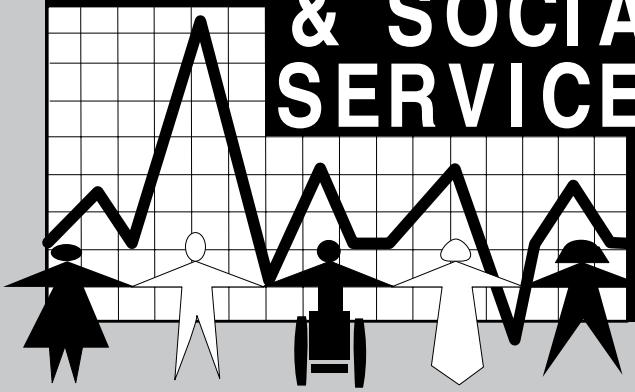
HEALTH & SOCIAL SERVICES



LAO

65 YEARS OF SERVICE

2006-07 Analysis

MAJOR ISSUES

Health and Social Services

☑ **Medi-Cal Budget Should Be Adjusted for Effects of Medicare Drug Benefit**

- We review the state's response to problems in the rollout of the new federal Medicare Part D prescription drug benefit and recommend Medi-Cal reductions of almost $330 million over two years to more accurately reflect lower costs to the state for the program. (See page C-94.)

☑ **A Targeted Strategy to Constrain Costs and Improve Access to Community Care**

- The Legislature should take steps to deter costly nonemergency visits to emergency rooms (ERs) and to improve access to care and quality of care in community settings. This could be accomplished by seeking federal funds to improve access to primary care and by establishing effective copayments on the inappropriate use of ERs. (See page C-103.)

☑ **Medi-Cal's Bitter Pill: High Payments to Pharmacies**

- Medi-Cal's lack of accurate information about the prices of prescription drugs means that the program is reimbursing pharmacies much more than appears to be reasonable. We recommend legislation to ensure that reimbursement for drugs is set at more appropriate levels. (See page C-118.)

☑ **Future Federal Funding Shortfall for Healthy Families**

- Future uncertainty about reauthorization of federal funding and the eventual exhaustion of unspent federal funds pose a risk of significant future increases in state costs for the Healthy Families Program (HFP). We present alternatives to hold down increases in overall HFP costs and to obtain additional financial support for the program. (See page C-142.)

☑ **Reform of Licensing and Certification of Health and Social Services Providers**

- The administration is proposing changes to the way the state conducts licensing and certification of providers of certain health and social services. We concur in some proposals, recommend others be reduced to correct overbudgeted staffing and funding, and propose further changes to improve the way these functions are carried out. (See page C-35.)

☑ **Strategies To Meet Federal Work Participation Requirements**

- The federal Deficit Reduction Act of 2005 significantly raises the required work participation rates for California's low-income families in the CalWORKs program. Failure to meet these higher participation rates would result in annual federal penalties which begin in 2008-09 at $173 million, and increase by about $70 million each year to a maximum of $725 million per year in 2016-17. We present a range of strategies for meeting this challenge including: increasing participation among existing recipients, bringing former recipients who are employed back into the participation calculation, and establishing separate programs for those who may face substantial barriers to work. (See page C-188.)

☑ **California Failing to Meet Child Welfare Performance Goals**

- Federal law requires California to improve its performance on federal outcome measures established for the child welfare system. As of January 2006, California is failing all seven outcome measures. Unless California improves its performance by the fall of 2006, the state faces $59 million in federal penalties. (See page C-206.)

☑ **Reject Freeze for County Administration of Health and Human Services Programs**

- The Governor proposes to freeze future state participation in county administrative costs for health and social services programs at the 2005-06 level. In subsequent years, state support would be adjusted for caseload but not inflation. We recommend rejecting the Governor's proposal because it would restrict legislative flexibility to adjust funding and services levels. (See page C-65.)

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Health and Social Services

OVERVIEW

Health and Social Services

General Fund spending for health and social services programs is proposed to increase by 4.5 percent to almost $28.5 billion in 2006-07. This net increase in spending is due primarily to a variety of caseload and cost increases that are partially offset by grant savings in certain social services programs.

EXPENDITURE PROPOSAL AND TRENDS

Budget Year. The budget proposes General Fund expenditures of $28.5 billion for health and social services programs in 2006-07, which is 29 percent of total proposed General Fund expenditures. Figure 1 shows health and social services spending from 1999-00 through 2006-07. The proposed General Fund budget for 2006-07 is $1.2 billion (4.5 percent) above estimated spending for 2005-06. Special funds spending for health and social services is proposed to increase by $267 million to about $6.7 billion.

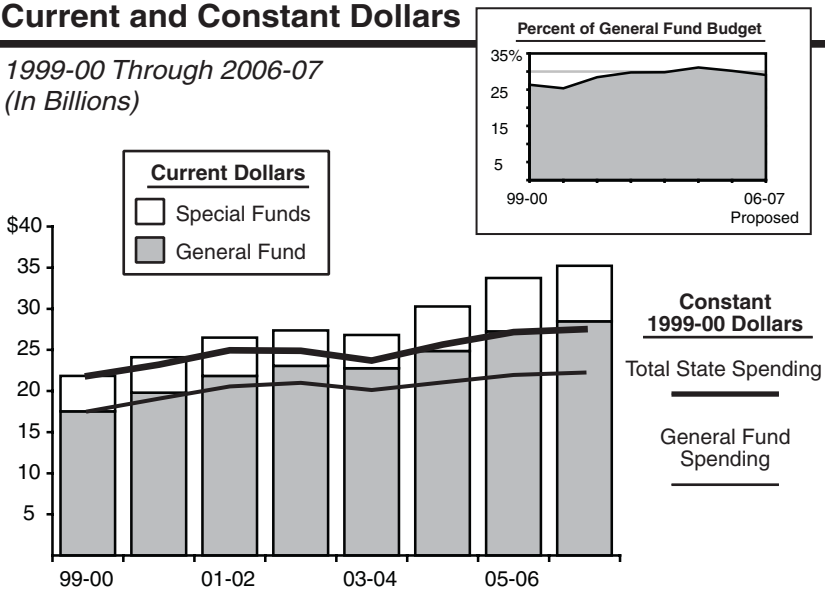
Historical Trends. Figure 1 (see next page) shows that General Fund expenditures (current dollars) for health and social services programs are projected to increase by $10.9 billion, or 63 percent, from 1999-00 through 2006-07. This represents an average annual increase of 7.2 percent. Similarly, combined General Fund and special funds expenditures are projected to increase by about $13.4 billion (61 percent) from 1999-00 through 2006-07, an average annual growth rate of 7.1 percent.

Adjusting for Inflation. Figure 1 also displays the spending for these programs adjusted for inflation (constant dollars). On this basis, General Fund expenditures are estimated to increase by 27 percent from 1999-00 through 2006-07, an average annual rate of 3.5 percent. Combined General Fund and special funds expenditures are estimated to increase by 26 percent during this same period, an average annual increase of 3.4 percent.

Figure 1

Health and Social Services Expenditures
Current and Constant Dollars

1999-00 Through 2006-07
(In Billions)



CASELOAD TRENDS

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

Medi-Cal Caseload. As shown in Figure 2, the Governor's budget plan assumes that a modest increase in caseload will occur during the budget year in the Medi-Cal Program. Specifically, the overall caseload is expected to increase by about 127,000 average monthly eligibles (1.9 percent) to a total of about 6.8 million in 2006-07. This would be a slightly higher pace of growth than is projected for 2005-06. The caseload projections for 2006-07 take into account the Governor's budget proposals discussed below to encourage eligible, but currently unenrolled, children to sign up for Medi-Cal, in part by simplifying the annual eligibility redetermination

Figure 2

Budget Forecasts Continued Growth in Medi-Cal Caseloads

1996-97 Through 2006-07
(In Millions)

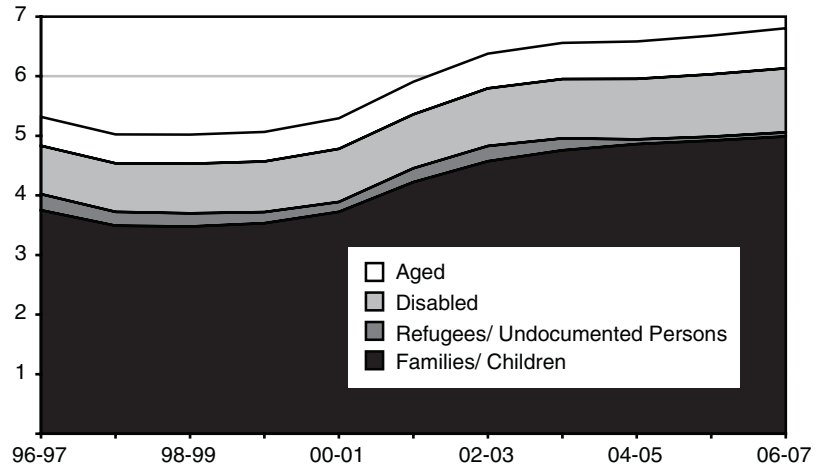
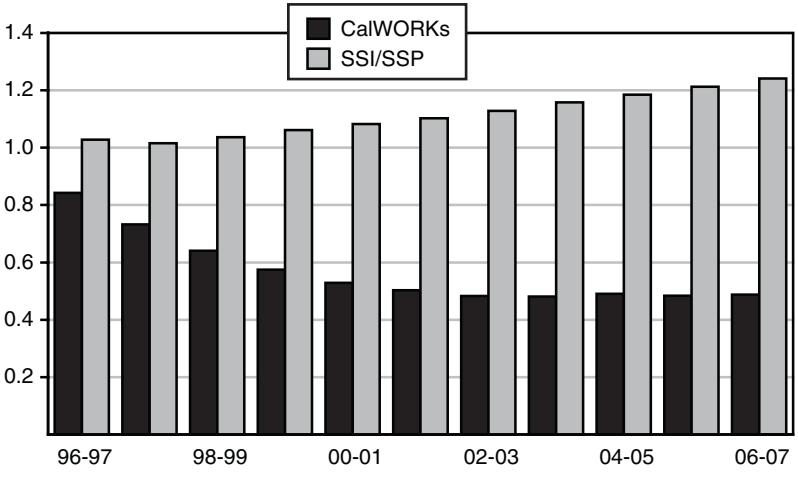


Figure 3

CalWORKs Caseload Flat, SSI/SSP Caseloads Increasing Slightly

1996-97 Through 2006-07
(In Millions)



form. This change is expected to result in a caseload increase of 27,000. The Medi-Cal budget proposal also reflects continued growth in several eligibility categories, primarily aged and disabled beneficiaries and non-welfare families.

Healthy Families Program (HFP) Caseload. The Governor's budget plan assumes that the current-year enrollment for HFP will fall short by about 40,000 of the number assumed in the *2005-06 Budget Act*. However, the spending plan further assumes that the program caseload will increase by about 106,000 children or almost 13 percent during the budget year. Of this increase, about 30,000 are forecast to be due to the implementation of various program outreach activities and changes in the HFP enrollment process. The budget proposal estimates that a total of 933,000 children will be enrolled in HFP as of June 2007.

The CalWORKs and SSI/SSP Caseloads. Figure 3 shows the caseload trend for CalWORKs and SSI/SSP. While the number of cases in SSI/SSP is greater than in the CalWORKs program, both programs serve about 1.2 million persons. (The SSI/SSP cases are reported as individual persons, while CalWORKs cases are primarily families.)

As Figure 3 shows, the CalWORKs caseload declined steadily since 1996-97, essentially bottoming out in 2002-03. For 2005-06 and 2006-07, the budget projects the caseload will remain essentially flat with no net growth. The substantial CalWORKs caseload decline shown in Figure 3 was due to various factors, including the improving economy, lower birth rates for young women, a decline in legal immigration to California, and, since 1999-00, the impact of CalWORKs program interventions (including additional employment services). The recent flattening of the caseload may be attributable to the composition of the remaining caseload, part of which includes adults who face substantial barriers to employment.

The SSI/SSP caseload can be divided into two major components—the aged and the disabled. The aged caseload generally increases in proportion to increases in the eligible population—age 65 or older (increasing at about 1.5 percent per year). This component accounts for about 30 percent of the total caseload. The larger component—the disabled caseload—typically increases by about 3 percent per year. Since 1998 the overall caseload has been growing moderately, between 2 percent and 2.5 percent each year.

SPENDING BY MAJOR PROGRAM

Figure 4 shows expenditures for the major health and social services programs in 2004-05 and 2005-06, and as proposed for 2006-07. As shown in the figure, three major benefit payment programs—Medi-Cal, CalWORKs, and SSI/SSP—account for a large share (about 74 percent) of total spending in the health and social services area.

Figure 4

Major Health and Social Services Programs[a]

(Dollars in Millions)

	Actual 2004-05	Estimated 2005-06	Proposed 2006-07	Change from 2005-06 Amount	Change from 2005-06 Percent
Medi-Cal					
General Fund	$11,593	$13,197	$13,739	$542[b]	4.1%
All funds	32,171	33,767	34,742	975	2.9
CalWORKs					
General Fund	$2,054	$1,958	$1,951	-$7	-0.4%
All funds	5,351	5,118	5,007	-112	-2.2
Foster Care					
General Fund	$429	$411	$396	-$15	-3.6%
All funds	1,722	1,621	1,621	1	0.0
SSI/SSP					
General Fund	$3,411	$3,506	$3,564	$58	1.7%
All funds	n/a	8,621	8,986	365	4.2
In-Home Supportive Services					
General Fund	$1,198	$1,259	$1,310	$52	4.1%
All funds	3,531	3,744	3,909	165	4.4
Regional Centers / Community Services					
General Fund	$1,719	$1,838	$1,998	$160	8.7%
All funds	2,689	2,883	3,099	216	7.5
Community Mental Health Services					
General Fund	$304	$309	$672	$364[b]	118.0%
All funds	1,743	2,505	2,398	-107	-4.3
Mental Hospitals / Long-Term Care Services					
General Fund	$661	$833	$912	$79	9.4%
All funds	882	920	994	74	8.0
Healthy Families Program					
General Fund	$288	$327	$377	$51	15.5%
All funds	793	908	1,047	139	15.3
Child Welfare Services					
General Fund	$610	$616	$631	$15	2.4%
All funds	2,112	2,081	2,192	111	5.3
Child Support Services					
General Fund	$252	$470	$473	$3	0.6%
All funds	948	1,259	1,264	4	0.3

a Excludes administrative headquarters support.

b Medi-Cal General Fund would increase $901 million or 6.8 percent if $359 million in spending were not shifted to the Department of Mental Health budget. General Fund for Community Mental Health Services would grow by $5 million or 1.6 percent absent this technical funding shift.

As Figure 4 shows, General Fund spending is proposed to increase in all major health programs. The large increase in community mental health services is due primarily to a technical funding shift of General Fund support to the Department of Mental Health budget that previously had been displayed in the Department of Health Services (DHS) Medi-Cal budget. If this change did not occur, the increase in General Fund support shown for the Medi-Cal Program would be greater than shown here.

In regard to social services programs, General Fund support for SSI/SSP, In-Home Supportive Services, Child Welfare Services, and Child Support would increase, while General Fund support for CalWORKs and Foster Care would decline. Overall, the budget proposes to increase spending by about $150 million (1.7 percent) compared to 2005-06. With the exception of the SSI/SSP grant reduction, and reductions in CalWORKs county block grant funds discussed below, the social services budget generally funds the requirements of current law. We note that current law already suspends the state cost-of-living adjustments (COLAs) for both SSI/SSP and CalWORKs during 2006-07.

In contrast, most health programs would be funded in a way that is consistent with existing eligibility, benefits, and other requirements, and some aspects of the budget plan would expand Medi-Cal, HFP, and various public health programs.

MAJOR BUDGET CHANGES

Figures 5 and 6 (see page 14) illustrate the major budget changes proposed for health and social services programs in 2006-07. (We include the federal Temporary Assistance for Needy Families [TANF] funds for CalWORKs because, as a block grant, they are essentially interchangeable with state funds within the program.) Most of the major changes can be grouped into five categories**:** (1) funding most caseload changes, (2) further delaying welfare COLAs, (3) reductions in allocations for county administration of health and social services programs, (4) shifts of funding and programs so that they are no longer supported from the General Fund, and (5) other policy changes.

C***aseload Changes.*** The budget funds caseload changes in the major health and social services programs. For example, the Medi-Cal budget reduces spending for lower-than-anticipated caseload in the current year but adds resources for the cost of caseload increases expected in the budget year. Also, the Medi-Cal budget would be adjusted upward by $493 million for significant growth in the baseline costs and utilization of services by various groups of eligibles, but especially the aged and disabled. General Fund support for community services at regional centers for the developmentally disabled would continue to grow due mainly to caseload

growth, rate increases, and utilization increases in these services. Funding would be adjusted downward in the current year for HFP to reflect lower than anticipated caseload in 2005-06, but increased in the budget year for anticipated strong caseload growth.

Figure 5

Health Services Programs
Proposed Major Changes for 2006-07
General Fund

Medi-Cal (local assistance)	**Requested:**	**$13.7 billion**	
	Increase:	**$542 million**	**(+4.1%)**

\+ $493 million from higher costs and utilization of pharmacy and inpatient hospital services, mainly for the aged and disabled

\+ $212 million net increase in costs from implementing the new Medicare drug benefit for beneficiaries also enrolled in Medi-Cal

\+ $147 million from increased costs for premiums paid by Medi-Cal on behalf of beneficiaries who are also enrolled in Medicare physician and hospital services

\+ $70 million from growth in the number of enrollees in Medi-Cal managed care

\+ $20 million from higher enrollment from simplifying redetermination of eligibility

\– $359 million reduction from a technical shift of funding for mental health services

\– $121 million net decrease in costs from various funding shifts related to new federal hospital finance waiver and related state legislation

\– $21 million reduction from not providing a cost-of-living increase for Medi-Cal county administration

Public Health (local assistance)	**Requested:**	**$392 million**	
	Increase:	**$11 million**	**(+3%)**

\+ $46 million to enhance statewide emergency preparedness, mitigation, and response activities related to pandemic influenza and other disease outbreaks

Figure 6

Social Services Programs
Proposed Major Changes for 2006-07
General Fund

CalWORKs	**Requested:**	**$2.0 billion**	
	Decrease:	**-$7.4 million**	**(-0.4%)**

+ $58 million for Temporary Assistance for Needy Families to replace General Fund in Child Welfare
+ $20 million for caseload increase

– $93 million from proposed net reduction in county block grant allocations for child care, administration, and welfare-to-work services
– $30 million from delaying payment of performance incentives

SSI/SSP	**Requested:**	**$3.6 billion**	
	Increase:	**$58 million**	**(+1.7%)**

+ $66 million for caseload increase

– $17 million in increased savings from further delaying the "pass through" of the January 2007 federal cost-of-living adjustment until July 2008

In-Home Supportive Services	**Requested:**	**$1.3 billion**	
	Increase:	**$52 million**	**(+4.1%)**

+ $108 million for caseload increase

– $51 million from full-year implementation of quality assurance initiative

Cash Grant COLAs. The budget follows current law, which suspends both the state SSI/SSP COLA for January 2007 and the state CalWORKs COLA for July 2006. Current law delays the "pass-through" of the SSI/SSP January 2007 federal COLA until April 2007. The budget proposes to further delay the SSI federal COLA until July 2008.

Reductions in County Administration. The budget reduces CalWORKs county block grants for administration, child care, and welfare-to-work services by $93 million, spread over 2005-06 and 2006-07. The budget also provides no inflationary adjustment for county administration of health and human services programs. Moreover, the budget proposes trailer bill language which would make counties permanently responsible for any future costs related to inflation.

Funding and Program Shifts. Following an increase in General Fund costs in 2005-06 for hospital services, the Governor's budget proposal for Medi-Cal reflects a $121 million decrease in these costs in the budget year. This is due to the shift of certain Medi-Cal hospital costs to local governments under the terms of a statewide hospital financing waiver provided by the federal government and state legislation. Some federal funds available as part of the waiver package would also be used to reduce General Fund support for various health services programs operated by DHS, such as California Children's Services. Additional tobacco tax revenues generated under Proposition 99 would be used to offset Medi-Cal costs to achieve General Fund savings.

Also, the budget would achieve some savings by using TANF federal funds to replace General Fund expenditures in child welfare services.

Other Policy Changes

Disaster Preparedness Efforts. The proposed spending plan increases General Fund support for Department of Health Services (DHS) and the Emergency Medical Services Authority to support various actions intended to prevent the state from suffering a flu pandemic or other public health outbreaks and to respond more effectively in the event such a disaster occurs.

Enrollment in Children's Health Coverage. The administration is proposing a series of actions in the Medi-Cal and HFP to enroll more children in health coverage and to increase the number in such programs who renew their enrollment each year. The proposals do not change eligibility but focus on increasing the number of children in coverage who are already eligible for benefits under current law.

Licensing and Certification Reform. Health and Human Services Agency departments are responsible for licensing and certification of nearly 500,000 facilities and professionals, including child care providers, nursing homes, foster care homes, hospitals, and various health professionals. To improve these efforts, the Governor is proposing to add about 160 new staff positions to the DHS licensing and certification division, the state agency that licenses nursing homes. The administration is also proposing to collect

some fees every other year instead of each year, and would deposit the fees that are collected in a new special fund instead of the General Fund. Also, the Governor is proposing 76 more staff positions for the Department of Social Services to meet the required workload for licensing and inspecting child care, foster care, and adult residential facilities.

Mental Health Program Changes. The budget plan states the Governor's continued intent to develop a plan to eliminate a state mandate for a mental health services program for children enrolled in special education and sets aside some funding in the education and Commission on State Mandates budgets for this purpose. The administration also proposes to add 453 positions to the state hospital system to respond to federal civil-rights investigations.

Proposition 36. The spending plan proposes to extend on a one-time basis in 2006-07 the $120 million in General Fund support currently being provided for implementation of Proposition 36, a measure approved by voters in November 2000 to divert certain drug offenders from jail and prison to community drug treatment programs. The administration indicates its support of the continued funding is conditional upon the legislative enactment of changes to Proposition 36, including greater authority for judges to impose short jail sentences on offenders who fail to show up for treatment and to impose drug-testing requirements as a condition of probation.

CROSSCUTTING ISSUES

Health and Social Services

IMPROVING LONG-TERM CARE

In this review of the state's system of long-term care, we provide an analysis of its caseload and costs and a discussion of recent trends. We also analyze the Governor's 2006-07 budget proposals related to long-term care, suggest a strategic approach the Legislature should take to address long-term care issues, and examine whether the statutory authority for the Long-Term Care Council should be continued.

ANALYSIS OF LONG-TERM CARE CASELOAD AND COSTS

Our analysis of California's long-term care programs shows that an increasing portion of long-term care spending is for home- and community-based services rather than institutional care. Generally, long-term care costs have grown, driven mainly by increases in caseloads and the cost per case for three programs—In-Home Supportive Services, regional centers, and state hospitals.

Background

Chapter 895, Statutes of 1999 (AB 452, Mazzoni), directed the Legislative Analyst's Office to provide in our *Analysis of the 2001-02 Budget Bill* and in our *Analysis of the 2006-07 Budget Bill* a summary of spending on state long-term care programs and, to the extent feasible, estimates of the population served by each program. The first required report was published on page C-50 of the *2001-02 Analysis*. In accordance with Chapter 895, in this section we provide an inventory of the state's long-term care services, spending for these 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.

Characteristics of Long-Term Care

Figure 1 summarizes the state's primary long-term care programs, describes the services provided, the departments that administer or provide funding for the programs, the total amount of funding appropriated in the *2005-06 Budget Act*, the types of services provided, and the clients served.

Long-Term Care Encompasses a Wide Array of Services. Long-term care services generally address an individual's health, social, and personal needs and try to maximize an individual's ability to function independently outside an institution. 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; and eating, bathing, or dressing.

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

Where Long-Term Care Services Are Provided. As Figure 1 shows, long-term care services are provided in two primary settings: (1) institutional care (for example, nursing facilities) and (2) community-based services. Community-based services include nonmedical residential care facilities and services such as transportation and meals, to assist individuals in remaining in their homes instead of being placed in an institution.

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

The state's framework for delivering long-term care services largely reflects the state's role as an administrative entity for federal funds. For example, the federal government requires a single state agency to be responsible for receiving federal Medicaid funds. In California, DHS receives all federal Medicaid funding and disburses some of these funds to other departments to administer programs providing long-term care services.

Figure 1

Many State-Funded Programs Provide Long-Term Care Services

2005-06
(In Millions)

Program	Department	Total Cost	Services	Clients
Institutional Care				
Nursing facilities/Intermediate Care Facilities ICF)—fee-for service	Medi-Cal/ Health Services	$3,001	Continuous skilled nursing and supportive care in private, licensed facilities.	Medi-Cal eligible elderly, disabled, or needy.
State Hospitals	Mental Health	888	State institutions.	Mental health patients.
Developmental Centers	Developmental Services	708	State institutions.	Developmentally disabled.
ICF—Developmentally Disabled	Medi-Cal/ Health Services	374	Private, licensed health facilities.	Medi-Cal eligible developmentally disabled.
Nursing Facilities—managed care	Medi-Cal/ Health Services	254	Long-term care provided by County Organized Health Systems in an institutional setting.	Medi-Cal eligible elderly, disabled, or needy.
Veterans' Homes-Nursing facilities and ICFs	Veterans Affairs	57	State institutions.	Elderly or disabled veterans.
Veterans' Homes-residential	Veterans Affairs	50	State institutions.	Elderly or disabled veterans.
Community-Based Care				
In-Home Supportive Services	Social Services	$3,811	Personal care and case management services coordinated by county welfare departments, to allow persons to remain in their homes.	Low income, elderly, blind, or disabled.
Regional Centers	Developmental Services	2,932	Includes day programs, community care facilities, and support services.	Developmentally disabled and residing in own home, home of a relative, or in community care facilities.

Continued

Program	Department	Total Cost	Services	Clients
SSI/SSP Nonmedical out-of-home	Social Services	$498	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	418	Health, therapeutic, and social services on a less than 24 hour basis.	Elderly or younger disabled adults.
Nutrition services	Aging	148	Congregate or home-delivered nutritional meals.	Elderly.
EPSDT[a] shift nursing	Medi-Cal/ Health Services	147	In-home private duty.	Medi-Cal eligible under age 21.
Supportive services	Aging	85	Programs authorized by the Older Americans Act, including case management and transportation.	Elderly.
Program of All-Inclusive Care for the Elderly	Health Services	83	Full range of care, including adult day health, case management, personal care, provided on a capitated basis.	Elderly.
Senior Care Action Network	Medi-Cal/ Health Services	64	Medical, social, and case management services provided on a capitated basis.	Medi-Cal eligible elderly.
Multipurpose Senior Services Program	Aging	45	Case management program to prevent or delay premature institutional placement.	Medi-Cal eligible elderly certifiable for nursing facility care.
Family Caregiver Support Program	Aging	36	Respite, day care, and transportation to assist caregivers.	Caregivers for elderly or grandparents raising grandchildren.
Nursing Facility Subacute Waiver	Medi-Cal/ Health Services	33	Home- and community-based alternative to nursing facility subacute care.	Medi-Cal eligible, physically disabled meeting nursing facility subacute care criteria for 180 days.
Conditional Release Program	Mental Health	22	Assessment, treatment, and supervision.	Judicially committed.

Continued

Program	Department	Total Cost	Services	Clients
AIDS Waiver	Medi-Cal/ Health Services	$20	Alternative to nursing facility or hospital care.	Medi-Cal eligible with HIV infection or AIDS.
Nursing Facility A/B Waiver	Medi-Cal/ Health Services	16	Alternative to nursing facility level A or B.	Medi-Cal eligible, physically disabled meeting nursing facility A or B care criteria for 365 days.
Alzheimer's Day Care Resource Centers	Aging	14	Day care.	Persons with Alzheimer's or other dementia, and their caregivers.
In-Home Medical Care Waiver	Medi-Cal/ Health Services	14	Alternative to care in an acute hospital.	Medi-Cal eligible, severely disabled requiring care in an acute hospital for 90 days.
Independent Living Centers	Rehabilitation	13	Grants for a full range of services.	Disabled.
Caregiver Resource Centers	Mental Health	12	Nonprofit resource centers.	Caregivers of brain-impaired adults.
Long-Term Care Ombudsman	Aging	11	Advocates for rights of residents in 24-hour long-term care facilities.	Elderly.
Linkages	Aging	10	Case management to prevent or delay premature institutional placement (services provided regardless of Medi-Cal eligibility).	Elderly or younger disabled adults.
Alzheimer's Disease Research Centers of California	Health Services	4	Diagnostic, treatment, education, and research services.	Persons with Alzheimer's or other dementia.
Traumatic Brain Injury project (TBI)	Mental Health	1	Hospital and community-based services to help retain independence.	Adults with TBI, caused as a result of an external force to the head.
Senior Companion Program	Aging	1	Companionship and transportation services.	Elderly.
Respite care	Aging	—[b]	Temporary or periodic services to relieve primary and unpaid caregivers.	Elderly or disabled, and their caregivers.

[a] Early and Periodic Screening, Diagnosis and Treatment program.

[b] Amount is less than $1 million.

State, Federal, and Local Governments Provide Funding for Services. The bulk of funds spent on long-term care services come from the state and federal governments. In large part, these expenditure sources are related to the Medicaid program, known as Medi-Cal in California. The federal Medicaid program requires states to provide institutional benefits to all eligible persons and permits states to make community-based services available through waivers of federal Medicaid rules. Federal funds flow to the state as a Medicaid match to the state's funds. In addition, the federal government provides various small grants targeted at increasing community-based services and pays for a limited number of days in a nursing home after a person has been released from an acute care hospital.

There is also a county share of cost for some of the state-operated programs. For example, counties share in the cost of the (In-Home Supportive Services) IHSS program and in the cost of state-operated mental hospitals.

Summary of Long-Term Care Expenditures and Caseload

Key Findings. Figure 2 summarizes *2005-06 Budget Act* appropriations by funding source, caseloads, and the cost per case for the major long-

Figure 2

Long-Term Care Services Funding and Caseload

(Funding in Millions)

Program	2005-06 Budget Act Funding[a]				Estimated Caseload[b]	Annual Cost per Case
	State	Federal	Local	Total		
Institutional Care						
Nursing facilities/ Intermediate Care Facilities (ICF)—fee-for-service	$1,501	$1,501	—	$3,001	68,060	$44,100
State Hospitals	809	8	$71	888	5,609	158,317
Developmental Centers	381	327	—	708	3,016	234,748
ICF-Developmentally Disabled	187	187	—	374	6,320	59,157
Nursing Facilities—managed care	127	127	—	254	8,446	30,102
Veterans' Homes—nursing facilities and ICFs	37	20	—	57	2,340	24,235
Veterans' Homes—residential	36	14	—	50	3,295	15,182
Institutional Care Totals	($3,077)	($2,184)	($71)	($5,332)	97,086	($54,924)
Community-Based Care						
In-Home Supportive Services	$1,241	$1,895	$675	$3,811	374,986	$10,163
Regional Centers	1,881	1,051	—	2,932	205,155	14,292
SSI/ SSP nonmedical out-of-home	270	228	—	498	59,568	8,361
Adult Day Health Care	209	209	—	418	40,800	10,250

Continued

term care services provided by the state. The data demonstrate some important points regarding California's current system of long-term care:

- ***Most Long-Term Care Spending Is for Community-Based Services.*** Estimated expenditures for home- and community-based services are approximately $8.4 billion in 2005-06 compared to a little more than $5.3 billion for institutional care.
- ***Community-Based Services Have a Greater Caseload.*** About 375,000 individuals rely on the IHSS program for assistance, in

Program	2005-06 Budget Act Funding[a]				Estimated Caseload[b]	Annual Cost per Case
	State	Federal	Local	Total		
Nutrition services	9	65	75	148	18,841,884[c]	4
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) shift nursing	73	73	—	147	1,682	84,718
Supportive services	2	35	48	85	944,821	39
Program of All-Inclusive Care for the Elderly	41	41	—	83	2,102	39,340
Senior Care Action Network	32	32	—	64	3,929	16,321
Multipurpose Senior Services Program	22	22	—	45	13,867	3,216
Family Caregiver Support Program	—	23	12	36	17,378	1,341
Nursing Facility Subacute Waiver	16	16	—	33	281	117,025
Conditional Release Program	22	—	—	22	709	30,324
AIDS Waiver	10	10	—	20	2,897	5,370
Nursing Facility A/B Waiver	8	8	—	16	289	54,478
Alzheimer's Day Care Resource Centers	4	—	10	14	3,168	1,326
In-Home Medical Care Waiver	7	7	—	14	67	200,955
Independent Living Centers	—	13	—	13	41,000	305
Caregiver Resource Centers	12	—	—	12	e	e
Long-Term Care Ombudsman	5	3	3	11	45,873	172
Linkages	8	—	2	10	4,319	1,922
Alzheimer's Disease Research Centers of California	$4	—	—	$4	3,228	$1,239
Traumatic Brain Injury project	1	—	—	1	1,204	914
Senior Companion Program	—	—	1	1	235	1,702
Respite care	>1	—	—	>1	26,476	15
Community Care Totals	($3,878)	($3,732)	($826)	($8,436)	d	d
Totals	**$6,955**	**$5,916**	**$897**	**$13,768**	**d**	**d**

a Budget Act amounts unavailable for some programs, therefore funding levels are estimated based on prior year.

b Caseload may be a monthly average, and therefore not represent the number of persons served annually.

c Number of meals served.

d An unduplicated count of clients across programs could not be calculated.

e Caseload data not available.

contrast to less than 100,000 relying on institutional care. Numerous additional persons use community-based care services. The total caseload in community care cannot be determined because many individuals use multiple services, making it impossible to provide an unduplicated count. For example, a single person might simultaneously receive IHSS, Early and Periodic Screening, Diagnosis and Treatment shift nursing, and senior companion program services.

- ***Cost Per Case Generally Greater for Institutions.*** On average, institutional care costs nearly $55,000 per case annually. The annual costs for community-based care vary widely depending on the types of services provided, from over $200,000 annually for individuals receiving certain in-home medical services to about $10,000 per case for IHSS recipients. Because of the great variation in the nature of community services, a meaningful cost average cannot be computed for them. But, in most situations, the cost per case is lower for community care than for institutional care.

- ***Most Long-Term Care Spending Concentrated in a Few Programs.*** About $3.8 billion ($1.2 billion from the General Fund) was appropriated in the *2005-06 Budget Act* for IHSS, $3 billion ($1.5 billion from the General Fund) for nursing facilities, and $2.9 billion ($1.9 billion from the General Fund) for Regional Centers. These three programs alone account for about 71 percent of long-term care spending.

- ***General Fund Accounts for More Than One-Half of Long-Term Care Spending.*** The major long-term care programs, including IHSS, services for the developmentally disabled, and nursing facilities, are funded by Medi-Cal. The state receives matching federal dollars for most of the services provided under these programs, with the result that the federal government contributes about 43 percent of the overall support for the state's long-term care programs. On balance, however, the General Fund is the primary source of funding for long-term care services, accounting for 51 percent of the total. The remainder of the funding comes from local governments.

