the monitoring contract will be awarded during 2001-02.

Workforce Investment Act Funding. One of the major components of the project is the development of a Workforce Development Program

(WDP) to meet the needs of workers involved in health care delivery system restructuring areas. The WDP is a jointly developed program through the County of Los Angeles DHS and Service Employees International Union designed to:

- Implement training programs that address critical labor shortages by training county employees to promote into needed occupations.
- Support restructuring by upgrading worker skills through innovative training programs.

Under the terms of the extension agreement, the WDP is to be supported by the state and county at a 2-to-1 ratio, with a combined contribution of $40 million during the extension period (fiscal year 2000-01 through 2004-05). The state's share of this funding is estimated to be about $27 million over five years.

The Governor's budget would provide the state's share from the General Fund. Our analysis indicates, however, that the workforce retraining activities required under the Medicaid demonstration project appear to be eligible for funding under the federal Workforce Investment Act (WIA). The *2001-02 Governor's Budget* appropriates about $800 million in federal funds received by the state under WIA. Of this amount, there are funds which are targeted to adults—including those facing dislocation from their current jobs—to assist them with their retraining and other needs. Up to 15 percent of the allocation is reserved for statewide activities, with the balance of funding allocated to counties. The Governor's proposed budget identifies few specific statewide projects and proposes to leave most allocation decisions to the California Workforce Investment Board.

Notably, the state-federal-county agreement to extend the Los Angeles County demonstration project specifically permits the use of non-Medicaid federal funds for the required retraining activity. Substitution of WIA funds for this purpose would result in General Fund savings of $27 million over the life of the five-year demonstration project.

Analyst's Recommendation. We recommend that the budget's request for $30 million General Fund annually for the Los Angeles County demonstration project be approved. Under the terms of the project extension, the contribution of state funds enables the county to obtain a significant amount of federal funds—$900 million over five years. Without this funding, the county cannot restructure its health operations and stabilize its costs and would risk a large-scale disruption of its health system. Further, if the demonstration project were halted as a result of a state decision to withhold its financial contribution, the county's reliance on expensive inpatient care would continue and the planned shift to outpatient setting would probably suffer a setback. In addition, the demonstra-

tion project does have some mechanisms in place to help assure that the county meets the project's goals, such as a monitoring plan and the state's ability to impose financial sanctions upon the county if the monitoring plan's requirements are not met.

However, there are significant risks for the state associated with the commitment of state General Fund support. This requires that the administration and the Legislature provide strong oversight of the demonstration project over its five-year life.

Accordingly, we recommend the adoption of the following supplemental report language:

> It is the intent of the Legislature that the State Department of Health Services (DHS) prepare a detailed written assessment of the progress of Los Angeles County toward meeting the goals outlined in the terms and conditions of the Medicaid Demonstration Project extension approved by the Health Care Financing Administration and report the assessment to the Chair of the Joint Legislative Budget Committee and the chair of the fiscal committee of both houses of the Legislature by December 1, 2001, and by December 1 of each subsequent year through 2005. It is also the intent of the Legislature that, by January 1, 2003, DHS prepare a detailed written assessment for the Joint Legislative Budget Committee and the fiscal committee of both houses of the Legislature of Los Angeles County's plans to address the significant budget deficits projected for its health systems, both during the term of the demonstration project and thereafter.

We also recommend deletion of the funding for the monitoring contractor that, based on our review, will not be needed in the budget year. We further recommend that the Legislature consider using available federal funds, at a state savings over five years of about $27 million, for workforce training related to the demonstration project.

Medi-Cal Estimate Should Be Redesigned

We recommend the enactment of legislation directing the department to revise the Medi-Cal estimate in order to make it a more useful tool for the Legislature. In addition, we recommend the department report at budget hearings regarding the additional resources it would need to complete the redesign of the estimate.

Estimate an Inadequate Tool. The annual Medi-Cal estimate is the basic tool the administration, Legislature, and other parties use to monitor Medi-Cal and evaluate proposed changes in this $25.4 billion ($9.4 billion General Fund) program. Yet, the estimate's approach and format have changed little over the last 20 years, resulting in a tool that is inadequate for the task. In the *Analysis of the 1999-00 Budget Bill*, we found that the

estimate's approach was outdated and failed to provide important information, such as data on caseloads and rates for the managed care plans, and provides almost no information explaining why proposed changes should occur. We proposed several ways to make the estimate a more useful tool for budgeting, monitoring, and evaluating the Medi-Cal Program.

The *1999-00 Budget Act* provided DHS funding for consultants and three limited-term staff through 2000-01 to assess the Medi-Cal estimate and determine the best approach for replacing the existing information system and identifying specific functional requirements. A feasibility study report (FSR) has been completed and is currently under review by the Department of Information Technology. Following approval of the FSR, DHS intends to revise the estimating process to implement improved technology. Because the redesign process is under way, with development and implementation expected over the next two years, we believe this is an opportune time for the Legislature to direct the department to take additional steps to improve the estimate.

Analyst's Recommendation. We believe that the recommendations we offered for such improvements in our *1999-00 Analysis* are still relevant and would assist the Legislature in determining the appropriate budget for the Medi-Cal Program. Accordingly, we recommend the enactment of legislation directing DHS to restructure the estimate to:

- 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 amount of funding for each.
- Provide detail on managed care costs, including an estimate of managed care costs, built up from specific rate assumptions, caseload projections, and cost trends for "carved-out" services.
- Provide a comprehensive analysis and spending forecast for DHS Medi-Cal services, including *actual* spending amounts for the past year and identification of factors responsible for spending trends.
- Identify General Fund cost trends for each group of Medi-Cal eligibles and services.
- Include concise, but informative, explanations of the basis and assumptions for each premise in the estimate.
- Separate out new and continuing policy proposals and provide more substantial documentation than is now available explaining the rationale and program details for those policy changes that represent new or significantly modified programs.

We recognize that revising the estimate as we propose may require additional DHS resources. Thus, we further recommend that the department report at the time of budget hearings regarding any funding and staffing required to carry out these changes.

Report Needed on Managed Care and Inpatient Rate Increases

We recommend that the Department of Finance and the Department of Health Services report at budget hearings regarding (1) their plans for Medi-Cal managed care and hospital inpatient rate increases for 2001-02 and (2) the potential amount of additional funding needed in 2001-02 to provide for any such rate increases. An estimate of the cost of providing anticipated rate increases for nursing homes is expected at the time of the May Revision.

Managed Care and Inpatient Rate Increases in the Current Year. A portion of the 2000-01 Medi-Cal deficiency is for rate increases the CMAC negotiated and DHS granted to Medi-Cal managed care plans and hospitals. The *2000-01 Budget Act* included about $67 million from the General Fund for rate increases for Medi-Cal managed care plans operating in the 12 counties under the "two plan" model. However, about one-third of the total cost of the rate increases for the current year—an additional $36 million—was not budgeted and is contributing to the Medi-Cal deficiency in the current year.

In addition to not fully funding the cost of managed care rate increases in the current year, the *2000-01 Budget Act* did not include any appropriations for the rate increases that hospitals negotiate with CMAC. The CMAC negotiated such rate increases in the current fiscal year and the related increase in inpatient costs is contributing $60 million to the current-year deficiency.

Potential Budget-Year Costs. The budget request for 2001-02 does not include any additional funding for Medi-Cal managed care or inpatient rate increases. Managed care rate increases are typically granted every year and it is likely that further inpatient hospital rate increases will also be granted. Excluding these costs results in under budgeting of the Medi-Cal Program. Furthermore, as discussed in the issues above, and in the *2000-01 Analysis*, we believe the deficiency process is not an appropriate funding mechanism for these rate increases. In addition, the 2001-02 budget proposal does not include any funding for anticipated increases in Medi-Cal expenditures due to rate increases for nursing homes. The DHS ordinarily provides an estimate of the cost of these rate increases at the time of the May Revision. The combined impact of managed care, inpatient, and nursing home rate increases could exceed $100 million in the budget year.

Analyst's Recommendation. For these reasons, we recommend that DHS and DOF report at budget hearings on (1) their plans for considering Medi-Cal managed care and hospital inpatient rate increases in 2001-02 and (2) the potential amount needed to provide for these rate increases. An estimate of the cost of providing anticipated rate increases for nursing homes is expected at the time of the May Revision.

Other Potential Rate Increases Not Included in the Budget

We recommend that the Department of Health Services report at budget hearings regarding (1) the impact of the settlement of the* Orthopaedic Hospital v. Belshe' *litigation on provider rates and (2) the potential amount of funding needed if provider rates increase in the budget year as a result of the settlement.

Potential Provider Rate Increases in the Budget Year. The recent settlement of the *Orthopaedic Hospital v. Belshe'* litigation and other related lawsuits pertaining to Medi-Cal payments for hospital outpatient services (discussed earlier) could result in provider rate increases. Work is currently under way to negotiate the final details of the settlement, which must then be approved by HCFA. Until this is complete, the impact of the settlement on provider rates and the Medi-Cal budget is unknown.

Analyst's Recommendation. We recommend that DHS report at budget hearings on the impact of settlement of these lawsuits on provider rates and the 2001-02 Medi-Cal budget.

Antifraud Expansion Should Increase Savings

The proposed Medi-Cal budget assumes that savings resulting from antifraud activities would be about the same as in the current year. However, a significant recent expansion of staff for antifraud activities should result in increased savings during the budget year, potentially amounting to millions of dollars. Accordingly, we recommend that the Department of Health Services (DHS) provide at budget hearings an updated estimate of expected fraud savings for 2001-02. The DHS report should also include the estimated savings for each type of antifraud activity. We recommend approval of the Governor's request to permanently establish 16 positions for the Medi-Cal Fraud Prevention Bureau.

Antifraud Expansion. During the past two years, DHS has been provided additional resources to combat the problem of Medi-Cal fraud and abuse. Specifically, an additional $2.7 million ($1.3 million General Fund), 41 new positions, and enhanced statutory authority were provided to DHS in 1999-00. The *2000-01 Budget Act* added $21 million ($9 million General

Fund) and 192 more positions for the Governor's Medi-Cal Fraud and Fiscal Integrity Initiative. The 2001-02 budget plan would continue the funding and positions added over the past two years. The DHS budget proposal also includes a request to make permanent 16 positions previously authorized for a limited term for the Medi-Cal Fraud Prevention Bureau at a cost of $1.4 million ($697,000 General Fund).

Additional Positions, But No Additional Savings Yet. The Governor's budget estimates that the 2001-02 savings from the expansion of antifraud activities will amount to $75 million ($38 million General Fund), the same level of savings that was estimated for 2000-01. This estimate was initially provided during the May Revision of the 2000-01 budget. At that time, the department indicated that $75 million represented the minimum level of anticipated savings and further indicated that savings would increase as the additional antifraud staff were hired and trained.

However, the 2001-02 budget assumes no increase in antifraud savings over the current year. Thus, the budget does not adjust for the additional savings that DHS indicated would result from having a larger and more experienced staff and expansion of antifraud activity. These additional savings could amount to millions of dollars that could reduce the General Fund amount budgeted for Medi-Cal in 2001-02. The department has indicated that a new estimate of antifraud savings will be prepared for the May Revision.

At the time this analysis was prepared, DHS was unable to provide information detailing estimated savings for each type of antifraud activity. The department's antifraud efforts initially focused on the following four types of providers: suppliers of durable medical equipment, such as walkers, wheelchairs, special beds, or breathing equipment; providers of prosthetic or orthotic services, and items such as artificial limbs or corrective braces; independent (nonchain) pharmacies; and providers of nonemergency medical transportation. With expanded resources, the department also intended to focus antifraud efforts in the areas of clinical labs, physicians, billing services, dental providers (through the Denti-Cal program), home health agencies, and adult day health care programs. In addition, new staff was to focus on medical exemptions claimed for Managed Care enrollees, precheckwrite reviews, and tightening the Medi-Cal provider enrollment process. Without detailed information about these antifraud efforts, it will be difficult for the Legislature to determine which are cost-effective and warrant continued funding in the future.

Analyst's Recommendation. For these reasons, we recommend that DHS report at budget hearings with an update of expected fraud savings for 2001-02 so that appropriate adjustments can be made to the Medi-Cal

budget. We further recommend that the department report on savings generated in the current year and its projections for the budget year for each type of antifraud activity. Finally, we recommend approval of the Governor's proposal to permanently establish 16 positions for the Medi-Cal Fraud Prevention Bureau.

PUBLIC HEALTH

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

The Governor's budget proposes $2.1 billion (all funds) for public health local assistance. This represents an increase of $5.6 million, or 0.3 percent, above estimated current-year expenditures. The budget proposes $405 million from the General Fund, which is a 12 percent decrease from current-year expenditures. The main reason for this decrease is the proposed shift of General Fund support from some public health programs to the proposed new Tobacco Settlement Fund (TSF).

BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT

Federal legislation was enacted in October 2000 that allows California to offer breast and cervical cancer treatment services as an optional benefit to low-income, uninsured persons under the Medicaid program with "enhanced" federal financial participation. We discuss related services that the state currently provides, the ramifications of this new federal law, and some options available to the state if it elects to implement these changes.

Background

Approximately 23,000 California women are expected to be diagnosed with breast or cervical cancer, and about 4,700 of these women are expected to die from the two diseases, in 2001. A disproportionate share of these women are from low-income and racial- and ethnic- minority groups.

Many are uninsured and do not currently qualify for any of the state's comprehensive health care programs, such as Medi-Cal or Healthy Families.

Research has shown that early screening, diagnosis , and follow-up treatment substantially improves the health outcomes and survival rates of persons diagnosed with cancer. The state currently provides breast and cervical cancer screening services to low-income, uninsured and underinsured women who do not qualify for Medi-Cal through three programs that are discussed in greater detail below.

- ***National Breast and Cervical Cancer Early Detection Program (NBCCEDP)***. The NBCCEDP was created by the Breast and Cervical Cancer Mortality Prevention Act of 1990. This federal program provides grants to states for breast and cervical cancer screens for uninsured and underinsured women with incomes up to 200 percent of the federal poverty level (FPL). Most woman served by this program are over 40 years of age.
- ***Breast Cancer Early Detection Program (BCEDP)***. In 1993, California enacted the state version of the NBCCEDP to provide greater access to breast cancer screening services, including mammography, for uninsured and underinsured persons over 40 years of age with incomes at or below 200 percent of FPL. In addition to screening services, BCEDP provides services required for a definitive diagnosis, assistance in obtaining follow-up treatment, and outreach and education. This is the largest of the screening programs currently available. The BCEDP is funded by state tobacco tax revenues.
- ***Family Planning Access Care and Treatment Program (Family-PACT).*** This program provides family planning and reproductive health services, including breast and cervical cancer screens, to women with income up to 200 percent of FPL. It is different from the other programs in that it generally provides screens to a younger group of women—those of child-bearing age. We would note that services required for a definitive diagnosis of breast cancer are not covered. Family-PACT is jointly funded by the state and federal government.

From Screening to Treatment. For nearly ten years, the state provided breast and cervical cancer *screening* services for low-income women who did not qualify for Medi-Cal. However, *treatment* services for these women were generally not available unless they were referred to nonprofit organizations which would help to pay for their treatment. This situation changed with the enactment of Chapter 660, Statutes of 1999 (AB 1107, Cedillo), a measure which created the Breast Cancer Treatment Program (BCTP). In 2001-02, BCTP is expected to provide treatment services to an

estimated 2,100 women. There is currently no state-funded program for low-income, uninsured women that provides the treatment services ordinarily required for women diagnosed with cervical cancer.

According to the Department of Health Services (DHS), there are approximately 920,000 women over age 40 with incomes at or below 200 percent of the FPL. About 270,000, or 29 percent, of these women are expected to receive a screening through the programs discussed above during 2001-02. Based upon the projected incidence of the diseases, we estimate that about 2,000 of these women will be diagnosed with breast or cervical cancer through the existing screening programs. Figure 1 shows the number of women served by the four programs.

Figure 1

Low-Income Women Receiving Breast and Cervical Cancer Services[a]

2001-02

Program	Estimated Number of Women Receiving: Breast Cancer Screens	Cervical Cancer Screens	Breast Cancer Treatment
National Breast and Cervical Cancer Early Detection	23,000	23,000[b]	—
Breast Cancer Early Detection	207,000	—	—
Family-Pact[c]	—[d]	40,000	—
Breast Cancer Treatment	—	—	2,100
Totals	**230,000**	**63,000**	**2,100**

[a] Women with income at or below 200 percent of the federal poverty level who are not eligible for Medi-Cal services.

[b] Women who receive both breast cancer and cervical cancer screens. Thus, the total number of women receiving screens from all three screening programs is 270,000.

[c] This represents the estimated number of screens for women over 40 years of age.

[d] Program does provide breast cancer screens. At the time this analysis was prepared, no estimate was available.

Gaps in Existing Treatment Services. Although BCTP filled a fundamental gap in the availability of cancer treatment services for low-income, uninsured women, we note that treatment services under this program are limited. For example, women are eligible to receive services for 18 months, even though their illness may require several years of treatment. In addition, certain benefits are not available, such as bone marrow

transplants, hospice care, home health care, and nutrition services. Also, because the program is limited to 18 months, many women who need tamoxifen—a standard drug treatment to control the spread of breast cancer—-are unable to receive this treatment. This is because tamoxifen has a five-year treatment protocol.

We would also note that while women over 40 years of age face the greatest risk of breast and cervical cancer, many younger women can and do get these diseases. Based upon our analysis, many younger low-income women are being screened for cervical cancer under Family-PACT. However, as indicated earlier, unless a woman otherwise qualifies for Medi-Cal or Healthy Families coverage, state-funded cervical cancer treatment services are generally not available to uninsured, low-income women of any age.

New Federal Legislation. The enactment of the Breast and Cervical Cancer Prevention and Treatment Act by Congress in October 2000 gives states the option for the first time to offer Medicaid coverage with federal financial participation to previously ineligible, low-income women who are diagnosed with breast or cervical cancer. The legislation provides enhanced federal matching funds of two federal dollars for every state dollar, instead of the dollar-for-dollar federal-state sharing ratio traditionally available to California under Medicaid.

Specifically, states have the option of providing full-scope benefits to uninsured women under age 65, with income up to 250 percent of FPL, who have been diagnosed with either breast or cervical cancer. Full-scope benefits means that the benefits available to such women would not be limited to those specifically required to treat breast and cervical cancer. All services for these women would be provided with enhanced federal financial participation.

Moreover, these benefits would be available for the entire length of the cancer treatment period. States would also have the option to provide these women "presumptive eligibility" to ensure that needed treatment begins as early as possible. This means an applicant is given coverage for one month based upon a cursory review of their income eligibility.

The new federal law allows women diagnosed under a state screening program (such as Family-PACT and BCEDP) to participate in the Medicaid option, as well as women diagnosed through the NBCCEDP. In addition, states have the option of expanding the provider network by certifying providers who do not currently participate in the existing programs to screen and diagnose women under the federal program.

Options for Developing an Expanded Cancer Treatment Program

If the Legislature wishes to expand cancer treatment services for women in accordance with the new federal law, it has a number of options for doing so. Below we discuss some of these options, including aligning income eligibility for treatment services with the existing screening programs, offering presumptive eligibility to ensure immediate access to treatment services for women diagnosed with cancer, and covering younger women. Finally, our analysis indicates that the state funds already budgeted for breast cancer treatment appear to be sufficient to implement the new federal Medicaid treatment option.

There are potentially significant benefits and costs for the state if it were to implement the new federal option to provide treatment services to women diagnosed with breast and cervical cancer. If the Legislature wishes to implement the new federal law, it has several specific options for structuring such a new state program. We discuss these options below.

Aligning Eligibility Rules for Screening and Treatment Programs. In order for cancer screening and treatment programs to operate effectively and efficiently together, their eligibility rules must be similar. Currently, the breast and cervical cancer screening programs in California are available to women with incomes at or below 200 percent of FPL. Under the new federal program, breast and cervical cancer treatment services could be provided to women with income at or below 250 percent of FPL. Although the federal law allows the state to cover women up to 250 percent of FPL, the Legislature may wish to consider aligning Medi-Cal income eligibility under the federal option at 200 percent of FPL to create a comprehensive system of care for at-risk women and women diagnosed with cancer.

This approach has several benefits. First, it would create a source of treatment for all women who are currently eligible for the existing screening programs. Second, it would simplify eligibility determination since these women would already have been determined to have qualifying income. Third, it would make presumptive eligibility easier to administer should the Legislature decide to adopt that option. We discuss this eligibility option below.

Offering Presumptive Eligibility. Because of the complexity of eligibility rules, Medi-Cal eligibility determinations can take 30 to 60 days. For individuals with certain life-threatening conditions, such a delay in obtaining medical services can make a significant difference in their health. The state currently provides presumptive eligibility for pregnant women, because of the potential health risks to a mother and developing child during pregnancy, thereby giving them immediate access to health care. For similar reasons, the Legislature may wish to consider extending presumptive eligibility to women who are diagnosed with breast and cervi-

cal cancer. The Legislature may wish to require DHS to report at the time of budget hearings regarding the feasibility and cost of extending presumptive eligibility to this population.

Defining the Target Population. Under the new federal law, the state has the flexibility to expand treatment services to all low-income women up to age 65, or to limit the benefit to some part of this group—for example, low-income women between 40 years and 65 years of age. There are several factors the Legislature might wish to consider in determining who to include in expanded coverage. The state screening programs provide a very limited number of cervical cancer screens for low-income, uninsured women over 40 years of age due to limited funding. Thus, the number of such women who could be diagnosed with cervical cancer and referred for treatment is limited. Similarly, fewer women under 40 years of age could be referred for breast cancer treatment since Family-PACT does not provide the services required for a definitive diagnosis. In the following pages, we offer some options for addressing problems in the existing screening programs.

Fiscal Effect of Implementing the New Law. The proposed state budget provides $20 million for BCTP in 2001-02. The Governor's budget, however, does not take into account approximately $4.7 million in current-year savings in the program that could be reappropriated for the budget year. Although $20 million was provided for the program in 2000-01, a contract with California Health Collaborative, the non-profit organization retained to administer BCTP, will cost the state $15.3 million, resulting in a current-year savings to the state of $4.7 million.

Thus, about $25 million in state funding potentially is available to draw down nearly $50 million in additional federal funds, providing a total of about $75 million that could be used to offer Medi-Cal coverage to women diagnosed with breast and cervical cancer. Based upon our analysis, this would be more than enough to cover our estimate of the cost of such Medi-Cal coverage in 2001-02.

We estimate that the budget-year cost of adopting the new Medicaid option for women over 40 years of age with incomes up to 200 percent of FPL would range from $7 million to $12 million (all funds), with the state General Fund share ranging from $2 million to $4 million. Thus, there could be state savings ranging from $21 million to $23 million in the budget year if treatment services were expanded under the federal law. Our estimate does not include the cost of offering presumptive eligibility to women diagnosed with breast and cervical cancer. However, we believe such costs would be minimal. The full-year costs in subsequent years would be greater.

The Legislature might wish to require DHS to report at the time of budget hearings on its projection of the cost—in the budget year and upon full implementation—of offering this Medi-Cal coverage to women with income up to 200 percent of FPL.

Options for Improving Cancer Screening Services

In this section, we discuss some of the problems in the existing cancer screening programs which we believe limit the state's ability to maximize federal funding under the new Medicaid option. Specifically, we found that the funding for screening services is decreasing, cervical cancer screens for high-risk women are limited, and that the limited number of providers certified for screening and diagnosis in the existing programs can limit access to treatment services. We have identified several options the Legislature may wish to consider to address these concerns.

Alternative Funding Could Stabilize BCEDP. Our analysis indicates that state funding from tobacco tax revenues is eroding, with significant consequences for any expansion of treatment services under the new Medicaid option. We explain why this is the case below.

The BCEDP was originally funded by a 2-cent per pack tax increase on cigarettes. However, growth in program caseload, combined with a decline in tobacco tax revenue, resulted in a shift of support for the program to the Proposition 99 Cigarette and Tobacco Products Surtax Fund. Due to a continued decline in smoking, Proposition 99 tobacco tax revenues are also declining and will eventually erode the funding available for BCEDP.

If the Medicaid option were adopted, BCEDP would be the primary source of referral of women diagnosed with breast cancer. If fewer low-income persons are able to obtain BCEDP screens as a result of a decline in program funding, fewer would be referred for treatment under the new Medicaid option. If the state intended to maximize its available federal funding for treatment services, an alternative and more stable state funding source would be needed in the long run for BCEDP.

Expanding BCEDP to Include Cervical Cancer Screening. Our analysis indicates that relatively few low-income women at greater risk for cervical cancer are receiving cervical cancer screens. While more than 230,000 women over 40 are expected to receive breast cancer screens in 2001-02, only 63,000 women over 40 years of age, who constitute the at-risk group, are projected to receive cervical cancer screens.

The relatively small number of cervical cancer screens reflects limitations of the programs available to do such screening. As we discussed earlier, cervical cancer screens are currently provided in two programs: the NBCCEDP and Family-PACT. Although NBCCEDP primarily serves

women over 40 years of age, the amount of federal funding available for this program means that only a very limited number of women, approximately 23,000, can receive cervical cancer screens. Moreover, only about 40,000, or 7 percent, of the women in Family-PACT, which is limited to women of child-bearing age, are over 40 years old and considered to be at higher risk of having cervical cancer. These program limitations mean that many low-income women at risk of cervical cancer will not have the benefit of early identification and treatment of the disease.

One approach to improve access to cervical cancer screens would be to expand BCEDP to include cervical cancer screens. Our analysis indicates that this could increase the number of women who receive cervical cancer screens by more than 200,000. This is because BCEDP has approximately 2,200 providers—a relatively large network compared to NBCCEDP's 150 providers.

We would note that the women who are at the greatest risk of having breast cancer also happen to have the greatest risk of cervical cancer. If the screens are provided by the same program, women can receive both screens during the same visit to a doctor's office. Based upon information provided by DHS, we estimate the state cost of this option would be about $11 million annually. We note that this would also increase the cost of providing treatment under Medi-Cal, since a greater number of women would be diagnosed with cervical cancer and referred for treatment. The Legislature may wish to direct the DHS to report on the feasibility, costs, and benefits of expanding BCEDP to include cervical cancer.

Expanding the Provider Network. Program rules regarding which doctors may make a diagnosis of breast or cervical cancer could limit access to the treatment services that could otherwise be provided under the new federal law. If a woman with qualifying income is screened and diagnosed with breast or cervical cancer by a doctor who has not been certified as a provider under the NBCCEDP, she would not be eligible for treatment services under Medicaid.

However, the state has the option under federal law to expand the provider network by certifying providers who do not currently participate in the existing programs to screen and diagnose women under the federal program. Given the fact that BCEDP is projected to serve only about 25 percent of women over 40 years of age with income at or below 200 percent of FPL, the Legislature may wish to require DHS to report on the feasibility, costs, and benefits of certifying additional providers.

Conclusion

Currently, the state provides some cancer screening services, but only limited treatment services for women diagnosed with cancer. The primary

screening program is funded by an unstable revenue stream. Although low-income women over 40 are at high risk for both cervical and breast cancer, the current patchwork of state and federally funded health programs does not provide broad access to cervical cancer screening services.

The federal Breast and Cervical Cancer Prevention and Treatment Act provides California an opportunity to provide comprehensive health coverage for low-income women diagnosed with cancer. We have outlined some options the Legislature may wish to consider that would address some of the problems with the existing cancer screening programs, and establish a better-coordinated and much-expanded screening and treatment system.

TOBACCO PREVENTION PROGRAM EXPANSION

Background

State smoking prevention programs have traditionally been funded by Proposition 99 tobacco tax revenues. Proposition 99, the Tobacco Tax and Health Protection Act of 1988, established a 25-cent tax on cigarettes and other tobacco products. Since the enactment of Proposition 99, the state has spent more than $781 million on tobacco control efforts. Of that amount, 31 percent has been used to support the statewide antitobacco media campaign and 64 percent has been used to support locally administered smoking prevention programs. The remaining 5 percent has gone for state administration and evaluations. However, due to the decline in smoking during this period, and the resulting decline in tobacco tax revenues, less money is available now to support these programs.