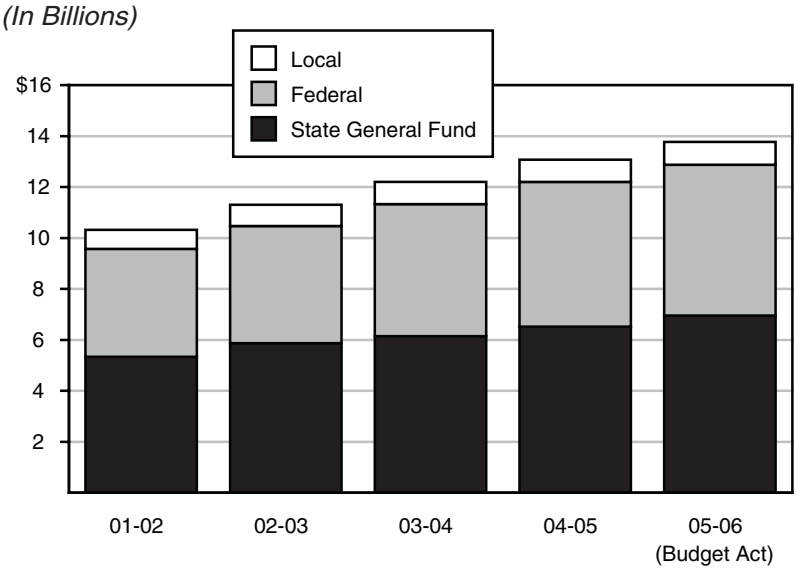
Historical Trends in Long-Term Care

Five-Year Expenditure Trend. The data below summarize the status of the long-term care system since our *2001-02 Analysis*. In general, total spending on long-term care services has grown significantly over the last five years, from over $10.3 billion ($5.3 billion from the General Fund) in 2001-02 to estimated spending of almost $14 billion ($7 billion from the

General Fund) in 2005-06 as shown in Figure 3. This represents average annual growth of 7.5 percent in overall costs during this time period. Finally, despite concerns about the lack of coordination in the delivery system for long-term care services, it continues to remain fragmented.

Figure 3

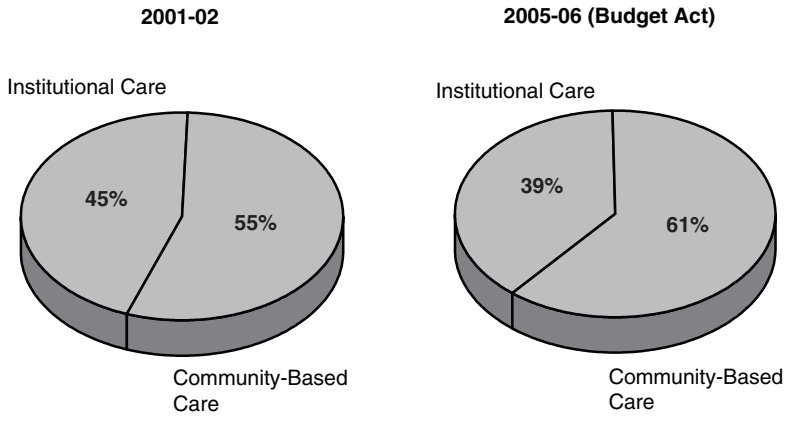
Long-Term Care Spending Continues to Increase



- ***Portion of Total Spending for Community-Based Services Has Grown.*** Figure 4 (see next page) shows that spending on community-based services comprises a greater percentage of total long-term care spending than it did five years ago. This category of spending is now 61 percent of the total.
- ***Shift in Spending Linked to Caseload Trends.*** The increased share of spending going to community care is mainly the result of efforts to divert individuals from institutional care by providing greater choices for community care. In general, the nursing home caseload for the Medi-Cal Program has remained relatively flat, with only about a 1 percent increase in caseload annually at a time when we estimate the population requiring long-term care services has grown by roughly 3 percent annually.

Figure 4

Share of Spending for Community-Based Services Is Increasing



- ***Spending Growing Quickly for Certain Community and Institutional Programs.*** Sizable increases in spending for IHSS, regional centers, and state hospitals have particularly contributed to the trend of increased long-term care program costs. Each has experienced total growth in costs exceeding 40 percent over the last five years including increases in caseloads and the average cost per case during the last five years. The IHSS cost increases have been driven mainly by a 38 percent increase in utilization of services and significant wage increases for workers. The state hospital population has increased 25 percent during the last five years. This is primarily because of growth in the number of mentally ill criminal offenders who have received commitments to the state hospital system. Regional center cost increases are due to several factors, including an aging population that requires more intensive services.

- ***State and Federal Spending Have Increased More Rapidly Than County Spending.*** Figure 3 shows how spending by funding source has increased since 2001-02. State spending for long-term care services has increased an average of 7 percent annually and federal spending grew by nearly 9 percent during the last five

years, including 2005-06 estimated spending. Local spending for long-term care services has increased less than 4.5 percent annually during the same period.

Delivery of Services Remains Fragmented. As noted in our *2001-02 Analysis*, multiple departments administering numerous programs has resulted in a fragmented delivery system of long-term care services. Our recent review shows that this problem persists and that little has been done to reduce fragmentation. Each program is designed with unique eligibility criteria and an individual needing assistance with activities of daily living may be assessed by three or four separate organizations in order to enable them to remain in the community.

With the exception of regional centers, which coordinate care for persons with developmental disabilities, little formal coordination of services occurs. Informal coordination does sometimes take place at the local level. An adult day health care center, for example, might assist an individual accessing other services, such as IHSS or transportation services.

Numerous state reports over the last 20 years have discussed the problem of fragmentation, including the Little Hoover Commission report in 1996 entitled *Long Term Care: Providing Compassion Without Confusion* and a report produced by the Health and Human Services Agency on long-term care in 1999 that was required by Chapter 269, Statutes of 1997 (AB 1215, Mazzoni). Both reports provide strategies for reducing fragmentation and promoting effective communication among long-term care departments such as establishing a "one-stop" service for consumers to obtain information, preliminary assessment of needs, and referrals to appropriate options.

GOVERNOR'S 2006-07 LONG-TERM CARE PROPOSALS

The budget proposes $5.6 million from all fund sources (including $2.1 million from the General Fund), and 45 new staff positions to implement various long-term care reform proposals. Our analysis indicates that the proposals are sound in concept but that only 39 of the 45 requested positions and $4.7 million ($1.8 million General Fund) of the related funding are warranted. (Reduce Item 4260-001-0001 by $338,000.)

Governor's Budget Proposals

The *2006-07 Governor's Budget* plan includes seven proposals intended to help meet the long-term care needs of seniors and persons with disabilities (SPDs). Two of the proposals would extend or make permanent

limited-term positions for activities that are already under way, and therefore are not considered further in this analysis. Two of the proposals are new and three build upon existing state and federal requirements. These five proposals are summarized below:

Long-Term Care Integration Pilot Projects. The Governor's budget proposes $1.2 million ($525,000 General Fund) and 11 positions to implement two long-term care integration pilot projects. The pilots are intended to improve the continuity of care in a managed care setting for (1) persons who are eligible for both Medi-Cal and Medicare and (2) for persons who are seniors or disabled and not eligible for Medicare. Both pilots are also intended to explore how the state can reduce the fiscal incentive for Medi-Cal managed care plans to inappropriately shift high-cost patients into nursing facilities, so that their medical costs would then be borne by fee-for-service Medi-Cal instead of managed care plans.

The first pilot program, Access Plus, would test the integration of Medi-Cal health services with institutional long-term care services and Adult Day Health Care (ADHC) by placing all of these services under one capitated rate for managed care plans. In San Diego and Sacramento, the two counties proposed for Access Plus, enrollment would be voluntary.

The second pilot, called Access Plus Community Choices, would use joint Medi-Cal and Medicare managed care plans that would be paid a capitated rate for providing coverage of acute and primary care services as well as home and community-based long-term care services. Enrollment in Access Plus Community Choices would be mandatory for SPDs in two counties. CalOPTIMA, the existing Medi-Cal managed care plan for Orange County, would administer an Access Plus Community Choices in that county. Another undetermined county would also offer such a plan. In addition, Access Plus Community Choices would operate on a voluntary basis for beneficiaries through the existing Senior Care Action Network program in operation in Riverside, San Bernardino, and Los Angeles Counties.

The proposal also includes an evaluation of the pilot programs over the five-year period to determine their effectiveness in meeting the needs of persons enrolled in Medi-Cal and Medicare.

Develop and Test Uniform Assessment Tool. The Governor's budget proposes the development of a tool that would provide a uniform assessment protocol for persons needing both health and social long-term care supportive services. The tool would enable health and social services programs to share information about an individual trying to access community-based services instead of entering a nursing home. These programs would no longer have to conduct separate and duplicative assessments of the same individual The administration requests one staff position and

contract funds at a cost of $595,000 from all fund sources ($297,000 from the General Fund) for the budget year to develop and test the assessment tool. This same level of funding is also expected to be needed in 2007-08.

Implement Assisted Living Pilot Program. In 2001-02, a state contractor was retained to assist with the design and implementation of an assisted living pilot project. The project is to serve persons with disabilities over the age of 21 living in residential care facilities for the elderly or in publicly subsidized housing, and who require certain relatively intensive levels of nursing care. Enrollment in the pilot program was to have begun recently. The budget proposes six staff positions and contract funds at a cost of $1.2 million from all fund sources ($467,000 from the General Fund) to provide monitoring and oversight for the up to 1,000 persons expected to participate in the pilot project.

Expansion of the Nursing Facility A/B Waiver. Chapter 551, Statutes of 2005 (SB 643, Chesbro), requires DHS to expand by 500 the number of slots available for persons in the Nursing Facility A/B Waiver. Specifically, the budget requests 14 positions at a cost of $1.2 million ($355,000 General Fund) to provide case management services for persons needing skilled nursing care. Unlike the assisted living waiver described above, there is no age limit for these services.

Reform ADHC. The administration proposes to reduce fraud and abuse in the ADHC program and generate estimated savings of $19.3 million ($9.8 million General Fund) in the budget year by restructuring program reimbursement rates. The state would also take steps to verify that only medically necessary services were actually being provided. The budget requests four positions in DHS and four in CDA at a total cost to the Medi-Cal Program of $873,000 ($140,000 from the General Fund) and $174,000 General Fund is requested in CDA to implement these changes. The budget also reflects $13.5 million in savings (including $6.7 million in General Fund savings) from extending an ongoing moratorium on the activation of new ADHCs.

Managed Care Pilot Programs Test Integration

Integration Projects Scaled Back. Last year, as part of a broader effort to restructure the Medi-Cal Program, the administration had proposed so-called Acute and Long-Term Care Integration (ALTCI) pilot projects in three counties. (We discussed these and other related proposals in more detail in our *Analysis of the 2005-06 Budget Bill*, see pages C-67 to C-73.) The ALTCI pilots would have served both Medi-Cal and Medicare patients and provided all acute care, primary care, prescription drugs, nursing facility care, and home- and community-based services for beneficiaries in three counties. However, the ALTCI proposal was not approved by the Legisla-

ture, in part because of unresolved complications involved with integrating ALTCIs with some county-operated programs, in particular IHSS.

This 2006-07 budget proposal targets much the same type of Medi-Cal population that ALTCIs would have served, but would not achieve the same degree of integration as had been proposed last year. For example, the capitated payments made to the Access Plus pilots would include health services and nursing facility care, but would not include home- and community-based services such as IHSS. Access Plus Community Choices pilots would integrate some home- and community-based services. However, IHSS, one of the largest social services programs, would be excluded.

Pilots Could Lay Groundwork for Further Integration. Our analysis indicates that the Governor's more scaled-back pilot projects have some merit. In our view, the pilots now being proposed have the potential to improve the quality of care provided to Medi-Cal beneficiaries and the cost-effectiveness of the health care delivery system. The administration's proposal could go further to integrate home- and community-based services such as IHSS into the various types of pilot programs. Creating more and different pilot programs could also increase fragmentation in the long-term care system in the short term. However, evaluating these new approaches for providing services to SPDs would be of value to the Legislature as it considers long-term strategies to achieve integration of acute and primary care and long-term care services.

Finally, based on our analysis of the workload associated with this proposal, only eight of the 11 positions requested would be needed in 2006-07. The remaining three positions for the managed care pilot programs are primarily responsible for duties that would not begin until 2007-08. Our recommendation is reflected in Figure 5.

Technical Budget Adjustments Warranted for Some Proposals

Our analysis of these measures found the proposals to be sound in concept. However, some of them raise technical budgeting issues that we discuss below.

Long-Term Care Assessment Tool. As proposed by the administration, the long-term care assessment tool budget request would provide more contract funding than would be needed for this purpose in the budget year. Although a full year of contract funding is proposed in the budget plan, the contract for the development of the assessment tool is not anticipated to be awarded until December 2006, halfway through the budget year. In addition, our review found that most of the workload described in the proposal is not ongoing. Accordingly, we believe it could be accomplished with one limited-term staff position instead of the one permanent position that is requested.

Assisted Living Pilot Does Not Reflect Phase-In. Six positions are requested to implement the assisted living waiver pilot project. The request is based on workload associated with full implementation of the project—specifically 1,000 participants living in 15 different sites. However, it is highly unlikely that participation in the waiver project will reach this level in the first few years. For this reason, we believe only three of the six staff positions are justified on a workload basis in the budget year.

Analyst's Recommendations. In summary, we recommend that the Legislature adopt the Governor's proposals related to the state's long-term care programs, but make adjustments to the requests for staff and contract funding that address the technical budgeting issues we have discussed above. If all of our recommendations were adopted, these budget requests would be reduced by $927,000 from all fund sources ($338,000 from the General Fund). Also, six of the requested 45 positions would be deleted, and one of the remaining positions would be approved as a limited-term position instead of a permanent position.

Figure 5 summarizes the staff positions requested to implement various long-term care services proposals and, in some cases, our recommended changes.

Figure 5

Long-Term Care Position Requests and LAO Recommendations

	Position Request	LAO Recommendation
Managed care pilot programs	11	8
Long-term care assessment tool	1	1
Assisted Living Waiver Pilot Project	6	3
Expansion of Nursing Facility A/B Waiver	14	14
Reform Adult Day Health Care	8	8
Office of Long-Term Care office technician	1	1
In-Home Supportive Services Plus Waiver	4	4
Total	**45**	**39**

While Proposals Generally Have Merit—Fragmentation Problem Left Largely Unaddressed

We recommend that the Legislature focus on adopting broad strategies to promote long-term care integration rather than an incremental approach that, as often seen in the past, increases fragmentation.

Most Budget Proposals Narrow in Scope. As discussed above, we find that the individual long-term care reform proposals included in the Governor's budget generally have merit, but most would not move the state toward unifying the fragmented array of long-term care services described earlier in this analysis. Aside from the plan to create a uniform assessment tool, none of the proposals would be implemented on a statewide basis. In fact, as noted above, the new budget proposals maintain or even worsen the fragmentation of these services through their approach of expanding a number of separate pilot programs.

Continue to Focus on Broad Strategies. Studies have repeatedly concluded that integration of long-term care services is the strategy most likely to meet client needs and potentially hold down the significant growth in state costs that is expected to occur in these programs in the future. Accordingly, we believe the Legislature should continue to focus on broader strategies that would integrate and coordinate medical, social, and behavioral health long-term care services. For example, in conjunction with the Governor's proposal for a uniform assessment tool, the Legislature could consider the additional step of establishing a "single point of entry" for long-term care services that could better ensure that individuals receive all the services for which they are eligible.

Twenty-five states operate single entry points to provide consumers with information about long-term care services, assess their abilities to function in various daily activities of living, determine their eligibility for Medicaid, and prescreen whether they are suitable for admission to nursing homes. Community-based organizations (CBOs) and Areas Agencies on Aging (AAAs) act as the single point of entry in many of these states. In California, CBO's and AAA's responsibilities could be similarly expanded by statute to use the proposed new uniform assessment tool as the state's single point of entry to provide "one-stop" services for consumers potentially in need of long-term care services. Alternatively, other agencies could be identified to carry out these functions.

Analyst's Recommendation. The Legislature should focus its efforts on proposing changes in the long-term care system that are broad in scope rather than continuing the present fragmented and incremental approach

to reform. For example, the Legislature could build on the Governor's proposal to develop a uniform assessment tool and enact policy legislation creating a single point of entry in California through AAAs or other appropriate agencies.

LONG-TERM CARE COUNCIL SHOULD SUNSET

The 1999 state law establishing the Long-Term Care Council should be allowed to expire because a more recently established advisory commission appears to serve as a more effective forum for the development of long-term care policy.

Background. Chapter 895 of 1999 (the same statutory measure that commissioned the report in this analysis on long-term care trends) also established the Long-Term Care Council within the California Health and Human Services Agency (HHSA). The council, which is comprised of the directors of departments that operate long-term care programs, is currently charged by state law with the responsibilities of coordinating long-term care policy development, program operations, and developing a strategic plan for long-term care policy through 2006.

Funding was appropriated to the council beginning in 2000-01 for one staff position. However, the statute establishing the council will automatically expire, or "sunset," at the end of 2006 unless the Legislature enacts a new law continuing its operation. The administration's budget plan continues full-year funding for this staff position even though the council would cease to exist halfway through the fiscal year.

Long-Term Care Council Now Dormant. The stated goal of the 1999 legislation establishing the council was to ensure an ongoing dialogue among the various state departments that play a role in delivering long-term care services. However, the council meetings were not as effective as had been anticipated at creating a forum for open discussions. Eventually, the council stopped meeting altogether. It also stopped producing the annual reports to the Legislature required by Chapter 895.

Olmstead Advisory Committee. Another state forum operating under the jurisdiction of the HHSA has largely supplanted the now-dormant council as a forum for the development of long-term care policy.

Known as the Olmstead Advisory Committee, the panel was created in 2004 by executive order in response to a 1999 ruling by the U.S. Supreme Court known as *Olmstead v. L.C.* The court had ruled in *Olmstead* that keeping persons in institutions who could transition to a community setting constituted discrimination under the Americans with Disability Act, a federal civil rights law for the disabled. The executive order directed

the committee to evaluate and revise a 2003 state plan for complying with the *Olmstead* ruling. The committee, made up of representatives selected by the Secretary of HHSA, continues to meet and provide advice to the administration on improving California's long-term care system.

Analyst's Recommendation. The Olmstead Advisory Committee appears to be functioning reasonably well as a forum for discussion of long-term care issues among citizens, organizations, and administration officials with an interest in these policy issues. We believe this committee serves the broader purpose intended by the Legislature of fostering collaboration among various long-term care programs. Extending the statutory life of the now-dormant council is unwarranted.

Accordingly, we recommend that the statute establishing the council be allowed to sunset, and that the staff position that was originally created for the council remain at HHSA to support the ongoing work of the Olmstead Advisory Committee.

LICENSING AND CERTIFICATION REFORM PROPOSALS

The Governor's budget proposes a number of changes to four of the licensing and certification programs within the Health and Human Services Agency to improve the state's oversight of health and community care facilities. We recommend that the Legislature approve the proposals, but we recommend reductions to the level of staff proposed in the Department of Health Services Licensing and Certification Division (DHS L&C). In addition, we propose that the Legislature consider enacting additional reforms in the Community Care Licensing Division in the Department of Social Services and in the DHS L&C.

KEY FEATURES OF THE GOVERNOR'S PROPOSAL

The *2006-07 Governor's Budget* proposes to improve the licensing and certification efforts of the Department of Health Services (DHS), Department of Social Services (DSS), Department of Mental Health (DMH), and the Emergency Medical Services Authority (EMSA) by undertaking a multiyear comprehensive reform effort. The reform proposals include:

- 155.5 new positions in DHS Licensing and Certification Division (L&C) and $18.9 million ($652,000 General Fund) to support licensing activities including timely investigations of complaints about nursing home care.
- 81 new positions and $6.1 million ($5.6 million General Fund) in DSS Community Care Licensing (CCL) division to increase inspection frequency and to implement administrative and management efficiencies.
- Five positions and $420,000 ($349,000 in General Fund) in DMH for increased workload associated with oversight of 165 residential care facilities that provide 24-hour psychiatric and rehabilitative care. Under the proposal, the administration would submit statutory language to allow DMH to begin to collect fees from two

types of facilities that would generate estimated revenues of up to $401,000 per year.

- Six positions in 2006-07 (a total of 30 positions would be phased in over the next three budget years) and a $1.5 million loan from the General Fund for EMSA to take over the licensing of certain categories of emergency medical technicians (EMTs) from local emergency services and public safety agencies and establish a uniform licensing protocol. The agencies that currently license these categories of EMTs often impose different licensing requirements. The licensing program would be fully fee supported and the General Fund loan would be repaid over a five-year period.
- The budget also proposes an extensive number of policy changes to the licensing and certification programs. This includes a proposal to establish a consistent set of core crimes for all programs that would result in a facility's lifetime ban from operation.
- In addition, we are advised that the administration plans to present a proposal to the Legislature at the time of the May Revision for reform of licensing and certification functions at the Department of Alcohol and Drug Programs.

EVALUATING THE GOVERNOR'S PROPOSALS

The DMH and EMSA Proposals. We raise no concerns with the budget proposals in DMH and EMSA included in the reform package. Specifically, we believe that the DMH proposal will help to ensure necessary oversight of residential care facilities. In addition, we find that the proposal for a statewide licensing program in EMSA for certain EMTs would provide consistency in licensing and a statewide registry of EMT personnel that could be helpful for disaster response preparation and during a statewide emergency.

The DHS and DSS Proposals. Thus, our analysis in the sections which follow focus on the proposed budget changes in the DHS L&C and in the DSS CCL division. We analyze each proposal and outline our recommendations for further reform.

Proposals for Additional Statutory Changes. In addition to the proposals discussed above, the administration is proposing extensive statutory changes to implement their broad concepts of L&C reform. While these proposals may have merit, they are beyond the scope of this analysis. We believe this proposed legislation does warrant scrutiny by the appropriate policy committees of the significant policy issues they raise.

LICENSING OF HEALTH FACILITIES: STATE OVERSIGHT NEEDS IMPROVEMENT

The state's existing system for licensing and oversight of 7,000 health care facilities across the state suffers from some serious weaknesses, including a failure to detect deficiencies during inspections, poor follow-up when problems are discovered, a lack of enforcement of state standards, and a drop in staff productivity. In this analysis, we evaluate an administration budget proposal to improve the operations of the Department of Health Services Licensing and Certification Division and comment on further steps the Legislature could take to strengthen the state's regulatory oversight of health facilities.

Background

Main Responsibilities. The L&C Division within DHS is responsible for ensuring and promoting a high standard of medical care in approximately 7,000 public and private health care facilities throughout the state. The L&C's primary responsibilities are to:

- Conduct annual certification surveys for participation in the federal Medicare and Medicaid (Medi-Cal in California) programs. (Most L&C workload is associated with ensuring that health facilities comply with federal requirements.)
- Conduct state licensing reviews and ensure compliance with state law.
- Issue state citations and federal deficiencies, impose sanctions, and assess monetary penalties on those facilities that fail to meet certain requirements.
- Investigate consumer complaints about health care facilities and incidents that are self-reported by the facilities. These complaints may be received via telephone, mail, personal contact, or during a facility inspection.

Later we discuss L&C's failure to meet some of these responsibilities, such as ensuring compliance with state law.

Other Agencies Involved. Several other state agencies are also responsible for providing oversight and inspections of health facilities, including the DHS Audits and Investigations Division, the Office of the Long Term Care Ombudsman within DHS, and the Bureau of Medi-Cal Fraud and Elder Abuse within the Office of the Attorney General. Also, DHS contracts with Los Angeles County to perform oversight and inspections in that jurisdiction in lieu of providing L&C staff for that purpose.

Revenues and Workload. Funding for L&C activities comes from licensing fees imposed on certain health facilities, federal funds, and additional state General Fund support. As shown in Figure 1, the *2006-07 Governor's Budget* proposes about $128 million for L&C operations, an increase of nearly $18 million, or 16 percent, from 2005-06.

Figure 1

Funding for Department of Health Services Licensing and Certification Division

(In Millions)

			Proposed Budget	
	2004-05	2005-06	2006-07	Change From 2005-06
Fee revenue	$34.8	$41.5	$63.4	$21.9
Federal funds	51.0	55.7	56.7	1.0
General Fund	8.4	5.7	0.7	-5.0
Other funds	5.8	6.7	6.7	—
Totals	**$100.0**	**$109.6**	**$127.5**	**$17.9**

As Figure 2 shows, nursing facilities comprise 69 percent or most of L&C's workload. This is primarily because most of the approximately 1,300 nursing homes in the state participate in the federally supported Medicare and Medicaid health care programs. The Centers for Medicare and Medicaid Services, the federal agency which administers these two programs, contracts with L&C to verify that California's health care facilities meet minimum standards to qualify for Medicare and/or Medicaid reimbursement.

Governor's Proposals to Improve Licensing of Health Facilities

The administration is undertaking a multiyear reform of state licensing operations within the Health and Human Services Agency in an effort to increase health and safety protections, modernize licensing systems, maximize the use of program resources, and use licensing fees to support these activities where appropriate. The proposals that specifically affect the DHS L&C Division include the following:

Figure 2

Nursing Facilities Comprise Most of Licensing and Certification Workload

Facility Types	Annual Workload (Hours)	Percent of Total Workload
Nursing facilities	441,731	61%
Intermediate Care Facilities for the Developmentally Disabled	67,594	9
Home health agencies	38,151	5
Hospitals	29,279	4
All other	148,144	21
Totals	**724,899**	**100%**

- ***Licensing Fee Increase.*** Licensing fees would be increased to support a greater portion of L&C costs and thereby reducing General Fund support for these activities by about $5 million in 2006-07. The cost of oversight activities performed in state-operated facilities would continue to be paid for with state General Fund support, and federal funding would continue to be received from CMS for the work that L&C performs on its behalf. A new special fund would be created in order to track the license fees that are collected and spent by L&C.

- ***Staffing Increase.*** About $17.6 million from the new special fund would be spent in 2006-07 to add 118 permanent positions and 23 two-year limited-term positions to complete state licensing and federal certification workload. More than one-half of these positions would be budgeted starting in mid 2005-06. The request also includes $2.7 million in contract funding for Los Angeles County to pay for 18 additional staff to perform licensing and certification functions within that jurisdiction.

- ***Fingerprint Investigations.*** About $1.3 million from the new special fund would be spent to add ten two-year limited-term positions and 4.5 permanent positions to address the current backlog and workload increases in the Fingerprint Investigation Unit. This proposal also includes $65,000 to explore using an information technology system to process criminal background checks. This would reduce the need in the future for additional position requests to handle this workload.

Serious Weaknesses Exist in Nursing Facility Oversight

Serious problems have been identified by federal authorities in L&C's oversight of health facilities. The weaknesses discussed below apply primarily to L&C's oversight of nursing facilities, which, as noted earlier, are by far the largest part of the division's inspection workload.

Deficiencies Understated or Not Found at All. A recent investigation by the U.S. Government Accountability Office (GAO) has found that L&C either understated serious quality-of-care and fire safety problems in its reviews of nursing homes or missed them altogether. Specifically, in July 2003 through January 2005, GAO conducted surveys of a sample of California nursing facilities during the same timeframe that the same facilities had been inspected by L&C staff. The federal comparative surveys found that, in 17 percent of their reviews, at least one serious deficiency had been missed by state surveyors. A serious deficiency is defined as being one that has at least the potential to cause more than minimal harm to a patient.

The overall percentage of homes receiving citations from L&C had decreased significantly—by nearly 23 percent since 1999-00. Absent the GAO reviews, this drop in citations might have been interpreted to mean that the quality of care in California nursing homes had improved. But the GAO reviews indicate instead that L&C's failure to identify serious deficiencies has caused a drop in the number of citations in recent years.

Why Are L&C Inspections Missing Problems? The federal review concluded that these failures by L&C are the result of several key factors.

One problem is that nursing home operators are now often able to predict in advance when a survey will occur. The federal government requires that nursing homes be surveyed at an average interval of 12 months. Surveys are thus considered to be predictable if they are conducted within 15 days of the anniversary of a home's prior survey. The federal review found that, in 2005, 28 percent of the nursing homes in California were surveyed within 15 days of that one-year anniversary. This is an 18 percent increase in predictability since 2002.

Another problem is a lack of timely follow-up on public complaints alleging harm but not immediate jeopardy to patients. In 2004-05, L&C reported that only about one-half of all such complaints were investigated within the ten-day timeframe required under federal rules. In 2001-02, nearly 72 percent of these complaints had been investigated within ten days. Similarly, there has also been a significant reduction in the timeliness of investigations related to incidents that are self-reported by nursing homes.

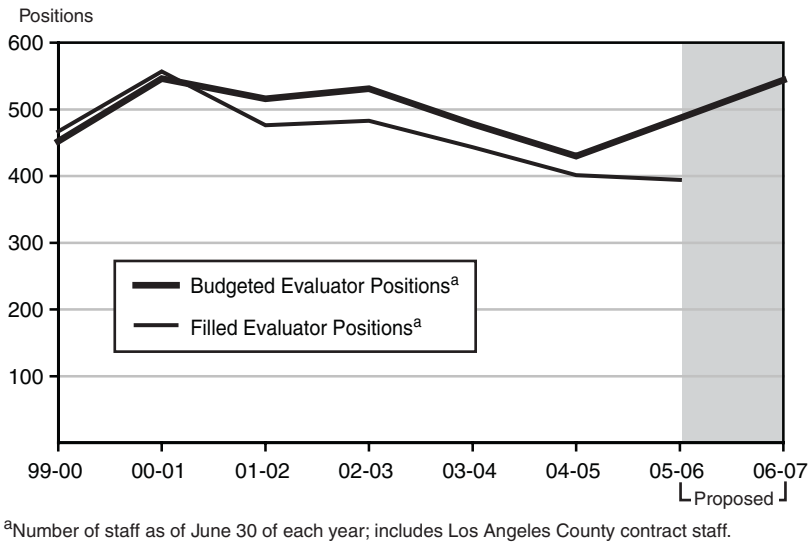
Reductions in Nurse Evaluators May Have Weakened Regulation

The DHS has acknowledged some of the problems found by the GAO, but has contended that reductions in its staffing during recent years have contributed to its failure to meet state and federal requirements. Our analysis suggests that there may be some merit to DHS' view that its performance has been compromised by reduced staffing levels.

DHS Staffing Levels Have Dropped. Figure 3 shows the staffing trend that L&C has experienced for nurse evaluators, the staff responsible for conducting most of the work related to facility oversight.

Figure 3

Evaluator Position Significantly Reduced In Recent Years



[a]Number of staff as of June 30 of each year; includes Los Angeles County contract staff.

As shown in the figure, the *2000-01 Budget Act* added approximately 100 nurse evaluator positions as part of what was then termed the "Aging With Dignity Initiative." The additional staff were intended to increase the frequency of inspections, make surveys less predictable, and provide more intensive and focused inspections and enforcement actions in regard to "problem" nursing homes most often found to violate federal and state standards.

The number of nurse evaluator positions that were filled remained relatively consistent during 1999-00 through 2002-03, aside from a spike in staffing in 2000-01 due to the Aging with Dignity Initiative. However, budget reductions in 2003-04 and 2004-05 eliminated many of the vacant positions from the budget—effectively reversing the staff increases provided in 2000-01. The number of filled positions also dropped in 2003-04 and 2004-05.

Our analysis indicates that the staffing reductions have negatively impacted staff productivity. Specifically, in 2003-04 and 2004-05, there was:

- A decrease in the timeliness of follow-up on complaints (dropping from 64 percent to 51 percent of complaints investigated within the time frames required by state and federal law).
- A reduction in the number of citations issued by L&C (dropping from 705 citations issued in 2003 to 461 citations issued in 2004).
- A drop in the amount of penalties imposed (dropping from $3.5 million in 2003 to $2.3 million in 2004).
- An increase in the predictability of the timing of nursing facility surveys as discussed earlier.

These negative trends in L&C's performance could be attributable to the reduction in staff, since these changes occurred during the same time period that the number of budgeted and filled staff positions declined. However, the Legislature lacks the information needed to be certain of the linkage between the decline in staffing and L&C's lagging performance. For example, absent an analysis of how effectively the staff in the 17 L&C field offices are actually being deployed, it is difficult to know whether the problem is a lack of staff or a lack of productivity by that staff. The Joint Legislative Audit Committee has been requested to authorize an audit in the near future to examine this issue.

Governor's Proposals a Step Forward, But Warrant Adjustments

We recommend that the Legislature approve the administration's proposal to have state-regulated health facilities pay a greater share of the state's cost of these regulatory activities. However, we recommend that the Legislature reduce the number of new staff positions requested for the Licensing and Certification Division because the proposal inappropriately assumes a reduced level of staff productivity than experienced in recent years. (Reduce Item 4260-001-3098 by $7.9 million and Item 4260-598-3098 by $346,000.)

In summary, we recommend that the Legislature approve the proposal to increase licensing fees to support L&C operations, reduce General Fund support, and create a special fund to track expenditures for these activities. However, while we recognize the need for additional staff in L&C to improve its oversight of health facilities, the number of new staff positions and contract funding requested for L&C is excessive and assumes a level of productivity that is less efficient than experienced in prior years. Also, the request for additional positions and funding in the current fiscal year should be deleted. Figure 4 summarizes the positions requested in L&C for 2006-07 as well as our recommendation to reduce the number of requested staff by 63 and related funding by $8.2 million ($346,000 General Fund.)

We discuss our rationale for these proposed actions below.

Figure 4

Positions Requested in DHS Licensing and Certification and LAO Recommendations

	Position Request	Positions Recommended by LAO
Fingerprint Investigation Unit	14.5	14.5
Licensing and Certification Division Workload		
Nurse Evaluators	96.0	55.0
Pharmacists	7.0	3.0
Support Staff	38.0	20.0
Subtotals	141.0	78.0
Totals	**155.5**	**92.5**

Proposal to Increase Licensing Fees Is Reasonable. We concur with the administration's proposal to increase licensing fees because we believe it generally makes sense for state-regulated health facilities to pay a greater share of these costs through fees, rather than to subsidize these activities with state General Fund resources. Notably, despite significant increases in state and federal licensing and certification requirements and resulting increases in regulatory costs during the last five years, licensing fees for most facilities have not been increased.

At this time, the specific level of the fee increase provided in the statutory language to implement the Governor's proposal is not known. This issue warrants careful legislative review. In addition, we believe the

proposed creation of a special fund should improve the Legislature's ability to track fees and expenditures related to the program.

Full Request for Nurse Evaluators Not Justified. As described earlier, the Governor's budget proposes an increase of 141 positions in L&C, including 96 nurse evaluators. The DHS estimates that each nurse evaluator position is the equivalent of 1,364 productive hours a year. However, no justification is provided in the budget request for this assumption about the productivity of these staff.