The state's 1998 settlement of litigation with the major tobacco companies will provide an estimated $21 billion over 25 years, with half going to the state and half to the counties. As we indicate in our analysis of the proposed TSF, there has been significant public and legislative interest in using these revenues for smoking cessation programs and other health care proposals.

The Budget Proposal. The Governor's budget plan would provide $20 million ($15 million ongoing and $5 million one time) from the TSF for youth smoking prevention programs. The proposal would fund a four-part strategy to reduce smoking prevalence among California teenagers, providing a total of between 23 and 34 competitive grants for (1) local enforcement of tobacco laws, (2) youth advocacy coalitions against tobacco usage, (3) local activities targeting the 18- to 24-year old population, and (4) surveillance and special studies. The four components are described in more detail below. Except for the surveillance and special

studies proposal, the budget does not specify how much money would be allocated to each component.

- ***Local Enforcement of Tobacco Laws***. Under the proposal, some funds would be provided to local law enforcement agencies and nonprofit organizations to enhance enforcement activities, particularly laws aimed at eliminating tobacco sales to minors, and free tobacco product sampling. This is the only proposal that requires grantees to provide a match to qualify for the grants.
- ***Youth Advocacy Coalitions.*** Under this proposal, college mentors are joined with high school students to form coalitions which undertake various activities aimed at reducing smoking in their communities. According to DHS, six counties currently administer a youth advocacy coalition program using Proposition 99 funds. The budget proposes to provide grants to expand existing programs as well as to increase the number of youth coalitions. The youth advocacy coalitions funded under the Governor's plan would be modeled after the Contra Costa County youth coalition.
- ***Activities Targeting 18- to 24-Year Olds.*** The proposal would provide grants to local agencies to conduct programs that target this population. Activities will include expanding efforts to (1) protect nonsmokers from exposure to secondhand smoke, and (2) counter the tobacco industry's presence on college campuses and in entertainment venues frequented by this group, such as movies, music, concerts, and sporting events.
- ***Surveillance and Special Studies.*** The budget proposal includes $2 million to conduct ethnic youth-specific surveillance studies, as well as studies of at-risk youth to better plan their programs around these populations. Surveillance studies allow the department to identify youth tobacco use trends, and determine if tobacco control programs are having an impact in reducing tobacco use. This would build on similar activities currently conducted by the department.

The proposal would also provide a total of $1 million for technical assistance and consultation related to each of the strategies outlined above. We note that, in addition to the proposed $20 million, the budget includes a separate proposal requesting $1 million for additional youth advocacy coalitions funded by a grant from the American Legacy Foundation.

Governor's Proposal Is Flawed

The budget proposal to expand youth smoking prevention efforts is flawed because the effectiveness of the proposed new programs has not

been demonstrated. Additionally, the proposed new state programs are not coordinated with local tobacco prevention efforts. We therefore recommend the deletion of $18 million from the Tobacco Settlement Fund. We withhold recommendation on the $2 million requested for surveillance and special studies, due to the lack of fiscal detail on the estimated cost of this component. We recommend approval of the $1 million requested for youth advocacy coalitions funded by the American Legacy Foundation. We further recommend that the Department of Health Services report at the time of budget hearings regarding the potential cost of implementing three of the four proposals as pilot programs. (Reduce Item 4260-111-3020 by $18 million.)

Surveillance and Studies Component Has Merit, But No Fiscal Detail. Based upon our analysis, the surveillance and special studies component of the Governor's proposal could serve to enhance smoking prevention programs by providing the information needed to allow the department to more effectively target ethnic subgroups and at-risk youth, particularly youth attending continuation school, teen mothers, out-of-school youth, and youth offenders. However, at the time this analysis was prepared, the department could not provide details on the $2 million cost estimate of this proposal.

No Evidence Specific Proposals Will Be Effective. At the time of our analysis, DHS could not provide information documenting that any of the proposed strategies is effective in reducing smoking. In support of these proposals, DHS points to the decline in smoking in California and research indicating that overall tobacco control spending has contributed to the decline in smoking prevalence. We note, however, that while it appears to be well-documented that tobacco control spending is generally cost-effective, this does not mean that all of the programs currently funded by the state are cost-effective.

In the case of the youth advocacy coalitions, the budget proposes to expand statewide the model currently used in Contra Costa County. Yet, at the time our analysis was prepared, the department could not provide any data demonstrating its effectiveness. Moreover, the department is not able to provide complete information on the amount of money that is currently spent on this program or the number of participants.

Given the administration's lack of evidence to support its budget request for either statewide expansion of current programs or statewide implementation of new strategies, limited pilot projects to test and evaluate these proposals may be a more reasonable approach.

State Projects Not Coordinated With Local Efforts. Given that the state's major source of funding for smoking prevention programs—Proposition 99—is declining, it is increasingly important that the state prioritize public health spending for programs that are well-coordinated with

other local programs with the same purpose. Counties are estimated to receive $10.5 billion in payments over 25 years under the 1998 tobacco settlement agreement. Given the availability of this local funding, one promising approach could be for the state to test new approaches for tobacco prevention in partnership with interested counties.

The state's past experience in the administration of public health programs suggests that creating partnerships with counties for such projects, such as by requiring counties to provide matching funds as a condition of obtaining state grants, could be beneficial. This approach would maximize the use of state funds, provide a greater incentive for counties to use their share of tobacco settlement funds for tobacco prevention programs, and could result in better overall state-county coordination of such activities.

We note that the budget includes a separate proposal funded by a grant from the American Legacy Foundation to provide $816,000 in the current year and $1 million in the budget year to further expand the number of youth advocacy coalitions. In effect, this budget proposal duplicates one component of the Governor's $20 million smoking prevention package.

Analyst Recommendation. Because of these concerns, we recommend that the $20 million requested from the TSF for the proposed tobacco prevention programs be reduced by $18 million to eliminate the proposed funding for three of the four new tobacco control programs. In lieu of the Governor's proposal, we recommend that the Legislature consider providing funding for these three proposals as pilot projects. If the projects demonstrated that the Governor's proposed new programs have merit, they could be expanded at a later date. Accordingly, we recommend that the DHS report at the time of budget hearings regarding the cost of implementing these three proposals as pilot projects.

We withhold recommendation on the $2 million proposed for surveillance and studies, pending fiscal detail on how DHS estimated the cost of this component. We recommend that the $1 million requested for the American Legacy Foundation proposal be approved and serve as a pilot project to test the effectiveness of youth advocacy coalitions. We further recommend that local matching funds be required for all of the pilots, and that funding be provided for an independent evaluation of their effectiveness.

Our proposals would allow the Legislature to target available TSF monies at smoking prevention activities with demonstrated positive results, provide an opportunity for the state to partner with the counties and not-for-profit organizations, and provide an incentive for counties to use their settlement funds for smoking prevention efforts.

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 (FPL). The Healthy Families Program provides health coverage for uninsured children in families with incomes up to 250 percent of the FPL who are not eligible for Medi-Cal.

The budget proposes $846 million from all funds for support of MRMIB programs in 2001-02, which is an increase of about $336 million, or 66 percent, over estimated current-year expenditures. This increase is due primarily to the proposed expansion of the Healthy Families Program to include parents, as well as projected caseload increases. The budget proposes General Fund expenditures for MRMIB programs of about $129 million, a decrease of 13 percent from estimated current-year expenditures. The decrease in the General Fund share is primarily the result of shifting some MRMIB program costs to the newly established Tobacco Settlement Fund.

HEALTHY FAMILIES PROGRAM

The Healthy Families Program implements the federal government's State 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. In 1999, it was expanded to include

children with family income up to 250 percent of the FPL as well as legal immigrant children.

The Governor proposes $739 million ($125 million General Fund) in MRMIB's budget for the Healthy Families Program in 2001-02, which is an increase of about 83 percent over estimated current-year expenditures. After accounting for program expenditures (outreach and related Medi-Cal benefits) in the Department of Health Services (DHS) and related expenditures in other departments, the total budget for the Healthy Families Program is proposed at $833 million ($163 million General Fund), which is an increase of 75 percent over the current year. The proposed increase is due primarily to the proposed expansion of the Healthy Families Program to include parents, as well as projected caseload growth. We note that the budget does not include funding for provider rate increases in 2001-02. 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 about 511,000 by the end of the current year and to about 735,000 by the end of the budget year.

Expansion of the Healthy Families Program to Parents

Background

The federal *Balanced Budget Act of 1997 (Act)* made available approximately $40 billion in federal funds over ten years to states to expand health care coverage for children under the State Children's Health Insurance Program (SCHIP). California's share is approximately $4.5 billion. The *Act* also provided states with an enhanced federal match as a financial incentive to cover children in families with incomes above the previous limits of their Medicaid programs. For California, the enhanced match is about two federal dollars for each state dollar, as compared to approximately a one-to-one match in the Medi-Cal Program.

California, along with many other states, has not spent all of the funds that are available. Despite the state's recent expansion of Healthy Families to children with family income up to 250 percent of the FPL, a sizeable portion of California's federal allotment would remain unspent over the next five years. Based upon our projections of available federal SCHIP funding and spending trends in the Healthy Families Program through 2004-05, we estimate that the cumulative SCHIP allotments over this period would exceed the cumulative spending of the existing Healthy Families Program by approximately $1.5 billion.

Recognizing that states needed additional flexibility to expand health insurance coverage and spend their allotted federal funds, the federal Health Care Financing Administration (HCFA) last July issued guide-

lines for demonstration project waivers. Specifically, HCFA indicated that the Secretary for the U.S. Department of Health and Human Services would consider five-year waivers that would allow states to use a portion of their SCHIP allotments for (1) coverage of parents of SCHIP enrollees and (2) public health initiatives designed to address or supplement targeted health needs of children. In addition, subsequent federal legislation allows states to retain a portion of their unspent 1998 and 1999 SCHIP funds for two additional years. Prior to this legislation, any given year's allotment had to be spent by states within three years.

Chapter 946, Statutes of 2000 (AB 1015, Gallegos) subsequently directed MRMIB to seek a federal waiver to expand the Healthy Families Program to uninsured parents of children eligible for the program.

California's Proposed SCHIP Waiver

Budget Proposal. In December, in accordance with Chapter 946, the Secretary for the California Health and Human Services Agency submitted a waiver request to federal authorities to expand Healthy Families coverage to parents. At the time this analysis was prepared, California's waiver request remained pending with federal authorities.

Based on the assumption that the waiver will be approved, the *2001-02 Governor's Budget* includes about $202 million in new funding to support California's proposed SCHIP demonstration project expanding Healthy Families to parents. Of that sum, $76 million would be allocated from tobacco settlement funds, $116 million from federal funds, $9 million from reimbursements, and about $700,000 from the General Fund. The MRMIB estimates that the demonstration project will expand coverage to 290,000 parents. The budget further assumes that 174,000 adults, or 60 percent of the eligible parents, will enroll during the budget year.

Eligibility. Under the proposed waiver, the following parents would be eligible for medical, dental, and vision benefits under the Healthy Families Program:

- Parents of Healthy Families eligible children with family income between 100 percent and 200 percent of the FPL.
- Parents of Medi-Cal eligible children who themselves are ineligible or enrolled in "share of cost" Medi-Cal with incomes between 100 percent and 200 percent of the FPL.
- Parents with income below 100 percent of the FPL who do not qualify for Medi-Cal because of assets. Although the state eliminated the Medi-Cal asset test for children to bring the program into conformance with Healthy Families, the asset test is still in place for adults.

Under the proposal, a mother who is enrolled in Healthy Families and becomes pregnant will be covered for labor and delivery. However, since the woman and her infant could qualify for Medi-Cal, the family will have a choice of enrolling them in that program instead of continuing in Healthy Families.

Premiums and Copayments. Monthly premiums would vary according to family income. Families with an income between 100 percent and 150 percent of the FPL would pay $20 per parent in addition to the premiums for their children, while those with a family income between 151 percent and 200 percent of the FPL would pay $25 per parent. However, consistent with the current program, a family could receive a $3 discount per parent by choosing the low-cost Community Provider Plan (CPP). The CPP is comprised of a combination of participating health, dental, and vision plans offering the lowest price in each county. Currently, parents pay between $4 and $9 per month for each child (up to two children for families with income up to 150 percent of the FPL, and up to three children for families with income above 150 percent of the FPL) depending on family income and the plan selected. Figure 1 shows the proposed premium structure for a family of four.

Figure 1

Family Premium Under Proposed Healthy Families Expansion

	Family of Four With:	
	Income Up to 150 Percent FPL[a]	Income Above 150 Percent of FPL[a]
Community Provider Plan		
Parents (2)	$34	$44
Children (2)	8	12
Total Monthly Premium	**$42**	**$56**
Noncommunity Provider Plan		
Parents (2)	$40	$50
Children (2)	14	18
Total Monthly Premium	**$54**	**$68**

[a] Federal poverty level.

The MRMIB has indicated that the copayment maximum for adults would be higher than the copayment limit for children, but at the time of

this analysis, the specifics of the proposal were not available. Under the existing program, a family cannot be required to pay annual health plan copayments of more than $250 for coverage of their children.

The proposed waiver would extend to eligible parents many of the same provisions that exist for children. Figure 2 lists the key features of the proposed waiver.

Figure 2

Key Features of the Proposed Healthy Families Expansion

- ***Parental Coverage***. Provides medical, dental, and vision coverage to 290,000 adults, including parents of Healthy Families eligible children with income between 100 percent and 200 percent of the federal poverty level (FPL), and parents with income below 100 percent of the FPL who do not qualify for Medi-Cal due to assets.
- ***Premiums and Copayments***. Parents will be required to share in the cost of coverage through monthly premiums and copayments. The premiums and copayments will be waived for American Indian and Alaskan Native parents.
- ***Continuous Eligibility***. Once enrolled, parents will remain eligible for one year. Eligibility will be redetermined after one year.
- ***Bridge Program***. Parents who are found ineligible for the Healthy Families Program at annual redetermination will remain on the program for two months—the time it takes to enroll in Medi-Cal.
- ***Minimizing "Crowd Out."*** Parents who have had employer coverage within the past three months will not be eligible.

The waiver seeks to demonstrate that by extending health coverage to parents, the number of low-income children that enroll in the program will increase. In addition, it seeks to demonstrate that covering parents will result in children maintaining health insurance coverage for a longer period of time.

Proposal Misses Opportunities to Improve Health Coverage

The proposed expansion of the Healthy Families Program appears to meet federal criteria for approval, but there are some missed opportunities to further reduce the number of uninsured and further conform and simplify the Healthy Families and Medi-Cal Programs.

California Appears to Meet Federal Criteria for Waiver. Based upon our review of the proposed waiver and federal requirements, California appears to meet the federal criteria for a demonstration waiver. The HCFA guidelines require states to adopt at least three of five policy options to promote the enrollment and retention of eligible children. California has already adopted three of the five listed. These include elimination of the assets test for children, the simplified mail-in application, and elimination of the Medi-Cal quarterly reports (or 12-month continuous eligibility).

The HCFA also requires that any state applying for a waiver demonstrate that sufficient federal funds are available to provide coverage to targeted, low-income children before parents can be covered. Based upon our analysis of projected enrollment and spending in Healthy Families, California will have sufficient federal funds to cover children who are currently eligible for the program as well as the population of adults under the proposed waiver.

Finally, HCFA requires that proposed waivers are "budget neutral." This means that the federal cost of the program operated with a waiver would not exceed the amount of SCHIP funding allotted to the state. As we stated previously, our analysis indicates that there are sufficient federal funds to cover the expansion to parents.

State Would Still Lose Federal Funds. Providing health coverage for parents under the Governor's proposal would allow California to spend an additional $1.6 billion of the state's federal SCHIP allotment over the five-year waiver period (state fiscal years 2001-02 through 2005-06). However, even with this proposed expansion, it is unlikely that the state will be able to spend all of the projected federal SCHIP allocations. The MRMIB estimates that during the waiver period, the state will return about $1.3 billion to the federal government. Although federal law would allow California to retain a portion of its federal fiscal year 1998 and 1999 allocations for two additional years, the effect of this law is to delay the actual reversion of California's federal SCHIP funds to a later date.

Some Low-Income Parents Still Excluded. The waiver request to expand coverage to parents is predicated on the idea that parental coverage will increase enrollment of Healthy Families eligible *children*, as well as improve continuity of coverage and the overall health of eligible *children*. The Healthy Families Program currently covers children up to 250 per-

cent of the FPL. However, the administration is proposing to cover only parents in families with an income up to 200 percent of the FPL. Thus, this proposal would only benefit a portion of the children eligible to enroll in the Healthy Families Program.

The administration has indicated that the primary reason for not covering parents earning between 201 percent and 250 percent of the FPL is concern about "crowd-out" or displacement of employer-based coverage. Our analysis indicates that crowd-out can become more of an issue as income levels increase. We would note that, under the waiver proposal, parents who have had employer-based health coverage within 90 days of applying would be ineligible to enroll in Healthy Families. In addition to this 90-day rule, the Healthy Families Program has premiums which may also serve as a barrier to crowd-out. One option available to the Legislature, which we discuss below, is to broaden the premium structure by adding a third premium level. This would allow the Legislature to set the premium for families with incomes between 201 percent and 250 percent of the FPL at a level that would help to minimize crowd-out.

Proposal Fails to Move Toward Conformity. There are several reasons for conforming health programs. Most importantly, it makes it easier for families to move between them as their circumstances change, and easier to determine eligibility in such instances. Program conformity increases the likelihood that individuals will maintain health coverage. It also ensures that similarly situated individuals are treated equitably across programs.

The expansion of Healthy Families to adults creates new opportunities for conforming the Medi-Cal and Healthy Families Programs. However, the administration's proposal does not take advantage of this chance to further conform the two programs.

Consider, for example, the treatment of assets in determining eligibility. The asset test is a part of the eligibility determination process in which applicants provide information on their personal assets, such as bank and trust accounts, residential property, and automobiles to screen out individuals who have low monthly earnings but significant assets. Under the proposed expansion, parents seeking to enroll in the Healthy Families Program will not be required to meet an asset test. This is consistent with the eligibility determination process for children in Healthy Families as well as children in Medi-Cal. However, adults in the Medi-Cal Program continue to be required to meet an asset test.

The budget therefore perpetuates inconsistencies between the two programs. There is also an issue of equity to the extent that Medi-Cal participants with lower incomes and, therefore, more likely to have fewer assets, must face asset limits that do not apply to a group with higher incomes and more assets. Finally, we note that it costs the Medi-Cal Pro-

gram more to administer the asset test than it would cost to provide Medi-Cal coverage to the relatively few individuals who are currently determined ineligible for the program because of it.

Families Required to Use Two Programs. Because Medi-Cal eligibility rules vary according to the age of a child, a family may have children in both the Medi-Cal and Healthy Families Programs. For example, a family with an income of 125 percent of the FPL and two children ages 4 and 6 would enroll the younger child in Medi-Cal and the older child and themselves in Healthy Families. This has many consequences for that family. The younger child's application would be processed by the local county welfare office, while the application for the older child would be processed by a state contractor in Sacramento. The two children might have to be enrolled in different health plans or see different doctors even if they were in the same health plan. These problems could be addressed, but the Governor's proposal fails to do so.

Options for Improving the SCHIP Expansion

In order to address some of the missed opportunities we have identified, we offer some options for legislative consideration, including (1) further expansion of parental coverage and (2) elimination of the Medi-Cal asset test.

Further Expansion of Parental Coverage. Following the release of the administration's plan to expand Healthy Families, there has been some legislative interest in further reducing the number of uninsured adults by expanding the Healthy Families Program to cover parents with income up to 250 percent of the FPL. In response, MRMIB has estimated that a modification of its proposal to expand coverage to parents with incomes up to 250 percent of the FPL would result in covering an additional 87,000 parents at an increased state cost of $66 million annually upon full implementation. Our analysis indicates that the state will receive sufficient federal funds to cover the federal share of cost of such an expansion through the five-year waiver period.

In addition to further reducing the number of uninsured, expanding coverage to all parents of Healthy Families eligible children would simplify the eligibility determination process for those children who are already enrolled, as well as simplify promotion of the program. In marketing the parent expansion, for example, MRMIB could state that "all parents with children enrolled in Healthy Families qualify," instead of saying that "if your child is enrolled in Healthy Families, you may qualify for the program." This would significantly reduce confusion or misunderstanding among parents about whether they qualify.

This option would also allow California to maximize a greater share of the federal funds allotted to the state. The MRMIB estimates that by covering parents up to 250 percent of the FPL, California would spend approximately $400 million more in available federal funds during the five-year waiver period.

Should the Legislature decide to expand Healthy Families coverage to parents in families earning up to 250 percent of the FPL, it may wish to consider creating a broader premium structure—perhaps with three premium levels instead of two. A broader premium structure would enhance the state's ability to set premiums according to participants' ability to pay, thereby improving MRMIB's ability to maximize enrollment in the program. It would also allow the Legislature to set the premiums for families with incomes between 201 percent and 250 percent of the FPL at a level that would minimize crowd-out.

While it seems likely the federal government will continue to offer enhanced federal matching funds for coverage of children, there is no assurance that federal funding for this program will be available after 2007. We note, however, that should the federal government decide not to reauthorize funding for SCHIP, the state could continue coverage of Healthy Families enrollees under the Medi-Cal Program.

In this event, income eligibility levels in the Medi-Cal Program would be increased and unique features of the Healthy Families Program, such as premiums and copayments, would need to be eliminated. The alternative would be to seek a waiver under Title XIX of the Social Security Act to allow the state to continue coverage with the existing insurance program features. Under either approach, the state would likely receive the dollar-for-dollar federal matching rate provided under the Medi-Cal Program.

Eliminating the Medi-Cal Asset Test Would Further Conformity. During each of the past two years, the Legislature passed budget bills that included a proposal to eliminate the Medi-Cal asset test for adults. However, the Governor has twice vetoed the proposal. The Legislature and Governor may wish to reconsider that decision in light of the new proposal to expand health care coverage. Eliminating the Medi-Cal asset test would conform the eligibility criteria for adults in Medi-Cal and Healthy Families, as well as simplify eligibility determination in the Medi-Cal Program. In an effort to conform Medi-Cal to the Healthy Families Program, the state has eliminated the asset test for children enrolled in Medi-Cal.

Under current law, a child might be enrolled in Medi-Cal, but the parent of that child might not qualify for Medi-Cal due to assets. Under the administration's proposal, the parent would be eligible to enroll in Healthy Families but not Medi-Cal. In such a case, the child and the parent(s) would have to be enrolled in different programs. Eliminating

the Medi-Cal asset test for adults would solve this problem. Elimination of the asset test would also result in a net state savings of approximately $4 million in the Medi-Cal Program.

Healthy Families Caseload Overestimated in the Budget Year

We recommend reducing the budget's estimated level of spending for the Healthy Families Program in the budget year by about $75 million ($39 million federal funds, $33 million Tobacco Settlement Funds, and $3 million General Fund) because the budget appears to overestimate projected caseload. (Reduce Item 4280-101-0890 by $39 million, reduce Item 4280-101-3020 by $33 million, and reduce Item 4280-101-0001 by $3 million.)

Our analysis indicates that the administration has overestimated Healthy Families caseload by 11 percent and has therefore overbudgeted the program by about $75 million ($39 million federal funds, $33 million Tobacco Settlement Funds, and $3 million General Fund). Our analysis further indicates that the budget plan overestimates the enrollment of parents under the proposed waiver, as well as children with family income between 201 percent and 250 percent of the FPL, and legal immigrant children. Figure 3 compares our enrollment projection to the proposed budget. We discuss our findings in greater detail below.

Figure 3

Healthy Families Caseload Estimates

2001-02

	Governor's Budget	LAO Estimate	Difference
Parents	173,668	147,173	-26,495
Children 100 percent to 200 percent of the FPL[a]	352,661	349,926	-2,735
Children 201 percent to 250 percent of the FPL[a]	175,431	138,015	-37,416
Legal immigrant children	33,054	18,207	-14,847
Totals	**734,814**	**653,321**	**-81,493**

[a] Federal poverty level.

Parent Enrollment Overestimated. The MRMIB estimates that approximately 174,000 parents, about 60 percent of the estimated number

of parents eligible for coverage, would be enrolled under the proposed expansion by the end of the budget year. Our estimate assumes that only about 147,000, or about 51 percent of the total eligible population, will enroll by then. Our lower estimate is driven by three factors: the level of the premiums, the demographics of the parent population, and the number of parents with employer-sponsored health coverage. Each factor is discussed in more detail below.

- ***Level of Premiums May Deter Enrollment***. The MRMIB has indicated that no survey was done to determine the willingness or ability of families to pay this amount for coverage. Our analysis indicates that, while the premiums proposed for family coverage in the Healthy Families Program are relatively low compared to the cost of family coverage available to many low-income working adults, they still may not be attractive for some groups. We believe this could be the case for families on the low end of the qualifying income range (those with income between 100 percent and 133 percent of the FPL), and individuals who would rate themselves as having excellent to good health and thus, perhaps, be less willing to pay for health coverage.

  Also, some of the adults who would become eligible for Healthy Families under the proposal are enrolled in Medi-Cal with a share of cost. Under Medi-Cal rules, these adults have the obligation of making a share of cost payment only when they visit the doctor rather than having to pay monthly premiums if they enroll in Healthy Families. Some will likely choose to remain on Medi-Cal with a share of cost, particularly if they consider themselves to be in good health.

- ***Demographics of Parent Population***. The MRMIB has limited data on the parents of children enrolled in Healthy Families, but demographic data on the uninsured as a whole indicate that adults ages 18 to 34 represent a significant portion of the low-income adults who lack health insurance. The rate of uninsurance among this group is significantly higher than the uninsurance rate for other age groups of adults. This is the very age group that is targeted for enrollment under the Governor's proposal.

  Research suggests, however, that the reason for the high level of uninsurance for this group is a prevailing perception among them that they are in excellent health. We also note that uninsured low-income young females with excellent-to-good health are more likely to seek health coverage only during pregnancy, at which time they would qualify for no-cost Medi-Cal.

- ***Parents With Employer-Based Coverage***. In estimating the total number of eligible parents, MRMIB has assumed that 38 percent of adults with incomes between 100 percent and 200 percent of the FPL have employer-sponsored health coverage. This assumption is based on 1997 survey data. However, the 1999 Current Population Survey indicates that 45 percent of parents in this income range have employer-sponsored health coverage. The MRMIB's assumption that relatively fewer adults targeted for enrollment in Healthy Families have employer-based coverage would tend to overstate the total number of eligible participants. Given the uncertainty of future employer coverage in this time of rising health care costs, we do not, at this time, recommend an adjustment on this basis to MRMIB's estimated number of total eligible parents. We would note, however, that a higher-than-anticipated level of employer-based coverage could result in lower-than-projected enrollment by adults in the Healthy Families Program during the budget year.

In summary, we believe a number of factors will result in the enrollment of 147,000 adults in Healthy Families—26,000 fewer than assumed in the Governor's budget proposal.

Children's Enrollment Overestimated. Our analysis indicates that the budget plan overestimates the enrollment of children with family income between 201 percent and 250 percent of the FPL. The MRMIB estimates that 175,000 children within this income group, or 100 percent of the eligible children with family incomes in this range, will enroll in the budget year. The budget further assumes that the average monthly enrollment of this group in Healthy Families will increase by 13 percent in the budget year to 6,640 per month. The MRMIB indicates that the accelerated enrollment rate of children will result from the expansion of the program to parents.

There are two reasons why we believe MRMIB has overestimated the enrollment of this group of children. First, we believe that some children in this income range would not be enrolled by their parents because they would prefer not to participate in government programs. In the Medi-Cal Program, for example, many people do not participate in the program even though it is free for them. Second, while we agree that opening enrollment to parents will result in the enrollment of additional children, we believe this impact is overstated in the budget estimate. This is because the proposed expansion would only cover the parents of children with family income between 100 percent and 200 percent of the FPL, and not parents in families with income between 201 percent and 250 percent of the FPL.

Our lower estimate assumes an average monthly enrollment of 5,200, based upon actual recent enrollment data that has been adjusted for the

impact of the expansion. At this rate, we project that approximately 138,000 children, or 79 percent of the total eligible population, will enroll by the end of the budget year.

Legal Immigrant Children Enrollment Overestimated. The budget assumes an average monthly enrollment for this group of 1,470 during the budget year. At this rate, approximately 33,000, or 82.6 percent of eligible legal immigrant children would enroll in the budget year. Given recent evidence indicating that immigrant families still have concerns regarding citizenship, our budget-year estimate assumes a lower average monthly enrollment of 560 per month. This is based on actual enrollment for this group in the current year adjusted upward to account for ongoing outreach and education related growth. Thus, we estimate that approximately 18,000 immigrant children, or 45 percent of eligibles will enroll during the budget year.

Analyst's Recommendation. Based upon these findings, we recommend reducing the amount budgeted for Healthy Families by about $75 million ($39 million in federal funds, $33 million in Tobacco Settlement Funds, and $3 million General Fund).

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 a variety of services, which are overseen by the Department of Developmental Services (DDS). The department contracts with 21 nonprofit regional centers (RCs) to coordinate educational, vocational, and residential services for more than 160,000 clients each year. In addition to providing some services directly, such as intake and assessment, individual program planning, and case management, RCs purchase a variety of services from community-based providers.

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 or in group homes that are designed to meet their medical and behavioral needs. The department also operates five developmental centers (DCs) and two smaller facilities, which provide 24-hour care and supervision to approximately 3,800 individuals.

The budget proposes $2.7 billion from all funds for support of DDS programs in 2001-02, which is a 5 percent increase over estimated current-year expenditures.

General Fund expenditures are proposed at $1.8 billion, an increase of $657 million. About $600 million of this increase is attributable to a purely technical shift of Medi-Cal General Fund expenditures from the Department of Health Services (DHS) to DDS. Prior to 2001-02, both General Fund and federal Medi-Cal dollars were displayed in the DHS budget and shown as reimbursements in the DDS budget. Beginning in

2001-02, only the federal match would be shown as a reimbursement in the DDS budget.

In addition to the General Fund transfer from DHS, the proposed increase in General Fund in the budget year is partly the result of caseload and cost increases for community-based services, and an enhanced system for reporting abuse, neglect, and exploitation of persons with developmental disabilities.

COMMUNITY SERVICES PROGRAM

The Community Services Program provides community-based services to clients through the RCs. The RCs are responsible for client assessment and diagnosis, the development of an individualized program plan, case management, and the coordination and purchase of various services. Services fall into three broad categories: residential, supported living, and day program services. Day program services include early intervention services for infants and young children, daytime activity programs for adults, and in-home respite care.

The budget proposes $2 billion from all funds ($1.5 billion from the General Fund) for support of the Community Services Program in 2001-02. The budget proposes a $142 million General Fund increase over the previous year for caseload and utilization growth in RC purchase of services.

Early Start Coordination Not Clear

We recommend approval of $2.6 million from the General Fund to increase regional center (RC) resources for evaluation and assessment functions under the Early Start program. However, we also recommend that the Legislature adopt supplemental report language directing the Department of Developmental Services to report to the Legislature by December 1, 2002, on RC and local education agency coordination, and RC performance in completing evaluation and assessment within statutory time frames.

Background. The Early Start program currently provides services through RCs to children from birth through two years of age. Early Start provides early intervention services to infants who have disabilities, or who are at risk of having disabilities, in order to enhance their development and to minimize the potential for developmental delays. An ultimate goal of the program is to promote educational attainment and quality of life for children with disabilities. The total number of children receiving RC services and eligibility testing has increased from nearly 13,000

in July 1993 when state participation in the federal program began, to about 19,000 currently, and is expected to reach more than 20,000 during 2001-02.

The Early Start program requires evaluation and assessment of children who are either applying for or receiving services. Evaluation involves the determination by qualified personnel of a child's present level of development, in the following five specific areas: cognitive development; physical and motor development, including vision and hearing; communication development; social or emotional development; and adaptive development. Assessment involves identification of a child's needs and services appropriate to meet those needs.

The DDS is the lead state agency for the administration of Early Start, which is operated in partnership with the State Department of Education (SDE). The program receives federal funding through Part C of the Individuals with Disabilities Education Act. In 2000-01, DDS received about $45 million in Part C funds, $20 million of which was transferred to SDE and other agencies. In 2000-01, the state for the first time contributed $1.3 million from the General Fund to pay for the cost of Part C services in excess of the available federal funds.

Governor's Budget Proposal. The Governor's budget includes about $48 million for the Early Start program ($28 million for RCs and $20 million for transfer to other agencies). Of that sum, $3.3 million would be used to offset an anticipated shortfall in federal funds. The budget proposes an additional $2.6 million from the General Fund to provide sufficient funding for qualified professionals to determine child eligibility, conduct assessments for service needs, and prepare for individualized family service plan development. Qualified professionals would include speech, physical, and occupational therapists, as well as audiologists, physicians, psychologists, and nurses. The additional resources would help ensure that the state complies with federal and state requirements to conduct multidisciplinary evaluations and assessments involving the five specific developmental areas within 45 days of receipt of a child's referral to the RC. In 1999, a federal review found that Early Start was not complying with the required time frame for conducting evaluations and assessments. It also found that Early Start evaluators did not always conduct multidisciplinary evaluations in all five developmental areas, as required.

Coordination With Local Education Agencies (LEAs). Not all of the evaluations and assessments of children served by the RCs are conducted by the RCs themselves. They are sometimes conducted by LEAs, which have overlapping responsibilities to provide evaluations and assessments of these children. The LEAs also provide certain early intervention services for these children. Because both RCs and LEAs have responsibility for providing these services at the local level, the RCs are required to

have local interagency agreements with LEAs for the purpose of coordinating their efforts.

However, the extent to which the RCs and LEAs are actually coordinating their intake, evaluation, assessment, and case management services for eligible children is unclear. Although DDS liaisons review the interagency agreements and provide technical assistance to RCs each year, there is no detailed information available which indicates how good a job RCs and LEAs are doing in coordinating their efforts. Consequently, the Legislature cannot determine whether the program is being appropriately coordinated.

Analyst's Recommendation. In order to ensure service delivery to children under three years of age and their families as intended by the proposal, we recommend that the Legislature approve the augmentation requested for Early Start, but also adopt supplemental report language directing the department to report to the Legislature, by December 1, 2002, regarding several key issues. These include the coordination of Early Start activities between RCs and LEAs, and whether multidisciplinary evaluations and assessments are being completed for all five specific developmental areas within the 45-day period required by law. The December 1, 2002, deadline would allow sufficient time for DDS to determine whether the additional resources provided in the budget for Early Start have improved the services provided to participating children. We recommend the adoption of the following language:

> It is the intent of the Legislature that the Department of Developmental Services (DDS) report to the Chair of the Joint Legislative Budget Committee and the chairs of the fiscal committees of both houses of the Legislature by December 1, 2002, on the coordination of Early Start activities between regional centers (RCs) and local education agencies (LEAs), and the performance of RCs in completing initial evaluations and assessments within 45 days of a child's referral as required. Specifically, the department shall provide the following information:
>
> - A summary of RC interagency agreements with LEAs, and an analysis of how effectively evaluation, assessment, and case management functions are being coordinated.
> - A summary of DDS' efforts to provide technical assistance to RCs to improve the quality of the agreements and the delivery of Early Start services.
> - A determination as to whether, within each RC catchment area, multidisciplinary evaluations and assessments of children are being completed as required by law for all five specific developmental areas within 45 days of referral, and, if this is not the case, the actual time required for the completion of evaluations and assessments.

- Identification and description of any proposed models for coordination which would result in more cost-effective and consistent service delivery, and any other recommendations for improved service delivery.

DEVELOPMENTAL CENTERS PROGRAM

The DCs provide residential care for developmentally disabled persons. The budget proposes $601 million from all funds ($322 million from the General Fund) for support of the DCs in 2001-02.

Report on DC Restructuring Due

We recommend the department report to the Legislature prior to budget hearings regarding (1) the recommendations for restructuring the developmental centers (DCs), (2) the effect these recommendations will have on the existing capital outlay program and assets, (3) the future capital outlay needs resulting from any changes in service delivery, (4) the effect of the recommendations on DC operating costs, and (5) a proposed timeline for implementing any changes.

For more detailed information about this recommendation, please see the "Department of Developmental Services" section of the "Capital Outlay" chapter of this *Analysis.*

ADMINISTRATIVE ISSUES

The DDS Proposal to Comply With Health Insurance Portability and Accountability Act (HIPAA)

We recommend that funding requested for activities relating to compliance with the Health Insurance Portability and Accountability Act (HIPAA) be deleted from the department's budget and instead be funded from a newly established fund for statewide HIPAA compliance activities in order to further legislative oversight.

For more detailed information about this recommendation, please see the "Crosscutting Issues" section of this chapter of the *Analysis*.

DEPARTMENT OF MENTAL HEALTH (4440)

The Department of Mental Health (DMH) directs and coordinates statewide efforts for the treatment of mental disabilities. The department's primary responsibilities are to (1) administer the Bronzan-McCorquodale and Lanterman-Petris-Short Acts, which provide for the delivery of mental health services through a state-county partnership and for involuntary treatment of the mentally disabled; (2) operate four state hospitals; (3) manage state prison treatment services at the California Medical Facility at Vacaville and, beginning next year, at Salinas Valley 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, and mentally disordered offenders and mentally disabled clients transferred from the California Department of Corrections.

The budget proposes $2 billion from all funds for support of DMH programs in 2001-02, which is an increase of almost 12 percent above estimated current-year expenditures. The budget proposes $953 million from the General Fund, which is an increase of $75 million, or 8.6 percent, above estimated current-year expenditures. Reimbursements that would be received by DMH—largely Medi-Cal funding passed through to community mental health programs—would increase $135 million or about 15 percent.

The overall increase in DMH expenditures is primarily due to (1) the expansion of the Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT) for children with emotional problems; (2) increases in caseload and provider rate increases for managed care plans providing community mental health treatment; and (3) special repairs, new alarm systems, and projects for Americans with Disabilities Act (ADA) compliance at state hospitals.

THE EPSDT PROGRAM COSTS STILL SOARING

The costs for providing mental health services under the Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT) for emotionally disturbed children are growing by 28 percent per year. This situation has resulted in a request in the Medi-Cal budget for a $126 million budget increase for the program in 2001-02 (about $61 million General Fund and $64 million federal funds). Despite the projection by the Department of Mental Health that this rapid growth rate will continue for at least several more years, state officials overseeing the program have not assessed whether the services being provided by counties to individual EPSDT clients are appropriate given the relative severity of their mental conditions. We recommend approval of the funding request. However, we further recommend that the Legislature initiate field audits to better understand the reasons why costs are escalating and consider options to help ensure that the program operates in the future with appropriate incentives for providing necessary services and controlling costs.

Background

The EPSDT program was established as a mandatory Medicaid service in 1967, and expanded by federal law in 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 under a 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. About 120,000 clients per year received EPSDT services in 1998-99, the most recent year for which complete DMH data were available. In this analysis, we focus exclusively on EPSDT mental health services.

Budget Proposal. Under the Governor's 2001-02 budget proposal, total spending on basic EPSDT services would reach $563 million in the budget year. Of that sum, counties would contribute about $128 million of their available mental health funding for EPSDT services. The federal government and the state General Fund would, respectively, provide an additional $224 million and $212 million through the Department of Health Services (DHS) Medi-Cal budget to support the program. (State and federal support for EPSDT are displayed as reimbursements within the DMH budget.)

In addition to the $563 million provided for basic EPSDT services, the 2001-02 budget proposes a $12 million augmentation (consisting of the reimbursement of about $5.9 million General Fund and $6.2 million

federal funds from the DHS Medi-Cal budget) to provide therapeutic behavioral services under the EPSDT program. This separate budget request is intended to provide for state compliance with a federal court order mandating the provision of these more intensive outpatient services for certain at-risk youth.

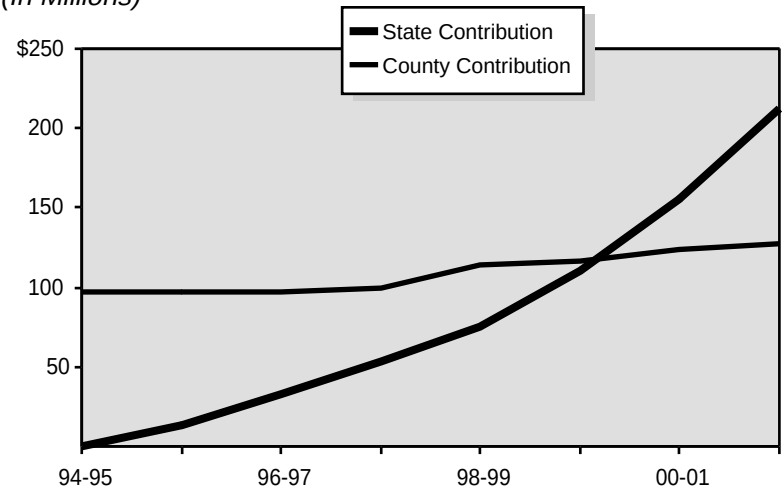
Rising EPSDT Costs a Continuing Concern

State Costs Could Double in Three Years. In our *Analysis of the 1999-00 Budget Bill*, we voiced concern about the rapid escalation of costs in basic EPSDT mental health services. We remain concerned due to the continued growth in program costs since that time. If the 2001-02 budget for basic EPSDT services is approved as proposed, annual state expenditures on the program will have increased by almost $200 million within seven years. As indicated in Figure 1, the state's contribution to the program will have increased 15 times over since 1995-96, when it was providing about $13 million annually to support the program. If this expenditure trend were to continue, state costs for the program could more than double within the next three years to almost $525 million annually.

Figure 1

Growth in State and County Contributions to EPSDT

1994-95 Through 2001-02
(In Millions)



County support for the program has grown more modestly due primarily to a 1995-96 interagency agreement between DMH and DHS that provides state matching funds for most of the nonfederal growth in EPSDT program costs. The counties' contribution to support of the EPSDT program—often referred to as the county baseline—is periodically adjusted for inflation and other cost factors. During 2001-02, state costs for EPSDT are projected to increase about $57 million, or 37 percent, compared to estimated current-year expenditures. County expenditures would go up about $4.3 million, or 3.5 percent.

The expansion of EPSDT mental health services initially came as the result of the settlement of federal litigation. The DMH has indicated that overall EPSDT costs have risen dramatically since that time because of a number of factors, including (1) growing participation by counties in the program, (2) growing caseloads within those participating counties, (3) increases in the services provided for clients, and (4) increased costs for providing those client services due to provider rate increases.

Inadequate Fiscal Incentives for Cost Control. The current cost-sharing arrangement between the state and counties was initially meant to be a short-term agreement until EPSDT program costs stabilized. We are concerned, as we noted in our *1999-00 Analysis of the Budget Bill*, that this cost-sharing arrangement does not provide counties with the fiscal incentive to use EPSDT funds in the most cost-effective manner, such as by implementing a rigorous utilization review of the services provided. Under the present arrangement, the entities primarily responsible for the administration of EPSDT programs—county mental health systems—bear relatively little of the responsibility for increases in program costs.

Our concern is based, in part, on DMH data indicating the costs and caseloads of EPSDT programs within individual counties. That data show significant increases in EPSDT costs and clients over time. For example, the average annual payment per EPSDT client increased about 40 percent between 1994-95 and 1998-99. During the same period the number of clients almost doubled to about 120,000. The data also show that the cost-per-Medi-Cal eligible for EPSDT tripled over five years.

The data also document some significant disparities among counties in their average expenditures for the program even within the same regions of the state. For example, the data indicate that one coastal Southern California county, Santa Barbara, spent an average of $5,200 per EPSDT client in 1998-99, more than three times as much as the $1,700 per client spent in San Diego County.

There may be appropriate reasons for these disparities, such as variations in client needs among mental health systems. But these disparities in spending amounts could indicate that some counties might be using

EPSDT resources inappropriately, such as by providing more intensive services than needed for children with less serious mental health treatment needs.

Unfortunately, DMH has not yet gathered data that would allow it to determine whether the services being provided by counties to individual EPSDT clients are appropriate given their mental health treatment needs. As a result, the state does not know whether more intensive and more expensive services than medically necessary are being provided to some EPSDT clients. Without such information, the Legislature cannot determine whether the 28 percent average annual increases in the budget for basic EPSDT services are warranted.

State Could Take Steps to Address Rapid Growth in Program Costs

Analyst's Recommendation. Given the legal mandates facing the state for the provision of such services, we recommend that the Legislature approve the 2001-02 budget request for additional funding for basic EPSDT services, as well as the additional request for funding for EPSDT therapeutic behavioral services. We further recommend that the Legislature initiate field audits of county EPSDT programs to better understand why EPSDT costs have grown so significantly and why these costs vary so widely among counties. For this purpose, the Legislature could direct that either DMH, DHS (as the state agency primarily responsible for the Medi-Cal program), or the Bureau of State Audits review samples of EPDST cases in selected counties to verify that only medically necessary services are being provided to clients in a cost-effective manner. The audit findings would be reported to the Legislature.

Because of our concern over the continuing escalation in EPSDT program costs, we further recommend that the Legislature consider options that we believe would help ensure that county mental health systems have appropriate fiscal incentives for management of the $563 million EPSDT program. We discuss these options below.

Counties Could Share Cost of Growth. One approach the state could take to address the concern over the rapid escalation of EPSDT costs would be to change the way the state and counties share in the cost of providing these services. As we noted earlier, while counties contribute substantial *baseline funding* for support of the EPSDT program, they collectively contribute a relatively small share of the costs resulting from *program growth* and thus, have little fiscal incentive to control increases in cost. One remedy might be to modify the interagency agreement between DMH and DHS to require that counties pay a larger share of any growth in EPSDT program costs, thereby giving them greater incentive to carefully manage these expenditures.

Requiring the local mental health systems to pay a larger share of the cost of EPSDT program growth does raise the concern that a financial hardship might be imposed upon counties. This concern could be addressed, however, by offsetting the projected increase in county costs for the upcoming fiscal year with an equivalent reduction in the county baseline contribution to the EPSDT program. For example, the state and counties might agree that the counties would pay a 20 percent share of the nonfederal increase in EPSDT program costs during 2001-02—now projected to be about $12 million—with the understanding that the counties would receive an offsetting $12 million reduction in their baseline contribution to the EPSDT program.

Our analysis indicates that, under such an approach, counties would have a greater fiscal incentive to manage EPSDT expenditures more effectively. That is because they would be able to shift any net savings achieved in their mental health systems through better management of these costs to other community mental health programs that were a local priority. To return to our prior example, if improved fiscal management meant that counties only needed to spend $8 million of their $12 million allocation for the program on EPSDT services, they would be able to use the remaining $4 million at their discretion for other mental health programs.

The overall amount the state would otherwise spend on EPSDT services would not change substantially during the first year of the new arrangement. The savings to the state from county acceptance of a greater share of the costs of EPSDT growth would be spent to offset a commensurate reduction in county baseline expenditures. However, in subsequent fiscal years, the state could achieve significant net savings potentially amounting to tens of millions of dollars to the extent that tighter county management of the program slowed the trend of dramatic increases in EPSDT expenditures. One further option for the Legislature would be to test such an arrangement with one or several counties as a pilot project to examine the impact, if any, of such a change on EPSDT program expenditures.

Realignment Options. In our analysis of the state-county realignment (in *The 2001-02 Budget: Perspectives and Issues*), we offer another option for the Legislature to address the rapid growth in the cost of EPSDT mental health services. Specifically, we propose that the counties accept additional fiscal responsibility for EPSDT in trade for receiving additional state tax revenues to support community mental health programs.

Under this option, county mental health systems would (similar to the proposal outlined earlier) be required to accept a greater share of the cost of growth in the EPSDT program. Rather than adjust county baseline contributions to EPSDT, however, the realignment option would allocate

additional state tax revenues to county mental health programs. These additional tax revenues would be allocated each year automatically by statute and would not be subject to the annual state appropriations process, much the same way realignment revenues are currently distributed. In order for this approach to work, the additional tax revenues shifted to counties would have to equal or exceed the EPSDT costs that would be shifted to county mental health systems.

We believe this option, as well, would provide counties with a fiscal incentive to manage EPSDT expenditures more effectively. This is because any county savings achieved from improved management of the EPSDT program would not reduce a county's future realignment tax allocation from the state. Thus, any savings could be shifted to other mental health programs that were deemed to be a local priority.

Incorporate Into Managed Care Allocations. At some point in the future, when EPSDT expenditures are no longer growing so rapidly, the Legislature may wish to consider incorporating EPSDT funding into the allocations that are now provided separately to counties for mental health managed care programs. This approach would effectively treat EPSDT like other Medi-Cal mental health services that are provided by counties under a managed-care approach in which they are paid by the state at a capitated rate. We believe that such an approach could encourage counties to more carefully monitor the utilization of EPSDT services. This approach may not be feasible at present, however, because of concerns that the consolidated managed care and EPSDT allocations would be insufficient to keep pace with the dramatic growth in the EPSDT program.

Conclusion

In considering the options we have offered in this analysis, the Legislature should bear in mind that some of these proposals represent alternative courses of action that do not work in combination with each other. For example, if counties accepted a greater share of the cost of growth in the EPSDT mental health services as part of a revised realignment effort, the Legislature would probably not pursue the alternative approach of reducing county baseline funding for the program.

Other proposals may complement each other. We believe there would be no conflict, for example, between adopting our recommendation to initiate field audits of EPSDT programs and making other changes in the state-county partnership for the provision of EPSDT mental health services.

COMMUNITY SERVICES PROGRAM ISSUES

Realignment Revisited—An Evaluation of the 1991 Experiment in State-County Relations

In 1991, the state enacted a major change in the state and local government relationship, known as realignment, which affected a variety of health and social services programs, including significant changes in the provision of mental health services. Our review of realignment ten years later found that it has largely been a successful experiment in the state-county relationship, with some areas for improvement. We recommend a number of proposed changes to strengthen realignment, including changes that would affect community services for the mentally ill.

Please see "Part IV" of *The 2001-02 Budget: Perspectives and Issues,* for our discussion of realignment and our recommendations to strengthen this ten-year-old experiment in the operation of health, social services, and mental health programs.

Report on Treatment Resources for Out-of-Home Placements Overdue

We recommend that the Legislature require the Department of Mental Health to report at budget hearings on the status of its findings regarding the availability of resources to assess and treat children in, or at risk of, out-of-home placement, as required by 1998 state legislation.

Background. Chapter 311, Statutes of 1998 (SB 933, Thompson), instituted significant reforms of the foster care system. Among these reforms, it expanded county mental health agencies' target populations to include children in, or at-risk of, foster care placement to the extent resources were available. It also required that DMH develop an estimate of the extent to which resources were available to provide mental health assessment and treatment to children in, or at-risk of, foster care placement. Chapter 311 required that the estimate be developed by June 1, 1999, and include an identification of specific resource gaps in the delivery of mental health services to this population.

Analyst's Recommendation. The estimate required by Chapter 311 is necessary to determine the adequacy of existing resources to meet this target population expansion. As a result, we recommend that the Legislature require DMH to report at budget hearings on the status of these estimates so that the Legislature can determine the extent to which available resources are adequate to implement the assessment and treatment objectives set forth in Chapter 311.

Institutions for Mental Diseases (IMDs) Project Could Be Funded With Federal Grant

We recommend that funding for Institutions for Mental Diseases transition pilot projects be reduced by $333,000 General Fund, with a corresponding increase in federal funds by $333,000, due to the availability of federal grant funds for such projects.

Institutions for mental diseases are institutions providing long-term nursing and psychiatric care that are operated and funded primarily by counties under state-local realignment. The DMH budget includes a request for $1 million from the General Fund in 2001-02 and the two subsequent fiscal years to seek community placement for individuals now in IMDs. We discuss the proposal, as well as our recommendation to seek federal grant funding to help reduce the General Fund cost of the projects, in the "Crosscutting Issues" section of this chapter of the *Analysis*. We propose a $333,000 reduction from the General Fund and a corresponding increase in federal funds for the projects.

STATE HOSPITAL ISSUES

Other Funding Available for ADA Projects

We recommend the deletion of $7.6 million from the General Fund requested in the budget year for Americans with Disabilities Act (ADA) compliance projects at Metropolitan State Hospital because insufficient information has been provided to the Legislature to justify the funding request and because funding for such ADA projects has already been set aside in the current fiscal year. (Reduce Item 4440-011-0001 by $7.6 million.)

Budget Proposal. The budget proposes a one-time General Fund allocation of $20 million in the support budget of DMH for various special repair projects, as well as projects to bring facilities into compliance with the ADA. Of that total proposed funding, about $12.4 million would be provided to address a backlog of special repair projects at each of the four state hospitals, with the remaining $7.6 million spent on projects to bring Metropolitan State Hospital facilities into ADA compliance. The ADA projects include widening doors; installing ramps and handrails; and modifying drinking fountains, showers, and restrooms.

Insufficient Information on ADA Request. We do not have any concerns at this time with the proposal for $12.4 million for special repair funding. We are concerned, however, that the information provided by DMH in support of the ADA compliance projects is insufficient to justify the $7.6 million budget request. A detailed cost summary for the Metro-

politan State Hospital projects, dated June 15, 2000, indicated that the ADA projects would cost about $6.1 million, or about $1.5 million less than is now requested in the budget.

In response to questions about this discrepancy, DMH has provided our office with a revised project estimate indicating that the full cost will be the budgeted amount. However, the revised cost estimate does not provide updated cost information for the specific projects that are proposed or indicate how their overall cost has escalated about 25 percent in six months. Without such information, the Legislature cannot determine whether the funding level requested is appropriate.

Other Funding Available for ADA Compliance. We are also concerned that the DMH budget request does not appear to take into account the availability in the current year of other state funds for such projects. Item 9906 of the *2000-01 Budget Act* provided a total of $60 million, including $20 million from the General Fund, to ensure that state buildings are accessible to the disabled. At the time this analysis was prepared, we were advised that the funding had not been allocated by the Department of Finance (DOF) for any specific projects. Thus, this funding would appear to be available for the ADA compliance efforts at the Metropolitan State Hospital, making any budget-year appropriation to DMH unnecessary.

Analyst's Recommendation. Because of the concerns discussed above, we recommend approval of the $12.4 million requested for special repair projects but deletion of the $7.6 million for ADA compliance efforts at Metropolitan State Hospital.

Our recommendation need not delay these projects, and could in fact expedite their completion, by making funding available at an earlier date. If, as the administration indicates, these ADA projects are a high priority for the state, they should be supported from the $20 million General Fund amount already appropriated for such projects in the current year. In applying for these funds to the DOF, DMH should provide justification for the $7.6 million requested, including updated cost information for the specific projects that are proposed and an explanation of how their overall cost has escalated about 25 percent in six months.

Security and Alarm Proposal

We withhold recommendation on $7.6 million requested in the support budget to install personal security alarm systems at various institutions because it is not clear how the request is related to various capital outlay requests. The department should report to the Legislature at the time of budget hearings with a complete security plan which identifies the coordination among projects and how each will be implemented.

Budget Proposal. The budget includes a total of about $7.6 million to install and upgrade the personal alarm systems at Atascadero, Metropolitan, and Patton State Hospitals. Personal alarms are devices that a staff member can activate to ensure that other staff provide assistance in dangerous or potentially life-threatening situations to protect themselves, patients, or visitors. An additional $901,000 is also requested under the department's capital outlay program (Item 4440-301-0001) to install personal alarms at the same three institutions. Thus, the budget includes a total of over $8.5 million to change the personal alarm systems at three hospitals.

Coordination of Projects Needed. While it is important to have appropriate security systems at these facilities, DMH has not identified how the separate proposals will be coordinated, or to what extent the proposals address the department's overall security needs. In order for the systems to work properly within each institution, the projects need to be properly planned and coordinated to ensure the resulting security system addresses the institutions' needs. To accomplish this, the work should be planned, designed, and installed as a single project at each institution. The fragmented proposals in the budget do not give the Legislature the information it needs to assess the separate requests.