When DHS sought additional such positions in 1994, it used a higher standard of 1,503 productive hours for each new nurse evaluator. Generally, a standard of 1,800 productive hours is applied for DHS staff positions. We believe it is reasonable to use a lower number than 1,800 hours in this case because of the training and experience necessary to become proficient at health facility inspections. But DHS has provided no support for its assumption that the productivity of nurse evaluators has markedly declined since 1994.

Accordingly, we recommend that the Legislature budget these new positions on the basis of 1,503 hours of productivity per nurse evaluator. This means 55 additional nurse evaluators would be needed to accomplish the estimated workload—41 fewer than are being requested by the administration. The $2.7 million proposed for the contract with Los Angeles County to conduct L&C activities is also based on an assumption of 1,364 productive hours for each nurse evaluator. For the same reason as above, we believe these contract dollars should be budgeted on the basis of 1,503 productive hours and the proposed contract funding reduced to $1.1 million.

Support Staff Request Should Be Reduced. Because the request for support staff for L&C is based on the number of additional nurse evaluators, we recommend that the staffing for support staff be reduced commensurately. Accordingly, we recommend that 20 of the 38 requested support staff be approved.

Number of Pharmacists Overbudgeted. The budget plan requests seven pharmacist positions to ensure pharmaceutical safety in hospitals and surgical clinics by reviewing medication error plans during licensure or survey visits. The request is based on an assumed workload in which each facility would receive one such survey each year. However, according to information provided by L&C, these facilities actually would only be surveyed once every two or three years. Based on our analysis of the annual workload, only three positions are justified. We recommend the Legislature reject the balance of this position request.

Request for Fingerprint Investigations Staff Reasonable. We recommend the Legislature approve the administration's request for 14.5 additional staff for the Fingerprint Investigations Unit. Our analysis found the request is justified on a workload basis.

Reject Request for 2005-06 Positions. The administration has requested that nearly one-half of the positions requested for the budget year be budgeted to start in the current year. However, as of January 2006, DHS had more than 80 nurse evaluator vacancies or a 24 percent vacancy rate. This high vacancy rate means it is unlikely that all of the positions requested, and the funding associated with them, could actually be used for the L&C unit in the current year.

Finally, we recognize there is a need for additional staff in L&C, but that the first priority should be filling existing vacancies. Accordingly, we recommend the request for current-year staffing and funding be rejected in its entirety.

Additional Health Facility Reforms Should Be Considered

In addition to the reforms proposed by the administration to improve the regulation of health facilities, there are other changes the Legislature may wish to consider for the same purpose. These include ensuring that nursing homes are inspected for their compliance with state standards, and improving the coordination of investigations of patient abuse and neglect with the state's chief law enforcement agency.

Compliance with State Laws Should Be Ensured

If the state wishes to ensure the quality of care in California's nursing facilities, we believe that both state and federal requirements for these facilities must be enforced. We recommend the enactment of legislation that requires Licensing and Certification Division to conduct a consolidated survey that covers both state and federal requirements and that clarifies that state regulators should routinely enforce state law.

State Laws Not Routinely Enforced. Legislative oversight hearings held during 2005 highlighted the fact that L&C does not routinely conduct evaluations of nursing homes regarding their compliance with state laws. Currently, only those violations of state law that are incidentally found during inspections for compliance with federal rules are resulting in state action by L&C. The issue is an important policy matter because state and federal legal requirements for nursing homes vary significantly. For example, the state has adopted laws and regulations that exceed fed-

eral nursing home standards, such as abuse reporting requirements and protections against theft and loss.

The administration has asserted that it has the discretion not to routinely conduct inspections to ensure compliance with these state provisions under Chapter 709, Statutes of 1992 (AB 396). The measure exempted nursing facilities that received certification for participating in Medicare and Medi-Cal from periodic state licensing inspections after their initial licensure. When the measure was passed, state and federal requirements were relatively comparable. Since that time, California has adopted numerous laws and regulations that exceed federal nursing home standards in an effort to ensure the safety and rights of nursing home residents.

However, Chapter 709 appears to be in conflict with the statutory language of Chapter 451, Statutes of 2000 (AB 1731, Shelley). Chapter 451 states that DHS is to conduct inspections of long-term care facilities at least once every two years to check whether they are complying with state laws.

We have requested that the administration explain why it is apparently not adhering to the requirements of Chapter 451. At the time we prepared this analysis, however, it had not provided the requested information.

Analyst's Recommendation. In order to avoid any uncertainty about the Legislature's intended policy, we recommend that it enact legislation reconciling Chapters 709 and 451 to clarify that L&C is responsible for regularly evaluating compliance by nursing homes with both federal and state requirements. Where state law exceeds federal law, we believe the appropriate standard should be for state regulators to evaluate compliance with, and to enforce, state law.

In order to ensure this effort is accomplished in a cost-effective manner, state law should be changed to further direct L&C to use consolidated surveys covering both state and federal requirements using a single survey tool whenever possible.

Address Lack of Coordination With Attorney General

We recommend the enactment of legislation to ensure that the Attorney General has direct access to information about the outcome of state inspections of nursing homes and timely referrals from Licensing and Certification Division when serious problems involving patient safety and quality of care are found.

Existing Data-Sharing Agreement Not Working. While the day-to-day responsibility for the identification of elder abuse and neglect rests with L&C, investigating and prosecuting patient abuse and neglect is the responsibility of the Attorney General's Bureau of Medi-Cal Fraud

and Elder Abuse. An agreement between L&C and the Attorney General was signed in May 2004 requiring DHS to provide the bureau with access to computerized information relating to all aspects of L&C program monitoring and investigation, including complaint information and survey information. In addition, the agreement established timeframes for referrals of cases from L&C to the Attorney General where inspections turn up serious problems. For example, a case resulting in a death apparently caused by an abusive act or negligent care is supposed to be referred to the Attorney General's Office within 24 hours.

Despite the signing of this written agreement, we are advised by the Attorney General's Office that it sometimes receives late referrals or none at all. Moreover, the Attorney General's Office still does not have direct computer access to information about L&C program monitoring and complaints investigations. We are advised that L&C has sometimes taken months to provide the information being sought by the Attorney General. According to the Attorney General's Office, these barriers to obtaining information about problems discovered during L&C investigations, and the subsequent delays in referrals of matters to his office, have hindered the Attorney General's efforts to substantiate allegations of abuse of nursing home patients. Our analysis indicates that this situation is weakening state efforts to enforce patient protection laws.

Analyst's Recommendation. We believe it is important that the state remedy the failure of the interagency agreement between the Attorney General's Office and L&C to ensure that the Attorney General receives timely referrals and direct access to information regarding nursing home inspections. Accordingly, we recommend the enactment of legislation directing L&C to provide the Attorney General referrals on a timely basis (as specified in their existing agreement) and direct computer access to L&C's nursing home inspection databases. In addition, the Legislature should direct L&C to report at budget hearings on the status of its efforts to address these problems.

Residential and Child Care Facilities: Inspections Alone Do Not Ensure Safety

The CCL division of the Department of Social Services (DSS) develops and enforces regulations designed to protect the health and safety of individuals in 24-hour residential care facilities and day care. The CCL oversees the licensing of a total of 92,000 facilities, including child care centers, family child care homes, foster family and group homes; adult residential facilities; and residential facilities for the elderly. Counties who have opted to perform their own licensing operations monitor approximately 11,000

of these facilities. The Governor's budget proposes total expenditures of $107.3 million ($25 million General Fund) for CCL in 2006-07. This is an increase of almost 40 percent, or slightly more than $7 million in General Fund support from the current year.

Licensing Inspection Visits

The CCL performs different types of inspection visits to licensed facilities. These inspection visits may be (1) routine inspection visits, (2) the result of complaints, (3) follow-up on violations of regulation, (4) the result of an incident, or (5) for a new license applicant.

Routine Inspection Visits. Licensed facilities may be subject to a routine inspection visit in any year in one of two ways. First, a routine inspection visit is required every year for certain facilities (about 5,800) that meet specified criteria, such as a federal requirement or probationary status

The other reason a facility would receive a routine inspection is if it is selected as part of a 10 percent random sample that is specified in current law. This equates to about 7,000 facilities per year. In practice, this sampling procedure means that most of the licensed facilities in California would receive a routine visit once every 10 years. We note that this level of inspection frequency is inconsistent with a separate statutory requirement that every facility should receive one visit every five years.

Other Inspection Visits. The CCL also inspects facilities initially when they apply for a license and later, as a result of any complaints or incident reports. In addition, licensing visits are conducted to verify that a violation has been corrected. Each year, CCL completes about 69,000 such visits. When these other visits are included, the total number of visits in a year is approximately 82,000. Because these additional visits target only facilities with complaints and violations, CCL does not visit all facilities within a year.

Governor's Proposal

The Governor's budget proposal for the Community Care Licensing Division increases inspection frequency to meet the requirements of current law and adds funds to implement other administrative programs and efficiencies.

The Governor's proposal consists of more licensing staff and other additional positions to enhance certain management and administrative practices. We describe these below.

Increase Inspection Frequency. The Governor's budget proposes an additional $6.1 million ($5.6 General Fund) to provide 38 permanent field staff positions and 29 limited term positions. With the additional permanent positions, CCL will be able to conduct 7,100 more routine inspection visits, allowing for an increased random sample of 20 percent. This increase in the sample will meet the current statutory requirement of an unannounced inspection every 5 years. The 29 limited term positions will be used to eliminate a backlog of inspections.

Enhance Management and Administrative Practices. The budget proposes an additional 12 positions to implement several administrative initiatives as follows.

- ***Training Academy.*** The CCL proposes to add five permanent staff positions to the Central Training Section to train licensing staff and develop standardized training materials.
- ***Flagging System for Individuals with Legal/Administrative Actions.*** The CCL proposes to develop a system which flags and communicates information regarding individuals who have been the subject of legal action. The CCL will create a database and provide access to other Health and Human Service Agency departments who carry out licensing functions. This will prevent individuals who have had a license revoked, or who have been excluded from a CCL-licensed facility for serious misconduct from reapplying or obtaining employment in another facility licensed by a county, CCL or another department. The proposal requests 2.5 positions to coordinate this effort.
- ***Department of Justice (DOJ) Conviction Information.*** As the result of a contract with DOJ, DSS will receive increased information on approximately 8,500 individuals who have been convicted of a crime and who require an exemption in order to remain employed at a licensed facility. The proposal requests 4.5 positions to handle the additional investigative workload generated by this information.
- ***Contracting for Testing.*** The budget proposes to develop a contract with a vendor to provide for the testing and certification of facility administrators. The cost for this contract will be covered by an anticipated $40 fee paid by the administrator.
- ***Automate Collections Processes.*** The budget also proposes $250,000 from the General Fund to implement an automated fee collection and accounting process. Current manual processes and staffing do not accommodate the existing accounts receivable workload. The department also plans to expand its capacity to

accept payments online. This proposal will allow the division to process the current workload and expand its electronic payment capability without hiring additional staff.

Governor's Proposal Does Not Address Enforcement Gaps

We have no concerns with the proposals to improve various administrative capabilities for the Community Care Licensing (CCL) division. However, because of its focus on inspection frequency, the Governor's proposal ignores gaps in the enforcement process, which is designed to ensure that facilities are either safe or if they are not, that they cease operation. We discuss concerns with the division's enforcement activities, and provide recommendations to increase CCL's enforcement effectiveness.

Inspection Frequency Is Only Part of the Picture. During 2005-06, CCL estimates that it will issue over 33,000 citations for violations that present an "immediate risk" to the health and safety of clients in facilities which it licenses. The CCL has the task of assuring the timely correction of these violations and taking enforcement action when necessary. The ability to inspect more frequently, as the Governor proposes, does not by itself improve safety, as we discuss below.

Current Enforcement System

Enforcement Model. The CCL follows a progressive enforcement model to achieve compliance with regulations. This model begins with inspections and citation for violations, which must be corrected within a specified amount of time. Current law requires that civil penalties be levied when a provider fails to correct a serious violation. Repeat violations within a 12 month period also result in penalties. In cases where facilities chronically fail to comply with licensing officials, CCL management may initiate a noncompliance conference, where a "plan of compliance" is developed. This is an alternative to immediately pursuing legal action against the provider's license. If the provider does not comply after this, CCL seeks a legal action to either place the provider on probation, or revoke the license. Although progressive enforcement is the typical approach to compliance, a serious, substantiated complaint or incident report, which presents an immediate risk of harm, usually results in a Temporary Suspension Order, which immediately shuts down the facility, pending the results of a hearing.

Figure 5 illustrates the progressive enforcement model. The wide base of the pyramid represents the relatively large number of citations and inspections. The narrow top represents the relatively small number of

license revocations. The levels in between are comprised of progressively more intensive enforcement actions designed to achieve compliance with regulation.

Figure 5

Community Care Licensing Enforcement Model

Civil Penalties. As shown in Figure 5, civil penalties are a central step in enforcing compliance with regulations, reflecting the consequences for failure to comply with licensing regulations. The details of civil penalty usage, including the amounts for each type of facility, circumstances and type of violation are defined in current law. Civil penalties are tiered in order to provide an increasing financial incentive to correct serious violations. Normally, penalties are assessed only after a provider has failed to correct a violation within a designated period of time. Penalties increase when serious violations are repeated twice within a 12 month period and again if a violation occurs in a third instance. In most cases, a penalty is levied as an amount per day until correction of the violation is achieved, providing an increasing incentive to correct the licensing violation. In some cases, statute requires that penalties be levied immediately with no correction time allowed. These instances include violation of background check requirements, operation of a facility while unlicensed, or if an individual in care becomes sick, injured or dies as a result of a deficiency.

Nonexpiring License. The CCL issues facility licenses that do not expire. Although licensees are required to pay an annual fee, there is no immediate consequence for nonpayment. The fee process has no bearing on the status of the license.

Problems With Enforcement System

As shown in Figure 6, we find that the current enforcement system of CCL contains a gap. This gap is the result of the following problems:

- Although required by statute, CCL does not appear to fully utilize civil penalties with non-compliant licensed facilities.
- Current law allows CCL to exempt a large proportion of child care facilities from civil penalties.
- The licensing division does not collect the information necessary to track the number, type or instances in which civil penalties are used.
- The nonexpiring license hinders the division's ability to collect penalties, overdue fees or to take action against licensees with a history of serious violations.

Figure 6

Community Care Licensing Enforcement Gap

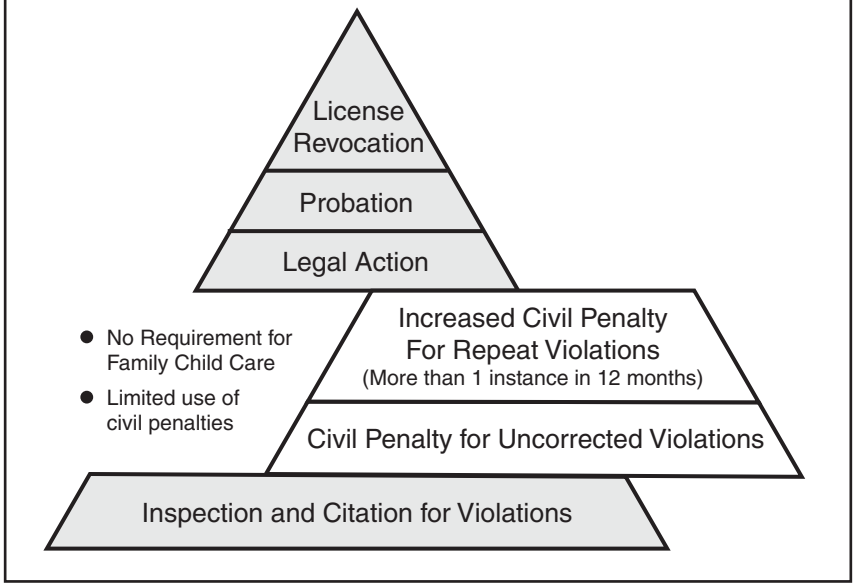


Figure 6 illustrates how problems outlined above create an enforcement gap. We elaborate on these problems below.

Limited Usage of Civil Penalties. Although current law requires that facilities are subject to civil penalty assessment for specified violations, DSS does not have information about the number of civil penalties levied, the types of facilities most frequently penalized, or any data revealing the instances in which the penalties were levied.

In the absence of actual civil penalty data, we developed an estimate of the amount of penalties that would likely be assessed during a year. Using actual data on violations, and conservative assumptions about the requirements for levying penalties, we estimate that approximately $2.4 million would likely be levied in a year. Actual assessments (not collections) were about $1 million in 2004-05. Thus, we believe that CCL is using this enforcement tool less than would be expected. Our estimate, along with anecdotal evidence that licensing analysts are inconsistent in applying penalties suggests that there is limited usage of this enforcement tool.

Legislature Needs More Data on Penalties. We believe that data regarding the usage of civil penalties is important management information that DSS should have in order to make the best possible use of a primary enforcement strategy. Like statistics on inspection visits and citations, this information should also be available to the Legislature. Because civil penalties are levied primarily in response to chronic and serious violations, they also provide information about the level of compliance of licensed facilities. The CCL should report at budget hearings on its plans to collect penalty information, the resources required, and an estimated timeline for such a project.

Currently, licensing fees are deposited in a special fund to allow additional oversight, and tracking of their volume. Given the lack of information about civil penalty assessment and collections, placing civil penalties in a special fund would be a good first step in improving the availability of this kind of information. This would provide the Legislature with some insight into trends in enforcement and compliance.

No Civil Penalty Requirement for Family Child Care Homes. A family child care home (FCCH) is a facility where licensees provide day care in their own homes for no more than 14 children. These homes care for about 35 percent of the children in licensed child care. The Health and Safety Code clearly requires civil penalties for all licensed facilities with the exception of family child care homes. As regards FCCHs, the statute states that CCL "may" levy civil penalties, thereby delegating this authority to the administration. The DSS has not issued regulations for civil penalties on FCCHs. We understand that with exceptions for violations of background check regulations, civil penalties are generally not levied

on family child care homes. The department has provided no explanation for this policy.

By not levying penalties on this facility type for licensing violations, CCL removes a key tool from its enforcement strategies. Without any monetary penalty, CCL must rely on more intensive levels of the enforcement structure when a facility fails to comply with regulation. Such enforcement procedures, such as repeated visits, non-compliance conferences or administrative action require more resources and offer a much less immediate consequence for a licensee. Thus, in our view, statute should be clarified to require civil penalties be applied to FCCHs.

Nonexpiring Licenses. The license issued by CCL to care providers in California is a non-expiring license. One study of other states' licensing (for child care facilities only) that we reviewed reveals that California is one of 12 states who grant licenses that do not expire. Once a facility has applied and successfully received its license, it is effective indefinitely, regardless of the licensee's record of compliance. Facilities do pay an annual fee for their license, which is due upon the anniversary of their licensing date. If the facility does not pay, licensing staff must initiate administrative procedures to close the facility.

In a system where a license expires, the state could deny the renewal request for providers with serious compliance problems or who have unpaid collections or fees. Under the current system, the only way to proceed against such a provider is to initiate an administrative action to revoke the license. This is a lengthy process, which can take six months or longer. Currently CCL collects about 50 percent of the civil penalties assessed. With a renewable license, the state could make payment of outstanding penalties and fees a condition of license renewal. This should result in increased collection without the need for time consuming collection efforts.

Analyst's Recommendations

As discussed above, the Governor's proposal does not address serious gaps in the enforcement process. Increased inspections alone, as the Governor proposes, will not guarantee safer facilities. Below we present a series of recommendations to improve CCL's enforcement and compliance procedures.

- Enact legislation that requires that FCCHs be assessed civil penalties for lack of timely correction of violations and for repeated violations.
- Establish a special fund for the deposit of civil penalty collections from all facilities including family child care homes. In the absence

of other data on civil penalties, such a fund will assist the Legislature in monitoring the amount of penalties and enforcement actions.

- Adopt supplemental report language that requires DSS to report on the costs and benefits of developing the capacity to track the following enforcement data: (1) the number of civil penalties issued for noncorrection of violations and for repeated serious violations, (3) the number of noncompliance conferences held and, (4) the number of resulting probationary, and revocation actions taken against facility licenses.
- Enact legislation instituting a license renewal requirement. Such a requirement could improve the state's ability to maintain compliance and to improve its collections of fees and penalties owed.

SOME PRACTICAL STEPS TO INCREASE CHILDREN'S ENROLLMENT

The Governor's budget plan includes a package of proposals that focus on encouraging the enrollment of uninsured children who are eligible for Medi-Cal and the Healthy Families Program but not currently participants. We find some of these proposals to be reasonable in their current form, but recommend that others be rejected or modified because they are overbudgeted or have not been demonstrated to be effective for combined General Fund savings of about $7 million.

A Multifaceted Approach to Enroll Children in Medi-Cal and HFP

Current estimates from the 2003 Children's Health Insurance Survey indicate that more than 450,000 children in California are potentially eligible for Medi-Cal and the Healthy Families Program (HFP), but are not enrolled. The Governor's budget plan proposes to increase the state's efforts to enroll these children into Medi-Cal and HFP through a multifaceted approach that includes the following main components:

- ***Grants for Local Outreach Efforts.*** Grant funding would be provided to counties to partner with a range of public and private community organizations to reach out to potential recipients and enroll them in Medi-Cal or HFP.
- ***Statewide Media Campaign.*** A new statewide media campaign would be launched that targets the families of uninsured children who could participate in Medi-Cal or HFP and encourages them to enroll in coverage.
- ***Incentives for Application Assistance.*** Additional incentives would be available to persons providing certified application assistance (CAA) who demonstrate quarterly increases in the number of children enrolled with their help.

- ***Streamlining of Enrollment Processes.*** Various changes would be enacted to the HFP enrollment process. Also the "redetermination" form that Medi-Cal beneficiaries must submit annually to have their eligibility reevaluated would be simplified.

The administration projects that these efforts will cost about $7 million General Fund ($17 million all funds) in 2005-06 and about $52 million General Fund ($121 million all funds) in 2006-07 for Medi-Cal and HFP local assistance combined. The costs of the various components of the package are summarized in Figure 1. Below, we comment on each component and its ramifications in more detail.

The Medi-Cal Program is administered by the Department of Health Services (DHS) and HFP is administered by the Managed Risk Medical Insurance Board (MRMIB).

Figure 1

The Administration's Proposal to Increase Enrollment in Children's Health Coverage

2006-07
(In Thousands)

Proposal	General Fund	Federal Funds	Total Funds
Outreach Efforts			
Certified application assistance (CAA) payments	$4,850	$6,932	$11,782
CAA incentive payments	1,044	1,496	2,540
County outreach	8,496	11,189	19,685
Media campaign	1,350	2,024	3,374
Streamlining Healthy Families Program (HFP) Enrollment Process	32	91	123
Toll free line	775	775	1,550
Caseload Effects			
CAA payments	9,711	17,000	26,711
Streamlining HFP enrollment process	3,500	6,053	9,553
Streamlining annual redetermination for Medi-Cal[a]	22,732	22,732	45,464
Totals	**$52,490**	**$68,292**	**$120,782**

[a] Includes county administration costs.

Grant Funding for County-Based Outreach Efforts

Our analysis indicates that a proposed new program to provide grants to counties for outreach for children's health programs could be effective in increasing enrollment in the Healthy Families Program and Medi-Cal, but we recommend that the Legislature modify the program's allocation plan and enrollment strategy.

The Governor's budget plan proposes to initiate a grant program to provide funds to counties for locally directed efforts to increase enrollment and retention of beneficiaries in Medi-Cal and HFP. The budget proposes $8.5 million General Fund ($19.7 million all funds) to begin phasing in this program in 2006-07, with a full-year cost of $13 million General Fund ($30 million all funds) for 2007-08 and subsequent years. The administration also proposes statutory language to establish this new program.

Grant Funding Targeted at Specified Counties. The majority of this funding is to be allocated among the 20 counties that DHS has identified as having (1) the highest number of children potentially eligible for Medi-Cal and HFP and (2) the largest existing caseload in those two programs. Based on survey data on uninsured children, two-thirds of this money would be divided among 5 of these 20 counties: Los Angeles, Orange, San Diego, San Bernardino, and Riverside. The other 38 counties would be able to apply competitively for a grant from a smaller pool of funds if they could demonstrate that they have an established coalition for outreach and enrollment. Counties receiving grant funds would be required to report quarterly on the results of their activities.

Proposed State Funding Could Replace Nonstate Sources. As now proposed by the administration, the grant funds provided by the state to counties could, in some cases, take the place of local public or private sources now used for these same activities. Various counties in the state are already conducting children's enrollment and retention outreach efforts supported through a mix of funding from the state, county, and nonprofit organizations. For example, Los Angeles County is currently funding outreach efforts using funds from the California Endowment and the First 5 California Children and Families Commission (which receives its funding from a state tax increase on tobacco products authorized by a voter-approved initiative known as Proposition 10). Other foundations such as the David and Lucille Packard Foundation have also provided money for enrollment and retention efforts around the state in recent years.

Discussions with DHS indicate that the administration expects some of the state funding to supplant local resources now spent for enrollment efforts, thereby freeing up those local funds to directly provide health coverage for children who are ineligible for Medi-Cal or HFP. This may not occur in cases where local donors to these activities had designated

their funds to be used only for outreach efforts. However, in other cases, it is possible that counties receiving these funds could shift local resources now used for outreach activities to other purposes.

We would also note, though, that counties have an incentive to use any additional state grant funding they receive to expand outreach for Medi-Cal or HFP, because in some cases it would relieve them of the cost of providing county-funded health care for these children.

Some Proposed Uses of Grant Funding May Be Ineffective. The Governor's budget plan envisions that counties will engage in several types of outreach and retention activities. One component identified as a "major activity" would be to have grant recipients follow up with every family that obtains, but does not submit, an enrollment application they received through the Child Health and Disability Prevention (CHDP) "gateway" program. The gateway provides temporary Medi-Cal coverage to children when they receive certain preventive services from CHDP programs operated by counties. The administration's proposal notes that only 16 percent of such applications given out to parents as part of the CHDP gateway are actually later completed by parents and submitted to the state.

Our review indicates that this strategy of relying upon the CHDP gateway program may not be an effective use of state resources. Each of these families already receives a follow-up reminder from the state if they have not followed through with their application. Also, DHS does not have information regarding how many of the children who use the CHDP gateway are likely to be eligible for full-scope Medi-Cal coverage or HFP coverage. A significant portion of these children may be eligible only for limited-scope Medi-Cal due to their immigration status, and thus may be less likely to be willing to apply.

Analyst's Recommendation. We recommend approval of this budget request, with some modifications, because we find that the proposed overall approach of building on existing local efforts and requiring regular reporting is a reasonable approach for expanding outreach efforts.

We are concerned that the proposed funding allocation formula creates the risk that the state will provide additional funding primarily for the very counties that are best able to obtain nonstate funding sources for these same purposes. Accordingly, we further recommend that the Legislature modify the proposed statutory language for this new program so as to account for a county's current access to other funding sources. This change is intended to allocate more grant funds to counties lacking alternative funding opportunities. The legislation should also be modified to require counties which receive the grants to maintain their ongoing level of support for these activities. The Legislature could consider permitting

an exception in cases in which counties receiving these grants shifted their available funding to the direct provision of health coverage for children.

Because it is highly uncertain whether the proposed CHDP gateway follow-up would be cost-effective, we recommend that the Legislature remove from the proposed statutory language the requirement for this activity, and instead specify that these activities would not be supported through the grant program.

Statewide Media Campaign

We recommend that the Legislature reject a proposal to fund a statewide media campaign to encourage enrollment in children's health programs because this approach has not been demonstrated to be effective in the past.

Proposal Would Reestablish Prior Media Efforts. From 1998 through 2002, the state conducted a paid media campaign to promote public awareness of the then-new HFP and the newly expanded eligibility rules for children in Medi-Cal. The media campaign funding was eliminated in 2002-03 because of the state's budget problems. The administration is now proposing to spend $1.4 million from the General Fund (about $3.4 million from all fund sources) in the budget year and $4.9 million General Fund ($11.9 million all funds) annually thereafter to conduct a similar new media campaign.

Benefits of Media Campaign Not Evident. The DHS reports that, after improvements were made in this prior media campaign, the volume of calls made to a toll-free information line for enrollment in Medi-Cal increased. However, DHS further indicated the increase in call volume did not result in a commensurate increase in enrollment. Notably, neither DHS nor MRMIB are projecting an increase in caseload associated with their respective health coverage programs as a result of the renewed media campaign.

Analyst's Recommendation. Because there is no evidence to demonstrate that the media campaign would meet its intended goal of increasing enrollment in Medi-Cal and HFP, we recommend that the Legislature deny this budget proposal in its entirety for General Fund savings of $1.4 million in 2006-07.

Expanding Application Assistance Incentives

We recommend the Legislature deny a proposal to provide increased incentive payments for certified application assistance to further encourage enrollment in children's health programs. We believe it is premature to test the proposed incentive payments before the effect of the existing payments has been evaluated.

CAA Payments. The administration is proposing that the state budget about $14.6 million from the General Fund ($38.5 million from all fund sources) for certified application assistance for Medi-Cal and HFP. Of the $38.5 million in total spending, $11.8 million is for support of CAA and $26.7 million is for HFP caseload growth expected to result from these CAA activities. The CAA payments had been discontinued a few years ago because of the state's budget problems, but were restored by this year's budget. Currently, under this program, CAAs are paid $50 for each beneficiary they successfully enroll in HFP or Medi-Cal, and $25 more for each successful HFP reenrollment at the time of annual redetermination. The MRMIB estimates that about an additional 17,000 children will be enrolled in HFP by June 30, 2006, under the existing CAA program.

In addition to these ongoing payments to CAAs, the administration is now proposing to budget an additional $1 million from the General Fund ($2.5 million from all fund sources) for increased incentive payments to CAAs to further encourage the enrollment of more children in Medi-Cal and HFP. These incentive payments would be made to CAAs that increased the number of assisted initial applications or renewals of their enrollments by 20 percent over the prior quarter. The incentive payment would equal 40 percent of the total payments made to a CAA in the qualifying quarter. The MRMIB and DHS have not provided the Legislature with an estimate for the number of additional children they expect to be enrolled in HFP and Medi-Cal as a result of adding these incentive payments to CAAs.

CAA Payments a Successful Outreach Strategy. The CAA payment program has a demonstrated record of effectiveness, in that each payment signifies the successful enrollment of a beneficiary in these programs. The use of CAAs can also reduce state workload for the processing of program applications and appeals of denials of enrollment. When funding for CAA payments ended several years ago, the number of incomplete applications for HFP increased from 40 percent in 2003 to approximately 70 percent the following year, while the number of appeals of denials of enrollment increased from 130 per month to more than 600 per month. The appeals constituted a significant additional workload for MRMIB and increased problems for families attempting to enroll children in the program.

Analyst's Recommendations. We recommend that the Legislature deny the proposal to provide increased incentive payments to CAAs for savings of $1 million General Fund in 2006-07. As previously mentioned, the basic CAA payment program was just restored last year. Consequently, we believe it is premature to test the proposed incentive payments before the full-year caseload impact of restoring the existing payments has been evaluated. Given that CAA proved before to be an effective strategy for increasing enrollment, it is unclear why additional incentive payments would be necessary.

Streamlining Healthy Families Enrollment

We recommend approval of funding and statutory changes proposed by the administration to streamline enrollment in the Healthy Families Program. Our analysis suggests these changes could significantly increase program enrollment for a fairly small administrative cost.

Changes Proposed to HFP Enrollment Process. The administration is proposing three changes to the application process to reduce barriers and expedite enrollment into HFP.

First, MRMIB is proposing to no longer require applicants to select a health plan at the time of their enrollment. Under this proposal, if a plan was not selected by a family when the child was being enrolled in HFP, the child would automatically be enrolled in the so-called community provider plan—the cheapest option for the enrollee.

Second, prepayments of the first month's premium would no longer be required when an HFP application was submitted. Instead, the child's family would be billed for premiums after the child was determined eligible and enrolled in the program.

The final change would be to expand the availability of the Web-based Health-e-App application to the general public so that any family could use a computer to apply for benefits online. Currently, Health-e-App is used only by county welfare offices and CAAs.

Assuming a January 1, 2007 start-up date for these three changes, MRMIB estimates that they would result in the enrollment of 12,400 more children in HFP by June 30, 2007. (We discuss this aspect of the HFP caseload estimate in a MRMIB analysis later in this chapter of the *Analysis*.) The MRMIB is requesting $32,000 from the General Fund ($91,000 all funds) to support a two-year limited-term position to coordinate these changes.

HFP Enrollment Changes Should Increase Enrollment. Our analysis indicates that all three of the administration's proposals to streamline the HFP enrollment process are likely to prove effective. According to MRMIB, more than 170,000 HFP applications per year fail to include the premium payment or specify the plan in which the child should be enrolled, resulting in the denial of their application. Meanwhile, 64 percent of the applications now being completed on the Web-based Health-e-App are successfully enrolled in HFP compared to 50 percent of applications completed on the mail-in form. Such Web-based applications automatically require that all needed data fields are completed, which reduces mistakes, and the electronic format ensures that readability of the information is not an issue. It is highly likely that more children will be enrolled in HFP as a result of these changes.

Analyst's Recommendation. For the reasons discussed above, we recommend approval of the funding and statutory changes proposed by the administration to streamline enrollment in HFP. Our analysis suggests these changes could significantly increase program enrollment for a fairly small administrative cost.

Simplifying Medi-Cal Reenrollment Forms

We find the administration's proposal to streamline the annual Medi-Cal reenrollment form to be a practical step to encourage beneficiaries to remain in the program. However, we recommend that the Legislature reduce the funding for the caseload increase associated with this change, which we find to be overbudgeted.

Changes to Medi-Cal Form Make Sense. The administration budget plan proposes to implement changes to the annual redetermination form so as to ensure that currently enrolled Medi-Cal beneficiaries continue their participation in the program. The revised form would combine some sections of the existing form and eliminate other parts of the form containing information that is unlikely to change from the initial application for benefits. Other questions on the form would be reformatted to ask about *changes* in a family's information rather than asking them to repeatedly provide information they have provided in the past. For example, the current form asks the applicant to list all children and other adults in the household, while a proposed revision would be less burdensome by asking only about any changes in the members of that household since the previous year.

The paperwork associated with programs like Medi-Cal has been cited in studies as a deterrent to applications for health coverage. Increased stability in the Medi-Cal rolls could also reduce the administrative costs associated with "churning," in which eligible beneficiaries repeatedly leave the program only to reenroll again. The administration's plan to simplify the redetermination form could effectively address these issues.

Estimated Medi-Cal Caseload Effect May Be High. The Governor's budget assumes that this change in the form will increase Medi-Cal caseload costs by about $20 million General Fund in 2006-07. Our review indicates that the projected increase in the Medi-Cal Program resulting from these changes in the redetermination forms is probably somewhat overstated.

The Medi-Cal budget request is based on counties' rough estimates of the impact of this change, and assumes the highest possible growth rate of caseload estimated by the various counties. If the actual growth rate that occurred was at the midpoint of the range of county estimates, the

General Fund cost of this caseload growth would be about $4 million less than assumed in the Governor's budget plan.

Analyst's Recommendation. We recommend that the Legislature reduce the General Fund budget for Medi-Cal local assistance by $4 million to reflect a more reasonable mid-point estimate of the increase in caseload likely to result from simplification of the Medi-Cal form for redetermination of eligibility. We believe the underlying strategy for increasing enrollment is a sound one.

Staffing for Some Activities Should Be Rejected

We recommend that the Legislature reject seven of the ten positions proposed for the Department of Health Services to enact the administration's children's enrollment initiative. These seven positions are either associated with programs we believe should be denied or are unwarranted on a workload basis.

Additional Ten DHS Positions Proposed. The Governor's budget plan includes ten positions and an augmentation of $466,000 from the General Fund ($932,000 all funds) for DHS to implement the various children's enrollment proposals presented by the administration. A significant portion of these resources would be devoted to the development of the proposed media campaign and implementation of the proposed program to follow up on every CHDP family that obtains an application for health coverage but fails to complete it. As stated above, we recommend that the Legislature deny these proposals. Also, we believe that fewer staff are needed for the other enrollment expansion activities proposed by the administration because the outreach effort would rely on county program structures already in place. For these reasons, we recommend that the Legislature deny seven of the requested ten DHS positions for savings of $307,000 General Fund in 2006-07. One MRMIB position would also be approved as propsed.

Conclusion

For the reasons stated above, we find that some of the administration's proposals to encourage the enrollment of uninsured children who are eligible for Medi-Cal and HFP are reasonable, while others should be rejected or modified because they are overbudgeted or have not been demonstrated to be effective. We recommend a combined reduction of about $7 million General Fund ($15 million all funds) and deletion of seven of 11 staff positions proposed for DHS and MRMIB.

BUDGETING FOR COUNTY ADMINISTRATION

The Governor proposes trailer bill legislation which would freeze state participation in county administrative costs in health and social services programs at the 2005-06 level. Under this proposal, state support for county administration would be adjusted for caseload and workload but not for inflation. We review the budgeting history for county administration, comment on the Governor's proposal, and recommend its rejection.

BACKGROUND

Health and Human Services Budget. The departments within the California Health and Human Services Agency (HHSA) operate an extensive array of health and social services programs. The departments have a combined total budget of $63.7 billion ($27.3 billion General Fund, $29.9 billion federal funds, and $6.5 billion special funds). With the exception of developmental and rehabilitation services and certain mental health services, county welfare departments administer most health and social services programs. For 2005-06, total spending on county administration is $6 billion, about 9.5 percent, of the budgets under HHSA supervision.

What Is County Administration? County administration covers a range of activities depending on the program. Sometimes county administration means administrative, clerical, or supportive efforts that facilitate delivery of a service or a benefit (for example, determining eligibility for benefits, payment of service provider bills, personnel management, accounting, and fraud prevention/investigation). The Medi-Cal Program generally fits this description. Counties receive approximately $1.2 billion to cover the cost of county eligibility workers who determine if applicants are eligible for Medi-Cal benefits. Another example is the CalWORKs program where county staff determine an individual's eligibility for the program, including determining the amount of the cash grant and employment services to be received by the recipient.

In other programs, county workers may not be providing a specific cash payment or "benefit." Instead, the salaries and support for the staff constitute the entire program. For example, the Child Welfare Services (CWS) program provides (1) social workers who respond to allegations of child abuse, (2) services to children and families where abuse or neglect has occurred, and (3) services to children in Foster Care who have been removed from their parents. Most of the services are provided by county social workers in the form of case management and counseling. In addition, the social workers are supported by a county administrative structure that provides services including accounting, personnel management, and clerical support. In sum, all program costs are for social workers and related county administrative staff. Child support enforcement is similar to child welfare services in that virtually the entire program is administration.

State and County Program Cost Sharing. The state and the counties share in the nonfederal costs of providing many social services programs. For some programs there are two separate cost-sharing ratios, one for administrative costs and one for benefit costs. Most of these sharing ratios were set in 1991 when the state "realigned" state/county cost shares. In contrast to social services programs, there is no county cost share in Medi-Cal benefits or administration. Figure 1 shows the cost-sharing ratios for county administration of health and social services programs.

Budget Methodology for County Administration. During the 1990s, most budgets for county administration of health and social services programs were set through the Proposed County Administrative Budget (PCAB) process. Under PCAB, counties submitted proposed budgets and staffing levels for their programs based on estimated costs, caseload, and workload. These requests included adjustments for inflation. State departments such as the Department of Social Services (DSS) or the Department of Health Services (DHS) then reviewed these proposed budgets to determine if the requests were "reasonable" and "consistent" with current state law and made any necessary adjustments. Under PCAB, administrative budgets reflected increased costs due to workload and inflation.

No Inflationary Adjustments for Most County Administration Social Services Budgets Starting in 2001-02. During the state's budget crisis, the Governor and Legislature began to freeze county administrative allocations within DSS. Beginning with 2001-02, most county-administered social services programs were held at their 2000-01 budget level, adjusted for caseload. No adjustment for inflation was provided. The one exception was for the CWS program. This program received an increase for inflation for 2001-02. Since 2001-02, there have been no adjustments to county administrative allocations to account for inflation in any DSS programs.

Figure 1

County Administration Programs Subject to Proposed Freeze; Current Budget and Sharing Ratios

2005-06
(In Millions)

Department/Program	Federal	State	County	Total	Nonfederal Sharing Ratio State/County
Department of Health Services					
Medi-Cal County Administration	$587.5	$587.5	—	$1,175.0	100/0
Department of Social Services					
Child Welfare Services	$627.1	$540.0	$170.4	$1,337.7	70/30
CalWORKs	809.9	342.3	57.5	1,209.6	fixed MOE[a]
Food Stamps	224.9	269.7	71.3	565.9	fixed MOE[a]
IHSS[b]	147.0	108.1	46.3	301.4	70/30
Statewide automated welfare system[c]	Unknown	Unknown	Unknown	Unknown	
Adult protective services	45.4	64.4	10.9	117.8	fixed MOE
Adoptions	38.6	48.1	0.4	87.1	100/0[d]
Foster care	48.2	35.0	12.7	95.9	70/30
Community Care Licensing	7.6	7.1	—	14.7	100/0
Cash assistance program for immigrants	—	11.4	—	11.4	100/0
KinGAP[b]	4.7	—	—	4.7	50/50
California Food Assistance Program	—	1.4	—	1.4	100/0
Department of Child Support Services					
Local child support administration	$627.6	$462.5	$10.0	$1,100.1	voluntary[e]
Totals	**$3,168.5**	**$2,474.7**	**$379.5**	**$6,022.6**	

a For CalWORKs and Food Stamps, counties meet a combined fixed maintenance-of-effort (MOE) amount based on 1995-96 spending.

b IHSS=In-Home Supportive Services; KinGAP=Kinship Guardian Assistance Program.

c According to the administration, costs for vendor contracts would not be subject to this proposal. The administration could not provide an estimate of which automation costs are subject to the proposed freeze.

d Base program has no county share, however, certain small training and grant programs have county shares.

e There is no county share, but some counties voluntarily invest county funds.

County administrative allocations within the Department of Child Support Services (DCSS) followed a similar pattern. County allocations were last increased in 2001-02. Then in 2002-03, county administrative allocations were reduced by 5 percent and have been frozen since then.

Medi-Cal Administration Costs Reflect Inflation. In contrast to the social services programs operated by DSS and DCSS, county administrative allocations for Medi-Cal have been adjusted annually for inflation through 2005-06.

GOVERNOR'S PROPOSAL

The Governor proposes trailer bill legislation to limit state participation in county administrative costs for "salaries, benefits, and overhead" to the amount provided in the *2005-06 Budget Act*, as adjusted for caseload. This limit would begin in July 2006 and would apply to 14 different programs operated by DSS, DHS and DCSS. Counties would have the option of using their own funds to pay for inflationary increases in administrative salaries, benefits, or overhead. If a county provides its own funds for inflationary increases, the county monies would draw down federal funds to the extent the federal government normally provides matching funds. Figure 1 shows the programs that would be subject to the proposed freeze in county administration.

CalWORKs Block Grant Restriction. Under current law, counties receive a flexible block grant known as the "single allocation" to fund the costs of administration, child care, and welfare-to-work services in the CalWORKs program. Counties may move funds from one block grant component to another to meet local needs. The Governor proposes trailer bill to prevent counties from using this flexibility to fund increases in salaries, benefits, and overhead.

Passing Medi-Cal Penalties on to Counties. In addition to the salary and overhead cost freeze, the administration proposes to hold counties financially responsible for any federal penalties or disallowances that result from the failure of the counties to comply with requirements of the Medi-Cal program. The penalty would be imposed by reducing the allocation of state funds to the county for eligibility determinations. The administration has not explained its rationale for this proposal. Moreover, if, as proposed, county allocations for salaries, benefits, and overhead were frozen indefinitely, it is possible that the counties' ability to make eligibility determinations in accordance with federal requirements might be impaired.

General Fund Savings. Compared to current law and current budgeting practice, the Governor's proposal results in General Fund savings of $21.2 million in the Medi-Cal Program in 2006-07. There are no savings in the other programs for 2006-07 because they have received no inflationary adjustments since 2001-02 or earlier. This proposal would result in some out-year cost avoidance.

COMMENTS ON THE GOVERNOR'S PROPOSAL

The Governor's proposal raises a number questions about the state county fiscal relationship. We discuss these issues below.

Proposal Would Remove Incentive for County Cost Shifts

As described above, the state has consistently funded inflationary adjustments for Medi-Cal administration while not providing any increases for social services program administration since 2001-02 or earlier. In all counties, social services programs and Medi-Cal are administered by the same county welfare department. In fact, in some counties the same workers determine eligibility for Medi-Cal, California Work Opportunity and Responsibility to Kids, and Food Stamps. Because Medi-Cal has received inflationary adjustments, while social services programs have not, it is possible that counties allocate more county-wide overhead to Medi-Cal rather than to other programs. By making all programs including Medi-Cal subject to a freeze, the Governor's proposal would end the potential for this cost shifting.

Controlling County Costs

One potential rationale for the Governor's proposal is that it limits the state's fiscal exposure to county budgetary decisions by limiting the state's contribution for support of county-administered health and social services programs. This in turn creates an incentive for counties to control costs. Some observers believe that county workers have more favorable overall compensation packages (higher salaries, benefits, and pensions with lower copayments and retirement contributions) than comparable state workers. We have no data to assess the validity of this hypothesis. However, the *2005-06 Budget Act* directed the Department of Personnel Administration to conduct a survey comparing state compensation packages to packages offered by other public and private entities including counties. When this information is available (probably by April 2006), we will provide our comments on it to the Legislature.

While counties have significant control over wages through the collective bargaining process, they have little control over rent, utilities, and energy costs. It is for these types of largely uncontrollable costs that the Governor's budget includes a 3.1 percent inflationary adjustment for state departments.

Will Counties Cover Inflation Costs With Their Own Funds?

Under the Governor's proposal, counties would have the option of covering costs related to inflation with their own funds. To the extent counties elect to cover these costs, program services would continue to be provided at their current levels. On the other hand, if counties cannot or will not cover these inflationary costs, service levels are likely to decline over time. The Governor's proposal essentially delegates the decision about whether to reduce service levels in the face of inflationary cost pressures to the counties. County decisions will vary based on their priorities and their individual fiscal situations.

Meeting State Objectives. Each of the programs that would be subject to the proposed freeze was enacted by the Legislature with specific state goals and objectives. Counties administer these programs as agents of the state with the aim of meeting the state established program goals. Unless the counties elect to use their own general purpose revenues to cover inflationary costs, lack of state funding for inflation could will slowly erode service levels.

Proposed Language Is Broad in Scope

Undefined Terms. The proposal freezes state participation in county costs for salaries, benefits, and overhead. However, the language provides no definition for these terms. Although not specified,"overhead" could include any or all of the following: rent, utilities, equipment, vehicles, contracts with vendors, allocated support costs from other county government functions, and gasoline. Adopting broad language such as this delegates the development of definitions to the administration.

Penalty Proposal Raises Policy Issues. The proposal to hold counties financially liable for certain federal penalties that Medi-Cal experiences raises significant policy concerns. For example, the Legislature may wish to consider whether such penalties should be borne by counties alone or whether in some cases they should be shared by the counties and the state. We believe this penalty liability proposal warrants further examination by the appropriate policy committees.

Proposal Is Inconsistent With Budget for State Operations

For 2006-07, the Governor' budget generally provides a 3.1 percent inflationary adjustment for most departments to cover increased costs in operating expenses and equipment. Counties face identical cost pressures, but, pursuant to the Governor's proposal would receive no state funds to cover inflationary costs.

Short-Term Budget Solution Vs. Long-Term Budget Policy

During times of fiscal difficulty, not providing inflationary adjustments is a potential budget solution. As discussed earlier, allocations for administration of most social services programs have not received an inflationary adjustment since 2001-02. Moreover, the Legislature and Governor have suspended the state cost-of-living adjustments for recipients of both Supplemental Security Income/State Supplementary Program and the CalWORKs program in 2005-06 and 2006-07. These budget solutions, however, have been adopted on a one-year or two-year basis. By proposing trailer bill legislation, the Governor is moving from a system of relatively short-term budget solutions to a long-term budget policy with implications for the state county fiscal relationship.

ANALYST'S RECOMMENDATION

The Governor's proposal would limit state participation in county administrative costs for salaries, benefits, and overhead to the amount provided in the *2005-06 Budget Act*, as adjusted for caseload. We recommend rejecting the Governor's proposal and offer suggestions for developing an alternative policy.

Reject Trailer Bill Proposal

In our view, there is not a compelling case for adopting trailer bill legislation creating a long-term budget policy of limiting state participation in county administration. The proposed language would restrict legislative flexibility to adjust funding and service levels in county administration.

Adopt a Consistent Approach to Budgeting County Administration

With respect to county inflationary adjustments, we recommend that the Legislature take a consistent approach for all county-administered state programs. Specifically, if an increase is to be provided, it should generally be the same percentage increase for all such programs. Conversely, a decision to provide no increase should be applied to all county-administered programs. Having a consistent policy would eliminate the incentive for counties to shift overhead costs from social services to Medi-Cal (where inflationary adjustments have been granted). This approach, has the merit of bringing consistency to budgeting for all county-administered health and social services programs. To the extent the Legislature is concerned about different service levels that have developed in the various programs as a result of differential inflationary adjustments, this could be addressed through separate budget action.

GETTING BETTER BUDGET INFORMATION

We recommend that the Legislature direct the Department of Finance (DOF) to include in the annual Governor's budget document a schedule of local assistance appropriations for Medi-Cal and public health programs for the prior, current, and budget year. It should also incorporate additional information on the proposed expenditure of Proposition 99 funding. Finally, the Legislature should establish new budget item numbers for certain major health programs so that the Legislature can more easily track the budgetary changes that are being made to these programs using a DOF information system. All of these changes are proposed to take effect for the 2007-08 budget.

Budget Data Could Be More Accessible and Useful

Health Program Spending Information. Every year, during the development of the Governor's budget, the Department of Health Services (DHS) prepares detailed information about local assistance health expenditures by program category and source of funding. For example, the so-called supplemental local assistance schedule shows that the administration is proposing to increase General Fund expenditures for AIDS-related programs by $12 million in 2006-07. This information is useful in tracking spending for Medi-Cal and public health programs from year to year, and provides additional data, such as the cost of eligibility determinations for Medi-Cal and utilization of services by enrollees in the program. However, this information is not readily available to the Legislature and the public. We note that this information was previously available in the DHS section of the Governor's budget document but was dropped from the document several years ago.

Additionally, the administration also prepares each year information indicating how Proposition 99 tobacco tax revenues are proposed to be distributed in the current and budget years under the budget plan for various state departments and specific programs (mainly for health, tobacco education, and resources). Information on past spending, estimated current-year spending, and proposed budget year expenditures for these

local assistance expenditures also are not available in one summary in the Governor's budget document.

System for Tracking Budget Changes. Each year, the Legislature and the administration propose a number of changes to the Governor's January 10 budget plan, a large number of which end up being adopted. The computerized information system for tracking changes made by the Legislature and the administration to the Governor's budget does not separately provide detailed information about changes made to several of the largest state health programs.

For example, the tracking system is currently configured to group together changes made to Medi-Cal local assistance with those made to other DHS public health local assistance programs. Similarly, changes made to the proposed budget for Healthy Families Program (HFP) local assistance are grouped in the Department of Finance (DOF) reporting system with other local assistance programs operated by the Managed Risk Medical Insurance Board. Also, budgetary changes to state operational costs for the developmental centers (DCs) and state mental hospitals are grouped with those made to the budgets for headquarters administration.

Because the dozens of budgetary changes to these major health programs are not tracked separately, it is difficult for the Legislature to monitor on a timely basis how these actions are affecting the overall proposed level of expenditures for these major programs, some costing the state billions of dollars annually.

We are advised by DOF that it is not possible to easily modify the present budget change tracking system to separately track budgetary changes to these major health programs. The DOF indicates an alternative approach would be to create new and separate budget items for the programs that the Legislature desired be tracked separately.

We note that precedent for this alternative approach can be found in the budget for the state Department of Veterans Affairs (DVA). Each of the state's three veterans homes is budgeted as a separate budget item, which permits changes to their budgets to be tracked on an ongoing basis in DOF's budget change tracking system. The Yountville home is the "8960" budget item, the Barstow home is "8965," and the Chula Vista home is "8966."

The budgets for major health programs could similarly be renumbered to allow them to be tracked separately. For example, the Medi-Cal Program could be changed to create a new "4265" budget item and its expenditures removed from the current "4260" category, where Medi-Cal local assistance expenditures are now grouped together with DHS public health local assistance.

Analyst's Recommendation. We recommend that additional information detailing DHS local assistance and Proposition 99 expenditures by program and subprogram be included in the Governor's budget document as a schedule.

The DOF has expressed concerns about this proposed approach, on the grounds that it would be difficult for the department to complete these schedules in time to be included in the budget galley. They propose instead that such information be posted on the DHS Web site to improve public access.

We nonetheless recommend that the Legislature direct that these changes proceed for next year. Both DHS local assistance and Proposition 99 expenditures involve very large amounts of state funding—cumulative more than $14 billion in 2006-07—for which key budget issues regularly arise for the Legislature. On those grounds, we believe that the need for better legislative and public access to this information in budget documents outweighs this objection. As for DOF's alternative, we believe the DHS Web site has so much information that the public would probably find it challenging to search for local assistance and Proposition 99 schedules even if they were placed there. (However, we do not object to this additional action being taken by the administration.)

We acknowledge that such a change could affect DOF's timetable for preparing budget documents. But we would also note the likelihood that improved access to this information in budget documents will help reduce the existing workload of DOF and state agencies, which must frequently respond to legislative and public requests for information about the past, present, and proposed future spending for these state programs. In the future, some of these information requests would be avoided because the information about these expenditures would henceforth be found where it is expected to be—on display within the Governor's budget document.

In addition, we recommend that the Legislature further direct DOF to establish Medi-Cal, HFP, DCs, and state mental hospital systems as new budget items so that changes to these budgets can be tracked separately and more easily in DOF's budgetary change tracking system. We note that there is a precedent for this approach in the DVA budgets for veterans homes.

Accordingly, we recommend the adoption of the following Budget Bill language in the DOF state operations budget, Item 8860-001-0001, given that DOF is primarily responsible for preparing the Governor's budget plan:

> Provision X. The Department of Finance (DOF) shall revise the numbering of budget items for certain major health programs as soon as possible, but in any event no later than by January 10, 2007, so that proposed changes in expenditures to the Governor's budget for the following programs

can be more easily identified and tracked separately by users of the DOF budget changebook tracking system. This change shall occur for at least the following major health programs: (1) Medi-Cal, (2) the Healthy Families Program, (3) the developmental center system, and (4) the state mental hospital system.

Proposition Y. The DOF shall revise the Governor's budget documents display for the Department of Health Services to include a display of the following information: (1) the supplemental local assistance schedule, including past year, estimated current year, and proposed budget year expenditures for each listed program and subprogram; (2) a Proposition 99 expenditure plan for both the current year and for the budget year detailing proposed expenditures for each department, program, and subprogram that has been allocated Proposition 99 funding, including the adjustments proposed in the Governor's budget plan relative to the budget act that year enacted for the current year.

In summary, we believe these changes would better enable the Legislature and the public to understand the Governor's January 10 budget proposal and would subsequently assist the Legislature in making sound decisions about the appropriate level of funding for its major health programs as budgetary changes are made.

DEPARTMENTAL ISSUES

Health and Social Services

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS (4200)

The Department of Alcohol and Drug Programs (DADP) directs and coordinates the state's efforts to prevent or minimize the effects of alcohol-related problems, narcotic addiction, and drug abuse. Services include prevention, early intervention, detoxification, and recovery. The DADP estimates that its treatment system will provide services to approximately 227,000 clients in 2006-07.

The DADP administers the Drug Medi-Cal Program, which provides substance abuse treatment services for beneficiaries of the Medi-Cal Program. It also negotiates service contracts and allocates funds to local governments (including funds provided under the Substance Abuse and Crime Prevention Act, the 2000 initiative also known as Proposition 36) and contract providers. The department also coordinates the California Mentor Initiative, a multidepartmental effort targeting youth at risk of substance abuse, teen pregnancy, educational failure, and criminal activity.

Governor's Budget Proposal. The Governor's budget proposes $615 million from all funds for support of DADP programs in 2006-07, which is an increase of about $5 million, or about 1 percent, above the revised estimate of current-year expenditures. The budget proposes about $243 million from the General Fund, which is an increase of about $4 million, or almost 2 percent, above the revised estimate of current-year expenditures.

The budget plan includes the following proposed spending and policy changes:

- ***Drug Medi-Cal.*** The spending plan proposes budget bill language that freezes provider rates in the budget year at current-year levels instead of allowing them to automatically increase in keeping with statutory rate-setting requirements. This would result in estimated state General Fund savings of $7.4 million in the budget year.
- ***Proposition 36.*** The spending plan proposes to maintain General Fund support at $120 million for 2006-07 to fund Proposition 36-related activities and reauthorize 29.7 positions related to the program. According to the administration, these funds are proposed to be authorized on a one-time basis, and are conditioned on the Legislature enacting significant policy changes to Proposition 36 that the administration contends will improve participant outcomes and accountability. We discuss this proposal in more detail later in this analysis.
- ***Audits.*** The spending plan proposes an increase of $286,000 all funds ($143,000 General Fund) and three positions for the Drug Medi-Cal program to provide increased fiscal oversight of Narcotic Treatment Program providers. According to the administration, these resources are needed to identify and deter fraud and ensure the health and safety of clients

THE SUBSTANCE ABUSE AND CRIME PREVENTION ACT: PROPOSITION 36 AT A CROSSROADS

Proposition 36 provided annual appropriations from the General Fund through 2005-06 to implement a voter-approved initiative requiring drug treatment instead of incarceration in prison or jail for certain nonviolent drug possession offenders. The appropriation expires at the end of 2005-06 and the Legislature for the first time has discretion to determine the appropriate level of funding for a program that counties will still statutorily be required to provide. We withhold recommendation at this time on the proposed General Fund transfer of $120 million to the Proposition 36 trust fund and on reauthorization of 29.7 positions pending review of a cost-benefit study of the measure due out April 1, 2006.

Program and Funding Overview

Measure Approved by Voters in November 2000. The Substance Abuse and Crime Prevention Act of 2000 (Proposition 36) was approved by the

voters in the November 2000 election and many of its provisions affecting criminal sentencing became effective July 1, 2001. The measure changed state law so that certain adult offenders who use or possess illegal drugs are sentenced to participate in drug treatment and supervision in the community, rather than being sentenced to prison or jail or being supervised on probation without treatment. For example, offenders convicted of nonviolent drug possession offenses are sentenced under Proposition 36 by the court for up to one year of drug treatment in the community and up to six additional months of follow-up care. Also, some offenders under parole supervision by the California Department of Corrections and Rehabilitation, and who are found to have committed nonviolent drug possession offenses, remain in the community and are directed to drug treatment. Some offenders, including those that refuse treatment or who had used a firearm while under the influence of an illegal drug, are excluded from the provisions of Proposition 36.

Sanctions Specified in Law. Under certain circumstances, offenders who fail to comply with their drug treatment requirements or who violated their conditions of probation or parole are subject to certain sanctions, such as being moved to an alternative or more intensive form of drug treatment. Once an offender has twice failed Proposition 36 treatment, he or she is subject to punishment with a 30-day jail sentence for a third conviction for a nonviolent drug possession offense.

Treatment Programs. Proposition 36 drug treatment programs must be licensed and certified by the state and can include various types of treatment methods selected by counties and the courts, including residential and outpatient services and replacement of narcotics with medications such as methadone.

Program Administration. Under the terms of the measure, the DADP allocates funds to counties, which administer or oversee the Proposition 36 drug treatment programs. Proposition 36 requires annual audits to ensure that its funds are spent only for the purposes allowed by the measure. Also, the initiative commissioned a study (now being conducted by a University of California at Los Angeles research institute) of the costs, benefits, and other outcomes of Proposition 36.

Proposition 36 Funded From State General Fund. Proposition 36 required automatic annual appropriations from the General Fund to a special fund called the Substance Abuse Treatment Trust Fund. The measure specifically allocated $60 million in startup funds for the 2000-01 fiscal year and $120 million per year for 2001-02 through 2005-06. These funds were generally not subject to annual appropriation in the budget act. About $116 million has been provided annually to counties for the operation of local Proposition 36 programs. In addition, about $3.9 million

was provided to DADP to offset its administrative costs to operate the program. No appropriations are provided by Proposition 36 for 2006-07 or subsequent years, leaving it to the Legislature to determine how much, if at all, to appropriate for this purpose in the future.

Annual Spending Now Higher Than Annual Funding Allocations. Proposition 36 permits counties to carry over unspent Proposition 36 allocations from year to year, and a number of counties have done so. For example, only about $7 million of the initial $60 million round of funding was spent in 2000-01, with the balance carried over by counties into later years. The amount of available carryover funds available to counties has been dropping in recent years as programs have been ramped up.

Current annual county spending is higher than the current annual Proposition 36 appropriation of $120 million. This is because a number of counties have increased spending to a higher level by using the funds they carried over from prior years. In 2004-05, the last year for which complete cost reports are available, about $143 million was spent. However, that figure does not take into account any expenditures that could be disallowed as a result of ongoing annual audits discussed above. Netting out disallowed expenditures would probably eventually result in a modest reduction in this expenditure level.

Legislature May Augment Proposition 36 Appropriation. Proposition 36 states that the Legislature may appropriate additional funding to the trust fund beyond the $120 million in annual General Fund appropriated under its own terms through 2005-06. This has not occurred, although the Legislature has earmarked about $8.6 million per year in federal Substance Abuse Prevention and Treatment (SAPT) block grant funds for drug testing of Proposition 36 participants, partly because Proposition 36 does not allow for monies from the trust fund to be used for drug testing of participants.

The Future of Proposition 36

Funding Discontinued, but Requirement for Treatment Remains. While the appropriations required by Proposition 36 cease at the end of 2005-06, the requirement for diverting certain offenders from prison and jail to drug treatment remains fully in effect. If the state were to simply stop or significantly reduce funding, many counties would either have to reduce expenditures for their Proposition 36 programs or identify other funding sources to continue to support them. The loss of some or all of this funding could also affect the state correctional system because some trust fund resources are now used by counties to provide treatment services for state parolees who violate parole rules by possessing illegal drugs.

Federal Rules Limit State Options. The state currently receives about $262 million annually under the federal SAPT block grant program, almost all of which is used for the support of community drug treatment systems operated by counties. The SAPT block grant is provided to states on the condition that they maintain a specified ongoing level of state support for their drug or alcohol programs. States that violate this so-called maintenance-of-effort (MOE) requirement are at risk of losing one federal dollar of SAPT block grant funding for every state dollar they spend below the required MOE level. The Proposition 36 funding is counted as part of the SAPT MOE.

Thus, if the Proposition 36 appropriation were completely eliminated, and state spending on other eligible drug treatment programs did not increase to offset this loss, the MOE rules would cost the state about $180 million in federal funding over two years under the specific federal rules for SAPT MOE. This would amount to a major loss of funding for county drug treatment systems. We note that increasing spending levels under Proposition 36 may also "ratchet up" the level of funding that would have to be sustained in the future to meet the SAPT MOE requirements.

Administration's Budget Proposes Major Policy Changes

The Governor's budget proposes to maintain General Fund support of the trust fund at $120 million General Fund on a one-time basis for 2006-07 to fund Proposition 36 related activities. The allocations would largely mirror the current split in funding, with about $3.5 million allocated under the Governor's budget proposal for DADP administration of the program and about $116.5 million allocated to counties. The budget request would also reauthorize the 29.7 positions that now exist at DADP to carry out various Proposition 36-related activities, including auditing functions. According to the administration, these funds are proposed to be authorized on a one-time basis, and are conditioned on the Legislature enacting significant policy changes to Proposition 36 that the administration contends will improve participant outcomes and accountability. Any such changes would likely have to go back to the voters for their approval. The administration's proposed changes include:

- ***Jail Sanctions.*** Judges would be given authority to sentence offenders to short jail terms of a few days if offenders failed to attend required drug rehabilitation treatment programs. The administration indicates that this measure is meant to provide judges with increased powers to punish offenders that are not making a good-faith effort to participate in their programs.
- ***Required Drug Testing.*** All courts would be required to impose drug testing as a condition of probation. (Courts now have the

option whether to require drug testing for Proposition 36 offenders.) The administration says this change would allow the courts to better monitor the offender's compliance with treatment programs and progress towards rehabilitation. This mandatory drug testing would be funded with existing resources outside the Proposition 36 trust fund.

- ***Judicial Monitoring.*** County Proposition 36 programs would provide for judicial monitoring of eligible offenders through dedicated court calendars and other features commonly used in drug court programs, a number of which existed before the enactment of Proposition 36 and which continue today for both Proposition 36 and non-Proposition 36 offenders. The administration says that this change would improve collaboration among treatment providers and law enforcement and improve the supervision of the progress made by participants in their drug treatment through regular review hearings.
- ***Treatment Tied to Offenders' Assessments, Culture, and Language.*** The administration proposes that offenders receive appropriate treatment to overcome their addiction and that the availability of culturally and linguistically appropriate services be assured.

Funding Would Continue Through the Trust Fund. The administration proposes to continue to fund Proposition 36 activities through a General Fund appropriation in the annual budget bill that would be transferred to the existing Proposition 36 trust fund. The administration acknowledges in its budget proposal that other mechanisms for funding Proposition 36, that we discuss later in this analysis, are possible. For example, the budget could provide a General Fund appropriation to support Proposition 36 activities that would not be transferred to the trust fund. However, the administration cites potential legal problems with these alternative approaches and states its view that its funding mechanism is consistent with the will of the voters.

Setting an Appropriate Level of State Funding for Proposition 36

As noted earlier, the administration budget proposal would keep the state's contribution to county Proposition 36 programs and its support of related DADP administration at roughly the same funding level that has been in place for five years. We believe there are a number of technical, fiscal and policy issues the Legislature should weigh as it decides how much funding to provide for Proposition 36 in 2006-07 and in future years, which we summarize in Figure 1, and discuss below.

Figure 1

Setting An Appropriation Level for Proposition 36

Issues for Legislative Consideration

- ***Cost-Benefit Analysis Due out in April.*** A cost-benefit study of Proposition 36 is due to the Legislature April 1, 2006, and the results of the study will be relevant to the Legislature's deliberations over funding levels.
- ***Federal Maintenance of Effort (MOE) Requirements.*** The state would violate federal MOE requirements and lose federal grant money if it reduces Proposition 36 spending without increasing spending on other drug programs.
- ***Alternative Funding Mechanisms.*** The Legislature may increase its control over Proposition 36 policy and implementation by funding Proposition 36 through alternative funding mechanisms instead of through the Substance Abuse Treatment Trust Fund. However, the Legislature should seek legal counsel regarding this option, if it wishes to pursue it.
- ***Alternatives to General Fund Support.*** Proposition 36 costs could be offset through the collection of fees that could be charged to offenders or by any third-party insurance coverage available to offenders.
- ***Technical Funding Adjustments.*** The Legislature could adjust annual appropriations to take into account carryover funds from prior appropriations and the amount of funding recovered due to audit disallowances.

Cost-Benefit Analysis Relevant to This Decision. As noted earlier, an ongoing study of Proposition 36 outcomes is under way. Specifically, Chapter 78, Statutes of 2005 (Senate Bill 68, Senate Committee on Budget and Fiscal Review), requires DADP to submit a cost-benefit analysis of the measure to the Legislature by April 1, 2006. The results of that study will be relevant to the Legislature's decision on a funding level for Proposition 36.

For example, if the study demonstrated significant county savings, the Legislature could consider setting a state funding level that assumes a county share of support for the program. We believe it is reasonable for the counties to share in the ongoing cost of Proposition 36 programs if it is found they share a substantial part of the savings resulting from the measure. If the study demonstrated state savings that substantially exceeded state costs, the Legislature may wish to consider expanding eligibility and the appropriated state funding to include other appropriate populations of offenders likely to increase the net savings to the state from Proposition 36.

Flexibility Exists for Meeting MOE Requirements. The Legislature could choose to fund Proposition 36 at a lesser amount than the $120 million General Fund proposed by the administration without necessarily

incurring a loss of federal SAPT funds. As we noted earlier, this could occur if the Legislature increased funding commensurately for other drug programs—such as by expanding Drug Medi-Cal services that are available for women. (Such an expansion is allowed under past legislation that was enacted but never implemented because of a lack of state funding.) The SAPT MOE rules require that the state provide an *overall level of support* for eligible drug treatment programs, but does not require that *any specific state program* receive the same level of funding as before.

Alternative Funding Mechanism Might Allow Greater Legislative Control. If the Legislature approves a General Fund appropriation to transfer to the trust fund, as the administration budget proposal contemplates, all of the existing restrictions on the use of these monies would continue to apply (absent changes to the Proposition 36 statute). Alternatively, it may be possible for the Legislature to fund Proposition 36 through (1) a direct General Fund appropriation for support of the program, or (2) a General Fund transfer to a new and separate trust fund created for this purpose. We note that further review of these approaches would be warranted in order to ensure they do not legally conflict with the statutory provisions of Proposition 36.

If the Legislature chose to fund Proposition 36 activities on an ongoing basis under one of the alternatives discussed above, any future unexpended General Fund appropriations could be reverted to the state General Fund instead of remaining with counties. Also, under this approach, it is possible that the restrictions imposed by Proposition 36—such as a prohibition on use of trust fund monies for drug testing—would no longer apply.