Analyst's Recommendation. As we further discuss in the "Capital Outlay" chapter of this *Analysis*, we recommend that prior to budget hearings DMH provide clarifying information to the Legislature. This information should include at least the following for each institution:

- A detailed analysis of the current personal alarm system throughout the institution.
- A detailed analysis of the current personal alarm security plan for the entire institution.
- The scope of work for each project.
- How the projects are related and how the projects address the institution's personal alarm security needs.
- How the projects will be coordinated through planning, design, and construction

Pending receipt and review of this information, we withhold recommendation on the $7.6 million requested under Item 4440-001-0001.

ADMINISTRATIVE ISSUES

Health Insurance Portability and Accountability Act (HIPAA)

We recommend that $2.4 million ($1.2 million General Fund and $1.2 million in reimbursements) requested to implement federal regulations issued under the Health Insurance Portability and Accountability Act (HIPAA) be deleted from the Department of Mental Health (DMH) budget but funded instead from a special budget item to further legislative oversight of HIPAA compliance activities. We further recommend approval within the DMH budget of the nine staff positions requested to implement the federal regulations.

We discuss the HIPAA compliance proposal, as well as our recommendation for shifting the funding for this new activity to Item 9909 of the *2001-02 Budget Bill*, in the Crosscutting Issues section of this chapter of the *Analysis*.

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 $6.7 billion from all funds for support of EDD in 2001-02. This is a decrease of $26 million, or 0.4 percent, over estimated current-year expenditures. The budget proposes $30.5 million from the General Fund in 2001-02, which is a reduction of $4.7 million (13 percent) compared to 2000-01.

Disability Insurance Tax Rate Now Complies With Current Law

From January through March 2000, the Disability Insurance (DI) contribution rate was below the level required by current law. Since April of 2000, the DI tax rate has complied with statutory requirements. Despite a low balance of $5 million in December 2000, the Employment Development Department projects that the DI Fund will be able to pay anticipated claims without the need for short-term borrowing from the General Fund.

Background. The DI program provides benefits to workers who are unable to work due to non-work-related illness, injury, or pregnancy. The DI program is financed by a payroll tax on workers' earnings.

Statutory Formula for Setting the DI Contribution. Section 984 of the Unemployment Insurance Code specifies a methodology for the Director of EDD to set worker contribution rates for the DI Program each January. Section 984 also grants the Director discretionary authority to reduce or increase the statutory "formula" rate by 0.1 percent. The statute also requires the Director to prepare a public statement by October 31 of each year which declares the rate of worker contributions for the succeeding calendar year.

Rate Setting Process for 2000. The statutory formula for setting the DI tax rate for calendar year 2000 produced a rate of 0.8 percent, which at the Director's discretion could be reduced by 0.1 percent to 0.7 percent. However, the rate was left unchanged from the 1999 rate at 0.5 percent until April 2000. Thus, between January and March 2000, the DI rate was below the level required by statute. Effective April 1, 2000, EDD increased the DI rate to 0.7 percent, a level that complied with statutory requirements.

Rate Setting Process for 2001. The statutory formula indicates that the worker contribution rate be 1 percent during calendar year 2001. Exercising his discretionary authority to reduce the rate by 0.1 percent, the Director announced a rate of 0.9 percent for calendar year 2001. We note that this rate complies with current law.

Fund Condition. Since reaching a peak of $1.8 billion at the end of 1995-96, year-end DI fund balances have declined steadily, reaching $157 million in June 2000. The trend toward lower fund balances largely results from decisions by the current and past EDD directors to use their discretionary authority to reduce the DI contribution rate by 0.1 percent below the "formula" rate. We note that the period from January through March of 2000, when the rate was below statutorily required levels, further increased stress on the fund. In December 2000, the fund reached a low of about $5 million. Despite the low balance, EDD projects that the fund will be able to pay anticipated benefit claims without the need for short-term borrowing from the General Fund because contributions into the fund are now exceeding claims. The fund is projected to have a balance of $360 million at the end of June 2001, rising to nearly $900 million at the end of June 2002.

Unemployment Insurance Benefits in California

The Unemployment Insurance (UI) program provides weekly benefits to unemployed workers who become jobless through no fault of their own. Benefit levels are set by state law and have not been increased since 1992. We review the UI program and estimate the cost of increasing the maximum benefit to a level of wage replacement in 2002 that would be roughly equivalent to that of 1992.

Background. The UI program provides weekly, unemployment insurance payments to workers who lose their jobs through no fault of their own. To be eligible for benefits, a claimant must be able to work, be seeking work, and be willing to accept a suitable job.

The UI program is a federal-state program, authorized in federal law but with broad discretion for states to set benefit and employer contribution levels. The program is financed by unemployment tax contributions paid by employers for each covered worker. We note that California law allows a part-time employee to file a UI claim.

Statutory Benefit Level. State law establishes benefit levels. Currently, the maximum weekly benefit is capped by state law at $230 per week for 26 weeks. The amount of benefits available is based on the claimant's earnings in the "base period." The "base period" is a 12 month-long period. The quarter within the base period in which the highest wages were received generally determines the weekly benefit amount. To qualify for benefits in California, a claimant must have generally earned at least $1,300 in the highest quarter of the base period.

Current Benefit Payments. The purpose of UI is to ensure that at least basic necessities, (food, shelter and clothing) can be met while an active search for new employment takes place. In California benefit payments vary depending on the claimant's base period earnings. According to EDD:

- About 50 percent of UI claimants receive between $40 and $149 per week in UI benefits.
- 25 percent of unemployed workers receive between $150 to $229 per week in UI benefits.
- The remaining 25 percent of unemployed workers receive the maximum wage benefit amount of $230.

Benefits Last Increased in 1992. As noted above, state law establishes benefit levels, and benefits were last increased in 1992. This change was the final increment of a three-year phased-in maximum benefit increase mandated by Chapter 1146, Statutes of 1989 (SB 600, Roberti). We note that recent legislation, SB 546 (Solis), would have gradually increased the maximum weekly benefit to $380 by January 2003. The bill was vetoed, in part because it lacked a financing mechanism, and therefore would have adversely impacted the UI Fund.

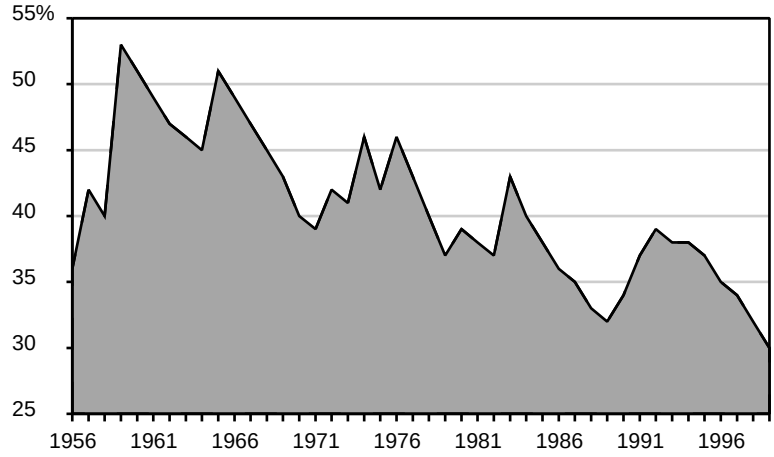
Wage Replacement Over the Life of the Program. As noted above, the maximum benefit was raised to $230 in 1992. At that time, this maximum benefit level represented 39 percent of the average weekly nonagricultural wage in California. Figure 1 (see next page) tracks the percent of wages replaced by UI benefits since 1956. We define the term "wage re-

placement" as the maximum UI benefit at the time divided by the average weekly nonagricultural wage. In other words, that portion of a claimant's earnings that are substituted by benefits is the "wage replacement." As of December 2000, the maximum UI benefit of $230 replaced 30 percent of the average weekly nonagricultural wage. As the figure shows, this is an all-time low.

Figure 1

Unemployment Insurance Wage Replacement Now at Historic Low

1956 Through 1999



Comparison to Other States. Among the 50 states, California's average weekly benefits paid are low. Specifically, California's average weekly benefit amount is a little over $159 versus a national average of about $222. Put another way, California ranks 49th, ahead of only Mississippi, which pays its claimants an average of about $157 per week. Among the ten most populous states, California has the lowest average weekly benefit, about $56 less than the next lowest state, Georgia. We note that nearly all California workers are covered by UI. This may not be the case in other states.

The maximum UI benefit level is a policy decision for the Legislature. Below we discuss the costs of increasing the maximum benefit level to a level of wage replacement roughly equivalent to 1992, the last time benefits were increased.

Cost of Restoring UI Benefits to 1992 Wage Replacement Level. During calendar year 2000, the UI program paid benefits in the amount of $2.8 billion to about 14.8 million workers. If the Legislature wanted to raise the level of the wage replacement to the 1992 level, the maximum benefit level would need to be raised from $230 to $300. With this increase, the maximum weekly benefit would then replace about 39 percent of average weekly nonagricultural wages.

According to EDD, increasing the maximum weekly benefit amount would raise total benefit payments by $178 million in calendar year 2002, $261 million in 2003, $269 million in 2004, and $275 million in 2005.

Financing the Benefit Increase. One way to finance the benefit increase would be to raise the taxable wage base. Currently, employers pay unemployment taxes on up to $7,000 in wages paid to each worker. To finance the proposed increase with no adverse impact on the UI Fund, the $7,000 ceiling would have to be raised by $700 to $7,700. This increase in the taxable wage base would raise the average annual cost to the employer by $19 for each employee who reaches the $7,700 taxable wage.

Summary. The UI benefit levels are a policy decision for the Legislature. Benefits have not been increased since 1992. Raising benefits in 2002, to a level of wage replacement equivalent to 1992, would raise the average annual cost to employers by $19 per employee.

Federal Welfare-to-Work Block Grant Program

California received $367.6 million in Welfare-to-Work block grant funds from the Department of Labor. Recent federal legislation extended the deadline for expending Welfare-to-Work funds from July 2002 until July 2004.

Background. *The Balanced Budget Act of 1997* (*Act*) authorized the federal Department of Labor (DOL) to provide Welfare-to-Work grants to states and local communities. The Welfare-to-Work program was largely intended to complement the Temporary Assistance for Needy Families (TANF) program by providing additional assistance to hard-to-employ TANF recipients who had specific barriers to employment. States must provide a $1 match for every $2 of Welfare-to-Work grant funds awarded. To date, matching funds have been budgeted in the Department of Social Services.

Initial Conditions of the DOL Grants. California received $367.6 million from the Department of Labor in two allocations. The state was required to allocate, by formula, 85 percent of the funds to local Workforce Investment Boards (formerly known as Private Industry Councils [PICs]). The remaining 15 percent was used for state administration and a competitive grant program. In 1998, California allocated $161.9 million to local boards. In 1999, an additional $150.6 million was allocated. Under the

original provisions of the *Act*, California had three years to expend the federal funds and the necessary state match.

California's Spending Rate. As of September 30, 2000, California spent a total of $91.5 million of the first grant, about 57 percent. Only 7.9 percent of the second-year grant has been expended. The expenditure rate varies widely among local areas.

Extension of Spending Deadline. The Department of Labor Appropriations Act (P.L. 106-554) extended the deadline for expending Welfare-to-Work funds. Specifically, the act extends the availability of Welfare-to-Work funding from three to five years from the original start date. This means that the first-year grant's deadline is now extended to June 2003. Similarly, the second-year deadline is extended to July 2004. The extension period also applies to matching funds. We note that, absent this extension, it appeared likely that California would be unable to expend all of its federal funds.

As noted above, the extension also applies to the state match. Please see our CalWORKs analysis for a discussion of the budget for matching funds.

Legislature Needs Spending Plan for Discretionary WIA Funds

The Governor's budget provides no details on the proposed expenditure of $43.6 million in Workforce Investment Act discretionary funds. We recommend that the Legislature not appropriate these funds until the administration presents an expenditure plan which is reviewed for consistency with legislative priorities.

Background. The federal Workforce Investment Act (WIA) of 1998 replaced the Job Training Partnership Act which provided employment training services to youth and adults. The goal of WIA is to strengthen coordination among various employment, education, and training programs. As required by WIA, the Governor appointed a 63-member Workforce Investment Board in December 2000. The board advises the Governor on the operations of the state's workforce investment system. We note, however, that board actions are not binding on the Governor.

Pursuant to federal law, 85 percent of WIA funds ($629.9 million in federal funds in 2001-02) are allocated to Local Workforce Investment Boards (LWIBs, formerly known as PICs). The remaining 15 percent of WIA funds ($94.5 million) may be used by the state for discretionary purposes, such as administration, statewide initiatives, or competitive grants.

Current-Year Expenditures. In 2000-01, discretionary WIA funds totaled $94.5 million. With the exception of $15 million for the Caregiver

Training Initiative, the *2000-01 Governor's Budget* included no specific WIA expenditure plan. Instead, the Governor, working with recommendations from the state board, determined how WIA funds were allocated. In 2000-01, $21.7 million was used for administrative costs at EDD and the state board. The remaining $72.8 million was used for various discretionary programs.

Figure 2 (see next page) shows estimated WIA expenditures in the current year, and a proposal by the administration to the state board for expenditures in the budget year. As the figure shows, about $16 million is allocated to required WIA activities in both 2000-01 and 2001-02. These required activities include technical assistance for LWIBs and certain programs for youth. We note, however, there is no federally mandated minimum spending threshold for these activities and therefore the amount could be modified.

Budget-Year Expenditure Plan. Like the current-year allocation, the budget-year WIA discretionary funding is estimated to be $94.5 million. As shown in Figure 2 (see next page), the proposal for 2001-02 allocates similar amounts for administration and statewide program expenditures. The remaining $59.7 million is proposed for unspecified proposals, initiatives, and required activities.

In separate analyses, we indicate that the Legislature may wish to consider the option of using part of the WIA funds for (1) efforts to implement Proposition 36 and (2) a Los Angeles County Medicaid demonstration project. The Proposition 36 proposal is discussed under the "Cross-cutting Issues" section of this chapter, while the Los Angeles County proposal is discussed as part of our analysis of the Medi-Cal Program.

Analyst's Recommendation. In order to exercise its oversight and budget review responsibilities, the Legislature needs a complete expenditure plan for WIA funds. Because the Governor's budget provides no details on how it will expend $43.6 million, we recommend that the Legislature not appropriate these funds until an expenditure plan is presented and reviewed for consistency with legislative priorities.

National Emergency Grant Program

In order to streamline the process for allocating National Emergency Grant (NEG) funds to local entities, the Governor's budget includes a provision that exempts federal NEG augmentations from the midyear legislative review process prescribed in Section 28 of the* 2001-02 Budget Bill. *Although streamlining the authorization process is desirable, we recommend (1) deleting of the proposed budget provision and (2) incorporating estimated NEG expenditures into the "regular" budget process. This approach streamlines the allocation process while preserving legislative oversight.

Figure 2

Workforce Investment Act (WIA) Discretionary Funds

(In Millions)

	2000-01	2001-02
Administration		
Employment Development Department	$17.0	$18.3
State board	4.7	4.8
Subtotal	($21.7)	($23.1)
State-Level Discretionary Projects		
Training for local workforce investment staff	$3.3	$3.3
Services to dislocated workers	5.7	5.7
California Cooperative Occupational Information System	2.7	2.7
Subtotal	($11.7)	($11.7)
Local Discretionary Projects		
Competitive grants for workforce development services	$20.0	—
Caregiver Training Initiative	15.0	—
Governor's award for veteran's grants	6.3	—
Interagency contract with Department of Education	2.3	—
Hollywood Entertainment Museum	1.0	—
Subtotal	($44.6)	($43.6[a])
Required WIA Activities		
Incentive grants and technical assistance to locals	$6.3	—
Assistance to locals for eligible youth	7.0	—
Fiscal and management information system	1.0	—
Eligible Training Provider List (database of providers)	0.8	—
Evaluations of workforce investment activities	1.2	—
One-stop system operating needs	0.2	—
Subtotal	($16.5)	($16.1[b])
Total WIA Discretionary Funds	**$94.5**	**$94.5**

[a] No specific proposal provided for local discretionary projects.

[b] For 2001-02, the spending proposal identifies activities similar to the current year, but does not specify amounts for the various subcomponents.

Background. Under the NEG program, states may request federal funds to provide readjustment assistance (for example, retraining) to workers that face dislocation due to unforseen events, such as a flood or a freeze. During the last four fiscal years, annual NEG funding for Cali-

fornia has ranged from $17 million to $74 million. After the EDD receives these funds, they are allocated to local entities, usually local Workforce Investment Boards, to provide readjustment assistance to displaced workers. Typically, EDD obtains the authority to expend the additional federal funds by submitting a letter to the Legislature pursuant to Section 28 of a given budget act.

Streamlining the Process. The Governor's budget includes a provision in Item 5100-001-0869 that would exempt NEG funds from Section 28 notification to the Legislature. The administration indicates that it is proposing this provision in order to allocate NEG funds to dislocated workers more quickly. Although we agree that reducing the time it takes to move emergency funds to dislocated workers is desirable, we believe the Legislature needs to retain oversight over this process. In our view, the reduction in processing time for NEG funds could be achieved by incorporating a request for NEG federal expenditure authority into the Governor's budget. The amount of proposed expenditure authority could be set at the average of annual NEG expenditures over the past four years, about $45 million. In the event that NEG expenditures ultimately exceed $45 million, the EDD could seek additional budget authority through the Section 28 process with a waiver of the standard 30-day review period. In fact, all recent NEG federal augmentation proposals have included such a waiver request and the Legislature has concurred with the need for these waivers.

Analyst's Recommendation. We recommend that the Legislature delete provision 3 of Item 5100-001-0869. We further recommend that EDD submit a budget change proposal for the 2001-02 budget to provide EDD with the authority to expend up to $45 million in NEG funds. This approach streamlines the process while maintaining legislative oversight. If during 2001-02, EDD obtains NEG funds in excess of $45 million, EDD and the Director of the Department of Finance may request, in their Section 28 letter, a waiver of the 30-day waiting period.

DEPARTMENT OF CHILD SUPPORT SERVICES (5175)

The Department of Child Support Services (DCSS), created on January 1, 2000, administers California's child support program by overseeing 58 county child support offices. The primary purpose of the program is to collect from absent parents, support payments for custodial parents and their children. Local child support offices provide services such as locating absent parents; establishing paternity; obtaining, enforcing, and modifying child support orders; and collecting and distributing payments. The *2001-02 Governor's Budget* proposes expenditures totaling $1.1 billion from all funds for support of DCSS in the budget year. This is an increase of $157 million, or 17 percent, over estimated current-year expenditures. The budget proposes $487 million from the General Fund for 2001-02, which is an increase of $79 million, or 21 percent, compared to 2000-01. Most of this increase is attributable to a higher federal automation penalty and lower federal incentive payments.

Total Automation Penalties Could Reach $1 Billion

Since 1998, California has been subject to penalties for failing to implement a statewide child support automation system. The penalties, estimated to be $114 million in 2000-01 and $163 million in 2001-02, are levied in the form of a reduced federal share of child support administrative expenditures. The penalties are expected to continue through 2004-05, potentially reaching a total of $1 billion since 1998.

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

through the annual budget process. Chapter 479 also provides that the state General Fund could be used to backfill for the loss of federal support, or the state also could distribute some share of the penalties to the counties.

Total Penalties Could Reach $1 Billion. From 1997-98 through 1999-00, California's child support program incurred penalties totaling $104 million and the state General Fund backfilled the loss of these federal funds. The penalty is set by federal law at 25 percent and 30 percent of estimated federal expenditures for child support administration for federal fiscal years (FFY) 2000 and 2001, respectively. California faces a $114 million penalty in 2000-01 and an estimated $163 million penalty in 2001-02. Thus, California will have incurred penalties of about $380 million through 2001-02.

We note that with even modest increases in administrative expenditures, child support penalties could approach or exceed $200 million for each of the years during the three-year period of 2002-03 through 2004-05. When added to the penalties incurred through 2001-02, this means that California could incur penalties totaling almost $1 billion over this time period. The statewide automation system is scheduled to meet federal requirements in 2005, at which time the penalties would be discontinued.

Counterproductive Nature of the Penalties. In previous analyses, we have shown that the principal goal of the child support program—the collection of support—is strongly related to the amount of fiscal resources committed to the program (that is, administrative expenditures). (For further detail, see our April 1999 report entitled *The Child Support Enforcement Program From a Fiscal Perspective: How Can Performance Be Improved?*) We concluded that administrative effort has a particularly strong relationship to collections—explaining about 70 percent of the variation in collections between counties. In other words, counties that did poorly in making child support collections generally had invested less in administrative effort. Conversely, counties that did well in child support collections had made higher administrative expenditures.

We note that until the statewide child support automation system is fully implemented increased administrative spending in the child support program will result in increased penalties. This is because the federal penalty is based on administrative expenditures. Thus, any net direct fiscal benefit (that is, increase in collections) to government from increased administrative spending is reduced significantly. We note that the collection of child support is essential for families.

Child Support Automation Penalties Overbudgeted

We recommend that proposed spending for child support administration be reduced by $7.9 million from the General Fund because historic spending trends indicate the federal penalty will be less than budgeted. (Reduce Item 5175-101-0001 by $7,900,000.)

As noted previously, future federal child support automation penalties will be levied as a 30 percent reduction in federal funds to support administrative costs of the child support program. The Governor's budget estimates a 2001-02 penalty of $163 million from the General Fund. This estimate assumes a 21 percent increase in total administrative spending in the FFY 2001 (October 2000 through September 2001), based on the actual increase in spending between 1998-99 and 1999-00. We believe this estimate is inflated because it has not been adjusted downward to reflect a number of one-time expenses in 1999-00. In addition, our examination of historic trends in the "core" administrative functions of the program found that expenditures increased at a lower rate of approximately 14 percent. A federal penalty based on this slower rate of growth would be $155 million, resulting in a General Fund savings of approximately $7.9 million. Accordingly, we recommend that the budget be reduced to reflect the lower cost for the federal penalty.

Child Support Automation Proposal Lacks Detail

The budget proposes $16.5 million ($5.6 million General Fund) for interim child support automation improvements over the next three fiscal years, 2001-02 through 2003-04. Without prejudice to the merits of the proposal, we recommend that the Legislature (1) delete this multiyear funding request and (2) instruct the department to include a specific interim automation proposal for 2001-02 only in the May Revision to the Governor's budget that is consistent with federal guidelines. (Reduce Item 5175-101-0001 by $5,600,000.)

The Governor's budget for 2001-02 proposes a total of $18.1 million for support of an interim child support automation system. This amount consists of $16.5 million for local assistance and $1.6 million for state operations. We discuss the local assistance proposal in this write-up and the state-operations proposal in the following write-up.

Background. Pursuant to federal law, the Statewide Automated Child Support System (SACSS) was intended to provide automated child support enforcement tracking and monitoring capability through local child support offices. Following several years of difficulty, the state terminated the SACSS project in late 1997. The cancellation of SACSS resulted in the need for California to implement interim automation systems until a new

statewide system is functional. The new statewide system—known as the California Child Support Automaton System (CCSAS)—is scheduled to be fully implemented in 2005.

Interim Automation Systems. Pursuant to Chapter 479, counties may be required to modify their current child support automation systems or to change to a different system in preparation for the new statewide automation system. The Governor's budget proposes $16.5 million ($5.6 million General Fund) to be expended over three years for the costs of converting counties from various automation systems to one of the six interim systems approved by the federal government. Although interim system improvements may be necessary, we believe that the proposal does not provide the Legislature with sufficient detail regarding budget-year and out-year costs. Therefore, we recommend the deletion of the $16.5 million ($5.7 million General Fund) and the related budget bill provision. We further recommend that DCSS submit at the time of the May Revision a proposal that reflects only estimated budget-year funding requirements. The revised budget-year proposal should demonstrate consistency with the most recent federal guidance on interim automation efforts.

Pre-Statewide Interim Systems Management (PRISM)

We recommend that the Legislature approve $1.6 million for the continued support and operation of the Pre-Statewide Interim Systems Management (PRISM) project. We further recommend adoption of budget bill language requiring the Department of Child Support Services to obtain federal approval prior to implementation of PRISM modifications.

Background. Chapter 479 required DCSS to assume a more active role in overseeing the maintenance and operation of the interim automation systems of the child support program until the new statewide CCSAS is operational. Prior to the interim systems, counties had been responsible for maintaining, enhancing, and supporting their existing systems with minimal state oversight and involvement. In response to this new requirement, the state combined all of the individual systems into one project known as the PRISM project.

The PRISM project, which will spend almost $1 billion in state and federal funds over a six-year period, currently supports six county-based child support enforcement systems, performs data conversions to one of these six systems, and operates and maintains the state's interim federal case registry. The state will operate PRISM until 2006 when it will be discontinued and replaced with the CCSAS system.

Chapter 479 also required DCSS to ensure that the automation activities of these interim systems are consistent with the new statewide sys-

tem, and if necessary, seek federal funding and approvals for those activities. Counties were prohibited from changing or enhancing those interim systems without prior approval by DCSS.

The DCSS Requested Federal Funds for PRISM Support. In April and August 2000, DCSS submitted requests to the federal Administration of Children and Families (ACF) for additional federal funding to maintain PRISM systems. Specifically, DCSS requested funds to:

- Operate and enhance the six systems to comply with various mandates.
- Convert all counties to one of the six systems.
- Operate the state's interim case registry system which transmits California child support orders to the Federal Case Registry.

The ACF Denies or Defers Decision on Funds for Systems Enhancements. In July 2000, ACF either denied federal funds or deferred its decisions (pending receipt of additional cost information) relating to a number of the enhancement requests. In response, DCSS reorganized its priorities, redirected funds to continue some enhancements, and asked ACF (in August 2000) to reconsider its decision to defer funding on the remaining requests.

In October 2000, the Department of Finance (DOF) notified the Legislature that ACF had denied a portion of DCSS' request, but that DCSS intended to redirect existing resources to fund activities in the current year. The DOF letter, however, indicated that it might request additional funds for the budget year.

Federal Government Denies Funding, but DCSS Allows County Enhancements to Proceed. Because of the urgency of the time lines and momentum of the projects involved, DCSS subsequently allowed counties to spend $3.1 million in the current year for various deferred system enhancements. In November 2000, ACF ultimately notified DCSS of its denial of $8.9 million in federal funds requested for various adjustments to PRISM in the current year, of which $4.1 million was for the deferred enhancements.

Budget Request. The budget reflects an ongoing General Fund increase of $3.8 million in the current year and proposes an additional ongoing augmentation of $1.6 million in the budget year.

Concerns. The sequence of events which occurred with PRISM are similar to those that have occurred with other child support automation activities (see our analysis of the Franchise Tax Board's California Arrearage Management Project [CAMP] under Item 1730 of the "General Government" section of this *Analysis*). In each of these situations, the administration initially sought legislative approval for short-term or interim

automation systems pending development of a statewide system. Concurrent with seeking legislative approval, the administration also sought federal funding approval. Generally, federal funding decisions are made months after enactment of the budget act. In the case of both CAMP and PRISM, the federal government took a more restrictive view of the short-term system and decided to limit its funds only to those activities which directly enhanced the single statewide system. This left the state in a difficult position—either proceed without federal funds or stop the short-term projects.

The problem in the case of PRISM is that the state assumed federal approval and decided to proceed by redirecting support from the General Fund. When federal funds were denied, the department had a shortfall of $3.8 million.

Recommendation. The increases reflected in the Governor's budget for PRISM in the current year ($3.8 million) and proposed for the budget year ($1.6 million) are consistent with the state's prior commitment to the federal government and we, therefore, recommend budget-year approval. In order to avoid future situations, however, which create deficiencies in the department's budget, we recommend that the Legislature adopt the following budget bill language:

> It is the intent of the Legislature that the Department of Child Support Services shall receive federal funding approvals prior to any changes in scope or funding of the Pre-Statewide Interim Systems Management Project.

Permanent Positions Are Needed to Support Child Support Automation Activities

We recommend that the Legislature reject the budget proposal to provide ongoing oversight of county-based automation activities through the use of consultants and instead authorize 3 personnel years to provide such oversight. (Reduce Item 5175-001-0001 by $11,000 and add three positions.)