Alternatives to General Fund Support for Proposition 36 Possible. The Legislature could consider the appropriateness of using other sources of funding besides the General Fund to assist Proposition 36 offenders. For example, the Legislature should carefully examine the extent to which part of program costs could and should be funded by any third-party insurance coverage available to Proposition 36 offenders, as we discussed in our *2001-02 Analysis* (see page C-48). Some ongoing Proposition 36 costs could also be offset through the collection of fees that could be charged to offenders for their treatment, as already allowed under the initiative.

Technical Funding Adjustments Could Be Considered. In determining the level of Proposition 36 funding it wishes to provide each year for counties, the Legislature could adjust the appropriation amount to take into account: (1) the amount of any carryover funding from prior appropriations for Proposition 36 that may be available to counties and (2) the amount of funding recovered by the trust fund due to audit disallowances and thus available for redistribution to counties. Specifically, it could reduce the appropriation it believes is warranted for this program

each year by an amount equal to the estimated amounts that are available from these sources. Such funding offsets could amount to a few million dollars in 2006-07.

Enacting Additional Policy Changes

As noted, the Governor's proposed funding for Proposition 36 is contingent on the enactment of policy changes he has identified. There are a number of key policy issues the Legislature may wish to consider as it evaluates these proposals. We discuss these issues below and summarize them in Figure 2.

Figure 2

Enacting Policy Changes to the Proposition 36 Statute

Issues for Legislative Consideration

- ***Governor's Policy Proposals Lacking Key Details.*** The administration proposes significant policy changes that warrant legislative consideration. However, critical details of the administration's proposal are missing.
- ***Other Policy Options Available.*** In a 2004 report, we proposed shifting various state funding allocations for drug treatment programs, including Proposition 36 funding, into a block grant. Additional policy changes relating to mental health services for Proposition 36 offenders and the way county allocations are made are also worth consideration.
- ***Some Changes Would Likely Require Voter Approval.*** Some of the changes being considered for the program likely could not take effect without voter approval.

Administration Proposals Lacking Key Details. As described above, the administration proposes a series of significant policy changes to the Proposition 36 program. These proposals warrant legislative consideration and debate, given that the state and counties now have almost five years of experience with Proposition 36 programs. However, at the time this analysis was prepared, important details of the administration's proposal were missing. The administration has not submitted any proposed statutory changes for its proposal to the Legislature and has indicated it does not intend to do so. Depending on how such changes in Proposition 36 were crafted, they could constitute a new state mandate on local government for which state reimbursement would be required under the State Constitution. If the administration intends to *require* that counties assign each offender to the treatment level for which he or she is assessed, the cost to the state for such a potential mandate could be very costly in the future and state fiscal control over the program would be weakened. On

the other hand, if the administration's intention is to *voluntarily* encourage counties to more closely align offender treatment assessments with the treatment these offenders actually receive, it is possible that the creation of a new reimbursable state mandate could be avoided.

Legislature Could Advance Its Own Policy Changes. As it examines the administration's proposals to modify the existing Proposition 36 statute, the Legislature may wish to consider other policy changes that could improve its implementation.

For example, the Legislature might wish to expand the permitted uses of state funds to allow them to be used for mental health services for offenders who have a dual diagnosis of both drug addiction and serious mental illness. (We discussed this concept on page C-46 of our *Analysis of the 2001-02 Budget Bill*.) The Legislature could also consider imposing additional conditions on the use of state funding to support Proposition 36, such as rewarding counties with the best performance and outcomes or which contribute the most matching resources to implement Proposition 36. (This concept was discussed in our 2000 policy report entitled *Implementing Proposition 36: Issues, Challenges and Opportunities*.) Finally, in a 2004 report to the Legislature, *"Remodeling" the Drug Medi-Cal Program*, we proposed that the state shift various state funding allocations for drug treatment programs, including those for Proposition 36, to counties in the form of a block grant to provide counties greater flexibility and authority in the use of the state funds to meet locally determined treatment priorities.

Some Changes Would Likely Require Voter Approval. Proposition 36 specifies that it can be amended by a two-thirds vote of the Legislature, but only to further the act in a way consistent with its purposes. Depending on the specific changes desired by the Legislature, it is possible that some of the changes being considered could not take effect without being submitted to the voters for their approval.

The Office of Legislative Counsel last year examined some legal issues relating to Proposition 36 and concluded, for example, that legislation to jail Proposition 36 offenders for first-, second-, or third-time drug-related probation violations would constitute an amendment that would not further the act and would not be consistent with its purposes—and thus would require voter approval to go into effect. Depending on specifics, similar issues could arise regarding other proposals to change the measure.

Analyst's Recommendation

Based on our review, we recommend the Legislature:

- ***Delay Funding Level Decision Until April.*** We withhold recommendation at this time on the proposed General Fund transfer of $120 million to the Proposition 36 trust fund and on reauthoriza-

tion of 29.7 positions pending review of the cost-benefit study due out April 1, 2006. As it decides on the appropriate level of state funding for this purpose, the Legislature should also take into account how it will meet the MOE requirements, whether it wishes to adopt a funding mechanism providing more legislative control of the program, potential alternative sources of funding besides the General Fund, and the technical funding adjustments we have proposed.

- ***Require More Details.*** We further recommend that the Legislature direct the administration to present to the Legislature more specific and detailed proposals for the policy changes that it is seeking no later than March 15.
- ***Seek Needed Legal Advice.*** Once the details of the policy changes proposed by the administration, as well as other approaches that the Legislature may wish to consider, have been identified, we recommend that the Legislature seek further legal advice from the Office of Legislative Counsel.
- ***Consider Additional Policy Changes.*** We again recommend that the Legislature enact policy legislation, such as we proposed in our 2004 report, to restructure county drug treatment finances and make other improvements in state drug treatment programs. We further recommend that the Legislature consider other policy changes besides those proposed by the administration to improve the implementation of Proposition 36. As noted earlier these could include changes to expand mental health services for Proposition 36 offenders and to reward counties with the best performance and outcomes or which provide the most matching resources to implement the measure.

DEPENDENCY DRUG COURT FUNDING

Current law requires that the Dependency Drug Court program be funded unless it is determined that he program is not cost-effective with respect to the Foster Care and Child Welfare Services Programs. The proposed budget does not provide funding for Dependency Drug Court or provide trailer bill language to suspend this requirement. Accordingly, we recommend that the administration report at budget hearings on why it has not funded this program.

We discuss our recommendations related to "Dependency Drug Courts" in the "Child Welfare Services" analysis in this chapter.

MEDI-CAL
(4260)

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

GOVERNOR'S 2006-07 MEDI-CAL BUDGET PROPOSAL

The budget proposes Medi-Cal expenditures totaling $35 billion from all funds for state operations and local assistance in 2006-07. Figure 1 displays a summary of Medi-Cal General Fund expenditures in the Department of Health Services (DHS) budget for the past, current, and budget years. The General Fund portion of the spending for local assistance ($13.7 billion) increases by about $542 million, or 4.1 percent, compared with estimated General Fund spending in the current year. However, this understates expenditure growth in this program. This is because about $359 million that would have previously been included in the DHS General Fund budget for Medi-Cal (about $340 million in base costs for mental health services plus $19 million in related caseload growth) is proposed to be shifted to the Department of Mental Health (DMH) budget in a purely technical change. If these funds were to remain in the Medi-Cal budget, General Fund expenditures for Medi-Cal would total $14.1 billion, an increase of $901 million, or 6.8 percent.

Figure 1

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

(Dollars in Millions)

	Expenditures			Change From 2005-06	
	Actual 2004-05	Estimated 2005-06	Proposed 2006-07	Amount	Percent
Local Assistance					
Benefits	$10,923	$12,429	$12,979	$549	4.4%
County administration (eligibility)	589	671	661	-10	-1.4
Fiscal intermediaries (claims processing)	81	97	100	3	2.8
Totals, local assistance	**$11,593**	**$13,197**	**$13,739**	**$542[b]**	**4.1%**
Support (state operations)	$107	$113	$120	$7	6.5%
Caseload (thousands)	6,585	6,680	6,807	127	1.9%

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

[b] The Medi-Cal total General Fund budget would have increased by $901 million, or 6.8 percent, if $359 million in spending were not shifted to the Department of Mental Health.

Detail may not total due to rounding.

The remaining expenditures for the program are mostly federal funds, which are budgeted at $20 billion, or 2.3 percent more than estimated to be received in the current year. In addition, the spending total for the Medi-Cal budget includes an estimated $708 million in local government funds for payments to DSH hospitals. About $3.9 billion of total Medi-Cal spending consists of funds budgeted for programs operated by other departments, counties, and the University of California.

As summarized in the "Health and Social Services Overview" of this chapter of the *Analysis*, the spending plan proposes a number of significant adjustments and policy changes that are reflected in the budget year totals.

- ***Baseline Estimates ($493 Million Cost).*** The budget plan proposes a $493 million increase in General Fund expenditures for "baseline" costs for prescription drugs and inpatient hospitals. These increases are unrelated to any change in state policy and are due to estimated increases in caseload, costs, and utilization of services mostly by aged, blind, and disabled beneficiaries.

- ***Medicare Part D Adjustments ($212 Million Cost).*** The federal Medicare Modernization Act passed in 2003 created the new Part D prescription drug benefit that shifted drug coverage for persons eligible for both Medi-Cal and Medicare (referred to as dual eligibles) to the federal Medicare program effective January 1, 2006. The Governor's budget projects that this shift will result in a net increase in costs of $212 million General Fund in 2006-07. The factors contributing to the net increase include a $1 billion General Fund reduction in drug costs. This savings would be more than offset by increased costs of (1) $768 million resulting from state contributions to the federal government required by the law and (2) a loss of $544 million General Fund from the decrease in rebates now paid by drug manufacturers to the state.

- ***Medicare Premiums ($147 Million Cost).*** The Medi-Cal Program pays the premiums for Medi-Cal beneficiaries who also are eligible for Medicare, thereby obtaining 100 percent federal funding for those services covered by Medicare. The budget estimates that the General Fund cost of these so-called "buy-in" payments will increase by $147 million in 2006-07.

- ***Reversal of Savings From One-Time Actions ($49 Million Cost).*** The 2005-06 budget plan achieved savings of $183 million for the General Fund by claiming federal funding for prenatal services provided to undocumented immigrants through the State Children's Health Insurance Program, which receives 65 percent federal funding, rather than through the current state-only program. This amount of savings reflected two years of claiming. Savings to the state are expected to be $91 million less in 2006-07 because the budget request is now based on only one year of claiming. In addition, the budget plan assumes the state will achieve $42 million in savings in 2005-06 on a one-time basis from the settlement of a lawsuit related to the state being overcharged for a drug used by AIDS patients.

- ***Cost and Caseload Increases ($115 Million Cost).*** Medi-Cal managed care plans are expected to experience increased costs of nearly $70 million General Fund due to growth in the number of enrollees. Rate increases provided to certain long-term care

facilities as required by Chapter 875, Statutes to 2004 (AB 1629, Frommer), are also expected to increase General Fund expenditures by more than $40 million in the budget year. In addition, General Fund costs for legal immigrants whose benefit costs are not shared by the federal government are expected to increase by $23 million. These costs are partly offset with $18 million in General Fund savings that are projected to result from a 5 percent reduction in the rates paid to certain providers that went into effect upon the resolution of a court case challenging the rate reduction. The budget plan reflects the automatic end of the rate reduction in January 2007, consistent with current state law.

- ***Expansion of Children's Coverage ($20 Million Cost).*** As part of the Governor's proposal to expand medical coverage for California children, the Medi-Cal annual redetermination form is being revised to make it easier for Medi-Cal beneficiaries to complete. This change is projected in the budget plan to increase caseload and related General Fund costs by $20 million in 2006-07. The budget plan includes other proposals to increase the Medi-Cal children's caseload.

- ***Mental Health Funding Shift ($359 Million Savings).*** As mentioned previously, about $359 million in the Medi-Cal General Fund was shifted to the DMH budget in a purely technical change to more accurately reflect the program for which these expenditures are made.

- ***Hospital Financing Waiver Savings ($121 Million Savings).*** Following an increase of $135 million in General Fund costs in 2005-06 for hospital services, the Governor's budget proposal reflects a decrease of $121 million in these costs for the budget year. This is due to a shift of certain Medi-Cal hospital costs to local governments under the terms of a statewide hospital financing waiver provided by the federal government and state legislation (Chapter 560, Statutes of 2005 [SB 1100, Perata]).

CASELOAD PROJECTION REASONABLE

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

Administration's Caseload Projections. The budget projects that the average monthly caseload of individuals enrolled in Medi-Cal will grow in the current and budget years. However, we note that the current-year projections are nearly 60,000 below the caseload assumed in the *2005-06 Budget Act.* The Governor's budget plan estimates caseload growth from 2004-05 to be 1.5 percent in 2005-06 and nearly 2 percent in 2006-07. The Governor's estimated growth rates for the current and budget year are projected to somewhat exceed the overall state population growth rates.

Nonwelfare Families Caseload Continues to Grow. Figure 2 shows the budget's forecast for the Medi-Cal caseload in the current year and 2006-07. The majority of the projected Medi-Cal caseload increase occurs in the families and children eligibility categories. The budget plan estimates that the caseload for this group will increase by 1.2 percent in the current year and an additional 1.4 percent in the budget year, although these overall increases mask some larger, contrasting trends within this category. Nonwelfare families account for most of the caseload increases. The budget estimates that the caseload of Medi-Cal eligible nonwelfare families will increase by about 4 percent in the current year and by an additional 2 percent in the budget year. Some of this projected budget year growth is the result of the Governor's proposal to simplify the annual redetermination form, which is expected to result in a caseload increase of 18,000. However, caseload for the California Work Opportunity and Responsiblity to Kids (CalWORKs) families is expected to decline by 3.7 percent in the current year and remain flat in the budget year, reflecting overall CalWORKs trends.

The overall projection of nonwelfare families and children caseload growth appears consistent with recent trends and generally reflects growth rates that may be gradually slowing. However, the impact of ongoing changes in Medi-Cal is hard to predict, and significant revisions to the projection could be occurring for various reasons. The Governor's budget proposals to increase children's enrollment in Medi-Cal and the continuing effects of recent policy changes, such as funding Medi-Cal application assistance in the 2005 budget, add uncertainty to the 2006-07 caseload projection.

Significant Growth in Medically Needy Aged and Disabled. Caseloads for the aged, blind, and disabled are expected to grow by about 51,000 beneficiaries, or about 3 percent, in the current year and by an additional 56,000 beneficiaries, or about 3 percent, in the budget year. The increase in the current year is consistent with underlying population growth trends.

Figure 2

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

(Eligibles in Thousands)

			Change From 2004-05			Change From 2005-06	
	2004-05	2005-06	Amount	Percent	2006-07	Amount	Percent
Families/children	4,863	4,920	57	1.2%	4,990	71	1.4%
CalWORKs[a]	1,351	1,301	-50	-3.7	1,301	—	—
Nonwelfare families	2,872	2,988	116	4.0	3,046	59	2.0
Pregnant women	189	198	9	4.9	203	5	2.6
Children	451	433	-18	-4.0	440	7	1.7
Aged/disabled	1,644	1,695	51	3.1	1,750	56	3.3
Aged	626	648	21	3.4	674	26	4.1
Disabled (includes blind)	1,017	1,047	29	2.9	1,076	29	2.8
Undocumented persons	79	67	-12	-14.8	67	—	—
Totals[b]	**6,585**	**6,680**	**96**	**1.5%**	**6,807**	**127**	**1.9%**

a California Work Opportunity and Responsibility to Kids.

b Detail may not total due to rounding.

Caseload increases for the aged and disabled are being driven primarily by those aged and disabled individuals who qualify as medically needy. (The medically needy category includes those who do not quality for, or choose not to participate in, Supplemental Security Income/State Supplementary Program, such as low-income noncitizens or individuals who must pay a certain amount of medical costs themselves before Medi-Cal begins to pay for their care.) The aged caseload in this eligibility category is expected to grow by about 20,500, or 11 percent, in 2006-07, and the disabled caseload is expected to grow by about 11,200 or 10 percent. Some of the projected growth in the aged and disabled population that qualifies as medically needed is also expected to result from the Governor's proposal to simplify the annual eligibility redetermination form.

The public assistance and long-term care eligibility categories project modest growth of less than 2 percent for the aged, blind, and disabled in 2006-07. These categories are not assumed to be affected by the Governor's proposal to change the annual eligibility redetermination form.

Analyst's Recommendations. Our analysis indicates that the Governor's budget request is reasonable and is generally in line with available

Medi-Cal caseload data. Accordingly, we recommend approval of the budget request. However, we note that there is both upside and downside risk to the budget estimate as presented. While it is possible that the simplification of the annual eligibility redetermination form will result in fewer eligibles than assumed in the Governor's budget plan, it is also possible that this action, combined with other actions to increase the children and families caseload, could result in caseload growth that is greater than projected. Given this situation, we will continue to monitor Medi-Cal caseload trends and will recommend any appropriate adjustments to the budget estimate at the May Revision.

THE EFFECT OF THE MEDICARE DRUG BENEFIT ON MEDI-CAL

The January 1, 2006 rollout of the new Medicare Part D prescription drug benefit has had a direct and immediate impact on the state's Medi-Cal Program and the approximately one million beneficiaries whose drug coverage was shifted from Medi-Cal to Medicare. In this analysis, we briefly review implementation of Part D, describe the state's response to recent implementation problems, and recommend that the Legislature reduce state spending by about $330 million in the current year and budget year combined to adjust for this rapidly changing situation. (Reduce Item 4260-101-0001 by $275 million.)

Background

The Medicare Prescription Drug, Improvement and Modernization Act, also referred to as the Medicare Modernization Act (MMA), became law on December 8, 2003. The Medicare drug benefit component of MMA, known as Part D, went into effect beginning January 1, 2006. As of that date, Medicare began to pay for outpatient prescription drugs through prescription drug plans (PDPs) and through Medicare managed care plans known as Medicare Advantage. The implementation of Medicare Part D has already had far-reaching fiscal and policy implications for the state, which we describe in more detail later in this analysis. For further information on the Medicare Part D drug benefit and its impact on the state, please see our *Analysis of the 2005-06 Budget Bill* (page C-105, "Part 'D' Stands for 'Deficit': How the Medicare Drug Benefit Affects Medi-Cal").

Medicare and Medicaid. The two major federally supported health programs are Medicare and Medicaid, both of which are administered by the U.S. Centers for Medicare and Medicaid Services (CMS). Medicare is a federal health insurance program that provides coverage to eligible seniors and persons with disabilities (SPDs). Most individuals 65 and over are automatically entitled to some Medicare coverage if they or their spouse

are eligible for Social Security payments. People under 65 who receive Social Security cash payments due to a disability generally are eligible for Medicare after a two-year waiting period.

Medicaid (known as Medi-Cal in California) provides health care services to welfare recipients and other qualified low-income persons, primarily families with children and SPDs. Medi-Cal is administered by the state Department of Health Services (DHS). Medi-Cal costs are shared about equally between the state General Fund and federal funds.

Dual Eligibles. So-called "dual eligibles" are individuals who are entitled to some Medicare benefits and some Medicaid benefits. In California, about one million dual eligibles are enrolled in Medicare and Medi-Cal. Dual eligibles tend more often than the population generally to be in fair or poor health due to chronic illnesses and conditions that require ongoing treatment.

Mandatory Transition for Dual Eligibles to Part D. As of January 1, 2006, dual eligibles who had been receiving their drugs through the Medi-Cal Program began to receive their drugs instead through the new Part D benefit. Those dual eligibles that had not enrolled with a PDP or a Medicare Advantage plan during a voluntary enrollment period that began November 15, 2005 and ended December 31, 2005 were automatically assigned to a Part D provider. Generally, this assignment was made without any review as to whether a drug plan's formulary is the most appropriate for the patient. However, dual eligibles are permitted to transfer to another PDP or Medicare Advantage plan if they find another provider would better meet their needs.

Also effective January 1, 2006, the state lost almost all federal matching funds for drugs that had previously been provided to the dual eligibles under the Medi-Cal Program. (The federal government will continue to share in the cost of these drugs for other Medi-Cal beneficiaries.) As a result, under the terms of MMA, any continued coverage the state were to provide for dual eligibles would generally be paid for entirely with state General Fund resources. The state is able to receive a federal match for certain drugs for dual eligibles that are not covered under Medicare Part D, such as over-the-counter drugs or certain medical supplies. Coverage for these drugs is often termed "wraparound" coverage.

The Effect of Part D on the Medi-Cal Budget

The implementation of the Part D benefit affects the Medi-Cal budget in several important respects. The DHS estimates that, after a series of separate budgetary components of Part D have been taken into account, the overall result will be a net General Fund savings to Medi-Cal local

assistance of about $205 million in 2005-06 and that cost and savings will mostly offset each other in 2006-07.

However, we note that these budget estimates were prepared by the administration before a recent decision by federal CMS administrators that could significantly increase the state savings in the Medi-Cal Program that will result from the implementation of the new Medicare drug benefit. We discuss these recent developments later in this analysis.

Below we describe several of the major components of implementing Part D that affect the Medi-Cal budget in the near term. Figure 3 summarizes the fiscal effects of Part D as it is reflected in the *2006-07 Governor's Budget* proposal.

Figure 3

Medicare Part D General Fund Impact As Reflected in the Governor's Budget Plan

(In Millions)

	2005-06 (Half-Year)	2006-07
Medicare Part D Drug Benefit	-$706	-$1,792
Clawback[a]	503	1,271
Drug rebate	—	544
Managed care savings	-58	-115
Wraparound coverage	41	103
100-day prescription drug supply	19	—
Miscellaneous costs	-4	-11
Totals	**-$205**	**—**

[a] Does not reflect a reduction in California's clawback assessment announced by federal authorities on February 6, 2006.

Medicare Part D Drug Benefit. As a result of the transition of dual eligibles from Medi-Cal drug coverage to Medicare Part D, the state will no longer pay for drugs for dual eligibles (with a few exceptions that we discuss later). These costs will be funded by the federal government. As a result, the Governor's budget plan assumes that General Fund costs for drugs for Medi-Cal dual eligibles will decrease by $706 million General Fund in 2005-06 and by about $1.8 billion in 2006-07.

Clawback. The MMA does not allow California or other states to keep all of the savings they will realize from the reduction in their drug costs due

to the implementation of Part D drug coverage for dual eligibles. The measure includes a so-called "clawback" provision that is intended to require each state to pay back much of its estimated savings on dual eligible drug coverage to the Medicare Program. The MMA requires the states to pay the federal government 90 percent of their estimated savings in calendar year 2006. During the following nine years, the clawback percentage is reduced by 1.66 percent per year until state contributions reach 75 percent of their estimated drug savings on dual eligibles. The clawback payments would then remain set at that percentage of their estimated savings.

The Governor's budget plan estimates that the state's clawback payment will be about $503 million from the General Fund for 2005-06 and at $1.3 billion for 2006-07, the first full year of these payments to the federal government. However, on February 6, 2006, CMS announced that it had reduced the clawback payments it had previously assessed to California and other states on the basis of updated estimates of prescription drug costs for dual eligibles. For California, the revisions will mean a reduction in clawback payments of more than $110 million in the 2006 calendar year. This recent federal action is not reflected in the Governor's budget plan.

The state Attorney General has announced that California will challenge the clawback payment in court. We provide more detail on this lawsuit in the text box (see next page).

Drug Rebates. Under federal law, California and other states may obtain rebates from drug manufacturers that partly offset the cost of the drug coverage they provide for their Medicaid beneficiaries. The shift of dual eligibles to Medicare Part D coverage means that the Medi-Cal Program will receive lower amounts of these rebates in the future since these beneficiaries will no longer receive their drug coverage from Medi-Cal. This decline in the collection of these rebates has the effect of eventually increasing state General Fund costs for the support of the Medi-Cal Program to make up for the loss of these state revenues.

The effect on Medi-Cal from the shift of dual eligibles is likely to be particularly significant because, prior to implementation of Part D, dual eligibles had accounted for about 57 percent of total Medi-Cal drug purchases. Because the collection of rebates often lags as much as a year behind the date when the drugs were initially provided to Medi-Cal beneficiaries, the loss of rebates is not expected to begin to affect the Medi-Cal budget until 2006-07. Specifically, the Governor's budget plan assumes that the loss of rebates due to Part D coverage will increase state General Fund costs by $544 million in 2006-07.

Managed Care Savings. The Governor's budget plan reduces the capitation rates paid to Medi-Cal managed care plans for the dual eligible enrollees. This adjustment accounts for the savings that will be realized

by these plans on pharmaceutical costs for dual eligibles that will now be covered under Part D. As a result, the Governor's budget plan assumes that General Fund costs for Medi-Cal managed care plans will decline by about $58 million in 2005-06 and by $115 million in 2006-07.

Wraparound Coverage. As noted earlier, Medi-Cal will continue to provide coverage for dual eligibles of certain drugs that are excluded from Part D coverage. The Governor's budget assumes that the General Fund cost of wraparound coverage to the Medi-Cal Program will be about $41 million in 2005-06 and about $103 million in 2006-07.

100-Day Prescription Drug Supply. In order to assist in the transition of dual eligiles to Part D, the Governor's budget plan provided for some added drug benefits in the current year. Specifically, dual eligibles were allowed to obtain 100-day prescription refills in December 2005, in effect allowing them to obtain a larger supply of drugs for which they normally would only have been able to obtain a 30-day prescription. This change was intended to address concerns that implementation of Part D might disrupt dual eligibles' prescription drug supplies. The Governor's budget

Attorney General to Sue Over Clawback

The state Attorney General announced February 1, 2006, that California will join with other states in a lawsuit against the federal government to challenge the clawback payments required under Medicare Modernization Act (MMA). A multistate complaint was expected to be filed for this purpose in February with the U.S. Supreme Court.

The state Attorney General contends that the clawback provisions of the MMA (which were described earlier in this analysis) violate provisions of the U.S. Constitution. Specifically, the lawsuit is expected to assert that the clawback requirement impermissibly infringes on states' legislative power by requiring them to pay for a federal program, in effect imposing a federal tax on states and infringing on state sovereignty with an invalid condition on the receipt of federal funds. We note that the Attorney General announced plans for the lawsuit before the U.S. Centers for Medicare and Medicaid Services informed the state that its clawback payment had been reduced.

The State Controller's Office has announced that it intends to refuse to send the clawback payment to the federal government when the first bill comes in February 2006. We will continue to monitor these developments because of their potentially significant fiscal impact on the Medi-Cal Program.

plan assumes the 100-day supply allowance will result in state General Fund costs of about $19 million in the current year.

Miscellaneous Costs Associated With Part D. In addition to the major state fiscal impacts described above, the implementation of Part D was anticipated to result in other, smaller costs to the Medi-Cal Program. This included the costs of beneficiary outreach, provider relations, and eligibility systems changes. The Governor's budget plan assumes these factors will result in a combined increase in General Fund costs of about $1.8 million General Fund in 2005-06 and $55,000 in 2006-07. The implementation of Part D is also estimated in the Governor's budget plan to result in state savings on processing of treatment authorization requests, adjudication of claims, and other changes that are expected to amount to about $5.8 million from the General Fund in 2005-06 and about $11 million in 2006-07.

Ongoing Staff Workload for Part D Implementation. The administration budget plan requests four staff positions for DHS in the budget year at a cost of $264,000 from all fund sources ($66,000 from the General Fund) for the third-party liability unit at DHS. This unit has additional workload created by the implementation of the federal Medicare Part D drug benefit, such as resolving problems related to the enrollment of Medi-Cal beneficiaries into Medicare Part D and ensuring that Medi-Cal is the payer of last resort for medical benefits.

State Taking Action to Help Transition to Part D

In our *2005-06 Analysis,* we noted that the MMA and CMS had established an aggressive timeline for choosing the providers that will deliver Part D benefits and that this tight schedule could complicate the rollout of the new drug benefit to Medicare beneficiaries. The DHS also voiced concerns at the time that the federal rollout of the Part D benefit would likely result in confusion and uncertainty for dual eligibles.

To address these concerns, the Legislature approved some measures in the *2005-06 Budget Act* to assist the dual eligibles with this transition. For example, the Legislature approved about $1.1 million from the General Fund for beneficiary outreach that was conducted by DHS and adopted statutory language directing DHS to develop a plan to provide drug coverage to dual eligibles in the event that the federal implementation of Part D was problematic. However, DHS did not request funds for the implementation of such a plan in the proposed 2006-07 Medi-Cal budget.

Federal Implementation of Part D Has Been Problematic

Medicare Part D coverage for dual eligibles began on January 1, 2006 and, almost immediately, some beneficiaries experienced difficulty obtain-

ing their drugs or were unable to obtain their drugs at all. In response, the state stepped in to ensure that dual eligibles would be able to obtain their drugs while Part D implementation problems were addressed by federal authorities.

Specifically, the Legislature and Governor approved a deficiency request providing $22.5 million in General Fund resources to reimburse pharmacists for prescription drugs given to dual eligibles who were unable to obtain their medications under Part D. The program began on January 12, 2006 and originally was approved to continue on an emergency basis for five days. On January 20, additional legislation was enacted (Chapter 2, Statutes of 2006 [AB 132, Nuñez]), bringing the total General Fund appropriation for these purposes to $150 million from the General Fund so that this emergency drug coverage for dual eligibles could be extended in phases until February 11, 2006. Then, on February 9, legislation was enacted (Chapter 7, Statutes of 2006 [SB 1233, Perata]), to extend this emergency drug coverage to at least February 15, 2006 and, with advance notice to the Legislature, for additional 30-day periods of time until May 16, 2006.

We note that federal authorities have indicated that the states will be reimbursed for most of the costs that they incurred to maintain drug coverage for dual eligibles. However, at the time this analysis was prepared, it was unclear how much of these costs would be reimbursed or the time frame for reimbursement.

Adjustments to Governor's Budget Plan Warranted

Our analysis of the Governor's budget plan indicates that the state is likely overbudgeted in several areas as it takes into account the various fiscal effects of Medicare Part D. We outline our findings below.

Federal Clawback Calculations Have Changed. As noted earlier, the Governor's budget plan does not take into account the most recent CMS determination of California's clawback payment. As part of the President's proposed new federal budget plan, the assessment to California and other states will be revised downward to reflect slower growth in the prescription drug costs for dual eligibles than it had assumed. Previously, CMS assumed a 36 percent increase in the cost of providing drugs for Medi-Cal dual eligibles. The CMS has now revised its rate of growth in these costs to about 25 percent.

On this basis, federal authorities estimate that the state's clawback payments for the 2006 calendar year would decrease by more than $110 million. This roughly 10 percentage point reduction in clawback costs would result in as much as a $55 million reduction in General Fund spending for Medi-Cal local assistance in the current fiscal year, which ends in June.

Assuming these lower clawback assessments stay in place through 2007, we estimate that General Fund support for Medi-Cal local assistance is similarly overbudgeted by as much as $150 million in the budget year.

Impact of Drug Rebates Overstated in the Budget Year. Our analysis indicates that the loss of drug rebates, and the resulting increase in General Fund costs for the Medi-Cal Program due to the implementation of Part D, is overstated by as much as $125 million in the budget year.

The Governor's budget estimates that this loss of rebates will be $544 million in 2005-06. We are advised by DHS that this estimate assumes that about 97 percent of drug rebates are ordinarily collected within six months after the drugs are provided to Medi-Cal beneficiaries. However, the data we have reviewed indicate that it sometimes can actually take up to a year for DHS to collect some rebates. If this is the case, then the loss of rebates in 2006-07 is significantly overstated in the budget plan.

Most Emergency Drug Coverage Funds Likely To Go Unspent. The DHS indicated on February 1, 2006 that, of the $150 million in General Fund appropriated to date for emergency drug coverage for dual eligibles, only about $12 million to $15 million had actually been spent. At this spending rate, it is unlikely that much more of the $150 million that was made available will be needed.

Moreover, as we discussed above, federal authorities have indicated that they will reimburse the states for most of the costs of providing emergency drug coverage to the dual eligibles.

Chapter 2 provides that any unspent funds would revert to the General Fund as of June 30, 2007. However, reversion of these funds at the end of the budget year means they would not be available for other purposes as the Legislature deliberates on a budget for 2006-07.

100-Day Drug Prescriptions May Be Overbudgeted. As noted above, the Governor's budget provided $19 million in General Fund support in the current year for providing 100-day subscriptions in December 2005 for dual eligibles. We are advised that preliminary data indicates that fewer than expected dual eligibles actually obtained 100-day subscriptions. Thus, the budget plan likely provides more funding for this purpose than was necessary.

Further Part D Adjustments Warranted. State law requires Medi-Cal providers to submit treatment authorization requests (TARs) for reimbursement for specific procedures and services, such as prescription drugs. The volume of prescription drugs paid for by Medi-Cal is expected to decrease by 57 percent beginning January 2006 because of the implementation of Medicare Part D. It is likely that the TAR volume for prescription drugs will decrease by at least an equivalent amount.

The 2006-07 budget proposes a reduction of $4.8 million (with a savings of $1.2 million to the General Fund) for contract staff, including pharmacists and support staff, who process TARs. Seven contract pharmacist positions would remain, however, in addition to some support staff. Also, none of the 55 state pharmacist positions or state support positions have been proposed for reduction. The relatively small staff reduction raises a question as to whether further adjustments in DHS staffing are warranted.

At this time, the Legislature does not have sufficient information to evaluate DHS' separate budget proposal requesting additional staff for the third-party liability unit. The ongoing level of workload that would justify the continuation of these positions is not clear.

Analyst's Recommendations

Based on the above findings, we recommend that the Legislature adopt the following adjustments to the Medi-Cal budget and other DHS budgets:

- ***Reduction in Clawback Payments.*** We recommend the Legislature reduce the General Fund budget for Medi-Cal local assistance by $55 million in 2005-06 and $150 million in 2006-07 to reflect the reduction in the CMS assessment of California's clawback payments. The DHS has advised us that it will present the Legislature with an updated estimate of state clawback payments, as well as other fiscal effects of the Medicare drug benefit on Medi-Cal, at the time of the May Revision.

- ***Rebate Adjustment.*** We recommend that the Legislature reduce the General Fund budget for Medi-Cal local assistance by $125 million in 2006-07 to reflect the likelihood that the full loss of rebates due to Part D implementation will not occur until 2007-08. We estimate that the loss of rebate revenues will be $125 million lower than the administration has projected, and thus that the backfill of these losses through an increase in General Fund expenditures for Medi-Cal is likewise overstated by $125 million. At the time this analysis was prepared, we were awaiting additional information from DHS regarding the lags that occur in the timing of rebate collections. Accordingly, we will provide the Legislature with an updated estimate of this adjustment once we have received this additional information from DHS.

- ***Reversion of Emergency Funds.*** We recommend enactment of legislation to revert some or all of the remaining General Fund appropriation provided for emergency drug coverage for dual eligibles at the end of the current fiscal year instead of at the end of the budget year, as now provided under Chapter 2. It appears

unlikely that any significant additional portion of these funds will be necessary to provide emergency drug coverage to dual eligibles. This action would make these funds available to help balance the 2006-07 state budget.