The budget proposes an augmentation of $224,000 for departmental consulting services to oversee counties' ongoing child support automation activities. For the past three years, three limited-term positions within the department have provided these activities.

The DCSS Required to Provide Ongoing Oversight of County Child Support Automation. Chapter 479 requires each county to enter into an Annual Automation Cooperation Agreement (AACA) with DCSS by December 1 of each year or risk losing its funds. Chapter 479 further allows a county to modify its AACA to reflect subsequent changes in law and requires DCSS to issue guidelines and review all AACAs and AACA modifications.

The DCSS Oversight Activities Are Expected to Continue. We anticipate that DCSS' planning and oversight of county AACAs and county-based automation efforts will need to continue not only during the period of the PRISM project but after implementation of the statewide system as well. The DCSS, for example, will need to review any design enhancements to internal county systems to ensure compliance with the county's AACA.

The DCSS Should Not Acquire Consulting Services for Ongoing Activities. We recommend the establishment of permanent positions to undertake the proposed planning and oversight activities. This is because these activities to be performed are ongoing in nature and are less expensive when performed by state staff. Therefore, we recommend that the Legislature reduce the proposal by $11,000 and authorize 3 personnel years for ongoing departmental oversight of county automation activities. This would leave $198,000 for personnel services and $15,000 for operating expenses and equipment to support the three positions.

DEPARTMENT OF SOCIAL SERVICES STATE OPERATIONS (5180)

The Department of Social Services (DSS) administers four major programs: welfare, social services, community care licensing, and disability evaluation. The department is responsible for (1) supervising county delivery of social services, (2) determining eligibility for federal and state disability programs, (3) licensing residential facilities, (4) providing adoption services, and (5) assisting disaster victims.

The budget proposes $433 million from all funds ($97 million from the General Fund) and 4,344 personnel-years of staff for DSS state operations in 2001-02. Proposed General Fund spending represents a decrease of 2 percent compared with estimated General Fund spending in the current year.

Department Should Develop eGovernment Plan

We recommend that the Legislature deny the Governor's proposal for a one-time increase of $250,000 for the development of a feasibility study report for the Department of Social Services' eGovernment services, until the department develops an eGovernment plan.

The budget proposes a one-time augmentation of $250,000 ($159,000 from the General Fund and $91,000 from other funds) to acquire consulting services for the development of a feasibility study report (FSR) for DSS eGovernment services. The FSR would:

- Identify DSS business processes that would work well with Internet technology.
- Recommend Internet development tools.
- Define the department's eGovernment technical and infrastructure requirements.

The eGovernment Policies and Guidelines Will Be Issued Soon. It is our understanding that the administration will soon release a number of eGovernment policies which will address departmental planning, technical standards, and infrastructure requirements. The administration has issued an executive order that requires every department to prepare an eGovernment plan and submit it to the Department of Information Technology for review and approval. Departments must have their eGovernment plans in place prior to starting eGovernment projects.

The DSS Should Develop eGovernment Plan First. In view of the pending eGovernment policy directives from the administration, we believe it is inappropriate for DSS to develop an FSR for an eGovernment project when it has not yet developed an eGovernment plan. Departments should have their eGovernment plans in place before preparing FSRs for individual eGovernment projects in order to adequately oversee and manage all project activities. For this reason, we recommend that the Legislature deny the augmentation to develop an eGovernment services FSR until the department develops an eGovernment plan.

DEPARTMENT OF SOCIAL SERVICES CALWORKS PROGRAM

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

The budget proposes an appropriation of $5.5 billion ($2.1 billion General Fund, $143 million county funds, $15 million from the Employment Training Fund, and $3.2 billion federal funds) to the Department of Social Services (DSS) for the CalWORKs program. In total funds, this is a decrease of $126 million, or 2.3 percent. However, General Fund spending is proposed to increase by $193 million (10 percent). The increase is due to (1) replacing the current-year, one-time General Fund reduction of $154 million (due to a retroactive reduction in the maintenance-of-effort [MOE] requirement) and (2) an increase of $40 million in spending for the Department of Labor Welfare-to-Work match requirement.

Caseload Decline Slowing

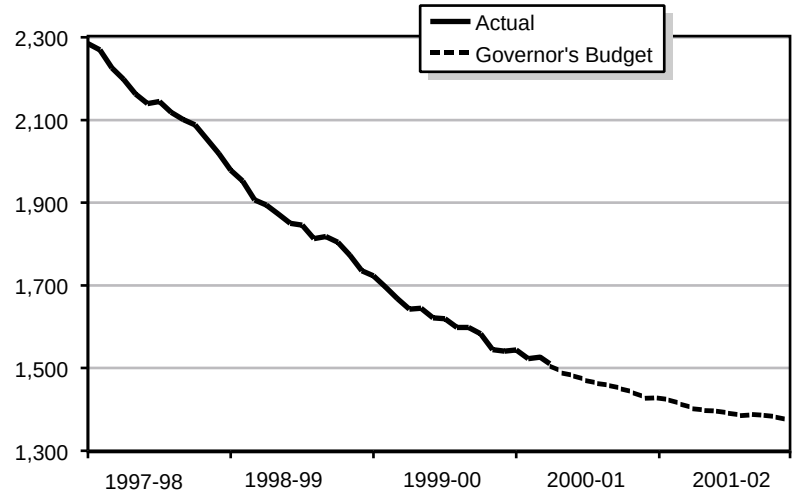
The California Work Opportunity and Responsibility to Kids caseload has declined significantly since 1994-95. However, recent caseload data suggest a deceleration in caseload decline, and the Governor's budget projects a continued deceleration in the budget year.

The CalWORKs caseload has declined every year since 1994-95, when caseloads reached their peak. During 1999-00, the average monthly number of persons in the CalWORKs program decreased by approximately

13 percent. However, the Governor's budget projects that the caseload decline will slow to 9 percent in 2000-01. The most recent caseload data (July to September 2000) is consistent with the Governor's current-year caseload forecast. The budget projects a further deceleration in caseload decline in the budget year, when the average monthly caseload is projected to decrease by only 6 percent. Figure 1 illustrates the recent trend toward slower caseload decline.

Figure 1

CalWORKs Caseload Decline Slowing



Because the CalWORKs caseload drives program costs, we will continue to monitor caseload trends and advise the Legislature accordingly.

Budget Underestimates Cost of Providing Statutory Cost-of-Living Adjustment

The General Fund cost of providing the statutory cost-of-living adjustment will be $10 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 cost-of-living adjustment (COLA), effective October 2001,

at a General Fund/Temporary Assistance for Needy Families (TANF) fund cost of $132 million. The statutory COLA is based on the change in the California Necessities Index (CNI) from December 1999 to December 2000. The Governor's budget, which is prepared prior to the release of the December CNI figures, estimates that the CNI will be 4.85 percent, based on partial-year data. Our review of the actual full-year data, however, indicates that the CNI will be 5.31 percent. Based on the actual CNI, we estimate that the cost of providing the COLA will be $141 million, an increase of $10 million compared to the Governor's budget. We recommend that the budget be increased to reflect these costs.

Figure 2 shows the maximum CalWORKs grant and food stamps benefits for a family of three, effective October 2001, as displayed in the Governor's budget assuming a 4.85 percent CNI and as adjusted to reflect the actual CNI of 5.31 percent. As the figure shows, based on the actual CNI, grants for a family of three in high-cost counties will increase by $34 to a total of $679, and grants in low-cost counties will increase by $33 to a total of $647.

Figure 2

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

2000-01 and 2001-02

		2001-02		LAO Projection Change From 2000-01	
	2000-01	Governor's Budget[a]	LAO Projection[a, b]	Amount	Percent
High-cost counties					
CalWORKs grant	$645	$676	$679	$34	5.3%
Food Stamps[c]	251	237	236	-15	-6.0
Totals	**$896**	**$913**	**$915**	**$19**	**2.1%**
Low-cost counties					
CalWORKs grant	$614	$644	$647	$33	5.4%
Food Stamps[c]	265	252	250	-15	-5.7
Totals	**$879**	**$896**	**$897**	**$18**	**2.0%**

[a] Effective October 2001.

[b] Based on California Necessities Index at 5.31 percent (revised pursuant to final data) rather than Governor's budget estimate of 4.85 percent.

[c] Based on maximum food stamps allotments effective October 2000. Maximum allotments are adjusted annually each October by the U.S. Department of Agriculture.

As a point of reference, the federal poverty guideline for 2000 (the latest reported figure) for a family of three is $1,179 per month. (We note that the federal poverty guidelines are adjusted annually for inflation.) When the grant is combined with the maximum food stamps benefit, total resources in high-cost counties will be $915 per month (78 percent of the poverty guideline). Combined maximum grant and food stamps benefits in low-cost counties will be $897 per month (76 percent of the poverty guideline).

Impact of MOE Requirement

The Governor's budget proposes to expend in 2001-02 all but $85 million of available federal block grant funds and the minimum amount of General Fund monies required by federal law for the California Work Opportunity and Responsibility to Kids (CalWORKs) program. Any net augmentation to the program in excess of the proposed $85 million reserve will result in General Fund costs and any net reductions will result in an additional reserve of federal block grant funds (which would be carried over by the state).

The MOE Requirement. To receive the federal TANF block grant, states must meet a MOE requirement that state spending on assistance for needy families be at least 75 percent of the federal fiscal year (FFY) 1994 level, which is $2.7 billion for California. (The requirement increases to 80 percent if the state fails to comply with federal work participation requirements.) Although the MOE requirement is primarily met with state and county spending on CalWORKs and other programs administered by the DSS, we note that $478 million in state spending in other departments is also used to satisfy the requirement. (Below we comment on the Governor's proposal to reduce General Fund spending by $154 million in the current year due to a retroactive reduction in the MOE.)

Proposed Budget Is at MOE Floor. For 2001-02, the Governor's budget for CalWORKs is at the MOE floor. We note that the budget also includes $89 million for the purpose of providing state matching funds for the federal Welfare-to-Work block grant. These funds cannot be counted toward the MOE because they are used to match other federal funds.

The Governor's budget also proposes to spend all but $85 million of available federal TANF funds in 2001-02, including the projected carryover of unexpended funds ($263 million) from 2000-01. The $85 million will be held in a reserve for unanticipated future program needs.

Proposition 36 Could Be New Source of MOE Funds. As noted above, California meets its MOE requirement partially through spending in other departments, which the Governor's budget assumes to be $478 million in 2001-02. As we indicate in our analysis of Proposition 36, certain expenditures of Proposition 36 funds may also be countable towards the

MOE requirement. (Please see "Crosscutting Issues" in this chapter.) In that analysis, we also cite the possibility of using Proposition 36 funds to draw down additional federal funds, in which case they could *not* be used to satisfy the MOE requirement. To the extent that some Proposition 36 expenditures on CalWORKs-eligible families are *not* used to draw down new federal funds, they could be counted towards the MOE requirement.

Budget Proposes Reductions in County Performance Incentives

The Governor's budget contains two proposals to reduce county performance incentives by a total of $397 million in 2000-01 and 2001-02. Specifically, the Governor proposes urgency legislation to reduce the current-year appropriation for county performance incentive funds by $153 million. In addition, the Governor 's budget proposes no funding for performance incentives in 2001-02, resulting in a savings of $244 million compared to the amount suggested by current law.

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

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

The of *2000-01 Budget Act* appropriated $250 million to counties for performance incentives. Since this amount was less than the estimated prior-year obligations ($320 million), it was assumed that counties would earn no new performance incentives in the current year, consistent with the provision of Chapter 108.

Current-Year Proposal. Although earlier estimates had assumed that prior-year obligations owed to the counties would exceed $250 million, the department's current estimate of the arrearage is only $97 million. The Governor has proposed urgency legislation to reduce the current-year appropriation for performance incentives to $97 million, resulting in a TANF savings of $153 million.

Budget-Year Proposal. The department has estimated that, under the statutory formula for determining performance incentives, counties would earn approximately $244 million in 2001-02. However, the Governor's

budget exercises the option, created by Chapter 108, to spend less for performance incentives than the amount suggested by the statutory formula. Specifically, the budget proposes no funding for county performance incentives, resulting in a savings of $244 million.

Expenditure of Performance Incentives. By the end of 1999-00, counties had earned approximately $1.2 billion in performance incentives, and had been paid $1.1 billion. However, as of December 2000, counties had spent only $46 million of these funds. As required by Chapter 108, nearly all the counties have submitted their performance incentive spending plans for the current year, which describe how the expenditure of these funds will be coordinated with existing services for CalWORKs recipients as well as the nonrecipient working poor. The department is still reviewing these plans.

Current-Year Proposal Raises Policy Issues. As we have indicated, the Governor proposes to reduce county performance incentive payments in the current year. We note that the Governor proposes to use the resulting TANF savings ($153 million) to replace essentially an equivalent amount of General Fund monies, which he proposes to "free-up" in 2000-01 as a result of a federal decision regarding the state's MOE. The amount appropriated for county performance incentives, as well as the treatment of the state's MOE, are policy decisions for the Legislature. Below we comment on these two current-year proposals.

Proposal for Current-Year MOE Reduction Savings Should Be Incorporated Into 2001-02 Budget Process

The Governor proposes urgency legislation in the current year to reduce the appropriation for county performance incentives by approxiamtely $150 million. He further proposes to use the resulting Temporary Assistance for Needy Families (TANF) savings to replace a like amount of General Fund spending during 2000-01. Both of these current year proposals are significant policy decisions for the Legislature.

If the Legislature elects to reduce county performance incentives through urgency legislation, as proposed by the Governor, we recommend that the Legislature amend the legislation to prohibit the expenditure of the resulting TANF savings in the current year. This action will effectively move the decision about whether to reduce General Fund spending (resulting from the maintenance-of-effort reduction) into the budget process for 2001-02. The Legislature could then deliberate fully on its priorities with respect to General Fund support for California Work Opportunity and Responsibility to Kids and the level of the TANF reserve for future years.

Retroactive Reduction in the MOE Requirement. As described earlier, states must meet a MOE requirement in order to receive the federal

TANF block grant funds. Specifically, state spending on welfare for needy families must be at least 75 percent of the FFY 1994 level, which is $2.7 billion for California. The requirement is 80 percent if the state fails to comply with federal work participation requirements. During FFY 1997, California assumed that it would not meet the federal work participation rate, so the state budgeted sufficient General Fund monies to satisfy the higher 80 percent MOE level.

In December 1998, the federal Department of Health and Human Services (DHHS) notified California that (1) it had not met the federal work participation requirements and (2) was subject to a penalty. California appealed the penalty, and in August 2000, DHHS notified the state that in fact it had met the federal work participation requirements in FFY 1997 and therefore would not be penalized. Based on this successful appeal, California's MOE requirement is retroactively reduced by about $150 million in FFY 1997. By amending a series of historical federal financial reports, California may reduce its General Fund spending for CalWORKs by the same $150 million, in the current year or future years, while remaining in compliance with the federal MOE requirement. Although DSS indicates that amending historical federal financial reports is a common practice, we note that the federal Administration for Children and Families is reviewing whether such amendments with respect to TANF and MOE spending are appropriate.

Governor's Proposal. The Governor's budget proposes to score the General Fund savings in the current year. In order to reduce General Fund spending and hold total CalWORKs program spending harmless, the Governor proposes to backfill the General Fund savings with federal TANF funds realized from his proposal to reduce county performance incentives in the current year. He proposes to achieve this reduction in performance incentives through urgency legislation in the current year. This approach fully funds the CalWORKs program in 2000-01. However, it has the effect of reducing the TANF reserve because the TANF savings resulting from the reduced county performance incentives would have otherwise gone to the reserve.

Governor's Proposals Represent Significant Policy Changes for the Current Year. The amount of spending for county performance incentives in the current year is a policy decision for the Legislature. Similarly, the amount of General Fund support for CalWORKs and the level of the TANF reserve are also policy judgments for the Legislature.

Because federal TANF funds may be carried over indefinitely, the amount of the TANF reserve is important. In future years, the TANF reserve could be used to cover potentially higher costs for (1) child care for working and former recipients and (2) higher grants pursuant to the statu-

tory COLA. We also note that the annual TANF block grant is only authorized through the end of FFY 2002. Some observers believe that Congress may reduce the block grant after 2002 because the TANF caseload has declined significantly since the block grant was created in 1996.

We note that achieving any savings from reducing county performance incentives cannot wait until the budget year. If current law is not changed during this fiscal year, counties would establish claims to the entire $250 million appropriated. Conversely, there is no urgency with respect to achieving the General Fund savings pertaining to the retroactive FFY 1997 MOE adjustment. This could wait until the budget year, or longer. Consequently, we believe the proposal to reduce General Fund support for CalWORKs by decreasing the TANF reserve should be considered during the regular budget process for 2001-02 rather than be "rushed through" in the current year as the Governor proposes.

Analyst's Recommendation. We recommend that the Legislature take necessary action to ensure that the decision about any General Fund savings resulting from the 1997 MOE reduction is moved into the 2001-02 budget process. Adopting this approach will give the Legislature time to deliberate fully on its priorities with respect to General Fund support for CalWORKs and the level of the TANF reserve for future years.

Moving the decision about whether to reduce General Fund spending because of MOE relief into the budget year can be achieved in two different ways. First, if the Legislature rejects the urgency legislation proposal, such an action would automatically move the decision into the budget year. If, however, the Legislature approves the urgency legislation proposal, we recommend that such legislation be amended to prohibit the expenditure of the resulting TANF savings during the current year. This will effectively move the policy decision about any General Fund savings into the 2001-02 budget process.

Advance Drawdown of TANF Funds May Not Comply with Federal Law

The U.S. Department of Health and Human Services issued a program instruction clarifying that states may not draw down federal Temporary Assistance for Needy Families (TANF) funds prior to their immediate expenditure. California's practice of drawing down county performance incentive funds may not be consistent with this instruction. Thus the state may be required to return some TANF funds along with any interest that may have been earned. We recommend that the department provide an estimate at budget hearings on the potential interest liability and report on how it will comply with the federal instruction.

The Administration for Children and Families, U.S. Department of Health and Human Services (DHHS), which administers the TANF program, issued a program instruction notice on January 2, 2001, regarding the draw-down of TANF funds in advance of a state's immediate need to expend the funds. The instruction indicates that TANF funds, which are subject to the Cash Management Improvement Act (CMIA), shall be advanced only when they are immediately required for program purposes. The notice further indicates that states or their grantees (including counties) that have violated the draw-down rules must return the overdrawn TANF funds along with any interest earned on the funds.

California's practice of paying counties performance incentives when they are earned, rather than when they will be used for program purposes, may not be consistent with CMIA and DHHS regulations. Accordingly, we recommend that DSS report at budget hearings on (1) the estimated cost of refunding the interest earned on TANF funds that may have been drawn down prematurely and (2) what steps it will take to comply with the federal instruction.

Mental Health and Substance Abuse Spending Below Appropriations

The California Work Opportunity and Responsibility to Kids legislation requires that counties provide for the treatment of substance abuse or mental health problems that may prevent a recipient from becoming self-sufficient. The Governor's budget allocates $109 million to the counties for substance abuse and mental health treatment services in 2001-02, an amount virtually identical to the current-year allocation. Because counties have historically been unable to fully expend their substance abuse and mental health treatment funds, we withhold recommendation on the proposed appropriation for 2001-02 pending receipt of additional data on current-year spending.

Background. National evaluation studies, as well as information from California counties and other states, suggest that 20 percent to 30 percent of CalWORKs recipients may have a substance abuse or mental health diagnosis (or, in some cases, a "dual diagnosis"). The CalWORKs legislation requires that, to the extent funding is available, counties provide for the treatment of substance abuse or mental health problems that limit a participant's ability to make the transition from welfare to work or retain long-term employment. The legislation requires county welfare departments to collaborate with county alcohol and drug departments to coordinate assessment and treatment. The legislation also stipulates that available mental health services must include assessment, case management, and treatment services.

Each year since 1998-99, the budget has included funding for both substance abuse treatment and mental health services. This funding is counted toward the state MOE requirement.

Governor's Proposal. The Governor proposes an appropriation for 2001-02 of $55 million for substance abuse treatment and $54 million for mental health treatment, for a total of $109 million. The Governor proposes an additional $1.7 million from the CalWORKs budget for mental health and substance abuse treatment for Native American health clinics.

Prior-Year Spending Below Appropriations. In 1998-99, counties were allocated $85 million for substance abuse and mental health treatment (see Figure 3). However, counties spent only $21 million, or 25 percent of available funds. With the expectation that counties would fully implement their treatment services in 1999-00, $118 million was appropriated for substance abuse and mental health treatment in 1999-00. However, counties spent only $68 million. Specifically, counties claimed only 62 percent of their allocation for substance abuse ($38 million out of $61 million) and only 52 percent of their mental health allocation ($30 million out of $58 million).

Figure 3

County Expenditures of CalWORKs Mental Health and Substance Abuse Treatment Funds

(Dollars in Millions)

	Mental Health			Substance Abuse		
		Expenditures			Expenditures	
	Appropriation	Amount	Percent	Appropriation	Amount	Percent
1998-99	$25.0	$11.2	44.9%	$59.7	$10.0	16.8%
1999-00[a]	57.7	29.8	51.7	60.5	37.6	62.1
2000-01[b]	54.1	4.6	8.6	54.8	7.0	12.7

[a] Does not include supplemental claims which may accrue through March 2001.
[b] Expenditures through September 2000.

Spending in 1999-00 varied widely among counties. In terms of the mental health funding, for example, 23 counties spent more than 90 percent of their allocation (with 11 counties spending above their allocation), while 28 spent less than 50 percent of their allocations. In fact, nine counties spent less than 10 percent of available funds. Spending on substance abuse followed a similar pattern.

Current-Year Spending Uncertain. The current-year appropriation for substance abuse and mental health services is $109 million ($55 for sub-

stance abuse and $54 for mental health). Expenditure data from the first quarter indicate that counties have spent only $12 million, or 11 percent of their current-year allocation. Whether this is indicative of a trend in the current year is uncertain. Given the large number of counties that under-spent their allocations in the prior year, it may be that they are continuing to spend below their allocations in the current year, despite technical assistance from the department and efforts to disseminate best practices information. Any unspent funds would ultimately revert and result in an increase in the TANF reserve.

On the other hand, first quarter data are typically low relative to later quarters and, therefore, do not provide a reliable estimate of full-year spending. Additionally, current-year spending is 66 percent higher than first quarter spending in the prior year. If counties continue to spend at this higher rate for the rest of the year, they would expend the entire 2000-01 allocation.

Proposition 36 Funding Adds to Uncertainty. In November, California voters approved Proposition 36, the "Substance Abuse and Crime Prevention Act of 2000." The measure provides $60 million (General Fund) in the current year and $120 million annually through 2005-06 to counties to pay for substance abuse treatment for specified adult offenders. The effect of Proposition 36 on CalWORKs spending for mental health and substance abuse treatment is uncertain.

On the one hand, to the extent that counties use Proposition 36 funding for eligible CalWORKs recipients, counties may use less of their CalWORKs allocation for substance abuse treatment services. On the other hand, as counties invest their Proposition 36 allocations in new program infrastructure, the additional treatment capacity may enable counties to spend their full CalWORKs substance abuse allocations. This may be the case, for example, in counties that have cited lack of capacity as a barrier to spending their full allocation.

Finally, to the extent that counties use the Proposition 36 funds to provide dual diagnosis treatment, the measure may impact counties' expenditures of their CalWORKs mental health allocations as well. (Please see "Crosscutting Issues" in this chapter for our analysis of Proposition 36.)

Withhold Recommendation on Governor's Proposal. Given the uncertainty of current-year spending for substance abuse and mental health treatment services, we withhold recommendation on the Governor's proposal to appropriate $109 million for these services in 2001-02. We will continue to monitor spending in the current year. Based on additional quarterly data, we will advise the Legislature about potential savings in the current year, as well as options for the budget year.

Child Care Shortfall

The Governor's budget provides only limited funding for child care for former California Work Opportunity and Responsiblity to Kids recipients who have been off aid for two years or longer.

The CalWORKs Child Care. The CalWORKs child care program is delivered in three stages. Stage 1 is administered by county welfare departments and begins when a participant enters CalWORKs. Participants transition to Stage 2, which is administered by the State Department of Education (SDE), once their situations become stable as determined by the counties. Participants can stay in Stage 2 while they remain on CalWORKs and for up to two years after they leave CalWORKs. Stage 3 refers to the broader subsidized child care system administered by SDE that serves both former CalWORKs recipients and working poor families who have never been on CalWORKs. Because there typically are waiting lists for Stage 3, in 1997 the Legislature created the Stage 3 "set-aside" in order to provide continuing child care for former CalWORKs recipients who are unable to find "regular" Stage 3 child care once they "time-out" of Stage 2.

Governor's Budget. The Governor's budget for the Stage 3 set-aside only provides funding for former CalWORKs recipients who will time-out of Stage 2 during the one month of July 2001; funding is not provided for those who will time-out during the rest of the budget year. The department has estimated that this results in a funding shortfall of about $61 million. In our analysis of the Department of Education's child care programs, we recommend using additional federal funds to backfill the shortfall. (Please see the "Education" chapter of this *Analysis*.) We note that if this shortfall is not addressed, it may result in former recipients returning to CalWORKs due to a lack of child care.

Welfare-to-Work Match Deadline Extended

California's remaining match obligation for the U.S. Department of Labor Welfare-to-Work grants is $89 million. Pursuant to recently enacted federal legislation, California's deadline for expending its federal grant and the required state matching funds has been extended from July 2002 to July 2004. We recommend that proposed spending for the Welfare-to-Work match be spread equally over the next three state fiscal years to take advantage of the extension. This would result in a General Fund savings of $59 million in 2001-02. (Reduce Item 5180-102-0001 by $59 million.)

The U.S. Department of Labor provides states with Welfare-to-Work grants to serve low-income persons with specific barriers to employment. States must provide a $1 match for every $2 of Welfare-to-Work grant funds awarded. Although the Employment Development Department administers the federal grant, state matching funds are included in the DSS'

budget and are appropriated to county welfare departments as part of the CalWORKs program.

California has received two Welfare-to-Work grants totaling $367 million. At the time the Governor's budget was prepared, it was assumed that the second grant ($177 million) would expire by July 2002. The budget, therefore, assumes that California would expend its remaining $89 million state match obligation in the budget year. However, pursuant to recently enacted federal legislation, California's deadline for expending the second grant has been extended to July 2004.

Consequently, we recommend that proposed spending for the Welfare-to-Work match be spread equally over the next three state fiscal years (about $29.5 million each year). Thus match spending in 2001-02 would be $29.5 million, resulting in a savings of $59.1 million. We believe this approach would not have negative program impacts, as California has had difficulty fully expending its Welfare-to-Work appropriations in prior years.

We note that if our recommendation is adopted, the department would need to increase the county allocations for employment services accordingly. This is because, as discussed below, the Welfare-to-Work matching funds are used as a partial offset to employment services allocations.

Welfare-to-Work Funds Should Be Incorporated Into County Budgeting Process

Because counties may use Welfare-to-Work funds to pay for California Work Opportunity and Responsibility to Kids employment services, the budget reduces county funding requests by $142 million, even though in the prior year most counties' budget requests had already accounted for these funds. To avoid a potential double reduction in employment services funding, we recommend that the May Revision address this issue.

Background. Pursuant to Chapter 147, Statutes of 1997 (AB 1111, Aroner), the budget for CalWORKs employment services is based on counties' expenditure plans. (For a full discussion of the county budgeting process, please see our report, *Improving CalWORKs Program Effectiveness by Changing the Employment Services Budget Process*.) In addition to their employment services allocation, counties have access to other sources of funds for employment services, including the federal Department of Labor Welfare-to-Work funds and the required state matching funds.

Governor's Budget. The Governor's budget recognizes the Welfare-to-Work funds as a funding source available to counties for CalWORKs services, and therefore reduces the counties' allocation by $142 million ($79 million in federal Welfare-to-Work funds and $63 million in state

matching funds). However, in 2000-01, most counties had already accounted for the Welfare-to-Work funds in developing their employment services expenditure plans. We expect counties to do the same in the budget process for 2001-02, in which case the $142 million reduction would represent a "double reduction."