- ***Revert Some Funds for 100-Day Drug Prescriptions.*** We recommend that the Legislature require DHS to report at budget hearings regarding how much of the $19 million in General Fund support included in the current year for 100-day prescriptions was actually spent for these purposes. Once this information has been obtained, the Legislature should reduce the Medi-Cal budget in the current year by this amount.
- ***Ongoing Workload for Medicare Part D.*** We withhold recommendation on the proposal to provide additional staff for DHS' third-party liability unit until the Legislature has been provided the information it needs to conduct an updated workload analysis of the request. Once this information is forthcoming, we will provide the Legislature with an updated recommendation regarding this proposal at budget hearings.
- ***TARs Staff Reduction.*** Based on the information now available, it is unclear if the administration's proposed reduction in TARs unit staffing to account for the implementation of Part D is commensurate with the expected reduction in the volume of TARs. We have requested information from the department about the level of filled and vacant positions, but, at the time this analysis was prepared, we had not received it. Accordingly, we withhold recommendation on this proposal until the Legislature can determine if an appropriate number of DHS staff positions has been eliminated.

A Targeted Strategy to Constrain Medi-Cal Costs And Improve Access to Community Care

We recommend that the Legislature take advantage of the opportunities now being provided by federal authorities to deter costly nonemergency visits to emergency rooms (ERs) and to improve access and quality of care at clinics and alternative sources of community care. In order to implement this strategy, we recommend that the Legislature establish effective copayments on the inappropriate use of ERs and seek available federal grant funds to improve access to primary care in the community.

Care Not Always Delivered in the Best Medical Setting

California's projected 6.8 million Medi-Cal beneficiaries qualify for a wide range of medical services, including primary care in doctors' offices or community clinics for prevention and treatment of less serious illnesses and injuries. In addition, emergency services provided in hospital ERs are intended mainly to treat immediate care needs that result from severe trauma and other life-threatening problems. However, Medi-Cal beneficiaries do not always receive medical care in the most medically effective and cost-efficient setting. For example, many Medi-Cal beneficiaries with relatively minor medical illnesses seek care in ERs instead of in doctor's offices or community clinics.

Below, we examine how and why this is often the case for participants in the Medi-Cal Program, and how this situation often contributes to the state paying more for health care than might otherwise be the case.

ERs Frequently Used for Nonemergency Care. Crowded conditions have been widely reported in many ERs in recent years. One major factor contributing to ER crowding is the frequent use of ERs by some patients as a source of nonemergency care. Various academic studies have documented the frequent use of emergency rooms by patients for primary care services or other nonemergency conditions that could have been provided in a less costly medical setting. Estimates of such nonemergency use of ERs have varied. A 2004 report by the California Institute for County Government cited data from the California Office of Statewide Health Planning and Development indicating that about 40 percent of all hospital ER visits for Medi-Cal and other patients in California are for conditions classified as "nonurgent."

Why aren't more patients going to clinics or doctor's offices instead of emergency rooms? One study of children in Medicaid who suffer from asthma found that their mothers cited a number of barriers to primary care as the reasons for seeking care at hospital ERs. These barriers included limited availability of appointments from primary care providers, limited availability of appointments after regular work hours, and a perception that primary care providers wanted them to use the ER. Also, the relatively low rates paid to physicians voluntarily participating in the Medi-Cal Program could be affecting access by patients to primary care and specialists in some communities. The Kaiser Family Foundation indicates that Medi-Cal payments for primary care services have recently fallen to 51 percent of Medicare levels (based on 2003 data), placing California 44th among states by that measure.

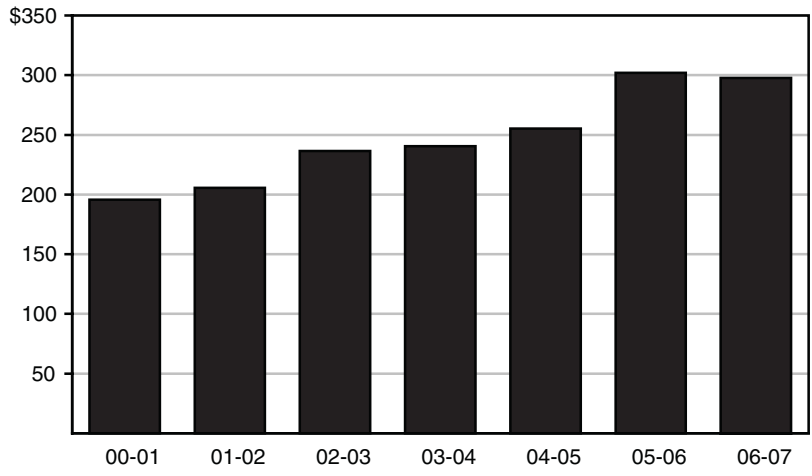
Payment Rates Vary by Care Setting. Where Medi-Cal patients receive their health care services can have significant fiscal ramifications for the state. In many cases, Medi-Cal pays different rates for the same

medical procedure depending on the setting in which that service is provided. For example, Medi-Cal payment rates for many procedures are 24 percent higher when the procedure is performed in an ER rather than a physician's office. Medi-Cal must typically also pay a facility charge for care obtained in an ER in addition to the payment for the health care practitioner's services. Various studies have concluded that many services provided in hospital emergency rooms cost more than when the patient receives the same services in nonemergency settings.

The potential higher cost of this health care is of particular concern given the state's ongoing fiscal problems and rising hospital costs. General Fund spending for Medi-Cal outpatient hospital services (including part of the cost of ER services) is projected to increase by more than $100 million, or 50 percent, between 2000-01 and 2006-07, as shown in Figure 4.

Figure 4

General Fund Spending for Outpatient Services Has Increased



Copayments Commonplace in Health Care Systems

Other Health Systems. Many private and public health care systems require their beneficiaries to make copayments, which are specified fees that patients must contribute to a provider in order to receive services. Medicare, the Veterans Administration system, and California Public

Employees' Retirement System health coverage all employ copayments to discourage overutilization of health care.

Current Medi-Cal Copayments Not Frequently Collected. Copayments are also authorized under federal and state rules in the Medi-Cal Program. In theory, Medi-Cal allows $5 to be charged per visit for a nonemergency visit to an ER, $1 per drug prescription filled, and $1 per visit for a variety of other types of providers, such as physicians, optometrists, and chiropractors. This copayment is ordinarily supposed to be collected by the medical provider.

However, relatively few such copayments are actually now being collected. That is primarily because federal law, until very recently, prohibited the denial of health care services if a patient cannot or does not make the copayment. In addition, federal and state law had specified that copayments generally cannot be required for Medi-Cal beneficiaries who are 18 years old and under, for those 21 years old or younger living in boarding homes or institutions, and for any children living in foster care. Also generally exempted from copayments were pregnant women, institutionalized individuals, and beneficiaries receiving family planning services. Individuals receiving emergency services could not be charged copayments, although persons receiving nonemergency services in emergency rooms were subject to them.

Medi-Cal providers' inability to actually collect copayments and the limits on which beneficiaries must pay them have rendered Medi-Cal copayments largely ineffective as a deterrent to the inappropriate use of medical services, including in ERs. That is the case even though there is substantial evidence, as discussed below, that copayments could be an effective strategy to reshape the way these services are provided in the Medi-Cal Program.

Copayments Can Affect Utilization of Services. Various studies published in health care journals have sought to determine the effect of different forms of cost-sharing on health care utilization. Some studies indicate that copayments appear to reduce unnecessary utilization of medical services, with even nominal cost-sharing leading to decreased use. However, the evidence regarding copayments' effectiveness also raises additional issues. Some research studies caution that such cost-sharing requirements can do more than curb overutilization of services by creating obstacles to appropriate and medically necessary care. Thus, the particular design of copayments is important because of the significant potential effects on the overall provision of health care.

Notably, California experimented in the early 1970s with a new copayment on Medi-Cal doctor visits while leaving hospital care free of charge. A subsequent study by RAND found some evidence that this copayment

policy likely reduced the demand for doctor visits by 8 percent, while demand for more costly hospital inpatient service increased by 17 percent.

Recent Federal Policy Changes Provide Opportunities to Reshape System

Findings from the RAND study and other research raise a further important question: Could Medi-Cal copayments be structured in a way to accomplish just the reverse of what occurred in California in the early 1970s? That is to say, could Medi-Cal copayments be established to *encourage* less costly primary care and *discourage* the inappropriate or excessive use of more costly hospital services? Our analysis indicates that recent changes in federal law and other recent developments in federal policy are opening the door to such a strategy.

Copayment Rules Easing. In recent years, CMS, the federal agency which administers the Medicaid Program (of which Medi-Cal is a part), granted some states greater flexibility in applying copayments by approving waivers of federal laws. Some states have used such waivers to enact copayments above the nominal level for various services, including the nonemergency use of ERs. In addition, the recently enacted federal Deficit Reduction Act of 2005 further increases states' flexibility to establish Medicaid copayments without first obtaining waivers. (See the nearby text box for a summary of several key changes contained in the new federal measure.) The measure contains a number of significant provisions regarding copayment levels and collections as well as various restrictions on who can be required to share in such costs. However, the federal measure maintains the authority of CMS to grant waivers to states to implement differing copayment options.

New Federal Funding Could Help Improve Emergency Room Alternatives. On their own, copayments for nonemergency ER use may be insufficient to encourage use of primary care providers because of the barriers beneficiaries face in accessing such providers. The recently enacted federal law offers states an opportunity to try to address these issues through newly available federal grant funds ($200 million nationwide) earmarked for improving access to primary care systems and implementing innovative programs to reduce Medicaid costs. These monies could contribute to implementing new approaches that would help "safety net" clinics and other primary care providers attract more Medi-Cal patients so that fewer would seek care at ERs.

While the federal grant amounts available to individual states are likely to be modest, California has demonstrated that it can operate a successful program to improve access to community care with limited resources. The Rural Health Demonstration Project (RHDP), operated by

The Federal Deficit Reduction Act of 2005

Congress recently made changes to a variety of federal programs through the passage of S. 1932, the Deficit Reduction Act of 2005. Key provisions of this bill potentially affecting copayments and access within the Medi-Cal Program include the following:

- ***Collectibility of Copayments.*** Health providers would now be allowed to refuse to provide services if the beneficiary does not make the copayment.
- ***Limitations Maintained for Certain Groups.*** Copayments still may not be required for specified eligibility and income groups, such as the aged and disabled or pregnant women and infants under specified income levels.
- ***Payments Capped.*** Copayments generally would be capped at 5 percent of the family's income.
- ***Certain Services Exempt.*** Copayments could not be charged for preventive services, pregnancy services, or emergency services, among others.
- ***"Nominal" Copayment Limits Linked to Inflation.*** The nominal level at which copayment levels are set in federal law (generally $3 for most services) could be adjusted by the state each year for inflation.

the Managed Risk Medical Insurance Board (MRMIB) to improve access to primary care for children under the Healthy Families Program, could serve as a model for using any additional funds available to the state in targeted areas. The program awards grants to address specific areas of need, such as increasing the number of hours that clinics are open on nights and on weekends and subsidizing the rates paid to providers so that they will offer care. A 2002 evaluation by MRMIB indicated that many clinics that received grants continued to offer expanded hours after their RHDP grants expired.

A Targeted Strategy to Reduce Medi-Cal Costs and Improve Community Care

As discussed above, recent changes in federal law and policy have created an opportunity to begin reshaping the Medi-Cal Program to provide better access to preventive-oriented community care and to reduce state spending for inappropriate visits to sometimes overcrowded ERs. At

The Federal Deficit Reduction Act of 2005 (continued)

Emergency Room Copayments. States could charge copayments of up to $6 for the nonemergency use of emergency rooms, provided that the hospital provides beneficiaries with (1) the name and location of an alternate available medical provider that could provide the services without copayments, and (2) a referral to coordinate the scheduling of the treatment.

- ***Copayments for Prescription Drug.*** In order to increase use of more cost-effective drugs, states could designate a "preferred" drug within each class and then charge copayments (or higher copayments) for others in that class to encourage more frequent prescription of the preferred drug.
- ***Grants for Improved Nonemergency Access.*** The sum of $50 million would be appropriated over four years for grants to improve Medicaid beneficiaries' access to primary care services.
- ***Grant Funding for Medicaid Innovations.*** An additional $150 million in grant funds would be available over two years for projects that improve Medicaid efficiency and effectiveness.

least one state has demonstrated that such a strategy could be effective. A review of a Medicaid demonstration project in Florida found, for example, that there was reduced use of ERs by Medicaid children resulting from coordinated efforts that included expansion of clinic or doctor's office hours and copayments for certain ER use.

Accordingly, we recommend that the Legislature take steps now, primarily though the enactment of policy legislation, to implement a new strategy that takes advantage of these opportunities. We summarize below the key components of this strategy:

- ***Seek Federal Help to Improve Access to Primary Care.*** We recommend that the Legislature direct DHS to apply for part of the $50 million in federal grant funding that will be made available over four years to help states improve access to primary care systems. The DHS should also be directed to seek proceeds from the $150 million in federal funding designated for implementing

innovative approaches to reducing Medicaid costs, which we believe this new state strategy represents.

- ***Build on the RHDP Model.*** We propose that DHS, possibly in collaboration with MRMIB, develop and implement a targeted new program to improve access to primary care services for Medi-Cal patients in areas where such access is now problematic. The new program could be modeled after RHDP or possibly established as an actual expansion of RHDP in order to minimize administrative costs. The program should initially focus on improving primary care in communities near hospital emergency rooms where Medi-Cal patients are frequently receiving services for nonemergency care.

- ***Establish an Effective and Meaningful ER Copayment.*** We recommend that the Legislature enact a meaningful and enforceable copayment in Medi-Cal—perhaps as much as $25 per visit in order to be effective as a deterrent to the nonemergency use of ERs. These copayments should be applied to health services provided through managed care as well as those provided on a fee-for-service basis. Providers would have the authority to deny medical services if a beneficiary declined to make a copayment. We recommend that the Legislature include most Medi-Cal beneficiaries in these requirements, given our proposed approach under which no Medi-Cal beneficiary would need to make a copayment to receive care from an appropriate primary care provider. We also recommend that the imposition of copayments begin no sooner than 2007-08, so that efforts to improve primary care systems can be undertaken before the new copayments go into effect.

- ***Direct Patients Toward ER Alternatives With No Copayments.*** We recommend that the state implement the new federal rules that would ensure that Medi-Cal patients can receive the nonemergency care they need with no copayment so long as they obtain that care in a medically appropriate location instead of an ER. Hospital ERs would screen incoming patients and assess their medical condition. If it were determined that a Medi-Cal beneficiary in an ER did not require emergency care, that beneficiary would be provided with the name, location, and a referral to an alternate medical provider verified as being available to provide services to them without a copayment. In addition, we recommend that the state repeal the existing "nominal" copayments for primary care in order to encourage more patient visits to clinics and doctor's offices instead of ERs.

- ***Use Copayments to Compensate Providers.*** We propose that any copayments collected from Medi-Cal patients be considered compensation for providers in addition to the amounts that Medi-Cal would otherwise reimburse them for services. In effect, collecting the copayment would provide a modest increase in overall reimbursement to providers that should help offset potential additional costs to them for collecting copayments from Medi-Cal beneficiaries and referring them to primary care providers.
- ***Carefully Monitor Results.*** Because of the significant potential effect of these changes on the health care of Medi-Cal beneficiaries, the state should carefully monitor the effect of this new strategy on the quality of care and the cost of care in both ERs and the network of primary care providers.

State and County Savings Likely. If an effective and meaningful copayment is established for receiving nonemergency services in ERs, some Medi-Cal ER users would likely seek care from appropriate primary care providers, which are generally less expensive than ER care. Some studies have indicated that in some cases copayments may deter visits to health care facilities that are medically unnecessary. In these cases, beneficiaries may decide to forego receiving nonurgent care in any setting, resulting in further savings. Based on our review of data on Medi-Cal payments to hospitals for 2004, such a change could result in significant state and county savings if ER use by Medi-Cal patients could be deterred or redirected to less costly care settings. These savings could be realized in both fee-for-service and managed care Medi-Cal. On a fee-for-service basis, payments per beneficiary would likely decrease. In managed care, additional savings to the state might eventually be realized through reduced pressure to increase rates for managed care organizations, which in turn would probably pay less in the future for services provided to their Medi-Cal enrollees.

In addition, we believe there would probably also be significant positive fiscal impacts (and positive health outcomes) from directing more patients to an improved primary care system. This improved system could lead to more *preventive care* that encourages Medi-Cal patients to maintain good health, as opposed to their current overreliance on *episodic care*, in which individuals inappropriately wait until they are seriously ill before seeking health care.

The amount of the combined savings to the state and counties from these direct and indirect fiscal effects are unknown but would probably eventually amount to the tens of millions of dollars annually.

Administrative Costs. Administrative costs to the state to implement this proposal are likely to be minimal if the amount of the copayment

was strictly limited to the level outlined in the new federal legislation. Establishing them at higher levels and for a larger portion of the Medi-Cal population, such as we have proposed, would require a federal waiver and probably result in modestly higher state administrative costs. For example, some additional staffing and funding may be needed by DHS to monitor care trends in areas that receive grants or to make one-time adjustments to eligibility information systems. However, these largely one-time administrative costs would eventually be much less than the savings we have identified above. The administrative costs for ERs themselves to collect the copayments (including UC and county hospitals) would likely not be significant because hospitals already typically collect copayments from privately insured individuals.

Analyst's Recommendation

We recommend that the Legislature enact policy legislation to promote use of the most cost-effective and medically appropriate settings for primary care for Medi-Cal beneficiaries. This could be accomplished through a combination of (1) a targeted copayment for nonemergency use of ERs and (2) the use of available federal grant funding to improve access to primary care through a program comparable to the existing RHDP. We believe that this approach would improve health care outcomes for beneficiaries, in part by linking them more closely to preventive care instead of episodic care. We believe this approach would also be cost-effective for the state.

HOSPITAL WAIVER INCREASING STATE GENERAL FUND COSTS

The Governor's budget proposal estimates that a new federal hospital financing waiver will result in a net increase of state General Fund costs over the first two years of about $39 million. However, the waiver could instead be implemented in a manner that avoids these costs and generates significant state savings. Accordingly, we recommend that the Legislature shift support for additional "safety net" health care programs to federal hospital funds so as to achieve net General Fund savings for the state. (Reduce Item 4260-111-0001 by $35 million.)

Background

Federal Waiver and Related State Legislation. In June 2005, the state received general approval from the Centers for Medicare and Medicaid Services (CMS) for a new waiver program that restructures the way Medi-Cal funding is used to finance inpatient hospital services in the state. The

Legislature subsequently approved legislation (Chapter 560, Statutes of 2005 [SB 1100, Perata]) that in effect ratifies and implements this waiver package.

Waiver Had Several Key Goals. The key goals of the waiver included increasing the overall federal funding that would be available for hospital inpatient services while ensuring that no hospital now participating in the Medi-Cal Program would lose funding as a result of these changes. The waiver also sought to curb the state's use of transactions known as intergovernmental transfers, some of which CMS contended inappropriately increased federal reimbursements for hospital services. (See page C-87 of our *Analysis of the 2005-06 Budget Bill* for a more detailed description of the waiver and related state fiscal issues.)

State-Only Programs Authorized for Federal Funding. Under the waiver terms, General Fund spending for state safety net health care programs can be offset with federal funds. Chapter 560 authorized the use of a designated part of the new federal hospital funds to offset specific state General Fund costs. Chapter 560 selected four existing programs operated by DHS for potential use in this way: the Medi-Cal Medically Indigent Adults Long-Term Care Program, the Medi-Cal Breast and Cervical Cancer Treatment Program, the California Children's Services Program, and the Genetically Handicapped Persons Program (GHPP). Under the waiver's terms, the state could have offset more General Fund spending for additional state-only programs with federal hospital funds.

Governor's Budget Proposal

Hospital Funding Shifts. The *2006-07 Governor's Budget* implements the hospital financing waiver agreement through various shifts of General Fund, local funding, and federal funds for the support of both private and public hospitals and other state safety net health care programs for the poor. Figure 5 (see next page) provides a summary of the various detailed funding changes that are proposed in the Governor's budget plan. These changes have a number of significant net fiscal effects in both the current fiscal year and the budget year that we discuss below.

Resources for Waiver Administration. For 2006-07, the Governor's budget plan also requests $748,000 from the General Fund ($1.5 million from all fund sources) for the establishment of 13 new positions and the continuation of seven existing limited-term positions to administer the hospital waiver. The proposed budget also includes a shift in support to the General Fund for 21 existing positions previously supported through intergovernmental transfers.

Figure 5

Hospital Waiver Increases General Fund Costs

(In Millions)[a]

	2005-06	2006-07	Two-Year Total
Medi-Cal			
Hospital programs			
Shift Medi-Cal match from General Fund to local expenditures for large public hospitals	-$388	-$407	-$795
Shift funding from intergovernmental transfers to General Fund for private and smaller public hospitals	338	357	695
Eliminate state administration fee	80	85	165
Transition costs—one-time General Fund payments for 2004-05 services	122	—	122
Subtotals	($152)	($35)	($187)
Shift of Medi-Cal programs from General Fund to federal funds			
Medically Indigent Adult—Long-Term Care	-$15	-$20	-$35
Breast and Cervical Cancer Treatment Program	-2	-2	-4
Subtotals	(-$17)	(-$22)	(-$39)
Net Effects on Medi-Cal Expenditures	**$135**	**$13**	**$148**
Shift of other health programs from General Fund to federal funds			
California Children's Services	-$32	-$47	-$79
Genetically Handicapped Persons Program	-9	-21	-30
Subtotals	(-$41)	(-$68)	(-$109)
Total Net Effects on General Fund[b]	**$94**	**-$55**	**$39**

a Positive numbers indicate General Fund costs. Negative numbers indicate General Fund savings.

b Detail may not total due to rounding.

Waiver Projected to Increase Net General Fund Costs

Net Loss to State Over Two Years. Our analysis of the Governor's budget plan to implement the hospital waiver takes into account the plan's fiscal effects on the Medi-Cal hospital allocations as well as DHS safety net health care programs for the poor referred to earlier in this analysis. Viewed on this basis, the proposal results in a net cost to the state General Fund for the combined two-year period of 2005-06 and 2006-07.

Specifically, the Governor's budget plan would result in a net increase in General Fund spending of about $94 million in the current year above the level of funding provided for these programs in the *2005-06 Budget Act.* Increased General Fund costs for Medi-Cal hospital allocations would be partly offset with a lesser amount of General Fund savings achieved in the four safety net health care programs. For 2006-07, the waiver in total results in net General Fund savings of about $55 million. This is because General Fund savings in the four safety net programs would exceed the additional costs to the state in the budget year for Medi-Cal hospital allocations. Thus, the combined effect of these changes in 2005-06 and 2006-07 is projected to be a net cost to the state of about $39 million.

Why the Budget Plan Reflects a State Loss From the Waiver. When the waiver proposal was under discussion last year, DHS had indicated that the waiver would be implemented in a way that was "cost-neutral" to the state. Why does the proposed budget plan now reflect a net loss to the state General Fund? Two main factors explain this situation.

First, the earlier representation about state cost-neutrality did not take into account the one-time transition costs of moving to the new hospital finance system. Hospital payments that lagged several months in arrears under the previous system now will be made in the same month that services are rendered. This means that Medi-Cal, which uses a cash-based system of accounting, will have to make extra payments for hospitals in the current fiscal year. We estimate the one-time cost to Medi-Cal in 2005-06 for this technical adjustment at about $122 million.

Second, state General Fund costs have also increased to reflect updated information about the payments that are required to reimburse various types of hospitals for inpatient services. The net effect of recognizing updated estimates of costs for various public and private hospitals is an increase in General Fund costs of about $30 million in the current year and $35 million in the budget year.

Budget Assumes More Federal Funds, But Additional Funding Possible

The Governor's budget proposal would result in an increase in the amount of federal funds available for the support of California hospitals, but the proposal also passes up an opportunity to obtain additional federal funding. We discuss these findings below.

Federal Funds for Hospitals Would Increase. While the waiver, as implemented in the Governor's budget plan, results in a net loss to the state General Fund over two years, it assumes that California hospitals will receive a significant increase in federal funding. Specifically, according to

DHS, the federal funds available to California hospitals would increase by $303 million in 2005-06 above the amounts otherwise received under the prior hospital finance system. In 2006-07, the federal funding increase for inpatient services is assumed to be $660 million above the level included in the *2005-06 Budget Act*. While perspectives may differ regarding how much of these amounts is truly "new" funding, a significant portion would likely not be available without the waiver.

We note that these amounts assume that all available federal funds will actually be drawn down in each year. However, some portion of these additional federal payments may not actually be realized by hospitals. This is because the waiver approved by CMS left unresolved which specific health care expenses incurred by county and UC hospitals could be counted in order to draw down these federal funds. Thus, depending upon how this issue is ultimately resolved with CMS, the actual increases in federal funding that accrue to California hospitals could be significantly less than the amounts mentioned above.

Waiver Deal Provided Additional Federal Funds. Among various changes, the waiver agreement also made available to California hospitals an additional $900 million in federal funds, which could be drawn down each year in equal installments of up to $180 million. However, the waiver agreement specified that the receipt of these additional funds was contingent upon the state meeting certain specified conditions.

During the first two years of the waiver—2005-06 and 2006-07—receipt of the annual $180 million installments (for a total of $360 million) is contingent upon the enactment of the expansion of Medi-Cal managed care to seniors and persons with disabilities (SPDs) in a form consistent with a 2005 administration proposal.

The Legislature and Governor jointly decided last year to exclude this policy decision from the state legislation to implement the waiver. At the time, the administration indicated that it believed more time was needed to develop a proposal that would both satisfy legislative concerns and meet federal waiver conditions. Under the terms of the waiver agreement, a portion of the available funds is lost for each month that the federal conditions are not met. As a result, about $315 million of the original $360 million in federal funds would remain available to the state as of the end of March 2006.

The Governor's 2006-07 budget plan does include some additional Medi-Cal Program pilot projects to expand managed care, but does not include a managed care expansion proposal of sufficient scope to meet the federal conditions for the $360 million. The administration indicates it has chosen to forego the balance of these federal monies by seeking legislative approval of only its more limited managed-care proposals.

This choice has important ramifications for the Medi-Cal Program. We examined the issue of expanding Medi-Cal managed care in our 2004 report *Better Care Reduces Health Care Costs for Aged and Disabled Persons* and in our *2005-06 Analysis* of the Governor's proposal for a full-scale expansion of managed care. We noted that, while an expansion should proceed carefully so as not to disrupt patient care, such changes provided real opportunities to improve access to care and quality of care for these Medi-Cal beneficiaries while eventually achieving significant savings for the state.

Additional Federal Fund Opportunities Will Be Available. The waiver agreement provides the state another opportunity to obtain additional federal funds for California hospitals. Another $180 million in federal funds will be available in 2007-08, 2008-09, and 2009-10 ($540 million in all), if the state enacts an initiative to expand health care coverage options for persons who currently lack health coverage. Matching funds must be found at the state or local level to draw down the federal allotments.

The waiver agreement also established certain deadlines that the state must meet in order to access the additional federal funds. The DHS complied with the first deadline by submitting a concept paper for the coverage initiative to CMS at the end of January 2006. This paper lays out broad guidelines and goals for the initiative, such as limiting participation to uninsured individuals not already in Medi-Cal or the Healthy Families Program. However, the concept paper does not specify how the program would actually operate.

By September 1, 2006, the state must submit to CMS a waiver amendment outlining the initiative's structure, eligibility criteria, and the benefits provided to participants. The DHS has indicated that state legislation will be necessary to move forward with such an initiative.

Need for Additional Waiver Staffing Unclear. Our analysis indicates that there are a number of significant issues to be resolved relating to the Governor's budget proposal to add positions to implement the waiver and the proposed funding shift for the 21 existing DHS staff. These issues include the workload justification for these positions and several technical questions. Until these questions have been resolved, the Legislature is not in a position to decide whether the Governor's budget request is warranted.

Analyst's Recommendations

As we noted earlier, the state could use additional federal hospital funds to reduce state General Fund costs for safety net programs. In light of the unexpected projection of a net cost to the state General Fund from

implementation of the hospital finance waiver, we recommend that the Legislature enact statutory changes that would increase General Fund savings and result in net savings over two years from these changes. Specifically, we recommend that the Legislature modify the state law that implemented the waiver agreement so that additional federal hospital funds could be used in lieu of state General Fund support for two additional safety net health care programs for the poor—the Expanded Access for Primary Care program and the AIDS Drug Assistance Program. We estimate that about $46 million in additional General Fund savings could be obtained in this way in 2005-06, with about $35 million in additional General Fund savings possible in 2006-07. The Legislature also has the option of achieving a lesser or greater amount of savings from such changes.

Our proposed approach would require state statutory changes because the recently enacted Chapter 560 limited the use of federal hospital funds by the state to only the four safety net programs already included in the administration budget plan. We would note that it is possible that alternative safety net programs could be identified, in lieu of the ones we have proposed here, to achieve this same level of savings.

In regard to the potential for obtaining additional federal funds, we recommend that the Legislature reconsider the administration's decision to forego the balance of the $360 million in federal hospital funds associated with implementing managed care for SPDs. We believe it would be both good health policy and good fiscal policy for the state to pursue a larger-scale expansion of managed care even if the $360 million in additional federal funds for hospitals were not at stake.

Finally, because of unresolved questions regarding the Governor's request for additional staff to implement the hospital waiver, as well as the proposed funding shift for some existing staff, we withhold our recommendation regarding these proposed positions and funding at this time.

MEDI-CAL'S BITTER PILL: HIGH PAYMENTS TO PHARMACIES

The Medi-Cal Program lacks accurate information about the prices of prescription drugs sold by drug manufacturers. In some instances, this means that Medi-Cal is reimbursing pharmacies significantly more than would appear to be reasonable. We recommend the enactment of legislation giving the Department of Health Services greater authority to ensure that reimbursement for prescription drugs is set at more appropriate levels.

How the Medi-Cal Drug Benefit Works

Multiple Players Involved in Medi-Cal Drug Benefit. There are four major players involved in the process of providing prescription and over-the-counter drugs to Medi-Cal patients: (1) drug manufacturers, (2) wholesalers that purchase drugs from the manufacturers, (3) pharmacies that buy drugs from wholesalers and then dispense them to Medi-Cal patients, and (4) Medi-Cal. Medi-Cal generally does not purchase drugs directly from drug manufacturers or wholesalers, but instead reimburses pharmacies for furnishing drugs to Medi-Cal beneficiaries at preestablished prices in keeping with various requirements established in federal and state law. The cost to the state of reimbursing pharmacies for providing drugs to persons enrolled in Medi-Cal is projected to be about $1.5 billion from the General Fund under the Governor's budget proposal.

State Relies on Average Wholesale Price (AWP). Most private and public entities reimburse pharmacies for drug costs relying on the price reported by drug manufacturers. This price is typically published in commercial publications and is referred to as AWP. Manufacturers represent AWP as being the average price paid by wholesalers to drug manufacturers for their drugs. However, the term AWP is not legally defined in federal or state law or regulations. Moreover, the reference publications essentially reprint the pricing information provided by drug manufacturers with no verification that the listed price is actually the price at which the drug was sold.

Nevertheless, most states and many private organizations rely on the AWP price data to help determine what they will pay for drugs because there is no alternative source of accurate pricing information available to them. Most state Medicaid programs, including Medi-Cal, also use AWP prices as the basis for reimbursing pharmacies for prescription drugs furnished to their beneficiaries.

Medi-Cal Reimbursement for Prescription Drugs. Under state law, Medi-Cal pays pharmacies a two-part reimbursement. Pharmacies receive:

- An *ingredient fee*, meant to reimburse pharmacies for the actual cost of obtaining the drug (usually from a drug wholesaler). This reimbursement is now set in state law as being 17 percent below AWP for most drug products.
- A *dispensing fee*, meant to reflect the cost of the actual staff time, store overhead, and other related costs for providing pharmacy services to Medi-Cal beneficiaries. This fee is now set in state law at $7.25 per prescription.

The "Spread" Is Costly to Medi-Cal

AWP Prices Seen as Inflated. The drug prices included in AWP lists are widely regarded by many, including consumer advocates, drug procurement experts, and the federal Office of the Inspector General as being inflated, with one common remark being that AWP really stands for "Ain't What's Paid." As a result, there is sometimes a significant difference between the ingredient fee paid by the state to a pharmacy and the much lower amount that the pharmacy actually paid to a wholesaler for the drug. This gap is widely called the spread. This phenomenon can apply both to brand-name drugs and generics.

Drug procurement experts note that a drug offering a pharmacy a relatively big spread is likely to be dispensed more frequently. For example, when pharmacies have a choice about which brand of drug to dispense, such as is often the case for generics, they have a strong financial incentive to dispense the particular drug that nets them the greatest profit. In return, over time, the choice by the pharmacy to dispense the drug that nets the largest profit could significantly increase the manufacturer's market share for its product.

Figure 6 illustrates how the spread can be costly to Medi-Cal. (This example is based on actual reimbursement data for the generic drug, Ipratropium bromide—an inhaler used to treat pulmonary disease.) In this example, a pharmacy buys the drug from a wholesaler for $0.47. The manufacturer reports, however, that it sold the drug to the wholesaler for $39.35, and this price becomes the official AWP published for that medication. Under state law, the reimbursement paid by Medi-Cal to the pharmacy for the ingredient cost of the drug is set at AWP minus 17 percent, or, in this case, $32.66. Since the pharmacy's actual out-of-pocket cost for the drug was only $0.47, the spread gained by the pharmacy is $32.19 ($32.66 minus $0.47). That amounts to a 99 percent profit to the pharmacy on the ingredient cost, and does not include the additional $7.25 dispensing fee paid to the pharmacy for each prescription that it fills of this drug.

Medi-Cal Reimbursement Significantly Exceeds Cost of Certain Drugs. As shown in Figure 7, recently collected Medi-Cal reimbursement information shows that the state has potentially paid a very large spread for some prescription drug products. For comparative purposes, and because California price data are not publicly available, our analysis uses drug cost information reported for another state to estimate the average price that is being paid by California pharmacies to wholesalers for medications used for the Medi-Cal Program. This information suggests that the state is paying high reimbursements for Medi-Cal drugs. The level of overpayments is unknown but could potentially amount to the tens of millions of dollars annually.

Figure 6

Medi-Cal's Bitter Pill– The High Cost of Spread

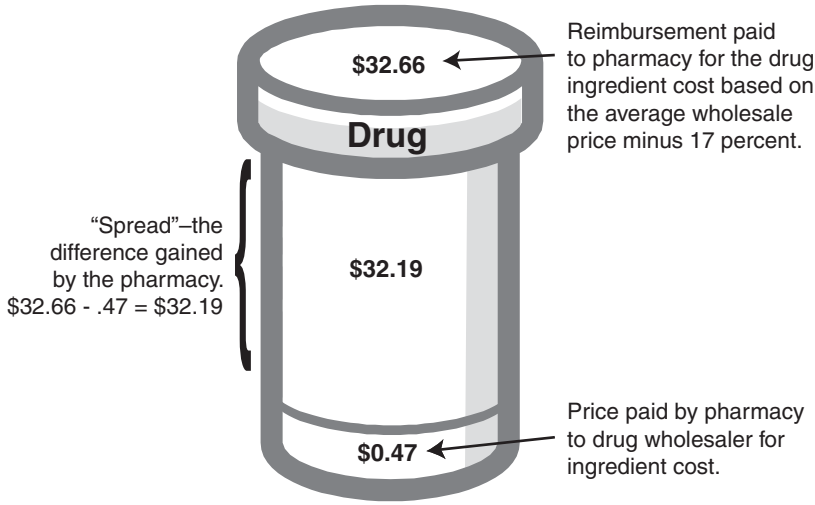


Figure 7

Examples of How Spread Is Increasing State Costs

2004-05

Generic Name	Payment by Medi-Cal[a]	Estimated Price Paid by Pharmacies to Wholesaler[b]	Pharmacy Spread	Spread as a Percentage of State Payment
Gammar 5 g. vial	$15,059.30	$157.14	$14,902.16	99%
Ipratropium Bromide 0.02 solution	32.66	0.47	32.19	99
Saline 0.45 solution	71.56	1.24	70.32	98
Haloperidol 1 mg. tablet	14.86	2.82	12.04	81
Albuterol 90 mcg. inhaler	17.00	5.63	11.37	67
Atenolol 50 mg. tablet	4.62	3.04	1.58	34

a Reimbursement based on average wholesale price-17 percent. Does not include dispensing fee.

b Data provided by the Attorney General based on prices paid by a pharmacy in another state.

State Suing Drug Manufacturers for Fraud. The state Attorney General is now suing numerous drug manufacturers for engaging in these practices, alleging that the state is being defrauded into paying inflated reimbursement rates. (Several other states have filed lawsuits similar to California's.) The Attorney General has alleged that these practices have created an inappropriate incentive for doctors and pharmacies to promote the prescription of those particular drug products offering the highest spread.

While the legal case proceeds, Medi-Cal continues to reimburse providers of certain prescription drugs at inflated rates based on the AWP because it now lacks any way to independently acquire accurate drug price information.

Federal Measure Would Reduce Drug Costs

As noted earlier, the AWP pricing system has resulted in high payments by California and other states for prescription drugs. Because the federal government shares in the cost of providing the Medi-Cal drug benefit (generally, 50 percent of the cost in California), these practices have also resulted in high payments of federal funds for the program.

Concerns about the federal government paying more than is appropriate has prompted Congress to include various provisions in the Federal Deficit Reduction Act (S. 1932) that are intended to reduce drug costs for state Medicaid programs. We discuss below these key changes that appear likely to help address Medi-Cal's drug-pricing problems. These proposed actions are likely to reduce drug costs for both the states and for the federal government and make drug prices for state Medicaid programs known to the public.

Federal Upper Payment Limit for Multiple Source Drugs. The federal measure would modify a previously existing federal upper payment limit for generics to limit reimbursement to 250 percent of the average manufacturer's price, a measure of drug prices known widely as AMP. The AMP is based on actual price data that drug manufacturers are required under federal law to report to the federal government, and is not a reference-type price such as AWP. The measure also amends federal law so that more drugs on the market would be considered generics and thus be subject to these price limits. (See nearby box for a comparison of the three ways that drug manufacturer's costs are reimbursed.)

AMP Data Made Public. Under the federal measure, information about AMP for generic drugs would be reported to states on a monthly basis and also be made publicly available. This change is intended to provide states with a potentially more accurate pricing measure than AWP

that could bring reimbursements to pharmacies for their reported ingredient costs more in line with the actual prices being paid for the drugs. In other words, this change should help reduce the spread being gained by pharmacies under the current system.

Other Reporting Requirements. The federal measure also requires that, beginning January 2007, state Medicaid plans must report to CMS annually various data, including the rates they are paying for drugs. This would permit federal authorities, as well as state officials in California and other states, to compare their performance in getting these drugs at the lowest prices. In addition, CMS will compare the retail sales prices being paid in each state by consumers for the 50 most widely prescribed drugs.

State Has Planned a New Measure—Average Wholesale Price

State Has Taken Some Actions Intended to Address the Spread Issue. In addition to pursuing fraud allegations against drug makers over drug-pricing practices, the state has taken other steps intended to help address the high cost of drugs to Medi-Cal. Notably, a 2004 state law authorized the Medi-Cal Program to impose a new type of price limit on ingredients that could be even lower than AWP minus 17 percent. This new pricing measure was termed the "average selling price" or ASP. The ASP was to be based on the actual average price paid by wholesalers for drugs in order to more accurately capture their true cost. Rather than continue to use AWP reference prices, the 2004 law authorized DHS to collect pricing information from drug makers to establish its own list of ASP prices that could be used to determine appropriate Medi-Cal reimbursement rates for pharmacies.

Three Types of Drug Prices and What They Mean

- ***Average Wholesale Price.*** The average price *reported* by drug manufacturers as being paid by wholesalers.
- ***Average Selling Price (ASP).*** The average price actually *paid* by wholesalers for drugs based on sales to all classes of trade, including retailers, hospitals, and nursing homes.
- ***Average Manufacturers Price.*** The average price *actually* paid by wholesalers based on sales of drugs to retail pharmacies. Since manufacturers typically charge *retail pharmacies* more for drugs than other classes of trade, such as hospitals, these prices can be higher than ASP.

Obstacles to Implementing ASP. Two years after it was authorized by state law, DHS has yet to implement the ASP system or begin to collect the new pricing information that would be needed for it to go into effect. State officials say the complicated nature of creating such a system has slowed their efforts to date. Recent federal developments pose additional obstacles as discussed below.

When California's ASP law was enacted, there had been indications that federal authorities intended to create their own ASP system in which California and other state Medicaid programs could eventually participate. The new federal deficit reduction measure instead relies on AMP rather than ASP as the basis for setting pharmacy reimbursement. Thus, it may no longer make sense for the state to incur the significant administrative costs and operational problems likely to result from creating its own new and separate pricing system now that AMP price data may soon be available for establishing Medi-Cal reimbursement rates. The state may be able to accomplish the same aim by piggybacking on such a new federal system, assuming one actually is implemented at the federal level.

We would note that additional future changes in addressing the spread issue are possible. For example, federal authorities might focus on ASP or altogether different strategies in the future to constrain payments for drugs.

Analyst's Recommendation

Given these changing circumstances, we believe it is important that the Legislature and DHS take a flexible approach to setting reimbursement rates for pharmacies that ensures that reimbursement for prescription drugs is set at more appropriate levels.

Specifically, we propose that the existing state ASP law be amended to give DHS greater authority to choose whether to use AMP, ASP, or other yet-unidentified pricing mechanisms to set reimbursements to pharmacies for drugs, especially generics. State law should provide DHS the authority to limit pharmacy reimbursements under whichever method it determines will result in the lowest net effective prices for the state for drugs after taking into account state administrative costs.

The legislation should also require DHS to report to the appropriate budget and health policy committees by April 1, 2007, regarding its timetable and plans for using the provisions in the revised statute to obtain lower prices on these drugs for Medi-Cal.

We believe this approach is likely to result in state savings of up to the tens of millions of dollars annually for Medi-Cal drug benefits once more accurate drug pricing information becomes available.

OTHER PROGRAM ADJUSTMENTS

Coordinated Care Proposals Should Be Modified

We recommend the Legislature not approve a new coordinated care management pilot project that would be largely duplicative of a disease management pilot project now in development. However, we recommend approval of another proposed pilot project to assist Medi-Cal beneficiaries who have both mental health and physical health problems, with a modification to use Proposition 63 mental health funding in lieu of General Fund support. (Reduce Item 4260-001-0001 by $208,000, reduce Item 4260-001-0890 by $79,000, and increase Item 4260-001-3085 by $127,000.)

Budget Proposes Two Pilot Projects. The Governor's budget requests five additional staff positions and $473,000 from all fund sources ($208,000 from the General Fund) for DHS to implement two "coordinated care management" pilot projects. One pilot would focus on persons with one or more chronic health conditions and who also have a serious mental illness. The other would focus on SPDs who have chronic medical conditions or who may be seriously ill and near the end of life.

Care Management Similar to Disease Management. Coordinated care management is very similar in concept to disease management services in that both health care strategies are intended to improve the coordination of health care services for persons with chronic diseases that put them at risk of expensive hospitalization or treatment if their care is not well-managed. In fact, some health care experts use the two terms interchangeably. In general, disease management programs are more likely to focus on helping a patient to manage one or a few chronic diseases. A coordinated care management program, on the other hand, is more likely to address all aspects of health care for an individual.

Efforts to better coordinate the care for persons with chronic health problems, such as disease management and care coordination management programs, have the potential to both reduce state health care costs and to improve the quality of care provided for SPDs. For these reasons, we initially proposed the disease management pilot project that was included in the *2003-04 Budget Act*.

As discussed earlier in this analysis, the Medi-Cal Program is now in the process of preparing an RFP to implement several disease management pilot projects that were authorized by the Legislature in 2003-04. The administration's 2006-07 budget proposal would initiate new and separate pilot projects that would be designated as efforts to provide coordinated care management for Medi-Cal beneficiaries.

First Pilot: Coordinated Care for Individuals With Mental Illness. In general, we conclude that the proposed new pilot project for coordinated care management focused on Medi-Cal beneficiaries who are mentally ill has merit. We believe this effort would provide new information about the potential for simultaneously improving the mental health and physical health of a population that often finds it difficult to cope with both types of health problems. However, we believe that an alternative funding source in lieu of General Fund should be considered for its support. Specifically, Proposition 63 imposed an income tax surcharge to finance an expansion of mental health services. These funds could be used in lieu of General Fund, and in combination with federal funds, to support this pilot project. The proposed pilot project appears to be consistent with the goals set forth in Proposition 63 of providing mental health services in a manner that integrates mental health services with the other health and social services needs of these patients in an innovative manner.

To accomplish such a funding shift, DHS could enter into an interagency agreement with DMH to reimburse DHS with Proposition 63 funding for activities related to this pilot project. We note that the Governor's budget similarly proposes to use Proposition 63 funding for another unrelated project partnering DHS and DMH, known as the California Mental Health Disease Management Program.

Second Pilot: Coordinated Care Project for SPDs. We recommend that the Legislature not approve the coordinated care management pilot project for SPDs with chronic illnesses because this new effort would be largely duplicative of the disease management pilots that are to get under way later this year. Rather than initiate another similar but separate pilot project, we believe a better strategy would be for DHS to concentrate its efforts on the successful implementation of the disease management pilot projects, which are to commence operation later this year.

Fiscal Impact of LAO Recommendations. Because only one pilot project would proceed under our recommendation, fewer staff would be needed than DHS has requested. Accordingly, we recommend that three of the five proposed positions be approved. Accordingly, the Legislature should reduce the General Fund request by $208,000, and make an adjustment in the DHS state operations budget to reflect the substitution of $127,000 in Proposition 63 funds for an equivalent amount of General Fund support. In addition, the appropriation of federal funds should be reduced by $79,000.

Reduce Funding for Disease Management Contract

We recommend the Legislature reduce Medi-Cal expenditures by $750,000 ($375,000 General Fund) in the current year and by $750,000

($375,000 General Fund) in 2006-07 to reflect the delay in implementing the disease management pilot project.

Contract Release Delayed. The DHS plans to test the efficacy of providing disease management services to fee-for-service Medi-Cal beneficiaries with chronic conditions such as heart disease. To do so, the department intends to award a competitively bid contract to a disease management organization. Release of the request for proposals (RFP) for this pilot project was initially delayed from March 2005 to December 2005, and we are advised by DHS that it is now likely that the RFP will be further delayed until February 2006 or later. As a result, it is unlikely that the contract will be awarded on March 1, 2006, or that payments to the contractor will begin in May 2006, as assumed in the Governor's budget plan. Given the delays to date, we estimate that the contract will not be awarded until July 2006, and that implementation of disease management services will not begin until September 2006 at the earliest.

Analyst's Recommendation. We recommend that the Legislature reduce Item 4260-101-0001 by $375,000 in 2005-06 and by $375,000 in 2006-07 to reflect the delay in awarding the contract. Appropriate further budget adjustments should also be made to reflect a lower appropriation of federal funds.

REQUESTS FOR ADDED STAFF EXCESSIVE

The budget request for the Department of Health Services includes $17.3 million ($7.8 million General Fund) to implement various proposals generally related to the administration of the Medi-Cal Program. We recommend that some of the requests for funding for additional staff and contract resources be approved, but recommend a reduction of $3.5 million General Fund because others are not justified on a workload basis. We further recommend a $2 million General Fund reduction in Medi-Cal local assistance to reflect some savings that will be achieved with additional staff.

Governor's Budget Proposal. The *2006-07 Governor's Budget* proposes additional staff positions and contract resources in DHS to implement various proposals generally related to the administration of the Medi-Cal Program. Some of these requests, and our related findings and recommendations, were discussed separately earlier in this analysis. These include budget proposals related to chronic care management, various long-term care pilot programs, the hospital financing waiver, and the implementation of Medicare's coverage of prescription drugs for persons enrolled in Medi-Cal and Medicare.

This analysis examines the 12 proposals summarized in Figure 8. The figure shows the general purpose of each request, the total costs and General Fund share, and the number of associated staff positions requested.

Figure 8

Medi-Cal Administration
Proposals for Positions and Related Funding

(Dollars in Thousands)

	Position Request	General Fund	Total Funds
Nursing home quality assurance fee	41	$3,415	$6,830
Breast and Cervical Cancer Treatment Program backlog	20.5	951	1,902
Antifraud program	20	824	2,314
Implementation of managed care expansion	17	718	1,616
Managed care expansion: California Medical Assistance Commission	1	66	—
Outreach to increase managed care enrollment	9	386	916
Third party liability: convert limited-term positions	15	247	989
Drug rebate program: extend limited-term positions	11	494	988
Treatment Authorization Request processing	6	285	713
Audit county administration cost claims	5	253	506
Medi-Cal fiscal intermediary oversight	3	74	294
Implementation of Self-Directed Services Waiver	2	96	193
Totals	**150.5**	**$7,809**	**$17,261**

Evaluating the Governor's Budget Requests

Our analysis of these 12 budget requests for DHS included a review of the department's overall staffing resources as well as an analysis of the justification offered by the administration for these specific proposals. The information we reviewed supports some of the DHS proposals, but raises questions about others.

Department Already Has More Positions Than It Can Fill

High Vacancy Rate at DHS. The *2005-06 Budget Act* provided the funding needed to support nearly 6,000 positions for DHS. It is not unusual for a portion of a department's authorized positions to be vacant

during the course of a fiscal year, as staff members leave for other jobs or retire and as efforts are made to recruit their replacements. The ordinary vacancy rate, which is "built in" to the budgets for most state functions, is about 5 percent. However, staffing data provided by the State Controller's Office indicate that a much higher portion of staff positions authorized for DHS—about 14 percent—was vacant as of January 2006.

DHS Has Some Flexibility to Meet Its Staffing Priorities. A number of factors can lead to this high staffing vacancy rate. These include a surge of staff members reaching retirement age and difficulties in recruiting for specialized staff in fields where the public sector is in competition with the private sector and other public agencies for staff. In any event, this situation means that, generally, DHS has more position authority and funding in the *2005-06 Budget Act* than it is now likely to use in the current year. If this situation were to continue into the budget year, as seems highly likely, it also means that DHS has some flexibility to reallocate funding and reclassify positions (with the consent of other control agencies) to meet its staffing priorities.

Justification Lacking for Some Budget Requests

Our analysis indicates that some of the specific requests for position authority and contract resources for Medi-Cal administrative activities are not justified on a workload basis at this time. We discuss the specific budget requests that we have concerns about below.

Nursing Facility Quality Assurance Fee. The 2006-07 budget requests additional resources to continue the implementation of a nursing facility quality assurance fee and facility-specific rates as required by Chapter 875, Statutes of 2004 (AB 1629, Frommer). Based on our analysis, 10 of the 41 positions requested are not justified on a workload basis. Moreover, the $500,000 ($250,000 General Fund) proposed for a contractor to assist in these efforts would duplicate the work that would be accomplished by existing DHS staff.

A combination of General Fund and federal funds are proposed to fund the positions. However, we believe it would be more appropriate to fund the General Fund share of the cost for five positions out of the proposed Licensing and Certification Fund. This would be consistent with the administration's proposal to fund activities associated with the licensing and certification of nursing homes with license fees rather than General Fund.

Cancer Treatment Program Backlog. The *2006-07 Governor's Budget* proposes to continue an effort that began two years ago to reduce a backlog of applications and review the eligibility of participants in the Breast

and Cervical Cancer Treatment Program (BCCTP). The DHS received 11 limited-term positions to address the backlog two years ago. Our review of the caseload indicates that a backlog still exists, but that the number of positions requested to address this situation is excessive based on a comparison of the caseload to staff productivity. We believe only 11.5 positions of the requested 20.5 positions are warranted, and that 9.5 of these should be limited-term because the workload associated with the backlog is temporary.

Our review also indicates that the Medi-Cal budget request does not account for local assistance savings that are likely to result as the backlog of eligibility reviews is addressed with these new positions. Specifically, the cost of services is likely to decrease as eligibility reviews shift some participants from the full-scope program to more limited state-only benefits. We estimate that this switch would reduce benefit costs for BCCTP participants by about $2 million General Fund ($6 million all funds) in 2006-07.

Antifraud Activities. The Governor's budget proposes to make permanent 20 limited-term positions authorized in 2003-04 that are set to expire at the end of June 2006. We believe the Legislature needs more information about the current nature of the Medi-Cal fraud problem before it can assess this proposal. The *2003-04 Budget Act* provided DHS with resources to complete an annual Medi-Cal error rate study to quantify the level of fraud in various areas of Medi-Cal. Our discussions with DHS indicate that the 2005 error rate report has been delayed from its expected release in December 2005, but will be available shortly.

Managed Care Expansion. The 2006-07 budget requests additional resources to continue the implementation of the expansion of Medi-Cal managed care plans to 13 additional counties approved last year by the Legislature. The staffing request does not reflect the fact that the expansion will be phased-in over 2006-07 and 2007-08 and is likely to be delayed in some counties. For example, Imperial County, one of the expansion counties for which DHS resources are requested, has indicated that it is not supportive of implementing managed care by March 2007 as assumed in the budget plan. The *2005-06 Budget Act* provided 27 positions to begin the initial development and start-up work necessary for the expansion. Thus, we believe only 5 of the 17 additional positions requested in DHS are warranted at this time. We also do not believe that the related request for an additional position in the California Medical Assistance Commission is warranted because it should have sufficient staff to absorb this additional workload.

Outreach to Increase Enrollment in Managed Care. The DHS proposes several activities to increase the capacity of the Medi-Cal managed

care system to serve SPDs. Another related budget proposal would mandate that SPDs who reside in two counties where enrollment is currently voluntary enroll in Medi-Cal managed care plans. We believe these proposals have merit and should help DHS to develop the systems needed to ensure that quality care is provided to SPDs enrolled in managed care plans. However, our analysis shows that only three of the requested nine staff positions are warranted at this time. We believe that other separate budget requests for Medi-Cal managed care activities—proposals that we recommend the Legislature approve—would provide sufficient staff to ensure that the managed care infrastructure is adequate.

Resolution of Drug Rebate Disputes. The administration proposes to continue its efforts to resolve an outstanding backlog of disputes over rebates believed to be owed to the state from drug makers. We believe the proposal to continue 11 temporary positions for this purpose for one additional year may be warranted. However, we withhold recommendation on the request at this time so that we can review at the time of the May Revision whether any of these 11 positions is vacant. The request should be adjusted to eliminate any positions that are vacant at that time because it is unlikely that newly hired staff would be productive during the one-year extension. According to the department, new staff takes an average of nine months to reach proficiency in collecting outstanding rebates.

Treatment Authorization Requests (TARs). Medi-Cal requires some services, such as certain prescription drugs and hospital inpatient care, to be approved in advance based on TARs submitted by providers to Medi-Cal field offices. The Governor's budget plan includes additional staff resources to improve the consistency of TAR processing statewide and increase the use of electronic TAR processing. A discussion of TAR issues can be found on page C-92 of our *Analysis of the 2004-05 Budget Bill.* We find no justification for the six additional staff positions requested to address the same issues for which the Legislature provided 18 staff two years ago. Moreover, DHS indicates that the percentage of pharmacy TARs submitted using a new electronic "e-TAR" submission process rose fourfold in 2005, while the percentage of medical TARs submitted using e-TAR roughly doubled. This growth in the use of e-TAR should reduce staff workload by more than enough for DHS to undertake its proposed new projects to improve the TAR process without the additional staff requested in the 2006-07 budget plan.

Auditing of County Administration Claims. The Governor's budget proposes to conduct on-site fiscal reviews to verify the accuracy of administrative costs claimed by counties for eligibility determinations for Medi-Cal beneficiaries. Our analysis indicates that the additional workload (which involves conducting one audit a year in each of the 20 counties with

the greatest population and less frequently for smaller counties) for this purpose justifies only three of the five requested positions.

Self-Directed Services Waiver. The DHS provides administrative oversight and monitors consumers enrolled in the Department of Developmental Services' Independence Plus Home and Community-Based Services Waiver. Based on a workload analysis only one of two requested positions is justified.

Analyst's Recommendations

As noted above, some administration requests warrant approval but others lack justification on a workload basis. In addition, the 14 percent vacancy rate now being experienced by DHS calls into question whether the addition of a large number of staff is appropriate at this time.

Accordingly, we recommend that some of the administration proposals be approved as proposed, that others be modified (in most cases to reduce the number of positions requested and the associated operating expenses and equipment), and that some be disapproved by the Legislature. In summary, our recommendations would result in a reduction of 47 of the 150.5 requested positions. The amount of funding provided for these specific 12 proposals would be reduced by $3.5 million from the General Fund and $7.2 million from all fund sources, including a reduction we propose for contract funding for the quality assurance fee implementation. Also, we withhold recommendation regarding the requested extension of the 20 antifraud positions pending the release of the 2005 error rate report and the extension of the 11 limited-term positions for the drug rebate program.

In addition, the Medi-Cal local assistance budget should be reduced by $2 million General Fund in 2006-07 as a result of adding positions to more quickly perform eligibility functions in the BCCTP.

Our specific recommendations for each of the budget requests discussed in this analysis are summarized in Figure 9.

Figure 9

Summary of Requested DHS Positions and LAO Recommendations

	Position Request	LAO Recommendation
Nursing home quality assurance fee	41	31
Breast and Cervical Cancer Treatment Program backlog	20.5	11.5
Antifraud program	20	Withhold
Implementation of managed care expansion	17	5
Managed care expansion: California Medical Assistance Commission	1	—
Outreach to increase managed care enrollment	9	3
Third party liability: convert limited-term positions	15	15
Drug rebate program: extend limited-term positions	11	Withhold
Treatment Authorization Request processing	6	—
Audit county administration cost claims	5	3
Medi-Cal fiscal intermediary oversight	3	3
Implementation of Self-Directed Services Waiver	2	1
Totals	**150.5**	**72.5[a]**

[a] Total recommended does not include the request for 20 antifraud positions or the request for 11 positions for the drug rebate program, for which we withhold recommendations at this time.

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. Others are solely state-operated programs, such as those that license health facilities.

The Governor's budget proposes about $2 billion in local assistance from all funds for public health programs in the budget year, about the same level of funding provided in the current year. Total proposed expenditures in the budget year include $392 million from the General Fund, a 3 percent ($11 million) increase from the revised current-year level of spending. This increase is largely due to the administration's proposals for emergency preparedness, pandemic influenza, and other disease outbreaks.

BUDGET PROPOSALS

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

- ***Emergency Preparedness.*** The Governor's budget proposes about $46 million from the General Fund and 58 positions to enhance statewide emergency preparedness, mitigation, and response activities in regards to pandemic influenza and other disease outbreaks. We discuss this proposal in more detail within *the 2006-07 Budget: Perspectives and Issues*.
- ***Public Health Infrastructure.*** The Governor's budget proposes an increase of $6.8 million in special funds and 34 new staff positions to enhance the state's public health infrastructure, such as adding resources to inspect x-ray machines and medical waste generators. In order to accomplish these enhancements, the Governor proposes a new fee to recover costs for follow-up inspections of

facilities which use radiation sources, an increase in the fee assessed on environmental health specialists, an increase in the fee assessed on medical waste generators, and the ability to change fees in order to recover the costs of follow-up inspections of large quantity medical waste generators.

- ***AIDS Drug Assistance Program (ADAP).*** The ADAP provides drug subsidies for low-income persons with HIV who have no health insurance for prescription drugs. The budget proposes for 2006-07 about $296 million for this program (about $108 million from the General Fund, $101 million in federal Ryan White CARE Act funds, and $88 million from the drug rebate fund). This would provide a $28 million increase in overall funding for the program ($17 million more from the General Fund).

- ***Proposition 99 Funding Shifts.*** The Governor's proposed budget reflects a series of changes in the use of tobacco tax revenues deposited into the Proposition 99 special fund, including requests for: (1) $4 million and five positions to continue the implementation of the statewide asthma prevention program, (2) $7.4 million in one-time funding to address tobacco use and cessation in certain populations, and (3) about $18 million to pay Medi-Cal Program costs resulting from a settlement of litigation that required a retroactive increase in reimbursement rates for outpatient hospital services. The budget also reflects reductions in one-time expenditures for the California Healthcare for Indigents Program (about $21 million), the Rural Health Services Program ($2.5 million), and the Steven M. Thompson Physician Corps Loan Repayment Program ($3 million).

- ***County Medical Services Program (CMSP).*** The CMSP provides health care to certain low-income adults who are not eligible for the state's Medi-Cal Program and reside within one of 34 participating small California counties. Consistent with prior years' actions, the Governor's budget proposes legislation to again suspend in 2006-07 the state's General Fund appropriation of about $20 million to CMSP.

- ***California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP).*** The CCS and GHPP programs provide health care services to severely ill and medically fragile children and adults. The budget plan proposes $196 million ($44 million from the General Fund) in funding for CCS and $56 million ($31 million from the General Fund) for GHPP. Of this total amount, $47 million for CCS and $21 million for GHPP is federal funding from the "safety net care pool" resulting from

the recent Medi-Cal financing waiver and related state legislation. The budget plan would provide a total increase (all funds) of $15 million in support for CCS due mainly to caseload changes. A $22 million increase in support from all fund sources for GHPP is due largely to technical budgeting changes.

- ***Child Health and Disability Prevention Program (CHDP).*** The Governor's budget proposes $3.7 million ($3.6 million from the General Fund) in total expenditures for CHDP, a health-screening program for low-income children. This is an increase in about $830,000 from the General Fund due to technical budgeting changes.

- ***Vital Records Computerization.*** The budget requests about $11 million in special funds and the addition of 19 staff positions to continue the computerization of birth and death certificates. The Vital Records Image Redaction and Statewide Access system, developed pursuant to Chapter 914, Statutes of 2002 (SB 247, Speier), provides county recorders and local registrars the ability to search a state database for records, select a birth or death record for redaction, electronically submit a request to the state for a production of a redacted image, and electronically receive the requested redacted record from the state. The main purpose of these changes is to reduce the risk of "identity theft" using these state records.

- ***Implementation of Legislation.*** The budget includes increased expenditures for the implementation of recently passed legislation. This includes (1) $3.5 million from the General Fund for the Prostate Cancer Treatment Program reestablished by Chapter 442, Statutes of 2005 (SB 650, Ortiz), (2) $495,000 from the General Fund and four positions to address concerns about the chemical composition and safety of cosmetics sold in the state, as required by Chapter 729, Statutes of 2005 (SB 484, Migden), (3) $1 million from the General Fund and eight positions to regulate lead content in candy, as mandated by Chapter 707, Statutes of 2005 (AB 121, Vargas), and (4) $1.3 million in special funds and one position to increase food safety resources and prevent and reduce food borne illnesses and death, pursuant to Chapter 401, Statutes of 2005 (AB 1081, Matthews).

- ***Public Health-Related Mandates.*** The Governor's budget includes about $3.7 million in General Fund support to reimburse local governments for various public health mandates, including mandates pertaining to AIDS search warrants, Pacific beach safety, and perinatal services for alcohol and drug exposed infants.

PUBLIC HEALTH PROGRAM EXPENDITURES

Public Health Expenditure Information Unavailable

We recommend the adoption of trailer bill language (1) requesting the Bureau of State Audits to conduct an audit of the funding provided for various Department of Health Services (DHS) public health programs and (2) requiring the administration to include public health program expenditure information in the budget display because DHS is unable to provide the Legislature with detailed information about these expenditures on a timely and regular basis.

Governor's Proposal. The Governor's budget proposes aggregate expenditure information on certain major categories of public health local assistance funds administered by DHS. For example, the Governor's plan indicates that about $822 million would be spent in the category of public health spending for public health services. However, DHS often operates dozens of specific subprograms within a single category of spending. For example, the Primary Care and Family Health Division's Maternal, Child, and Adolescent Health Branch operates such subprograms as the Childhood Injury Prevention Program and the Oral Health Program.

Certain Budget Information Not Available. Detailed information on the actual past year, estimated current year, and proposed budget year level of spending for these subprograms is not now available to the Legislature in the Governor's budget documents. We note that this information was previously available in these budget documents. We are concerned that, for at least the last several years, DHS has been unable to produce an accurate and comprehensive list of the funding allocated for these public health programs for the Legislature despite past and recent requests that they do so. While the department has, on occasion, been able to respond to legislative inquiries for this type of information with regard to a specific particular subprogram, it has been unable to provide a comprehensive lists of subprograms, and their associated expenditures, for entire categories of public health spending. The DHS has indicated that it cannot do so due to limited staff resources and competing workload.

This situation raises two significant concerns. First, this lack of timely and regular information about DHS subprograms undermines the ability of the Legislature to provide policy and fiscal guidance and oversight of these funds, which amount to hundreds of millions of dollars annually. Second, and of equal concern, DHS' fiscal managers are not routinely collecting and using such information themselves on an ongoing basis to provide appropriate fiscal management of the department's array of public health subprograms. If DHS administrators do not routinely track how much is being spent by various other branches of the department

for these various subprograms, it raises a question as to whether they can exercise appropriate fiscal controls over these activities, let alone determine the appropriate amount of funding to request in the DHS budget for the broader categories of expenditures.

Analyst's Recommendations. Given the potential concerns over executive branch and legislative oversight of DHS' array of public health subprograms, we recommend that the Legislature request the Bureau of State Audits to conduct an audit to identify the actual past year, estimated current year, and proposed budget year expenditures for DHS' various public health subprograms. The audit should also evaluate whether these expenditures are now subject to appropriate fiscal controls by DHS.

We also recommend that the administration annually provide actual past year, estimated current year, and proposed budget year expenditures for DHS' various public health subprograms to the Legislature in the annual budget documents.

Women, Infants, and Children Program Could Face Major Penalties

The state faces a risk of as much as tens of millions of dollars in penalties for paying vendors more than permitted under federal limits in the Women, Infants, and Children (WIC) nutrition program. We recommend that the Department of Health Services report at budget hearings on the status of federal enforcement actions related to this issue and the implications of this situation for the state budget and the WIC program.

Background. The Women, Infants, and Children (WIC) program is a nutrition program that helps pregnant women, new mothers, and young children eat well and stay healthy. Program recipients receive food checks that are valid for items such as milk, eggs, and baby formula. These food checks are redeemed at retail vendors. The vendors are reimbursed by the state for the costs of the foods. About $1.2 billion ($936 million in federal funds and $297 million in special funds) is proposed for support of the program in 2006-07.

More than 3,600 vendors participate in California's WIC program. These vendors include almost 700 vendors that receive more than one-half of their annual food sales revenues from sales to WIC customers. (These are referred to as "above 50 percent vendors" and often include vendors that sell WIC-only food and vendors that are located near WIC offices.) Another 2,900 "regular vendors" receive a lesser amount of their revenue from sales to WIC customers.

A new federal law requires states to ensure that reimbursement levels for above 50 percent vendors do not result in higher food costs than if WIC

participants shopped at regular vendors. States are required to compare the average cost of payments for each type of food provided under WIC for the above 50 percent vendors and the regular vendors.

States are required to make these comparisons of costs on an ongoing basis and to make any adjustments to reimbursement levels that are needed to comply with the federal payment limits. States are subject to federal claims for recovery of any excessive payments made to vendors. At the time this analysis was prepared, legal challenges filed by above 50 percent vendors intended to block the enforcement of these new federal provisions were pending.

California at Risk of Being Penalized. California authorities have compared payments to regular vendors and the above 50 percent vendors and determined that the WIC program has been spending about $4 million more per month than permitted under federal limits that became effective December 31, 2005. Thus, if the overpayments continued the state faces the risk of federal penalties that could amount to tens of millions of dollars. At this point, it appears that the General Fund or potentially the WIC Food Manufacturer Rebate Fund could be used to pay such a penalty. (The federal government has not yet issued written clarification regarding what sources of funding states would be permitted to use to pay such penalties.) If the rebate fund were used to fully pay such penalties, it would reduce the amount of funding available for nutritional assistance.

We note that since 2000 DHS has been working on developing new state regulations for authorizing and reimbursing vendors in recognition of the differences in business practices and costs among regular vendors and above 50 percent vendors. However, the above 50 percent vendors have strongly objected to the draft regulations. The DHS is now working to address the concerns with the draft regulations.

Analyst's Recommendations. Given the risk to the state of these federal penalties, we recommend that DHS report at budget hearings on the status of any pending litigation and federal enforcement actions related to this issue and the implications of this situation for the state budget and the operation of the WIC program.

MANAGED RISK MEDICAL INSURANCE BOARD (4280)

The Managed Risk Medical Insurance Board (MRMIB) administers several programs designed to provide health care coverage to adults and children. The Major Risk Medical Insurance Program provides health insurance to California residents unable to obtain it for themselves or their families because of pre-existing medical conditions. The Access for Infants and Mothers (AIM) program currently provides coverage for pregnant women and their infants whose family incomes are between 200 percent and 300 percent of the federal poverty level (FPL). The Healthy Families Program (HFP) provides health coverage for uninsured children in families with incomes generally up to 250 percent of the FPL who are not eligible for Medi-Cal and, beginning in July 2004, provides health coverage for certain uninsured infants born to AIM mothers.

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

Budget Proposal. The budget proposes $1.2 billion from all fund sources ($380 million from the General Fund) for support of MRMIB programs in 2006-07, which is an increase of $127 million from all fund sources ($47 million from the General Fund) or about 12 percent over estimated current-year expenditures. This increase is due primarily to projected caseload growth in HFP and the administration's proposals to streamline enrollment for HFP and increase use of the electronic HFP application.