Analyst's Recommendation. With respect to the Welfare-to-Work funds, we recommend that the budget process be changed as follows. First, counties would specifically identify how they plan to use both the federal Welfare-to-Work funds and the state matching funds to serve their CalWORKs clients. In making this identification, counties would note any barriers or limits on using these funds. All of this information would be incorporated into the counties' budget requests. During their review process, DSS would then determine if the proposed county use of the federal funds and state matching funds were "reasonable" and "consistent" with CalWORKs purposes. We believe this approach will result in county allocations that correctly reflect the use of available funds for employment services. Finally, we recommend that the May Revision address this issue.

Over Half of Single-Parent Adults Will Reach Federal Time Limit in 2001-02

The department estimates that by June 2002, nearly 60 percent of single-parent adults in the California Work Opportunity and Responsibility to Kids (CalWORKs) program will reach their federal time limit. Because the CalWORKs program began 13 months after the start date of the Temporary Assistance for Needy Families program, assistance to these families will be funded with state-only funds. If trends continue, approximately 80,000 families could face grant reductions in July 2003.

Federal Time Limit. The federal welfare reform legislation of 1996, which created the TANF block grant, established a lifetime limit on federal assistance. Specifically, states may not use TANF funds to provide assistance to families in which an individual has already received a cumulative total of 60 months of assistance (beginning December 1996). However, a state may exempt up to 20 percent of its caseload from the federal time limit for "hardship." States that use their own funds for families who have reached the federal time limit may count such expenditures towards their MOE requirement.

CalWORKs Time Limit. Generally, under CalWORKs legislation, able-bodied parents or caretaker relatives may not receive cash assistance for more than 60 months. However, their children remain eligible, in which case assistance would be provided with state-only funds, countable toward the MOE requirement. Pursuant to federal legislation, California

may exempt up to 20 percent of the caseload from the time limit for hardship reasons, as determined by the county (for example, if an adult is determined to be incapable of maintaining employment).

Cases Will Be Shifted to State-Only Program. The CalWORKs adults will begin reaching their TANF time limit in December 2001. Because the CalWORKs program began in January 1998, 13 months after the federal TANF start date, adults who will reach their federal 60-month time limit in 2001-02 are eligible to receive CalWORKs for an additional 13 months. Assistance for such cases would be funded with state-only funds.

Governor's Estimates. The Governor's budget projects that by June 2002, a cumulative total of 139,000 adults, or 59 percent of all single-parent adults on the CalWORKs caseload, will have reached their federal 60-month time limit. Assuming that 20 percent of these adults will be exempted from the federal time limit, the department estimates that approximately 92,000, or 39 percent of single-parent adults, will be funded exclusively with state-only funds.

State Time Limit Approaching. If the same group of adults who will have reached their federal time limit by June 2002 remain on CalWORKs, about 80,000 families may face a grant reduction in July 2003 (this figure assumes some families will lose eligibility due to the youngest child reaching age 18).

Legislative Oversight: Cal-Learn Final Report Overdue

The department has not submitted a legislatively mandated report on the Cal-Learn program due July 1, 2000. We recommend that the department report at budget hearings on the status of the report and on its findings and recommendations.

Established in 1994 as a five-year federal demonstration project, the Cal-Learn program is designed to assist pregnant and parenting teens receiving CalWORKs to graduate from high school or its equivalent. The program provides intensive case management, payments for educational expenses and supportive services such as child care and transportation, as well as bonuses and sanctions based on academic performance. Participants may earn bonuses when they achieve satisfactory grades and upon graduating, while participants who do not make satisfactory progress are subject to a $100 sanction per report card period. Chapter 902, Statutes of 1998 (AB 2772, Assembly Committee on Human Services), made Cal-Learn a permanent program supported by the General Fund and TANF.

Current law requires the department to provide the final Cal-Learn report to the Legislature by July 1, 2000. At the time this analysis was prepared, the department had not submitted the report. We recommend

that the department report at budget hearings on the status of the final report and on its findings and recommendations.

Increase County Flexibility to Assist Working Recipients

By requiring recipients to enter community service after two years on aid, current law limits county flexibility in delivering services most likely to assist California Work Opportunity and Responsibility to Kids recipients in achieving self-sufficiency. We recommend enactment of legislation to give counties the option to provide employment services for more than two years so long as participants work at least 20 hours per week. We believe this approach will enhance program effectiveness for recipients who are working because counties are in the best position to judge whether employment services or community service offers the best approach for long-term self-sufficiency.

Background. The CalWORKs program requires parents to participate in employment or welfare-to-work activities for a specified number of hours per week (single parents must work 32 hours and two-parent families must work a combined 35 hours). Recipients who are unable to find employment after an initial job search are referred for an assessment of their work skills and any employment barriers. Following assessment, the recipient signs a welfare-to-work plan, which specifies the work activities and employment services in which the recipient will participate, as well as the supportive services the recipient will be provided (including case management, child care, or personal counseling). Employment services include vocational education and training; adult basic education; and mental health, substance abuse, and domestic violence services. The primary purpose of employment services is to enable recipients to obtain employment or to advance in their current job, so that they can leave CalWORKs and become self-sufficient for the long term.

The CalWORKs legislation has two separate time limits for adult recipients. Generally, adults are limited to 60 months of grant payments and 18 to 24 months of employment services. Once the welfare-to-work plan is signed, the participant's employment services time limit begins. After a cumulative period of 18 months on aid, or, at county option, 24 months, the participant must meet his or her weekly participation mandate (32 or 35 hours) either through unsubsidized employment, community service, or a combination of the two. After the 18- or 24-month time limit, employment services may only be offered in very limited circumstances. For example, education or training may be provided if it is required for the participant's community service placement. (Months in which a recipient is exempt from participation, or is sanctioned for noncompliance, do not count toward the employment services time limit.)

The Fair Labor Standards Act (FLSA). The Department of Labor believes that under FLSA, CalWORKs recipients participating in community service are considered employees and, therefore, must be compensated at the minimum wage. This means that a recipient's monthly hours of required participation in community service may not exceed the amount determined by dividing his/her grant plus his/her food stamp benefit by the minimum wage. As a result, smaller families with relatively low monthly grants cannot be required to participate in community service for the full 32 or 35 hours required by CalWORKs. Instead, they have to meet their work requirement with other work activities, such as employment services.

Figure 4 shows the maximum number of hours per week that nonworking recipients can be required to participate in community service activities. As the figure illustrates, two- and three- person families are unable to meet their participation requirements through community service activities alone. These families are required to participate in other welfare-to-work activities, including education or job training, to meet the balance of their work requirement.

Figure 4

Maximum Hours Per Week of Community Service

Region/Family Size	Combined CalWORKs Grant[a] Plus Food Stamp Benefit	Maximum Hours Per Week at Minimum Wage[b]	Weekly Hours Left to Fill Participation Mandate[c]
High-Cost Counties			
2 persons	$740	25	7
3 persons	915	31	1
4 persons	1,079	37	None
5 persons	1,222	42	None
Low-Cost Counties			
2 persons	$725	24	8
3 persons	897	30	2
4 persons	1,058	36	None
5 persons	1,198	41	None

[a] Maximum grant levels effective October 1, 2001.
[b] Minimum wage of $6.75 effective January 1, 2002.
[c] Assumes 32-hour per week participation mandate for single parents.

The Role of Community Service. We believe community service is an important component of the CalWORKs participation mandate, as it pro-

vides recipients an opportunity to gain valuable work experience prior to reaching their lifetime limit on cash assistance. This is especially true for recipients with limited or no work experience during their first 18 to 24 months on aid. However, we have identified two concerns with how current policy affects recipients who are working at least 20 hours when they reach their services time limit.

Current Policy Raises Cost-Effectiveness Concerns. Current law precludes counties from permitting *working* recipients to complete their participation mandate with education or training once they reach their services time limit (18 to 24 months). Thus, for example, after reaching the employment services time limit, a participant who was working for 20 hours and taking vocational education classes for the remaining 12 hours of his/her 32-hour participation mandate would instead be required to participate in community service activities for those 12 hours. Substituting a community service assignment for the employment services may be counter-productive to that participant ultimately reaching self-sufficiency. This may be true, for example, in cases where a working recipient is diverted from a successful education or training program to community service. To the extent this policy results in some CalWORKs recipients staying on assistance longer than they otherwise would, it may result in long-term costs that could be avoided.

Additionally, while not providing employment services to such recipients results in savings, there are offsetting costs involved in providing community service activities. Indeed, the costs involved in arranging transportation and child care for limited-hour community service activities may outweigh the public benefit associated with those activities.

Current Policy Raises Equity Concern. Under current law, some working and nonworking families are treated differently upon reaching their employment services time limit. After participating in community service for the maximum number of hours allowed by FLSA, certain small nonworking families can receive education or training services. Conversely, working families cannot receive such services to fulfill their participation mandate. Instead, they are required to meet their mandate with additional hours of community service. This creates a perverse incentive by "rewarding" small nonworking families with the opportunity to receive education and training in addition to their community activities, while preventing working families from receiving such services.

Analyst's Recommendation. Given the 60-month lifetime limit on cash assistance, we believe imposing a time limit on employment services may be necessary to move recipients into full-time work and, therefore, closer to self-sufficiency, as quickly as possible. As discussed above, however, the current policy raises several concerns for *working* recipients.

For working recipients who reach their employment services time limit, we believe that counties are in the best position to judge what mixture of employment, education or training, or community service is most likely to result in long-term self-sufficiency. Current policy, however, limits counties' flexibility to provide the services they deem most appropriate. We believe it makes more sense to give counties the option to provide employment services so long as a participant is *working* at least 20 hours a week. By requiring 20 hours of unsubsidized employment, this approach would be consistent with the CalWORKs policy to move recipients into full-time work as quickly as possible. This approach would also mean that participants who go to work full-time after signing their plan, and do not receive any employment services during their first 18 to 24 months on aid, would not be forfeiting their opportunity to meet the balance of their participation mandate with employment services if needed in the future.

FOSTER CARE

Foster care is an open-ended entitlement program funded by federal, state, and local governments. Children are eligible for foster care grants if they are living with a foster care provider under a court order or a voluntary agreement between the child's parent and a county welfare department. The California Department of Social Services (DSS) provides oversight for the county-administered foster care system. County welfare departments make decisions regarding the health and safety of children and have the discretion to place a child in one of the following: (1) a foster family home (FFH), (2) a foster family agency (FFA) home, or (3) a group home.

The *2001-02 Governor's Budget* proposes expenditures totaling $1.6 billion from all funds for foster care payments. This is an increase of $92 million, or 6 percent, over estimated current-year expenditures. The budget proposes $413 million from the General Fund for 2001-02, which is an increase of $25 million, or 7 percent, compared to 2000-01. Most of this increase is due to the proposed foster care cost-of-living-adjustment (COLA). The caseload in 2001-02 is estimated to be approximately 78,000, a decrease of 4 percent compared to the current year. Most of this decrease is due to child exits from foster care to the Kinship Guardianship Assistance Program, which is part of the California Work Opportunity and Responsibility to Kids program.

FOSTER CARE LENGTH OF STAY

Federal and state government policies generally view foster care as a temporary, not long-term, solution when children are removed from an abusive or neglectful home. Generally, the longer a child spends in foster care, the less time he or she spends in a permanent living arrangement. Our review indicates that (1) children stay longer in foster family agencies (FFAs) than other placement arrangements and (2) emotional and/or behavioral differences of FFA children do not explain the longer stay. We recommend enactment of legislation to pilot test a change in FFA rates intended to provide an incentive to accelerate FFA reunification and adoption efforts.

Permanency for Foster Youth

Federal Direction. In recent years, there has been an increased emphasis by both the state and federal governments to reduce the length of time children spend in foster care. This trend toward reducing the length of stay reflects concern about the dramatic growth in the number of children in foster care and their need for permanent, stable families. Pursuant to the Federal Adoption and Safe Families Act of 1997 (PL 105-89), California is required to file a petition to terminate parental rights on behalf of children who have been in foster care for 15 out of the most recent 22 months. Under this policy, the longer a child is in foster care, the less likely it is that he or she will be reunified with his or her family of origin. The goal of this policy is to ensure that children do not "drift" into foster care, but rather are moved to a permanent, stable setting. This could be reunification with the family of origin or an adoptive family.

Caseload and Costs Grow When Children Remain in Foster Care. The length of time youth spend in foster care affects government by increasing (1) the foster care caseload, (2) county workloads, and (3) total costs. From 1989 through 1999, the foster care caseload increased almost 70 percent. A portion of this growth was due to an increasing number of children entering foster care. A majority of the increase, however, was due to children remaining longer in foster care.

Increases in the foster care caseload affect local government by increasing the administrative and clinical workload of county workers. Workload increases result in costs to all levels of government. Foster care costs are shared by the federal, state, and local governments. Approximately 50 percent of costs are paid by the federal government. The remaining nonfederal costs are shared 40 percent by the state and 60 percent by the counties. The *2001-02 Governor's Budget* proposes expenditures totaling $1.6 billion from all funds for foster care payments.

Children Remain in FFA Placements Twice as Long as Other Placements

Range of Foster Care Placements. Following the investigation of child abuse or neglect, county welfare departments make decisions regarding the health and safety of children and have the discretion to place a child in one of three settings. These are: (1) a FFH (which costs $405 to $569 monthly plus "specialized care increments" for children needing special support services); (2) a FFA home (which costs $1,467 to $1,730 monthly); or (3) a group home (which costs $1,352 to $5,732 monthly). The FFHs must be located in the residence of the foster parent(s), provide services to no more than six children, and be licensed by DSS. The FFAs, created as an alternative to group homes, are nonprofit organizations that recruit foster

parents, certify them for participation in the program, and provide training and support services. Group homes may vary from small, family-like homes to larger institutional facilities and generally serve children with greater emotional or behavioral problems who require a more restrictive environment.

In theory, the respective foster care rates were designed to reflect the needs of children. Those placed in FFHs have the fewest needs for services and support, while children placed in group homes are the most in need of intensive services and supervision. The FFAs, positioned between FFHs and group homes, were created to provide "intensive treatment" to youth who might have otherwise been placed in a group home.

Comparing Length of Stay. Length of stay is a key performance measure of the foster care system. It shows how well the goal of permanence for children has been met. Figure 1 shows the median time in foster care for children who entered the system between 1993 and 1999, by placement type. As shown in the figure, those children for whom a FFA home was their primary placement stayed in care for almost two years, or twice as long as youth in nonrelative FFHs. As discussed above, increased time spent in foster care is generally considered undesirable, as children are less likely to be reunified with their family of origin or adopted.

Do Youth Characteristics Explain Differences in Foster Care Length of Stay? Longer stays in FFA homes might be justified if research indicated that the children in FFAs need more services prior to reunification or adoption than do children in FFHs. However, available research does not demonstrate such differences. In a report recently released by DSS, few differences between FFH and FFA youth populations were identified. County child welfare administrators surveyed in this report generally indicated that (1) behavioral issues, (2) mental health diagnoses, and (3) need for reunification services were similarly important factors in the placement of foster youth in either a FFH or FFA. We note that a legislatively mandated study is currently underway to evaluate county placement patterns, child outcomes, and oversight of FFHs and FFAs.

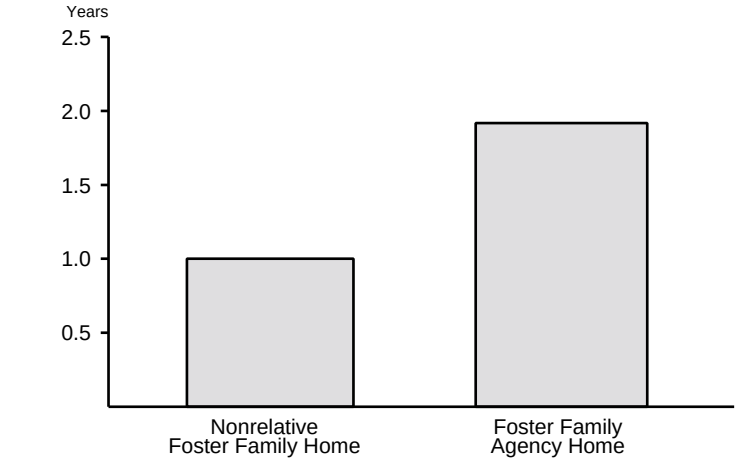
The FFA Placements Are the Fastest Growing Component of Foster Care

From 1989 through 1998, the number of children placed in FFAs increased tenfold, from 2 percent to approximately 23 percent of the total foster care population, while the proportion of FFH placements declined slightly. This trend has been accompanied by the longer length of stay for children in FFA placements. Below, we discuss how (1) the growth in FFA placements has been driven largely by a shortage in FFH slots, not children's need for FFA services; and (2) the FFA rate structure may provide an incentive to keep children in foster care longer.

Figure 1

Comparing Length of Stay[a] in Foster Family Homes And Foster Family Agency Homes

1993 Through 1999 Child Entries



[a] Based on data from University of California Child Welfare Research Center.

What Caused the Growth in FFA Placements? Local child welfare and probation officers have indicated during our field visits that counties frequently use FFA placements for children who, according to the county's assessment, would be more appropriately placed in a FFH if such facilities were available. This finding was recently confirmed by a DSS survey of county child welfare departments, discussed above. In this survey, over 40 counties cited a lack of FFH resources as a primary reason for FFA placement.

The FFA Rates May Create Fiscal Incentive to Increase Time in Foster Care. The FFA rate is more than three times the rate paid to FFHs, as shown in Figure 2 (see next page). In theory, the higher rates paid to FFAs reflect (1) their function as alternatives to more expensive group homes and (2) the cost of services and support for children with greater emotional or behavioral issues than those children in FFHs. However, as discussed above, available research does not show such differences between children in FFHs and FFAs. We believe that the FFA rate, including about $900 per child, per month for services and administration, potentially creates a fiscal incentive for FFAs to keep children in foster care longer.

Figure 2

Comparison of Foster Family Home and Foster Family Agency Rates

Age of Child	FFH Rate	Foster Family Agency Rate			Difference From FFH Home Rate
		Paid to Family	Treatment and Administration	Total	
0 to 4	$405	$595	$872	$1,467	$1,062
5 to 8	441	629	895	1,524	1,083
9 to 11	471	657	913	1,570	1,099
12 to 14	521	708	947	1,655	1,134
15 to 18	569	753	977	1,730	1,161

Reducing Children's Time in FFA Placements

As described above, children stay longer in FFAs than other placements, and these longer stays do not appear to be related to the needs of the FFA children. Given that FFAs cost more than FFHs, we discuss an approach to decreasing the length of time children spend in FFA homes by changing the FFA payment structure.

Adjusting FFA Treatment Rates. One adjustment that would provide incentives for FFAs to accelerate reunification and adoption efforts would be to gradually decrease the amount paid to FFAs for services and administration. While the rate paid to the FFA foster *family* would remain the same over time, the portion of the rate paid to the FFA *organization* for services and administration would decrease the longer a child remained in care. For example, the monthly services and administration component per child could be reduced by one-quarter (between approximately $220 and $250), incrementally, after each six-month period. Figure 3 shows an example of this incremental reduction in the treatment rate. Under this example, treatment and administrative costs would be funded at the full rate for the first six months a child is in placement. The funding would continue, at a reduced rate, for up to two years while a child remains in care. A similar step down of the treatment and administration component would be applied to all of the age-adjusted rates. (We note that many of the youth in FFAs are either reunified with their family of origin or adopted before two years has passed.) This tapering of the treatment and administration component of the rates could create an incentive system by encouraging FFAs to move children toward reunification or adoption more quickly. However, a decrease in rates could reduce the number of participating FFAs.

Figure 3

Example of Incremental Foster Family Agency Rate Reduction

Child 5 to 8 Years of Age

Time in Placement	Foster Family Agency Rate		
	Paid to Family	Treatment and Administration	Total
0-6 months	$629	$895	$1,524
7-12 months	629	671	1,300
13-18 months	629	447	1,076
19-24 months	629	223	852
over 24 months	629	—	629

Analyst's Recommendations. We recommend enactment of legislation to conduct a three-year pilot project whereby FFA treatment rates would incrementally decrease over time. Specifically, the treatment and administration component of the rate would decrease by one-quarter every six months, reaching zero after two years. The pilot would help identify how changes in the rates impact (1) time spent in FFAs and (2) the supply of foster care slots in up to three California counties. We further recommend that DSS conduct a study to evaluate the results of the pilot. Finally, in order to encourage participation, we recommend providing modest fiscal incentives to pilot counties to offset potential associated administrative costs. Such incentives could be in the form of block grants. The grants could be based on the county share of FFA costs.

OTHER ISSUES

Office of the Ombudsman for Foster Care

The budget proposes to convert four Foster Care Ombudsman positions from temporary to permanent, even though the department has not documented the permanent workload. We recommend retaining these positions as two-year limited term until the department can substantiate the ongoing workload.

Pursuant to Chapter 311, Statutes of 1998 (SB 933, McPherson), DSS established the Office of the Ombudsman for Foster Care to assist foster youth in resolving concerns related to their placement, care, or services. The office provides a toll-free phone service that is available 24 hours a

day, seven days a week. In addition, the office (1) conducts investigations, (2) resolves complaints, and (3) provides outreach to foster youth.

The *2001-02 Governor's Budget* proposes the conversion of four foster care ombudsman positions from temporary to permanent. However, the proposal fails to document the level of the ongoing workload. (The original justification for these positions was based on 1995-96 caseload data from the Michigan Children's Ombudsman Office.) Accordingly, we recommend retaining the positions as limited term until the department substantiates the ongoing workload.

Budget Underestimates Foster Care COLA

The cost of providing the statutory cost-of-living-adjustment to the foster family homes, foster family agencies, group homes, and related programs will be $2.4 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.

The budget proposes to provide the statutory COLA to FFHs, FFAs, group homes, and related programs effective July 1, 2001. The COLA is based on the change in the California Necessities Index (CNI) from December 1999 to December 2000. The budget, which is prepared prior to the release of the December CNI figures, estimates that the CNI will be 4.85 percent, based on partial-year data. Based on a CNI of 4.85 percent, the Governor's budget includes $69.3 million ($18.7 million General Fund) for these foster care COLAs. Our review of the final data, however, indicates that the CNI will be 5.31 percent. Based on an actual CNI of 5.31 percent, we estimate that the cost of providing the foster care COLA will be $77.3 million ($21.1 million General Fund). The administration should address this $2.4 million General Fund cost in the May Revision of the budget.

FOOD STAMPS PROGRAM

The Food Stamps Program provides food stamps to low-income persons. With the exception of the state-only food assistance program (discussed below), the cost of the food stamp coupons is borne by the federal government ($1.4 billion). Administrative costs are shared between the federal government (50 percent), the state (35 percent), and the counties (15 percent).

CALIFORNIA FOOD ASSISTANCE PROGRAM

Federal Restrictions on Benefits for Noncitizens. With respect to noncitizens, current federal law generally limits food stamp benefits to legal noncitizens who immigrated to the U.S. prior to August 1996, and are under the age of 18 or were at least 65 years old as of August 1996.

State Program for Noncitizens. Created in 1997, the California Food Assistance Program (CFAP) provides state-only funded food stamp benefits to (1) pre-August 1996 legal immigrants who are ineligible for federal benefits (generally individuals age 18 through 64), and (2) a very limited number of post-August 1996 legal immigrants whose sponsors are dead, disabled, or abusive. The CFAP purchases food stamp coupons from the federal government and distributes them to eligible recipients. Adult recipients are subject to a specified work requirement.

Chapter 147, Statutes of 1999 (AB 1111, Aroner), expanded eligibility, from October 1999 through September 2000, to legal immigrants who would be eligible for food stamps but for the fact they arrived after August 1996. Chapter 108, Statutes of 2000 (AB 2876, Aroner), extended the period of eligibility for these immigrants through September 30, 2001. The average monthly caseload for this expanded population is estimated to be 8,000 in the budget year.

Budget Proposal. For 2001-02, the average monthly caseload for CFAP is estimated to be 71,000 persons. The budget proposes an appropriation of $37 million from the General Fund for coupon purchases and an additional $15 million for administration in 2001-02. This is a decrease of $8 million from estimated expenditures in 2000-01, mostly attributable to nearly

all of the post-1996 immigrants on CFAP losing their eligibility effective October 1, 2001, pursuant to current law.

We note that $35 million of the proposed expenditures for 2001-02 counts towards meeting the federal maintenance-of-effort (MOE) requirement for the California Work Opportunity and Responsibility to Kids (CalWORKs) program. We also note that the cost of extending eligibility for the approximately 8,000 post-August 1996 immigrants added temporarily by Chapter 147 would be approximately $5 million in 2001-02 (October 2001 through June 2002) and $6 million annually thereafter.

RECENT FEDERAL CHANGES CREATE OPTIONS

The 2001 Agriculture Appropriations Act and new federal regulations together mandate several changes to the Food Stamp Program, while also providing California significant options to expand food stamp benefits for working families. We recommend that the department report at budget hearings on cost estimates for these changes and potential expansions.

Background. The Federal Food Stamp Program is administered by the U.S. Department of Agriculture's (USDA) Food and Nutrition Service. Issued as coupons, food stamps are designed to assist low-income households in purchasing the food needed to maintain adequate nutritional levels. To receive benefits, households must meet income and resource eligibility standards. However, CalWORKs recipients are automatically eligible for food stamps.

Recent Federal Changes. The Agriculture, Rural Development, Food and Drug Administration, and Related Agencies Appropriations Act for federal fiscal year 2001 (PL 106-387), hereafter referred to as the 2001 Agriculture Appropriations Act, provides states with several options to implement new eligibility rules and administrative procedures. Additionally, on November 21, 2000, USDA issued new regulations which provide states further options. The new regulations also mandate several eligibility and procedural changes, with various implementation dates. Below we discuss some of the most significant changes and options for California. We note that because the federal changes took place after the Governor's budget was prepared, the budget does not include current- or budget-year costs for any of the changes.

The Vehicle Asset Test

Eligibility for the Food Stamps Program is based on a number of factors, including the value of a household's assets. Generally, assets include such things as checking and savings accounts, investments, and vehicles.

When determining eligibility, a household's assets are added together and counted against a specified resource limit. For most households, the resource limit is $2,000.

The current rules for valuing vehicles as part of a household's assets are complex. Figure 1 illustrates the three different tests which are used to determine the value of a household's vehicles.

Figure 1

Vehicle Asset Tests—Food Stamps Program

Specified Use Exemption

- Vehicles used for certain purposes, such as transporting a physically disabled household member or producing income (such as through a delivery service), are exempt from the resource test.

Fair Market Value Test

- A vehicle's fair market value *in excess* of $4,650 is counted toward the resource limit.

Equity Test

- The amount that a household owes on a vehicle is subtracted from its fair market value to determine the vehicle's equity value, which then would be counted toward the resource limit.

Current Regulation. Currently, a household's nonexempt vehicles are subject to the following tests. Any vehicle used to go to work, training, or education, plus one vehicle per household, is subject only to the fair market value test. Any remaining vehicles are subject to a dual test: the fair market value test and the equity test. The higher result of this dual test is then counted toward the resource limit.

As a practical matter, households with vehicles subject to the dual test will only be eligible for food stamps if (1) the household has little equity in the vehicles and (2) their fair market value is well under $6,650 (the $4,650 exclusion plus the $2,000 resource limit).

New Regulations. The new regulations change the current rules in two important ways, with the result of exempting more vehicles completely and excluding more vehicles from the dual test. First, vehicles that could be sold for no more than $1,500 are exempted altogether from

the resource test. This means, for example, that vehicles in need of significant repairs might be exempt. Second, one vehicle per *adult*, rather than one per household, is exempted from the equity test and subject only to the fair market value test. Any remaining vehicles are subject to the dual test.

By exempting more vehicles completely and excluding more vehicles from the dual test, the new regulations make it somewhat easier for multiple-vehicle households to receive food stamps. However, the fair market value for all nonexempt cars must still be well under $6,650 to avoid hitting the $2,000 cumulative resource limit.

According to federal regulations, these changes must be implemented by June 1, 2001 for new cases. Current cases will be affected by the changes when they are recertified for food stamp eligibility (usually once every 12 months). We note that recent action by the new federal administration may delay this requirement until August 1, 2001.

Fiscal Impact. By making more households eligible for food stamps, the new regulations will result in additional federal food stamp benefits to California families, as well as additional state administrative costs associated with higher food stamp caseloads. The regulations will also result in higher caseloads in both CFAP and the CalWORKs program, since state law conforms the asset rules in these programs to the federal food stamp rules. California will bear the entire CFAP cost increase, while costs to CalWORKs will be paid with available Temporary Assistance for Needy Families (TANF) and state MOE funds.

The changes will result in one month of costs in the current year (for June 2001), and full-year costs in the budget year and thereafter. Because there is limited data on the value of recipient households' vehicles, it is difficult to estimate how many households will be affected by the changes. At the time this analysis was prepared, the department had not prepared specific cost estimates for this change.

However, the department has developed an estimate that can serve as an *upper bound* limit for the purposes of projecting the cost of the new regulations. Based on that estimate, total current-year state and county costs associated with the regulatory changes are estimated to be less than $500,000. Budget-year costs are estimated to be up to $35 million ($34 million for CalWORKs grants and administration, and $1 million for food stamps administration).

The Alternative Vehicle Allowance

The 2001 Agriculture Appropriations Act gives states the option of conforming the food stamp vehicle rules to their TANF vehicle rules, even if by doing so this would make more families eligible for food stamps. Under this option, states could make their TANF vehicle rules more gen-

erous than current food stamp rules, and apply the more generous rules to all food stamp recipients, including those not receiving cash assistance. States may implement the alternative vehicle allowance any time after July 1, 2001. We note that over half the states have already adopted TANF rules that are more generous than the food stamp rules. California, by contrast, has linked the CalWORKs rules to the food stamp rules.

Options for California. There are three approaches the Legislature could adopt for vehicle allowances. The first approach is to simply retain current CalWORKs and food stamp vehicle rules. As noted below, one advantage of this approach is that it would result in no additional state or county costs. The second approach is to increase the CalWORKs fair market value exclusion for vehicles (currently $4,650). Finally, the third approach is to exempt one or more vehicles entirely from the resource test, regardless of how the vehicle is used. Both the second and third approaches would result in additional state and county costs, as discussed below.

There are two primary advantages to both the second and third approaches. First, both would decrease the administrative costs associated with complicated vehicle valuations. Second, both approaches would enable more working poor families with vehicles to receive food stamp benefits and still keep their vehicles to look for a job or get to work. In areas with poor public transportation systems, reliable vehicles often are a critical component in the transition from welfare to work, as they provide recipients greater access to jobs in outlying areas and may make it easier to retain employment. Allowing CalWORKs families to keep or invest in a reliable vehicle may therefore help more recipients become self-sufficient for the long term.

We note that when the Food Stamps Act of 1977 established the fair market value test for vehicles, $4,000 was considered to be the value of a modest, reliable vehicle; anything in excess of $4,000, therefore, was to be counted towards the household's asset limit. Since 1977, the limit has been adjusted just once, to $4,650. Had that figure kept pace with inflation, it would be $12,850 today.

The primary disadvantage of the second and third approaches is the increased public costs associated with potentially higher CalWORKs and food stamp caseloads.

Fiscal Impact. The most significant impact of the second or third approach would be the federal cost of providing additional food stamp benefits for California families. The second largest cost would be in the CalWORKs program, and would be paid for with available TANF and state MOE funds. Adopting the second or third approach would also result in additional food stamp administrative costs, as well as increased CFAP costs, since CFAP rules conform to the food stamp rules. To the

extent modifying the vehicle rules simplifies the resource calculation for all three programs, there may be partially offsetting administrative savings associated with such a change.

Of the three courses of action discussed above, the third, eliminating one or more vehicles from the asset test, would result in the greatest costs (which would be partially offset by the greatest amount of administrative savings). The department has estimated that the costs of exempting one vehicle would be $35 million (including $34 million for CalWORKs, $1 million for food stamps, and unknown but modest costs for CFAP). The second option, raising the fair market value test limit, would result in lower, though unknown costs.

The Transitional Benefit Alternative

The November 21, 2000 regulations give California the option of continuing food stamp benefits to former CalWORKs recipients for up to three months after they leave cash assistance. Under this option, households would receive the same level of food stamps they received just prior to leaving CalWORKs (or, if the household would lose income as a result of leaving CalWORKs and would therefore qualify for a higher benefit level, the benefits would be frozen at the higher level). Families leaving CalWORKs because of program violations would not be eligible for the transitional benefits.

The purpose of the transitional benefit allowance is to provide automatic assistance to families during the transition period from welfare to work, thereby increasing income stability and decreasing the likelihood of returning to cash assistance. The transitional benefits would affect three types of households. The first type are households that would remain eligible for food stamps after leaving CalWORKs, but would not apply for them. The second type are households that would otherwise be income ineligible for food stamps when they leave CalWORKs. Finally, the third type are households that are already receiving food stamps after leaving CalWORKs. The only impact on these households would be a reduction in their reporting requirements for the transitional period.

Based on rough estimates of the percentage of CalWORKs leavers who are income ineligible for food stamps and the percentage of eligible households who do not receive benefits, we estimate that up to 75 percent of those transitioning off CalWORKs would benefit from this option.

Fiscal Impact. Adopting the transitional benefit option would result in additional federal food stamp benefits to California families, as well as some administrative costs for both the state and counties. Additionally, to the extent that the transitional benefits would also be offered to transitioning CalWORKs recipients who received CFAP, the state would

incur benefit and administrative costs in CFAP. However, these costs are likely to be small, as the total CFAP-eligible CalWORKs caseload is approximately 2,000. At the time this analysis was prepared, the department had not estimated the state and county costs of providing this option.

Analyst's Recommendation

We recommend that the department report at budget hearings on current- and budget-year cost estimates for the mandated vehicle asset rule changes, and, to the extent possible, more precise cost estimates for the alternative vehicle allowance and the transitional benefit allowance options.

ELECTRONIC BENEFITS TRANSFER

Delays May Result in Federal Penalty

We recommend that the Department of Social Services report at budget hearings on the potential federal penalties if the state is unable to implement the food stamp Electronic Benefits Transfer system by October 2002.

The federal welfare reform legislation enacted in 1996 required all states to implement Electronic Benefits Transfer (EBT) systems for food stamps by October 1, 2002. An EBT system uses debit-card technology and retailer terminals to automate benefit authorizations, delivery, redemption, and financial settlement. Chapter 329, Statutes of 1998 (AB 2779, Aroner) required that the Health and Human Services Agency Data Center (HHSDC) provide the project management for the state's implementation of EBT technology for the Food Stamps and California Work Opportunity and Responsibility to Kids programs.

Procurement Has Taken Longer Than Expected. In October 1999, HHSDC began to procure contract services for the EBT system. The procurement was delayed, and the contract is now expected to be awarded in June 2001. Because the contract has not been finalized, HHSDC has not provided any information concerning project development and roll out. We note that based on prior schedules, current known delays suggest the system will not be completed until after the federal deadline.

Department of Social Services (DSS) Should Report on Penalty Provisions. Since full statewide implementation is now expected some time after the federal deadline, the state may incur a federal penalty. For this reason, we recommend that DSS report at budget hearings on (1) the potential amount of the penalty and how it is determined, and (2) the steps DSS is taking to mitigate a potential penalty.

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 $2.9 billion from the General Fund for the state's share of SSI/SSP in 2001-02. This is an increase of $244 million, or 9.3 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, the cost-of-living adjustment (COLA) to be provided in January 2002, and an increase in the federal administrative fee.

In December 2000, there were 333,259 aged, 21,762 blind, and 723,958 disabled SSI/SSP recipients. In addition to these federally eligible recipients, the state-only Cash Assistance Program for Immigrants (CAPI) is estimated to provide benefits to about 12,000 legal immigrants in December 2000.

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 $7.7 million above the budget estimate due to an upward revision in the California Necessities Index. These costs should be reflected in the May Revision of the budget.

Background. Pursuant to current law, the Governor's budget proposes to provide a statutory COLA in January 2002. 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 Consumer Price Index for Urban Wage Earners and Clerical Workers, or the CPI-W) 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-W, the budget includes $156.4 million for providing the statutory COLA for six months, effective January 2002.

The CNI Revised. The January 2002 COLA is based on the change in the CNI from December 1999 to December 2000. The Governor's budget, which is prepared prior to the release of the December CNI figures, estimates that the CNI will be 4.85 percent, based on partial data. Our review of the actual data, however, indicates that the CNI will be 5.31 percent.

The CPI Overestimated. The January 2002 federal SSI COLA will be based on the change in the CPI-W from the third quarter (July to September) of calendar 2000 to the third quarter of calendar 2001. The Governor's budget estimates that the change in the CPI-W for this period will be 2.1 percent. Based on our review of the consensus economic forecasts for 2001, we estimate that the CPI-W will be 2.4 percent. This increase in the CPI-W (compared to the Governor's budget) reduces the state cost of providing the statutory COLA because it effectively increases federal financial participation toward the cost of the state COLA, which is applied to the entire grant.

Cost of Providing COLA Is Underestimated. Taken together, the changes in CNI and CPI-W (in relation to the Governor's budget) increase the General Fund cost of providing the statutory COLA by approximately $7.7 million. The administration should address this issue in the May Revision of the budget.

Supplemental Security Income/ State Supplementary Program Grant Levels

Figure 1 (see next page) shows SSI/SSP grants on January 1, 2002 for both individuals and couples as displayed in the Governor's budget and adjusted to reflect the actual CNI and our estimate of the CPI-W. As the figure indicates, grants for individuals will increase by $38 to a total of $750 per month, and grants for couples will increase by $67 to a total of $1,332 per month. As a point of reference, we note that the federal poverty guideline for 2000 is $696 per month for an individual and $938 per month for a couple. Thus, the grant for an individual would be 7.8 percent above the 2000 poverty guideline and the grant for a couple would be 42 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 Projections

January 2001 and January 2002

Recipient Category	January 2001	January 2002 Governor's Budget	January 2002 LAO Projection[a]	LAO Projection Change From 2001 Amount	LAO Projection Change From 2001 Percent
Individuals					
SSI	$530	$541	$543	$13	2.5%
SSP	182	206	207	25	13.7
Totals	**$712**	**$747**	**$750**	**$38**	**5.3%**
Couples					
SSI	$796	$812	$815	$19	2.4%
SSP	469	514	517	48	10.2
Totals	**$1,265**	**$1,326**	**$1,332**	**$67**	**5.3%**

[a] Based on actual California Necessities Index increase (5.31 percent) and projected U.S. Consumer Price Index increase (2.4 percent).

Certain Legal Immigrants Face Benefit Termination

California established the Cash Assistance Program for Immigrants (CAPI) to provide state-only funded Supplemental Security Income/State Supplementary Program benefits to certain legal immigrants who are federally ineligible for benefits because of their immigration status. The component of this program that provides benefits for post-August 1996 immigrants is scheduled to sunset on October 1, 2001. This will result in approximately 2,700 recent legal immigrants losing their benefits effective October 2001. We review the history of the CAPI and provide policy options for the Legislature.

State-Only Program Established In Response to Federal Restrictions. With respect to legal noncitizens, current federal law generally limits SSI/SSP benefits to noncitizens who were (1) on aid prior to August 1996 or (2) in the U.S. prior to August 1996 and who subsequently became disabled. In response to these federal restrictions, Chapter 329, Statutes of 1998 (AB 2779, Aroner) created CAPI. This program provided state-only funded SSI/SSP benefits to aged immigrants who lived in the U.S. prior to August 1996 and a very limited number of post-August 1996 immigrants whose sponsors were dead, disabled, or abusive. As enacted, this program was to sunset on July 1, 2000.

Sunset Eliminated for Pre-August 1996 Immigrants; Temporary Program Created for Post-August 1996 Immigrants. Chapter 147, Statutes of 1999 (AB 1111, Aroner) eliminated the sunset for the then existing CAPI program that almost exclusively served pre-August 1996 immigrants. Chapter 147 also made immigrants arriving in the U.S. after August 1996 eligible for CAPI, however, such immigrants would be subject to a five-year deeming provision. Under this provision a sponsor's income would be counted when determining an immigrant's eligibility for a period of five years. This expansion for post-August 1996 immigrants was scheduled to sunset on September 30, 2000. Because of the deeming provision, the temporary expansion was assumed to have no cost.

Chapter 108, Statutes of 2000 (AB 2876, Aroner) extended through September 2001 the temporary expansion of CAPI for post-August 1996 immigrants.

The CAPI Serves More Post-August 1996 Immigrants Than Anticipated. As noted above, it was believed that the five-year deeming provision would prevent nearly all post-August 1996 immigrants from receiving CAPI benefits. However, actual data from 2000-01 indicates this is not the case. As of October 2000, there were approximately 1,200 post-August 1996 immigrants receiving CAPI. About 60 percent of these immigrants have no sponsor. With no sponsor to deem, these immigrants are eligible for CAPI. Most of the remaining 40 percent have sponsors whose income is too low to be deemed to the immigrant. The budget projects that by September 2001, there will be approximately 2,700 post-August 1996 immigrants receiving CAPI benefits. Pursuant to current law, these 2,700 legal noncitizens will lose their benefits when the expanded program sunsets on October 1, 2001.

Proposed Budget. The Governor's budget divides the CAPI budget into two components: (1) the "base" program which primarily serves pre-August 1996 immigrants and (2) the "expanded" program for post-August 1996 immigrants that sunsets on October 1, 2001. Figure 2 (see next page) shows the projected caseload and costs for the different components of the CAPI. For the base program, the Governor's budget estimates that General Fund CAPI costs will be $81.3 million in 2000-01 and $92.9 million in 2001-02. Most of this increase is attributable to caseload growth and the January 2002 COLA. For the expanded program, the budget estimates costs will be $11.2 million in 2000-01 and $4.7 million in 2001-02. Nearly all of the reduction in costs between the current and budget years is attributable to the sunset of the expanded program on October 1, 2001.

Options for the Legislature. The issue of whether to modify the sunset of the expanded CAPI program is a policy decision for the Legisla-

ture. To assist the Legislature in making this decision, we have estimated the fiscal impact of four different options.

Figure 2

Cash Assistance Program for Immigrants Budget Proposal

(Dollars in Thousands)

Program/Eligibility Category	Sunset	Estimated September 2001 Caseload	Estimated Costs 2000-01	Estimated Costs 2001-02
"Base" Program				
Pre-August 1996 immigrants	No	11,310	$80,886	$92,435
Post-August 1996 immigrants (sponsors are dead, disabled, or abusive)	No	60	429	491
"Expanded" Program				
Post-August 1996 immigrants (no sponsor or very low income sponsor)	October 2001	2,700	$11,162	$4,722
Totals		**14,070**	**$92,477**	**$97,647**

- ***Retain Current Law***. The Governor's budget proposes to follow current law, whereby an estimated 2,700 legal noncitizens would lose their benefits effective October 1, 2001. This will result in a General Fund savings of $6.5 million in 2001-02 compared to the current year.
- ***Extend Sunset for Existing Recipients Only***. As noted above, the Governor's budget estimates that approximately 2,700 post-August 1996 immigrants will be receiving expanded CAPI benefits during September 2001. Extending the sunset for *these recipients only* would result in additional General Fund costs of approximately $17.3 million in 2001-02 compared to the Governor's budget.
- ***Extend Sunset for Immigrants Who Effectively Have No Sponsor***. The $17.3 million figure noted above covers the cost of continuing benefits to the 2,700 immigrants projected to be receiving benefits during September of 2001. The Department of Social Services (DSS) estimates that this caseload is growing by approximately 100 per month. If the sunset were lifted for additional immigrants that either have no sponsor or whose sponsor has no income to deem, the General Fund cost would be approximately $20.4 million in 2001-02 compared to the Governor's budget. This is

an increase of $3.1 million in comparison to the second option discussed above which does not assume any additional post-August 1996 immigrants are added to the program after September 2001.

- ***Extend the Sunset for All Post-August 1996 Immigrants.*** Extending the program sunset for all post-August 1996 immigrants has substantial cost implications because the five-year deeming provision would no longer prevent most sponsored post-August 1996 immigrants from becoming eligible for CAPI. The deeming period begins upon entry to the U.S. For example, a sponsored noncitizen who immigrated in October 1996 would no longer be subject to five-year deeming in October 2001 and thus, would be eligible for CAPI. The DSS estimates that extending the program sunset for all post-August 1996 immigrants would result in additional costs of approximately $55.5 million in 2001-02 compared to the Governor's budget. These costs would escalate rapidly in subsequent years as more immigrants become eligible for CAPI each month. To partially control such costs, the Legislature could make CAPI eligibility contingent upon a recipient attempting to become a naturalized citizen. Once an immigrant becomes a citizen they would receive federally funded SSI/SSP, resulting in significant net state savings.

Summary. The sunset of the expanded CAPI will result in approximately 2,700 legal immigrants losing their benefits on October 1, 2001. Above we have identified four options for consideration by the Legislature for addressing this situation.

IN-HOME SUPPORTIVE SERVICES

The In-Home Supportive Services (IHSS) program provides various services to eligible aged, blind, and disabled persons who are unable to remain safely in their own homes without such assistance. An individual is eligible for IHSS if he or she lives in his or her own home—or is capable of safely doing so if IHSS is provided—and meets specific criteria related to eligibility for the Supplemental Security Income/State Supplementary Program (SSI/SSP).

The IHSS program consists of two components: the Personal Care Services Program (PCSP) and the Residual IHSS program. Services provided in the PCSP are federally reimbursable under the Medicaid program. The PCSP limits eligibility to categorically eligible Medi-Cal recipients (California Work Opportunity and Responsibility to Kids and SSI/SSP recipients) who satisfy a "disabling condition" requirement. Personal care services include activities such as: (1) assisting with the administration of medications; and (2) providing needed assistance with basic personal hygiene, eating, grooming, and toileting. The following cases are excluded from the PCSP and, therefore, receive services through the Residual IHSS program: cases with domestic services only, protective supervision tasks, spousal providers, parent providers of minor children, "income eligibles" (generally, recipients with income above a specified threshold), "advance pay" recipients (eligible for payments prior to the provision of services), and recipients covered by third party insurance.

The budget proposes $843 million from the General Fund for the IHSS program, which is an increase of 13 percent over estimated current-year expenditures. This spending growth is primarily attributable to increases in the caseload and the minimum wage.

Wage and Benefit Increases for Certain IHSS Workers

Although budget trailer bill legislation—Chapter 108, Statutes of 2000 (AB 2876, Aroner)—authorized increased state participation in specified wage and benefit increases for In-Home Supportive Services providers working in counties that have established "public authorities," the actual

wage increases provided by counties have been less than budgeted. We summarize the wage increases provided by this legislation and their potential fiscal impact.

Background. Chapter 108 authorizes the state to pay 65 percent of the nonfederal cost of a series of wage increases for IHSS providers working in counties that have established "public authorities." The wage increases began with $1.75 per hour in 2000-01, potentially to be followed by additional increases of $1 per year, up to a maximum wage of $11.50 per hour. We note that state participation in wage increases after 2000-01 is contingent upon General Fund revenue growth exceeding a 5 percent threshold. Chapter 108 also authorizes state participation in health benefits worth up to 60 cents per hour worked.

Revenue Triggers. Starting in 2001-02, state participation in the $1 hourly wage increases is contingent upon the state achieving General Fund revenue growth (excluding transfers) of 5 percent. For example, if General Fund revenues (excluding transfers) in 2001-02 exceed General Fund revenues (excluding transfers) in 2000-01 by 5 percent, state participation in a $1 wage increase is triggered in 2001-02. Similarly, if 5 percent growth is achieved in 2002-03, then participation in another $1 increase is triggered. As noted above, maximum state participation is capped at a wage of $11.50 per hour, plus 60 cents per hour for benefits. The statute also allows for a wage increase if the 5 percent revenue growth takes more than one year to accrue. For example, if revenue growth in 2001-02 was only 3 percent followed by an additional 3 percent growth in 2002-03, state participation in the $1 hourly wage increase would not occur in 2001-02 but would be triggered in 2002-03 (when cumulative revenue growth would exceed the 5 percent threshold).

Wage Increases Less Than Budgeted in 2000-01. As noted above, Chapter 108 authorized state participation in wage increases of up to $1.75 in the current year (from the $5.75 per hour minimum wage in 2000 to $7.50 per hour). The *2000-01 Budget Act* provided sufficient funds for all counties that currently have public authorities to increase wages by $1.75. However, several counties did not increase wages by the full $1.75. This results in General Fund savings of $96 million compared to the amount appropriated for 2000-01.

Outlook for 2001-02. For 2001-02, the Governor's budget makes two important assumptions. First, it assumes that revenue growth will be 3.3 percent, so no further increase in state participation in wages is triggered in the budget year. Second, it assumes that some counties will have wages and benefits below the maximums for which the state would otherwise participate. If instead, all counties were to participate at the state authorized maximums, General Fund costs would be $41.1 million greater than budgeted. If at the May Revision revenue growth is projected to grow

at least 5 percent and if all counties participated in the higher wage levels that would be triggered by higher revenues, General Fund costs would increase by about $70 million beyond the $41.1 million mentioned above.

Budget Does Not Reflect Likely Savings

The proposed budget does not reflect likely savings from (1) actual costs being lower than budgeted for certain current- and budget-year augmentations and (2) an expansion in Medi-Cal eligibility that should result in reduced costs in the In-Home Supportive Services (IHSS) program. Accordingly, we withhold recommendation on the savings of up to $5 million in the IHSS program.

In addition to the wage and benefit increases for IHSS providers working in public authorities, the *2000-01 Budget Act* also funded (1) a 3 percent wage increase for nonpublic authority IHSS workers and (2) a 10 percent increase in the contract rates for counties that contract with public and private agencies to administer IHSS. The combined General Fund support for these augmentations is $13.2 million in the current year and $16.9 million in 2001-02. As with the public authority wage increase discussed previously in this chapter, counties have not increased nonpublic authority wages or contract rates as much as was budgeted. Such savings, however, are not reflected in the budget.

In addition, the budget does not reflect savings from a recent Medi-Cal policy change. Specifically, effective January 2001, Medi-Cal benefits, without a share of cost, were expanded for aged, blind, and disabled individuals. This change will result in unknown net savings in IHSS.

Because better information reflecting actual experience will be available at the time of May Revision, we withhold recommendation on savings of up to $5 million in the IHSS program.

CHILD WELFARE SERVICES

California's state-supervised, county-administered Child Welfare Services (CWS) program provides services to abused and neglected children, children in foster care, and their families. The CWS program provides (1) immediate social worker response to allegations of child abuse and neglect; (2) ongoing services to children and their families who have been identified as victims, or potential victims of abuse and neglect; and (3) services to children in foster care who have been temporarily or permanently removed from their family because of abuse or neglect. The *2001-02 Governor's Budget* proposes $1.9 billion ($633 million General Fund) for CWS and $1.6 billion ($413 million General Fund) for Foster Care. These represent increases of 3 percent (1 percent General Fund) and 6 percent (7 percent General Fund), respectively, from the current year.

IMPROVING CWS THROUGH STRUCTURED DECISION MAKING

Structured Decision Making (SDM) is a series of "tools" designed to aid child welfare workers in making critical child safety decisions. Research indicates that SDM improves child welfare outcomes, as compared to alternative approaches. Currently 14 California counties are using SDM and 10 additional counties are on the SDM waiting list. We recommend expansion of the program in the budget year and make several other recommendations to improve SDM implementation. (Increase Item 5180-151-0001 by $650,000.)

Background

Child abuse and neglect continues to be a serious problem in California. In 1999, over 600,000 allegations of child abuse and/or neglect were reported to county child protective services agencies. Approximately 400,000 of these reports were investigated; over 120,000 (30 percent) of those cases investigated were substantiated; and over 33,000 (28 percent) children who were victims of substantiated abuse or neglect were placed in foster care. In addition, a significant proportion of the families who

were the subject of reports and substantiation of abuse or neglect had prior contact with child protective services agencies.

What is SDM? California, like many other states, has used risk assessment to increase consistency and accuracy of CWS decisions. Structured Decision Making is a series of research-based risk assessment tools designed to aid child welfare workers in making critical child safety decisions. This approach has been shown to be more accurate and consistent in classifying children and families according to risk than alternative approaches. Key components of SDM are tools for determining (1) when to investigate abuse/maltreatment allegations, (2) the degree of child safety at the time of investigation, (3) the risk of future child maltreatment, (4) the targeted services to be provided to families at the highest risk of reabuse, and (5) whether to remove a child to foster care.

For example, the questionnaire used at the time of an in-person investigation aids social workers in determining whether a child is in danger of future abuse or neglect, whether a case should be opened, and how frequently services should be provided. As compared to some non-SDM assessments which may rely heavily on subjective criteria, most of these items tend to be objective, although some require the clinical judgement of the worker (see Figure 1).

Figure 1

Examples of Family Risk Assessment Questions

Item	Answers	Score (Circle to Indicate Score)
Current complaint is for abuse	No	0
	Yes	1
Number of prior abuse investigations	None	0
	One	1
	Two or more	2
Primary caretaker's assessment of this incident	Not applicable	0
	Blames child	1
	Justifies maltreatment of child	2

The resulting total score assigns families to risk categories according to the likelihood of future child abuse or neglect. A low score suggests a relatively low risk of reabuse, while a very high score implies a very high risk of further abuse. These classifications ("low," "medium," "high," and

"very high"), assist workers in determining whether a case will be opened and what level of services will be provided to the family. For example, a case opened for a low-risk family may require only one monthly visit from a social worker, whereas a case in which a family is assessed to be at very high risk of future abuse or neglect may require four social worker visits in a month. Because no assessment tool correctly predicts outcomes all the time, each tool allows child welfare workers discretion to reassign risk to a higher classification than the tool may otherwise indicate.

Structured Decision Making in California. Since the mid-1980s, the Children's Research Center (CRC), a division of the National Council on Crime and Delinquency, has developed and implemented SDM in a number of states, including New York, Michigan, Indiana, Georgia, New Mexico, Oklahoma, Wisconsin, Rhode Island, and Alaska. Structured Decision Making was implemented in California in 1999. Prior to implementation, CRC and several California counties analyzed over 2,000 local child abuse and neglect cases. Based on this analysis, the CRC designed California's assessment tools and then aided counties in implementing the program.

In 2000-01, a total of 14 counties are using SDM on a voluntary basis: Alameda, Fresno, Humboldt, Kern, Los Angeles, Merced, Monterey, Orange, Sacramento, San Bernardino, San Luis Obispo, Santa Clara, Sutter, and Trinity. These counties have been using the SDM tools for an average of approximately one year. In Los Angeles and San Bernardino Counties, only one regional office each is using SDM. After adjusting for these two counties not using the SDM tools countywide, approximately 30 percent of California's abuse and neglect reports are currently being investigated using the SDM approach. At this time, ten more counties have expressed an interest in using SDM: Del Norte, Marin, Placer, Riverside, Santa Barbara, Santa Cruz, Solano, Tulare, Yolo, and Yuba. However, due to a lack of funds for SDM in the current year, these counties have been unable to participate.

Research Indicates SDM Improves Outcomes

Research From Other States. Evaluations have concluded that SDM has significant value in predicting the likelihood of future abuse or neglect and that it improves child welfare outcomes. The most comprehensive evaluation of SDM was conducted by CRC in Michigan in 1995. In that study, 11 counties that were voluntarily using SDM were matched with 11 other counties in the state that were using other methods for managing CWS reports and caseloads.

After two years, all cases handled in these counties were compared. Statistically significant differences were found in both administrative process outcomes and child/family safety outcomes between the SDM

counties and the comparison counties. The process findings indicated that services in SDM counties were being appropriately redirected from lower-risk cases to higher-risk cases, effectively shifting resources to the families where the likelihood of future maltreatment was highest. The study also concluded that SDM counties had significantly improved child/family outcomes in contrast to the comparison counties. For example, for families who had prior contact with child protective services, the SDM counties had lower rates of (1) reported repeat abuse and neglect, (2) substantiations of abuse and neglect, (3) removal from the home, and (4) injuries (See Figure 2).

Figure 2

Michigan Evaluation Results Show SDM Reduces Adverse Child Welfare Outcomes

Child/Family Outcome	Comparison Counties	SDM Counties	Reduction in Adverse Outcomes
Reoccurrence of reports of abuse or neglect	20.4%	14.9%	-5.5%
Reoccurrence of substantiations of abuse or neglect	11.4	5.2	-6.2
Removal to foster care	5.7	3.4	-2.3
Child injury report	3.6	2.1	-1.9

Although both SDM and non-SDM counties had relatively few negative outcomes, SDM counties had even lower rates of reported repeat abuse and neglect, substantiations, removals to foster care, and child injuries. Because California has more than four times the number of children as Michigan, achieving these outcomes could improve the lives of thousands of California children and families.

Another evaluation, by CRC in Wisconsin and published in 1998, affirmed the findings of the Michigan study. In the Wisconsin study, child protective cases in three SDM counties were compared over a two-year period to determine (1) SDM's effectiveness in classifying families according to risk and (2) the impact of providing intensive services to high- and very-high risk families. Results showed SDM classifications were effective in helping set agency priorities and that more intensive interventions for high- and very-high risk cases improved outcomes significantly, reducing subsequent reporting of abuse.

A third study, conducted in Texas and published in 1997, was initiated to address SDM's (1) value in predicting reabuse or neglect and (2) ease of transfer to a different ethnic/cultural and geographic setting. This study concluded that many of SDM's risk assessment items were valuable in predicting future child maltreatment, could be transferred to a new geographic setting, and effectively applied to different ethnic groups.

Structured Decision Making May Reduce Bias in CWS Decisions. Although national researchers have concluded that the "true" rate of child abuse and neglect is equal across racial and ethnic groups, certain groups are significantly over represented in California's CWS system. For example, although African American children are only 7 percent of California's child population, these children are 35 percent of the children in foster care. In addition, African American infants under one year of age are four to five times more likely to be removed to foster care than infants of other racial groups.

While various factors may explain some of these differences, research indicates that some of these disparities may be due to bias at key decision points in child welfare cases. Although SDM and other research-based risk assessment tools were initially criticized as potentially further increasing the representation of children of color in the CWS system, process evaluations indicate that SDM reduces or eliminates this bias. In other words, children and families, regardless of race or ethnicity, are classified according to risk very similarly. Reducing the perception of bias is important because it is likely to (1) improve public confidence in the system and (2) improve confidence among the populations affected by the CWS system.

California SDM Implementation Challenges

While expansion of SDM could improve California's child welfare outcomes, there are barriers to further expansion as well as implementation issues. We discuss these problems below. The first two issues concern barriers to expansion, while the last issue concerns implementation.

Budget Does Not Propose Funds For Expansion. Fourteen counties are currently using SDM and another ten counties have expressed interest in utilizing the SDM system. However, the *2001-02 Governor's Budget* does not propose expansion of SDM. The budget proposes the same level of funding in 2001-02 as in the current year, which is $324,000 ($81,000 General Fund). This amount reflects the costs for continuing the current contract with CRC for support and technical assistance to counties who have been using SDM. According to the Department of Social Services (DSS), the cost to expand the SDM contract in the budget year to the ten counties on the waiting list would be $1.3 million ($317,000 General Fund; $1 million federal funds).

Current Technology Insufficient for Expansion. The Child Welfare Services/Case Management System (CWS/CMS) provides a statewide database, case management tools, and reporting system for the state's CWS program. While the system is in operation in all 58 counties, changes and additions to the system are both costly and time-consuming. According to DSS, the vendor for CWS/CMS estimated that it would cost $2 million (all funds) to integrate the SDM tools into that system. Instead of pursuing this option, CRC wrote its own software program, within the cost of the current contract, to provide the SDM assessment tools on workers' computers. While this solution has been effective for many of the counties currently using SDM, this software program has not been sufficient for large counties such as Los Angeles, and creates inefficient and redundant processes in some of the smaller counties. In order to solve these problems, CRC has proposed a technology solution that would allow for statewide expansion of SDM. The CRC estimates that this software program would cost approximately $500,000 ($125,000 General Fund).

Structured Decision Making Tool Completion Rates Not Maximized. Because SDM assessments aid in case management and resource allocation, it is important that the assessments are completed and the recommended service plans are followed. California is conducting a process evaluation of SDM to determine worker utilization of the SDM tools and family classification patterns. Preliminary results of this process evaluation indicate that while the "Response Priority" tool (used to determine timing of investigations) is completed almost 90 percent of the time by caseworkers, the remaining tools are being completed approximately 70 percent of the time. Although 70 percent shows a solid completion rate, there is room for improvement. More information is needed to determine what barriers may be hindering worker completion of assessment tools. Once barriers have been identified, solutions such as additional training or technical assistance to counties could be used to maximize completion rates in SDM counties.

Analyst's Recommendations for Expanding SDM in California

Research from other states indicates that SDM may improve outcomes in child welfare by decreasing repeated reports of abuse or neglect and admissions to foster care. Research also suggests that SDM may reduce bias at key decision points in CWS. Improving the CWS system in these ways could result in both fiscal savings to government and broader benefits to families. Below we make several recommendations to expand and improve SDM in California.

Expand SDM to Include Counties on Waiting List. As discussed earlier, the budget for the SDM project in 2001-02 is $324,000 ($81,000 General Fund) to provide support services in the 14 counties that have been using SDM. Also, ten additional counties have expressed an interest in using SDM: Del Norte, Marin, Placer, Riverside, Santa Barbara, Santa Cruz, Solano, Tulare, Yolo, and Yuba. However, due to a lack of General Fund support, these counties have been unable to implement SDM. According to DSS, expansion of SDM to these counties would cost $1.3 million ($317,000 General Fund) in 2001-02. (These costs include one-time start-up activities that are not incurred by the 14 current counties.) This would pay for technical assistance to the additional counties by a contractor. The DSS also indicates that SDM expansion would require the addition of two state staff positions to support the implementation phase. These positions would cost approximately $165,000 ($83,000 General Fund). We recommend SDM expansion to counties on the waiting list, at a total cost of $1.4 million ($400,000 General Fund).

Fund a Technology Solution. As we indicated earlier, one of the barriers to the expansion of SDM is the limitations of the current software. New technology must be implemented that (1) addresses Los Angeles County's expansion to the remaining 85 percent of its caseload (approximately 100,000 investigations annually), (2) reduces process inefficiencies in smaller counties, and (3) does not require integration into CWS/CMS. We therefore recommend funding a technology solution that addresses these needs. We estimate such a solution would cost approximately $500,000 ($125,000 General Fund).

Fund an Independent Outcome Evaluation. The only planned evaluation of SDM in California is a process evaluation. While this type of evaluation will provide important information about family risk classification and worker utilization, it will not provide California-specific information on SDM's impact on child welfare outcomes over time. An independent outcome evaluation is needed because (1) it will show whether California is attaining the results shown in research from other states and (2) it may suggest improvements and modifications for SDM in California. For these reasons, we recommend an independent outcome evaluation of California's SDM project at a cost of approximately $500,000 ($125,000 General Fund) in 2001-02.

Conclusion

Above, we present recommendations for the Legislature that would expand and improve SDM in California. We believe existing research on SDM justifies the expansion to the ten counties on the waiting list. At this

time, we recommend deferring a decision on further expansion of SDM until a California-specific evaluation has been completed.

THE CWS/CMS NEEDS STRATEGIC PLAN

We recommend that the Child Welfare Services (CWS) Stakeholders' Group develop a strategic plan for the Child Welfare Services/Case Management System (CWS/CMS) as a part of its review of the CWS system. We further recommend that, after 2001-02, the Legislature deny funding for any CWS/CMS modifications until the strategic plan is completed.

Background. Pursuant to the *2000-01 Budget Act*, the CWS Stakeholders' Group was established and funded for up to three years. Coordinated by DSS, the group was established to (1) review existing CWS programs, components, and systems; and (2) provide recommendations for improvements. The group is composed of approximately 60 members, including county, state, and federal government professionals; advocates; researchers; legislators; and former recipients of CWS. The CWS Stakeholders' Group plans to submit the following: (1) initial recommendations regarding immediate CWS improvements to the Director of DSS by June 2001, (2) progress reports on the implementation of action items beginning June 2001, and (3) an evaluation plan to measure progress toward objectives by October 2001.

Automation System. The CWS/CMS provides a statewide database, case management tools, and reporting system for the state's CWS program. The system is in operation in all 58 counties. The system has the potential to provide (1) more accurate, comprehensive, and timely information on which to base child welfare decisions; (2) key workload data and statutorily required information to managers; and (3) improved worker access to intercounty information.

While the system has now been implemented statewide for several years, the federal government and independent consultants have noted that CWS/CMS continues to be used inconsistently across the state and that barriers to more effective implementation exist. Because there is no program-level strategic plan for the CWS/CMS, changes and enhancements to the system have been authorized and funded in a fragmented fashion, sometimes without regard for statewide benefit.

Recommendation. Given its broad mandate to overhaul the CWS system, we believe the CWS Stakeholders' Group is well-positioned to provide direction on the program's future automation needs. Therefore, we recommend that the CWS Stakeholders' Group develop a five-year strategic plan for CWS/CMS. A long-range CWS/CMS strategic plan would

connect the ongoing efforts of the CWS Stakeholders' Group to improve the delivery of child welfare services with the potential benefits of CWS/CMS. In addition, a strategic plan designed with CWS programmatic expertise would provide a framework in which to evaluate the costs and potential benefits of additional changes to CWS/CMS. Accordingly, we further recommend that the Legislature, after 2001-02, not approve any funding for CWS/CMS modifications until the strategic plan is completed.

FINDINGS AND RECOMMENDATIONS

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may wish to consider that could assist counties in the successful implementation of the measure.

Long-Term Care Services

C-50 ■ **Summary of Spending and Caseloads**. More than half of the state's long-term care expenditures are for institutional care, while most long-term care consumers receive their care from home- and community-based services. Generally, long-term care spending is increasing, while caseloads are either remaining constant or growing at a much smaller rate than spending.

C-64 ■ **State May Be Eligible for Federal Grants to Fund New Projects. Reduce Item 4440-101-0001 by $333,000, Increase Item 4440-101-0890 by $333,000, and Increase Item 4260-001-0890 by $833,000.** Recommend reduction of $333,000 General Fund for Institutions for Mental Diseases pilot project, and offsetting increase in federal funding due to the availability of grant funds for such projects. For the same reason, we recommend that federal funds for pilot projects to expand community options for long-term care be increased by $833,000.

C-66 ■ **Staffing Level of New Nursing Home Complaint Unit Not Justified.** Withhold recommendation on $1.4 million ($500,000 General Fund) for a new unit within the Department of Health Services' Licensing and Certification program that would receive all complaints against long-term care health facilities. The department has provided insufficient justification for not redirecting district resources to the new unit.

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New Tobacco Settlement Fund

C-69 ■ **New Tobacco Settlement Fund**. Recommend establishing a 10 percent reserve for the new fund, instead of the proposed 5 percent reserve.

Child Health and Disability Prevention Program (CHDP)

C-74 ■ **The CHDP Fails as Gateway**. Recommend implementing legislation requiring providers to encourage CHDP clients to apply for Medi-Cal and Healthy Families. Recommend the adoption of supplemental report language directing Department of Health Services to examine the feasibility of linking CHDP data to Medi-Cal and Healthy Families data. Recommend legislation requiring all applications to be processed through a single point of entry. Recommend aligning CHDP eligibility with Healthy Families eligibility in order to maximize CHDP's capacity as a gateway to enrollment.

California Medical Assistance Program (Medi-Cal)

C-100 ■ **Caseload Estimate Reasonable, But May Be Overestimated.** We find that the budget's estimate for the Medi-Cal caseload is reasonable, but that the projected increase in the caseload of Medi-Cal families may be overestimated. Accordingly, we will monitor caseload trends and recommend appropriate adjustments at the time of the May Revision.

C-102 ■ **A More Rational Approach to Setting Medi-Cal Rates.** Despite state and federal requirements, the Department of Health Services (DHS) has not conducted annual rate reviews or made periodic adjustments to Medi-Cal rates to ensure reasonable access to health care services. As a result, rate adjustments have often been made on an ad

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hoc basis. Recommend both interim and long-term actions to establish a more rational rate-setting process.

C-110 ■ **Los Angeles County Section 1115 Medicaid Demonstration Project. (Reduce Item 4260-101-0001 by $3.4 Million and Item 4260-101-0890 by $3.4 Million.)** Recommend approval of $30 million General Fund annually requested for the extension of a Los Angeles County Medicaid demonstration project and the adoption of supplemental report language to increase Legislative oversight. Further recommend that the 2001-02 budget request for funding to monitor the demonstration project be reduced by $6.8 million (about $3.4 million General Fund and $3.4 million federal funds).

C-115 ■ **Medi-Cal Estimate Should Be Redesigned.** Recommend the enactment of legislation directing the department to revise the Medi-Cal estimate in order to make it a more useful tool for the Legislature. In addition, recommend the department report at budget hearings regarding the additional resources it will need to complete the redesign of the estimate.

C-117 ■ **Report Needed on Managed Care and Inpatient Rate Increases.** Recommend that the Department of Finance and the DHS report at budget hearings regarding (1) their plans for Medi-Cal managed care and hospital inpatient rate increases for 2001-02 and (2) the potential amount of additional funding needed in 2001-02 to provide for any such rate increases.

C-118 ■ **Other Potential Rate Increases Not Included in the Budget.** Recommend that DHS report at budget hearings regarding (1) the impact of the settlement of the *Orthopaedic Hospital v. Belshe'* litigation on provider rates and (2) the potential amount of funding needed if

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provider rates increase in the budget year as a result of the settlement.

C-118 ■ **Fraud Savings**. Recommend that DHS report an update of expected fraud savings for 2001-02 at budget hearings so that appropriate adjustments can be made to the Medi-Cal budget. Recommend that the department report on savings generated in the current year and its projections for the budget year for each type of antifraud activity. Finally, recommend approval of the Governor's proposal to permanently establish 16 positions for the Medi-Cal Fraud Prevention Bureau.

Public Health

C-121 ■ **Breast and Cervical Cancer Prevention and Treatment Act.** Recommend the Legislature consider options for modifying the Medi-Cal program and expanding treatment services to take full advantage of the new federal law, including (1) aligning Medi-Cal eligibility with existing programs, (2) offering presumptive eligibility, (3) using proposed state funds for the Breast Cancer Treatment Program to draw down federal funds, (4) stabilizing funding for the Breast Cancer Early Detection Program (BCEDP), (5) expanding the BCEDP to include cervical cancer screening, and (6) expanding the breast and cervical cancer screening and diagnosis provider network.

C-129 ■ **Smoking Prevention Proposal Is Flawed. Reduce Item 4260-111-3020 by $18 Million.** Recommend reduction of $18 million proposed to expand youth smoking prevention efforts because there is no evidence that the specific proposals are effective in reducing smoking. Withhold recommendation on $2 million requested for surveillance and special studies activities. Recommend that the DHS be required to report to the budget

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committees on the cost of implementing three of the four proposals as pilot programs. Recommend the approval of $1 million for youth advocacy coalitions funded by a grant from the American Legacy Foundation.

Managed Risk Medical Insurance Board

C-138 ■ **Health Insurance Waiver Plan Misses Opportunities**. Recommend the Legislature consider options for (1) further expansion of parental coverage, and (2) elimination of the Medi-Cal asset test to take advantage of missed opportunities to improve coverage of the uninsured.

C-142 ■ **Healthy Families Enrollment Overestimated. Reduce Item 4280-101-0890 by $39 Million, Reduce Item 4280-101-3020 by $33 Million, and Reduce Item 4280-101-0001 by $3 Million.** Recommend the Legislature reduce the level of funding budgeted for Healthy Families Program enrollment.

Department of Developmental Services

C-147 ■ **Early Start.** Adopt supplemental report language directing the Department of Developmental Services (DDS) to report back to the Legislature by December 1, 2002 regarding regional center (RC) and local education agency coordination, and regarding RC performance in completing evaluations and assessments within statutory time frames.

Department of Mental Health

C-152 ■ **Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) Costs Still Growing.** Recommend approval of request for $126 million ($61 million

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General Fund) to offset growing costs in the EPSDT for emotionally disturbed children but propose that the Legislature consider several options to help control future costs.

C-158 ■ **Overdue Report on Treatment Resources.** Recommend that the Department of Mental Health (DMH) comply with requirement that it report its findings regarding the availability of resources to assess and treat children in, or at-risk of, foster care placements.

C-159 ■ **Other Funding Available for Americans with Disabilities Act (ADA) Projects. Reduce Item 4440-011-0001 by $7.6 Million.** Recommend deletion of funding for ADA compliance projects at Metropolitan State Hospital because insufficient information ha been provided to justify the funding request and because funding for such projects has already been set aside in the current-fiscal year.

C-160 ■ **Complete Security Plan Needed.** Withhold recommendation on $7.6 million requested in the DMH support budget to install personal security alarms at various state hospitals because it is not clear how the request is related to various capital outlay proposals at the same facilities.

Employment Development Department

C-163 ■ **Disability Insurance (DI) Tax Rate Now Complies With Current Law**. From January through March 2000, the DI contribution rate was below the level required by current law. Since April of 2000, the DI tax rate has complied with statutory requirements. Despite a low balance of $5 million in December 2000, the Employment Development Department projects that the DI fund will

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be able to pay anticipated claims without the need for short-term borrowing from the General Fund.

C-164 ■ **Unemployment Insurance (UI) Benefits in California.** The UI program provides weekly benefits to unemployed workers who become jobless through no fault of their own. Benefit levels are set by state law and have not been increased since 1992. We review the UI program and estimate the cost of increasing the maximum benefit to a level of wage replacement in 2002 that would be roughly equivalent to that of 1992.

C-167 ■ **Federal Welfare-to-Work Block Grant Program**. California received $367.6 million in Welfare-to-Work block grant funds from the Department of Labor. Recent federal legislation extended the deadline for expending Welfare-to-Work funds from July 2002 until July 2004.

C-168 ■ **Legislature Needs Spending Plan for Discretionary Workforce Investment Act (WIA) Funds**. Recommend that the Legislature not appropriate $43.6 million in WIA discretionary funds until the administration presents an expenditure plan.

C-169 ■ **National Emergency Grant (NEG) Program.** Recommend deleting a proposed provision that would exempt NEG funds from Section 28 of the *2001-02 Budget Bill* and incorporating estimated NEG expenditures into the "regular" budget process. This approach will streamline the allocation process while preserving legislative oversight.

Department of Child Support Services

C-172 ■ **Total Automation Penalties Could Reach $1 Billion.** Since 1998, California has been the subject of penalties for

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failing to implement a statewide child support automation system. The penalties, estimated to be $114 million in 2000-01 and $163 million in 2001-02, are levied in the form of a reduced federal share of child support administrative expenditures and are expected to continue through 2004-05.

C-174 ■ **Child Support Automation Penalties Overbudgeted. Reduce Item 5175-101-0001 by $7,900,000**. Recommend that proposed spending for child support administration be reduced by $7.9 million General Fund because historic spending trends indicate the federal penalty will be less than budgeted.

C-174 ■ **Child Support Automation Proposal Lacks Detail. Reduce Item 5175-101-0001 by $5.6 Million.** The budget proposes $16.5 million ($5.6 million General Fund) for interim child support automation improvements over the next three fiscal years. Without prejudice to the merits of the proposal, we recommend that the Legislature (1) delete this multiyear funding request and (2) instruct the department to include a specific interim automation proposal for 2001-02 in the May Revision to the Governor's budget that is consistent with federal guidance.

C-175 ■ **Pre-Statewide Interim System Management Project**. Recommend that the Legislature adopt budget bill language directing the Department of Child Support Services to obtain federal approval prior to implementing enhancements to county-based systems.

C-177 ■ **Permanent Positions Are Needed to Support Child Support Automation Activities. Reduce Item 5175-001-0001 by $11,000**. Recommend that the Legislature deny the request for consulting services and instead authorize

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3 personnel years to provide ongoing support for child support automation activities.

Department of Social Services—State Operations

C-179 ■ **Department Should Develop eGovernment Plan**. Recommend that the Legislature deny the Governor's proposal for a one-time increase of $250,000 for the development of a feasibility study report for the Department of Social Services' eGovernment services, until the department develops an eGovernment plan.

Department of Social Services—CalWORKs Program

C-181 ■ **Caseload Decline Slowing**. The California Work Opportunity and Responsibility to Kids (CalWORKs) caseload has declined significantly since 1994-95. However, recent caseload data suggest a deceleration in caseload decline and the Governor's budget projects a continued deceleration in the budget year.

C-182 ■ **Budget Underestimates Cost of Providing Statutory Cost-of-Living Adjustment (COLA)**. The General Fund cost of providing the statutory COLA will be $10 million above the amount included in the budget, due to an upward revision in the California Necessities Index.

C-184 ■ **Impact of Maintenance-of-Effort (MOE) Requirement**. The Governor's budget proposes to expend all but $85 million of available federal block grant funds and the minimum amount of General Fund monies required by federal law for the CalWORKs program. Any net augmentation to the program in excess of the proposed $85 million reserve will result in General Fund costs and any net reductions will result in an additional reserve of federal block grant funds.

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C-185 ■ **Budget Proposes Reductions in County Performance Incentives**. The Governor's budget contains two proposals to reduce county performance incentives by a total of $397 million in 2000-01 and 2001-02. Specifically, the Governor proposes urgency legislation to reduce the current-year appropriation for county performance incentive funds by $153 million. In addition, the Governor's budget proposes no funding for performance incentives in 2001-02, resulting in a savings of $244 million compared to the amount suggested by current law.

C-186 ■ **Proposal for Current-Year MOE Reduction Savings Should Be Incorporated Into 2001-02 Budget Process**. The Governor proposes to replace approximately $150 million in General Fund spending with savings freed-up by urgency legislation that reduces Temporary Assistance for Needy Families (TANF) payments to counties for performance incentives by a like amount. Recommend that the Legislature amend any such urgency legislation to prohibit the expenditure of the resulting TANF savings in the current year. This action will move the expenditure decision on these TANF funds into the budget process for 2001-02 where the Legislature may then deliberate fully on its priorities with respect to General Fund support for CalWORKs and the level of the TANF reserve for future years.

C-188 ■ **Advance Drawdown of TANF Funds May Not Comply With Federal Law**. The DHHS issued a program instruction clarifying that states may not draw down federal TANF funds prior to their immediate expenditure. California's practice of drawing down county performance incentive funds may not be consistent with this instruction. Thus, the state may be required to return some TANF funds along with any interest that may have been earned. Recommend that the Department of Social

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Services (DSS) provide an estimate at budget hearings on the potential interest liability and report on how it will comply with the federal instruction.

C-189 ■ **Mental Health and Substance Abuse Spending Below Appropriations**. Withhold recommendation on the proposed appropriation for 2001-02 pending receipt of additional data on current-year spending, because counties have historically been unable to expend their substance abuse and mental health treatment funds.

C-192 ■ **Child Care Shortfall**. The Governor's budget provides only limited funding for child care for former CalWORKs recipients who have been off aid for two years or longer.

C-192 ■ **Welfare-to-Work Match Deadline Extended. Reduce Item 5180-102-0001 by $59 Million.** Recommend reducing proposed spending for the Welfare-to-Work match by $59 million because California's deadline for expending its federal grant and required state matching funds has been extended to July 2004.

C-193 ■ **Welfare-to-Work Funds Should Be Incorporated Into County Budgeting Process**. Because counties may use Welfare-to-Work funds to pay for CalWORKs employment services, the budget reduces county funding requests by $142 million, even though in the prior year most counties' budget requests had already accounted for these funds. Recommend formally incorporating Welfare-to-Work funds into the county budgeting process to avoid a potential double reduction in employment services funding. Further recommend that the May Revision address this issue.

C-194 ■ **Over Half of Single-Parent Adults Will Reach Federal Time Limit in 2001-02**. The department estimates that by June 2002, nearly 60 percent of single-parent adults will

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reach their federal time limit. Assistance to these families will be funded with state-only funds. If trends continue, approximately 80,000 families could face grant reductions by the end of 2002-03.

C-195 ■ **Legislative Oversight: Cal-Learn Final Report Overdue**. Recommend the department report at budget hearings on the status of the Cal-Learn report and on its findings and recommendations.

C-196 ■ **Increase County Flexibility to Assist Working Recipients**. Recommend enactment of legislation to give counties the option to provide employment services for more than two years so long as participants work at least 20 hours per week.

Foster Care

C-200 ■ **Foster Care Length of Stay.** Recommend a pilot test of a change in FFA rates intended to accelerate FFA reunification and adoption efforts because we have concluded that (1) children stay longer in FFAs than other placements, (2) emotional and/or behavioral differences of FFA children do not explain the longer stay, and (3) the FFA rates need to be adjusted.

C-205 ■ **Office of the Ombudsman for Foster Care**. The budget proposes to convert four Foster Care Ombudsman positions from temporary to permanent, even though the department has not documented the permanent workload. Recommend retaining these positions as two-year limited term until the department can substantiate the ongoing workload.

C-206 ■ **Budget Underestimates Foster Care Cost-of-Living-Adjustment (COLA).** The cost of providing the statutory

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COLA to the foster family homes, FFAs, group homes, and related programs will be $2.4 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.

Food Stamps Program

C-208 ■ **Recent Federal Changes Create Options**. Recommend the department submit current- and budget-year cost estimates for mandated vehicle asset rule changes, and, to the extent possible, more precise cost estimates for the alternative vehicle allowance and the transitional benefit allowance options.

C-213 ■ **Electronic Benefits Transfer System (EBT).** Recommend that the department report at budget hearings on the potential federal penalty if the state is unable to implement the food stamp EBT system by October 2002.

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

C-214 ■ **Budget Underestimates Cost of Providing Statutory Cost-of-Living Adjustment (COLA)**. The General Fund cost of providing the statutory SSI/SSP COLA will be $7.7 million above the budget estimate due to an upward revision in the California Necessities Index.

C-216 ■ **Certain Legal Immigrants Face Benefit Termination**. California established the Cash Assistance Program for Immigrants (CAPI) to provide state-only funded SSI/SSP benefits to certain legal immigrants who are federally ineligible for benefits because of their immigration status. The component of this program that provides benefits for post-August 1996 immigrants is

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scheduled to sunset on September 30, 2001. This will result in approximately 2,700 recent legal immigrants losing their benefits effective October 2001. We review the history of the CAPI and provide policy options for the Legislature.

In-Home Supportive Services

C-220 ■ **Wage and Benefit Increases for Certain In-Home Supportive Services (IHSS) Workers.** Although budget trailer bill legislation—Chapter 108, Statutes of 2000 (AB 2876, Aroner)—authorized increased state participation in specified wage and benefit increases for IHSS providers working in counties that have established "public authorities," the actual wage increases provided by counties have been less than budgeted. We summarize the wage increases provided by this legislation and their potential fiscal impact.

C-222 ■ **Budget Does Not Reflect Likely Savings.** Withhold recommendation on a portion of the budget for IHSS because it does not reflect likely savings of up to $5 million from (1) actual costs being lower than budgeted for certain current- and budget-year augmentations and (2) an expansion in Medi-Cal eligibility that should result in reduced costs in the IHSS program.

Child Welfare Services (CWS)

C-223 ■ **Improving CWS Through Structured Decision Making (SDM). Increase Item 5180-151-0001 by $650,000.** Structured Decision Making is a series of tools designed to aid child welfare workers in making critical child safety decisions. Research indicates that SDM improves child welfare outcomes, as compared to alternative approaches. Currently 14 California Counties are using

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SDM and 10 additional counties are on the SDM waiting list. Recommend increasing proposed Child Welfare Services spending by $615,000 for (1) budget-year expansion of the SDM program ($400,000), (2) software solutions to support SDM expansion ($125,000), and (3) independent outcome evaluation of SDM ($125,000).

C-230 ■ **Child Welfare Services/Case Management System (CWS/CMS) Needs Strategic Plan.** Recommend that the CWS Stakeholders' Group develop a strategic plan for CWS/CMS in their review of the CWS system.