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

- ***Increased Staff to Address Workload.*** The administration proposes to add ten positions and $983,000 ($248,000 from the General Fund) to address an anticipated increase in workload. We more fully describe this request and our analysis of the proposal later in this section.
- ***Streamlining of Enrollment Process and Promoting Use of Health-e-App.*** The budget proposes $91,000 ($32,000 from the General Fund) to implement changes to HFP eligibility and enrollment processes and to expand use of an electronic benefits application system known as Health-e-App. We discuss these proposals in more detail within the "Crosscutting Issues" section of this chapter.
- ***Increased Oversight of Mental Health Services for HFP Enrollees.*** The budget includes $432,000 ($151,000 from the Mental Health Services Fund and $281,000 in federal funds) to increase oversight in the delivery of mental health services for HFP enrollees with serious emotional disturbances.
- ***Elimination of Duplicate Healthy Families and Medi-Cal Enrollments.*** The administration proposes to eliminate the potential for duplicate enrollment in HFP and Medi-Cal by denying enrollment to an infant if the infant is currently enrolled in Medi-Cal or employer sponsored health coverage.
- ***Expedited Enrollment of Eligible Infants Born to Mother in AIM.*** The administration further proposes to expedite HFP enrollment for infants born to AIM mothers by allowing MRMIB to redirect a portion of the subscriber contributions paid by AIM participants to HFP and to apply this money toward the infant's HFP premium.
- ***Elimination of Legislative Oversight of Certain Expenditure Authority.*** The MRMIB is proposing Budget Bill language to allow the Department of Finance to change HFP General Fund and federal funds expenditure authority or establish permanent staff positions to the extent that foundation and grant funding are available without any advance oversight by the Legislature. We more fully describe this request and our analysis of the proposal later in this section.

HEALTHY FAMILIES PROGRAM

Background

Expanded Health Coverage for Low-Income Children. The federal *Balanced Budget Act of 1997* (BBA) made available approximately $40 billion in federal funds over ten years to states to expand health care coverage for children under the State Children's Health Insurance Program (SCHIP). The BBA also provided states with an enhanced federal match as a financial incentive to cover children in families with incomes above the previous limits of their Medicaid programs. Under SCHIP, the federal government provides states with flexibility in designing a program.

California decided in 1997 to use its approximately $6.9 billion share of its ten-year SCHIP funding to implement the state's HFP. Funding for the program generally is on a 2-to-1 federal/state matching basis. Through this program, children in families earning up to 250 percent (and in select cases up to 300 percent) of the FPL receive comprehensive health care coverage that includes dental, vision, and basic mental health care benefits. Families pay a relatively low monthly premium (generally between $4 and $15 per child) and can choose from a selection of managed care plans for their children. This program is administered by MRMIB.

The Budget Proposal. As shown in Figure 1, the budget proposes about $1 billion (all funds) in HFP expenditures in the budget year. This is an increase of about 15 percent over estimated current-year expenditures. The budget proposes $380 million in General Fund support for HFP, a $51 million increase above the current-year level. The increase in General Fund expenditures is primarily due to growth in caseload and the administration's proposals to streamline the enrollment process and increase usage of the electronic application process for the program.

Future Federal Funding Unlikely To Meet Program Requirements

Future uncertainties surrounding the reauthorization of federal funding and the eventual exhaustion of unspent federal funds pose a risk of significant future increases in General Fund expenditures for the Healthy Families Progam (HFP). In light of this potential problem, we present alternatives to hold down increases in overall HFP costs and to obtain additional financial support for the program.

Figure 1

Managed Risk Medical Insurance Board
Healthy Families Expenditures

(In Millions)

	2005-06		
	Budget Act	Revised	2006-07 Budget
Local Assistance	$958.5	$908.4	$1,047.1
State Operations	7.0	7.2	8.5
Totals[a]	**$965.5**	**$915.6**	**$1,055.6**
Proposition 99 Account	$2.2	$2.2	$2.3
General Fund	348.0	328.9	379.7
Federal funds	605.3	576.7	665.2
Reimbursements	10.0	7.8	8.2

[a] Details may not total due to rounding.

SCHIP Reauthorization

As previously mentioned, the BBA provided California with approximately $6.9 billion over ten years for HFP. The end of this ten-year period is approaching. Funding has been authorized by Congress only through the 2007 federal fiscal year (through September 2007) and the future actions of Congress in regards to SCHIP funding reauthorization are unknown. Furthermore, it is particularly difficult to estimate California's future allocation of federal SCHIP funding given that there has been significant variation in the allocation amount from year to year. For example, in the 2004 federal fiscal year, California was allocated $534 million, but the state received $667 million in the following year. This uncertainty in federal support is a major policy concern because Congressional actions could have significant impacts on the level of state spending on HFP, as we discuss in more detail later in this analysis.

State Has Expanded Use of Its SCHIP Funds

States must spend their federal SCHIP allocations within a set period of time (generally three years) or risk the reversion of these funds to the federal government. Consequently, California has expanded its use of SCHIP funds for health coverage programs over time, in part to prevent SCHIP funds from being reverted and lost to the state. In this section, we provide a brief description of some of these expansions in the use of SCHIP funding.

(We note that in January 2002, the state was granted a waiver by the federal government to expand HFP to uninsured parents of children eligible for HFP or Medi-Cal in families with incomes up to 200 percent of the FPL. The waiver will expire in January 2007 and at this time the administration does not propose to implement this expansion.)

Children's Eligibility Expansion. The program began enrolling children in July 1998 in families with incomes up to 200 percent of the FPL. In 1999, the program was expanded to include children with family incomes up to 250 percent of the FPL, as well as recent legal immigrant children who are not eligible for support with SCHIP federal funds. The budget includes about $90 million from the General Fund for these children.

CHIM Fund Program. In 2001, the Legislature expanded the use of SCHIP funds by establishing the CHIM Fund program. Through this program counties are able to access federal SCHIP matching funds to provide health coverage on a county-by-county basis to uninsured children living in families earning incomes between 250 percent and 300 percent of the FPL. As noted earlier, CHIM relies on no state funding but only on federal and county resources. In effect, counties leverage local funds to draw down some of the unspent portion of California's federal SCHIP allotment according to the same 2-to-1 matching rate used by the state. The Governor's budget plan includes $1.5 million in the CHIM Fund and $2.7 million in federal funds.

AIM Infants. As a result of enactment of the *2003-04 Budget Act*, infants born to AIM mothers are enrolled in HFP, while the mothers remain covered through the AIM program. Over time, this shift of new AIM infants into the HFP will result in an AIM program consisting only of mothers. The Governor's budget proposes about $19 million in state funds and about $36 million in federal funds for these AIM-linked HFP infants.

Presumptive Eligibility. The Child Health and Disability Prevention (CHDP) "gateway" program was implemented in 2003. Under the gateway program, when a child visits a CHDP provider for a check-up, the provider determines if the child appears to be eligible for Medi-Cal or HFP. If the child appears eligible for either of these programs, the child is presumed to be eligible for two months of benefits. The child's family must subsequently apply to Medi-Cal or HFP to be permanently enrolled in health benefits. The Governor's budget proposes about $41 million in state funds and $77 million in federal funds for HFP presumptive eligibility.

Prenatal Services. The *2005-06 Budget Act* expanded the use of federal SCHIP funds for support of prenatal services provided under Medi-Cal and AIM. Previously, state funds (General Fund and Proposition 99 funds) were used to support these services. The combined state savings for 2004-05 and 2005-06 is $304 million. The Governor's budget proposes about

$88 million in state funds and $163 million in SCHIP funds in 2006-07 for this same purpose.

Potential Future Federal Funding Shortfall

As a result of these program expansions and underlying growth in HFP caseload, the current level of SCHIP funds being spent each year now exceeds the SCHIP funds allocated annually to California, with the result that the balance of unspent SCHIP funds has been gradually declining. As shown in Figure 2, the Governor's budget plan proposes to use about $400 million from the previous years' unspent balance of SCHIP funding (the difference between the carryover in federal funding for 2006-07 and 2007-08). Assuming the Governor's proposal were adopted as proposed, we estimate that the state will exhaust its unspent balance of SCHIP funds in 2007-08. We base this estimate on MRMIB's estimates for federal fiscal year 2007 and use this estimate for 2007-08 and 2008-09.

Figure 2

Estimated Unspent Federal SCHIP Allotment

(In Millions)

	2005-06	2006-07	2007-08	2008-09
California's allotment of SCHIP[a] funding	$652.0	$761.8	$800.0	$800.0
Carryover federal funding	1,013.3	613.3	213.6	—
Total[b] Available Federal Funds	**$1,665.3**	**$1,375.0**	**$1,013.6**	**$800.0**
Healthy Family Program costs	726.5	853.5	853.5	853.5
CHIM[a] Fund program	5.3	3.3	2.0	2.0
AIM[a] infants	27.5	35.9	35.9	35.9
Presumptive eligibility	76.8	79.8	80.0	80.0
Prenatal services	216.0	189.0	156.0	156.0
Total[b] Expenditures	**$1,052.0**	**$1,161.4**	**$1,127.4**	**$1,127.4**
Unspent Federal SCHIP allotment	**$613.3**	**$213.6**	**—**	**—**
Potential General Fund Impact	**—**	**—**	**$113.8**	**$327.4**

Source: Managed Risk Medical Insurance Board.

a SCHIP=State Children's Health Insurance Program; CHIM=County Health Initiative Matching; and AIM=Access for Infants and Mothers.

b Details may not total due to rounding.

Consequently, if no changes are made to eligibility, benefits, rates paid to providers, or program funding sources, additional General Fund support would be required as early as 2007-08 in order to maintain the current level of services.

Alternatives for Addressing the Funding Shortfall

Early Action Has Advantages. Under the Governor's budget proposal, the Legislature is not likely to face a funding shortfall in the budget year for the HFP. However, as shown in Figure 2, the projections do show a funding shortfall of federal SCHIP funds in 2007-08 that would grow considerably in 2008-09. Consequently, we recommend that the Legislature begin to consider now how it might address this situation, particularly given its potential impact on the General Fund. Early consideration of this matter by the Legislature would (1) give it more flexibility and time to weigh its options, (2) potentially extend the availability of federal SCHIP funds, if early steps were taken that could slow the drawdown of the current balance of such funds, and (3) help factor this problem into administration and legislative proposals to further children's health coverage. (Our analysis of the administration's budget proposals to increase enrollment in HFP and Medi-Cal can be found in the "Crosscutting Issues" section of this chapter.)

In this section, we present alternatives for the Legislature to consider to address this future situation. While some of these alternatives could work in combination with each other, some represent conflicting approaches. See Figure 3 for a summary of these alternatives.

We note that under current law, the administration is permitted to cap enrollment of children in the HFP in order to live within the available funding for the program. (In 2004-05, however, the Legislature rejected the administration's proposal to cap enrollment and create waiting lists for HFP.) In this section we highlight additional options the Legislature could consider to address the likely future shortfall in SCHIP funding.

Benefits Package Could Be Trimmed. One alternative for reducing state costs for the HFP and extending the use of available SCHIP funds would be to reduce the scope of coverage that all HFP enrollees receive. Under this approach, no eligible child would be denied coverage, but the coverage each child would receive would be reduced in scope. For example, we estimate that the elimination of vision and dental care for all enrollees would eventually result in full-year state savings of as much as $77 million and allow $142 million in SCHIP funds to be carried forward for support of the program. (We note that it would not be feasible to obtain full-year savings in 2006-07 due to the timing of rate negotiations with the plans.)

Figure 3

Alternatives for Addressing Future Healthy Families Program Funding Shortfall

- ***Enrollment Could Be Capped.*** Cap the enrollment of children in the Healthy Families Program (HFP) in order to live within the available funding for the program.
- ***Benefits Package Could Be Trimmed.*** Reduce the scope of coverage that all HFP enrollees receive.
- ***Premiums Could Be Increased.*** Increase HFP premiums if monitoring shows recent increase has not adversely affected enrollment.
- ***Some Children Could Be Shifted to County Coverage.*** Fully or partly reverse the shift that has occurred in the cost of providing children's health care from the counties to the state.
- ***Some Children Could Be Shifted to Medi-Cal.*** Shift some HFP children to the Medi-Cal program so as to maximize available federal funds.
- ***Other Savings or Revenues Could Be Found.*** Adopt reductions in other state programs thereby, freeing up resources that could be used for HFP and explore options for obtaining additional state revenues to be used for HFP.

Premiums Could Be Increased. Beginning in 2005-06, the premiums for children paid by families with incomes between 201 percent and 250 percent of FPL were generally increased from $9 per child to $15 per child. This premium increase is projected to raise an additional $5.5 million in state revenue for the program in 2006-07. Initial disenrollment data (collected since the implementation of the premium increase) indicates that raising the premiums has not significantly increased the number of children disenrolled from HFP. The Legislature should monitor these disenrollment trends. If it appears likely that program enrollment would not be adversely affected, the Legislature could consider future premium increases as part of a solution to the SCHIP funding shortfall.

Some Children Could Be Shifted to County Coverage. The Legislature has the option of reducing costs in HFP by partially or completely reversing the expansion of coverage to families that occurred after the program was initially created and shifting coverage of those children to

the CHIM program, other local health coverage programs, and county indigent care.

This alternative could result in significant state savings. For example, reducing coverage for children in families with incomes above 200 percent of the FPL could save the state as much as $82 million in General Fund in 2006-07 that could be used to maintain eligibility and benefits for the children the state would continue to cover under HFP.

Under an alternative approach, this change could be phased in for new enrollees while those already enrolled in coverage could be permitted to remain in the program. The savings to the state under this option would ramp up slowly but would eventually become significant. In order to provide an alternative source of health coverage for these children in higher-income families, the state could adjust the CHIM program (subject to federal approval) to allow counties to provide coverage for children of families in this income group.

We note that increasingly since 1997, the state has provided coverage to an additional 3.4 million children and adults, many of whom were once only eligible for county programs. This occurred through the creation of the HFP and Medi-Cal 1931(b) eligibility without any reimbursement from the counties. The shift in coverage costs discussed above would in effect return some of these families to county-funded coverage.

Some Children Could Be Shifted to Medi-Cal. Similarly, the Legislature also has the option of shifting some HFP children to the Medi-Cal program. For example, children ages 6 to 19 in families with income under 133 percent of FPL could be shifted from HFP to Medi-Cal. Assuming that HFP has roughly the same proportion of 6- to 19-year-olds as the general population, this could free up about $6 million in federal SCHIP funding that could be used for ongoing support of HFP. Such a change would also allow families with income under 133 percent of FPL and children ages 1 to 5 and 6 to 19 to have children in one program (Medi-Cal), rather than have children in both Medi-Cal and HFP.

The federal match for Medi-Cal is on a 1-to-1 basis, while HFP is on a 2-to-1 federal/state basis. Nevertheless, shifting HFP children to Medi-Cal would save state dollars compared with covering these children only with state funds.

Consider Reductions in Other State Programs or Explore Additional State Revenues. Finally, if the Legislature does not wish to make changes to HFP, it could consider (1) adopting reductions in other state programs, thereby, freeing up resources that could be used for HFP and/or (2) exploring options for obtaining additional state revenues to help take the place of diminishing SCHIP funds.

Analyst's Recommendations. We recommend that the Legislature begin to consider now how it might address the significant mismatch that likely lays ahead for federal SCHIP funding and the state programs currently supported from that funding source. This is a particularly important issue for the Legislature to consider given its potential impact on the General Fund and given our out-year projections of a major structural gap between state operating revenues and expenditures if the administration's proposed budget were adopted. Early actions on this matter, we believe, would provide the Legislature more flexibility in its choice of solutions to this problem.

Caseload Projection Too High

For the last two years, the Managed Risk Medical Insurance Board has overestimated Healthy Families Program (HFP) caseload. We find the budget year projection for HFP also to be high. Consequently, we recommend the Legislature make a downward adjustment to the HFP budget. (Reduce Item 4280-001-0001 by $14 million and 4280-001-0890 by $26 million.)

Governor's Proposal. The Governor's budget plan assumes that the HFP caseload will increase by about 106,000 children or almost 13 percent during the budget year. The budget assumes that a total of 933,000 children will be enrolled in HFP as of June 2007.

The implementation of various proposals to expand program outreach activities and to change the HFP enrollment process are projected by the administration to account for a major part of this projected enrollment growth. (We evaluate the administration's proposals to increase enrollment in HFP in the "Crosscutting Issues" section of this chapter.) These proposed new activities are assumed to add 30,000 children to HFP during 2006-07.

Assessing the Governor's Proposal. Our analysis indicates that, for the last two years, the budget requests submitted to the Legislature by MRMIB have significantly overestimated HFP enrollment. The caseload for 2004-05 was overestimated by MRMIB at the 2004-05 May Revision by more than 30,000 children and thus overbudgeted by about $28 million from the General Fund. Similarly, it now appears that the 2005-06 May Revision caseload for HFP was overstated by 40,000 and about $19 million from the General Fund. The budget proposes to reduce funding in the current year to reflect this lower-than-expected caseload.

According to MRMIB, the 2005-06 caseload projection was overstated for two main reasons. First, the Medi-Cal/Healthy Families Bridge Performance Standards Program, an effort to ensure that children discontinued

from Medi-Cal due to increased income have the opportunity to apply for HFP, was not implemented as scheduled, with the result that enrollment of about 9,900 children will not materialize in 2005-06. Second, the actual enrollment trends for HFP (for which MRMIB had data through September 2005) have turned out to be lower than originally projected. This second factor prompted MRMIB to lower its end-of-year caseload projection for the current year by about 27,000.

Our analysis of caseload data indicates that the latest budget plan presented by MRMIB has again overestimated caseload growth, this time for the budget year. As mentioned previously, MRMIB estimates that almost 106,000 more children, an increase in caseload of 13 percent, will occur during the budget year.

Given that approximately 75 percent to 80 percent of the estimated population of children that is eligible for HFP is already enrolled in HFP, we believe that such a high growth rate for this maturing program is unlikely at this time. We estimate that caseload growth in the budget year will probably be about 85,000 children for a caseload increase of about 11 percent, this reflects a slower growth in caseload that continues to decline over time. Furthermore, our analysis indicates that MRMIB's estimated caseload growth due to the proposed changes to the enrollment process (with 12,400 more children expected to be enrolled between January 2007 and June 2007) is high and does not reflect a reasonable phasing in of the new caseload resulting from the simplification of the enrollment process.

Analyst's Recommendation. We recommend that the Legislature make an adjustment to the HFP budget for the reasons stated above. Specifically, we recommend a reduction of $40 million from all fund sources (with a General Fund reduction of $14 million). We will continue to monitor caseload trends and will recommend appropriate further adjustments in May when MRMIB's updated budget request is presented to the Legislature.

Protect Legislative Oversight of Expenditure Authority

We recommend the rejection of the administration's request to eliminate Budget Control Sections 28 and 28.50 requirements for the Healthy Families Program expenditures.

Control Sections 28 and 28.50. For a number of years, the Budget Act has contained Control Sections 28 and 28.50 which provide the administration with a process by which it can spend federal funds or other non-state funds which are received after enactment of the budget. Generally, these augmentations can only occur no sooner than 30 days after advance notification has been provided in writing to Legislature. This provides the

Legislature with the opportunity to review the proposal and raise any concerns it may have with the administration. Additionally, this process provides the Legislature with the opportunity to consider how such augmentations may impact future obligations of state dollars.

The Governor's Proposal. The Governor's budget includes Budget Bill language to exempt MRMIB from Control Sections 28 and 28.50 and to allow the Department of Finance to augment reimbursements to the General Fund and federal funds and-or establish permanent positions to the extent that foundation and grant funding are available without advanced notice to the Legislature. The administration proposes this change on the grounds that the current Control Sections 28 and 28.50 processes jeopardize MRMIB's ability to quickly respond to grant and foundation requirements and delay the receipt of grant and foundation funding. It argues that these control section processes can take anywhere from one to four months depending on coordination within the administration.

Analyst's Recommendations. We recommend the rejection of the administration's request to eliminate Budget Control Sections 28 and 28.50 for HFP expenditures. We note that these processes only require 30 days advance notice to the Legislature and even provide for a waiver of the 30-day review period if appropriate. All other delays should be worked out within the administration. The exemption of MRMIB from these control sections would decrease legislative oversight of MRMIB's expenditures.

MRMIB—STATE OPERATIONS

Request for Additional Staff Positions Unjustified

The Governor's budget requests ten additional staff positions to address current and anticipated workload within the customer service, policy, legal, research, and special program areas at the Managed Risk Medical Insurance Board. We recommend the approval of two of the positions and denial of the remaining eight positions on a workload basis. (Reduce Item 4280-001-0001 by $248,000, Item 4280-001-0236 by $35,000 and Item 4280-001-0890 by $513,000.)

Governor's Proposal. The Governor's budget includes a request for an additional ten staff positions and $983,000 in funding ($248,000 from the General Fund) to enable MRMIB to address current and anticipated workload within the customer service, policy, legal, research, and special program areas. These additional support resources would be used for five distinct types of activities: (1) processing of application and enrollee complaints and appeals, (2) supervision of legislation, external affairs, and major policy matters, (3) support of legal staff, (4) trend analysis of health

plan performance, and (5) monitoring and review of the Rural Health Demonstration Projects program.

Assessing the Governor's Proposal. The *2005-06 Budget Act* authorized an additional nine permanent positions for MRMIB and two one-year limited term positions for MRMIB that were intended to restore overall staffing to a level that existed in 2002-03 for its core operations. (This was in response to the elimination of 13.4 positions from MRMIB's budget over the two-year period beginning in 2002-03.) This year MRMIB is requesting to add positions on the basis that they are needed to keep pace with program growth, emerging policy issues, and health plan research.

However, our analysis indicates that, in many instances, MRMIB has not demonstrated that the workload increases cited as the basis for increased staff will materialize. For example, previous budget actions had at one point eliminated funding for HFP application assistance. Because elimination of these application assistance activities resulted in more problems in the applications which continued to come in for HFP, this change had the effect of temporarily creating additional workload in the form of a backlog of appeals of denied applications. However, this workload is temporary for two reasons. First, MRMIB has been working through this backlog and should have it completed no later than July 2006. Second, with last year's restoration of application assistance support, the number of appeals should be decreasing in the budget year.

Nevertheless, the Governor's budget request proposes to add five staff positions at a cost of $273,000 to MRMIB's complaints and appeals unit. We see no justification at this time for adding staff to address a backlog of work that should be resolved before these new staff could be hired and begin work.

There are other MRMIB position requests for which additional workload does appear likely to occur. But in these cases, before requesting new positions, MRMIB should seek to (1) fill existing vacant positions for which it was previously provided funding or (2) reclassify vacant positions to meet MRMIB's workload. For example, MRMIB's Benefits Division has two vacant research analyst II positions and one vacant associate governmental program analyst position. We believe it would be reasonable to expect that the workload that was to have been handled by at least two of the new positions requested in the Governor's budget could instead be addressed if MRMIB filled these vacant positions. We have similar concerns with MRMIB's request to add a new executive assistant position at a time when three office technician positions that MRMIB already has funding and position authority for remain vacant.

Analyst's Recommendations. On a workload basis, we recommend that the Legislature approve two of the ten positions requested by MRMIB (legislation/external affairs and management of health plan analysis) and delete the other eight requested positions. This would result in a savings of $796,000 from all fund sources ($248,000 from the General Fund).

DEPARTMENT OF DEVELOPMENTAL SERVICES (4300)

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

The Lanterman Act establishes the state's responsibility for ensuring that persons with developmental disabilities, regardless of age or degree of disability, have access to services that sufficiently meet their needs and goals in the least restrictive setting. Individuals with developmental disabilities have a number of residential options. Almost 99 percent receive community-based services and live with their parents or other relatives, in their own houses or apartments, or in group homes that are designed to meet their medical and behavioral needs. Slightly more than 1 percent live in state-operated, 24-hour facilities.

Community Services Program. This program provides community-based services to clients through 21 nonprofit corporations known as regional centers (RCs) that are located throughout the state. The RCs are responsible for eligibility determinations and client assessment, the development of an individual program plan, and case management. They generally pay for services only if an individual does not have private in-

surance or they cannot refer an individual to so-called "generic" services that are provided by the state, counties, cities, school districts, and other agencies. The RCs also purchase services, such as transportation, health care, respite, day programs, and residential care provided by community care facilities. The department contracts with the RCs to provide services to more than 200,000 clients each year.

Developmental Centers (DCs) Program. The department operates five DCs, and two smaller leased facilities, which provide 24-hour care and supervision to approximately 3,000 clients. All the facilities provide residential and day programs as well as health care and assistance with daily activities, training, education, and employment. More than 7,700 permanent and temporary staff serve the current population at all seven facilities.

Overall Budget Proposal. The budget proposes $3.8 billion (all funds) for support of DDS programs in 2006-07, which is a 5.7 percent increase over estimated current-year expenditures. General Fund expenditures for 2006-07 are proposed at $2.4 billion, an increase of $156 million, or 6.9 percent, above the revised estimate of current-year expenditures.

Community Services Budget Proposal. The budget proposes $3.1 billion from all funds ($2 billion General Fund) for support of the Community Services Program in 2006-07. This represents a $160 million net General Fund increase, or 8.7 percent, over the revised estimate of current-year spending. It primarily is a result of caseload growth, higher utilization rates for services, rate increases, and other program changes. The community services budget plan includes the following proposals:

- ***Rate Increase.*** A $67.8 million ($46.1 million General Fund) proposal to provide a 3 percent rate increase to vendors of certain specified services that are purchased by RCs.
- ***Cost Containment.*** A long-term cost containment proposal is projected to reduce costs in the budget year by about $14 million (about $11 million General Fund). The administration plans to implement the proposal administratively through contract negotiations with the RCs. Implementation of these changes is expected to cost about $7.6 million from the General Fund each year on an ongoing basis for additional RC resources. However, the General Fund savings from these measures are projected to grow to about $21 million in 2007-08 and $32 million in 2008-09.
- ***Autism Initiative.*** Additional funding of about $2.6 million from the General Fund is proposed in 2006-07 to provide additional RC staff and other resources to begin to implement a new autistic spectrum disorder initiative. The initiative would provide training

to RC staff, and develop best-practices guidelines both for treatment in such cases and to foster collaboration among the agencies that serve this group of clients.

The budget plan takes note of the status of the California Developmental Disabilities Information System (CADDIS) project. This information technology project, which has encountered serious problems with its development and implementation, is currently under review. The administration has indicated that it will come forward at an unknown later date with additional recommendations to the Legislature to determine the future of the project. The implementation of some pending proposals to draw down additional federal funds and to improve services to RC clients, such as the self-directed services initiative, largely depends on the successful implementation of CADDIS.

Developmental Centers Budget Proposal. The budget proposes $707 million from all fund sources ($383 million General Fund) for the support of the DCs in 2006-07. This represents a net decrease of $3.6 million General Fund, or about 1 percent, below the revised estimate of current-year expenditures. The decrease in General Fund resources is mainly due to the continuing decline in the DC population. The budget plan continues to assume the closure of the Agnews DC by July 2007, and provides resources to assist in the shift of some current Agnews residents to the community. The budget plan also proposes creation of a new intensive behavioral treatment residence unit at Porterville DC and provides additional funding and staffing for the Office of Protective Services, which provides law enforcement and firefighting services at the DCs.

Headquarters Budget Proposal. The budget proposes $37 million from all funds ($25 million General Fund) for support of headquarters. About 63 percent of headquarters funding is for support of the community services program, with the remainder for support of the DC program.

BETTER OVERSIGHT OF RC PURCHASES NEEDED

Our analysis indicates that spending for some specific services and supports varies so widely among regional centers (RCs) as to raise concerns as to whether there are adequate fiscal controls over these expenditures. We recommend the adoption of budget bill language requiring the Office of State Audits and Evaluations within the Department of Finance to evaluate the accuracy and the consistency of the purchase of services data now being reported by the RCs.

Background

Who Decides Which Services RC Clients Will Receive?

Individual Program Plan (IPP) Is the Basis for Provision of Services. The IPP forms the basis for the provision of services to RC clients. Each IPP is developed by a team consisting of a service coordinator and other RC representatives, the client, and when deemed appropriate, the family or guardian. The IPP provides a schedule of the type and amount of services that will be provided to the client in order for him or her to achieve stated written goals and objectives, such as living independently and obtaining employment.

Since the RCs serve a diverse group of clients with a wide range of developmental disabilities, IPPs are developed using what is often termed a "person-centered" planning approach. Person-centered planning is based on offering individuals with developmental disabilities choices about the services they prefer to receive and working towards their "preferred" future. Under person-centered planning, two individuals who are the same age, have the same developmental disability and who are clients of the same RC may nonetheless receive different services under their IPP based upon their preferences.

How Do RCs Provide Services for Their Clients?

The RCs provide services to clients through two mechanisms. First, RCs purchase services directly from vendors. These services are commonly referred to as "purchase of services." Secondly, RCs assist their clients in obtaining services from public agencies. These services are commonly referred to as "generic services" We discuss both types of services further below.

Purchase of Services. The budget for purchase of services consists of ten main service categories, plus one additional category relating to other adjustments. (A more detailed description of these categories is provided on page C-162 of our *Analysis of the 2005-06 Budget Bill*.) Figure 1 (see next page) shows the Governor's proposed spending plan for these purchase of services categories in 2005-06 and 2006-07.

Generic Services. Under state law, generic services are defined as those being provided by federal, state, and local agencies which have a legal responsibility to serve all members of the general public and that receive public funds for providing such services. There are more than a dozen different generic services that are regularly accessed by RC clients. For example, medical services for an eligible developmentally disabled person might be provided through the Medi-Cal health care program for

the poor. City or county park and recreation programs also provide generic services for developmentally disabled clients.

State law requires that RCs access generic services first and make purchase of services only when generic services are unavailable. Access by developmentally disabled clients for some generic services is fairly consistent throughout the state. For example, Medi-Cal eligibility and benefits are offered consistently on a statewide basis. However, access to other generic services, such as county and city recreation programs, can vary regionally, with the result that some RCs spend considerably more for some recreational services than others.

Figure 1

Regional Centers Purchase of Services By Service Category

(All Funds, In Millions)

Service Category	2005-06[a]	2006-07[a]	Difference	Year-to-Year Percent Change
Day programs	$625	$653	$28	4.5%
Community care facilities	623	673	50	8.0
Support services	380	419	39	10.3
Transportation	174	179	5	2.9
In-home respite	138	139	1	0.7
Habilitation services	123	124	1	0.8
Health care	61	66	5	8.2
Out-of-home respite	43	47	4	9.3
Medical facilities	14	14	—	—
Miscellaneous	201	223	22	10.9
Other adjustments[b]	8	55	47	587.5
Totals	**$2,390**	**$2,592**	**$202**	**8.5%**

a Reflects Governor's mid-year proposal for 2005-06 and the budget proposal for 2006-07.

b Reflects adjustments for cost containment measures, Medicare Part D, rate increases, provisions to control purchase of services expenditures, and others.

Some Purchase of Services Provided Under a Federal Waiver. Under the federal Home and Community-Based Services (HCBS) waiver, federal funds can be drawn down to pay for about one-half the costs of certain community-based services for individuals at risk of institutionalization. In order to remain compliant with the conditions of the waiver, DDS is

required to exercise fiscal oversight of RC expenditures. This includes conducting biennial audits of purchase of services, as discussed later in this analysis.

Tracking Purchase of Services Spending

The DDS, which is responsible for the overall supervision and fiscal management of community services, has a system in place to track RC expenditures for the purchase of services. When a RC purchases a service it is required to document that purchase and enter it into a central purchase of services database that allows DDS to track RC spending on a statewide basis. The data reported by the RCs are used to project future utilization of services by RC clients and now has become part of the basis for budget estimates submitted by DDS to the Legislature.

RC Purchase of Services Are Reported Under Expenditure Codes. As noted earlier, purchase of services fall into ten service categories. However, within those service categories, about 150 different and more specific expenditure codes are currently authorized by DDS and used by the RCs to classify purchase of service expenditures for entry into the central purchase of services database. Some service categories consist of more expenditure codes than others. For example, the habilitation services category shown in Figure 1 consists of three separate expenditure codes. In contrast, the miscellaneous service category shown in Figure 1 consists of 74 separate expenditure codes. The ten purchase of services categories are not mutually exclusive. For example, the expenditure code for a registered nurse is included under the health care, in-home respite, and miscellaneous service categories.

About 100 of the approximately 150 expenditure codes are established in official state regulations, and DDS defines the remainder. Most of these remaining 50 expenditure codes fall into the miscellaneous service category. The DDS periodically adds new expenditure codes or deletes obsolete codes as necessary to ensure that RC purchases are properly reported.

Expenditure Codes Are Audited by DDS Biennially. Federal rules require RCs to account for federal monies spent for services for the developmentally disabled. In order to receive federal funds under the HCBS waiver, DDS is required to audit each RC biennially. At the same time that DDS audits for compliance with the HCBS waiver, it also audits the RCs to determine compliance with applicable regulations and the provisions of the contract between DDS and the RCs. As part of that audit, DDS reviews a sample of reported purchase of services expenditures to determine whether the appropriate expenditure codes have been used by RCs. If the audit determines that incorrect expenditure codes have been used, audit findings are reported with recommendations for corrective action. In the

subsequent biennial audit of that RC, follow-up is required to determine if prior recommendations for corrective action have been implemented.

Purchase of Some Services Varies Greatly Among RCs

Some Variation in Spending Reasonable. A 2003 study commissioned by the state compared RC spending patterns and found clear variations among RCs in purchase of services expenditures for the five-year period of 1995-96 through 1999-00. This study focused on whether there was any evidence of discrimination based on ethnicity or gender, after legitimate reasons for variation in per-capita RC costs, such as age and residence type, were taken into account. The authors of the study found that there was no evidence of discrimination, but indicated differences in per-capita expenditures among RCs may be due to factors not available for analysis.

Pattern of Purchases Varies Widely. The study referenced above focused primarily on variations in RC spending based on a review of aggregate spending across many expenditure codes. Our analysis has focused on a different issue—the variation that occurs in the spending reported by RCs within the same expenditure code.

Our review of the expenditure code data being reported by RCs indicates that the amount of services purchased under a particular expenditure code has varied widely from RC to RC. Moreover, the data show that not all RCs actually purchase services under every expenditure code. For example, the most recently available data for 2004-05 show that only 7 of the 21 RCs reported purchases under the expenditure code for creative arts programs.

We found several examples in the 2004-05 data (as well as in prior-year data) where the variation in spending among RCs was great:

- Total statewide expenditures reported under the expenditure code for client/parent support behavior intervention training were $17.2 million. But one RC alone accounted for almost $10 million, or about 58 percent, of the total spending. Another 16 RCs accounted for the remaining $7.2 million and 4 RCs did not report any expenditures under this expenditure code.
- Total expenditures under the expenditure code for behavior analyst were $5.4 million, with 1 RC accounting for about $3.7 million, or 68 percent, of the total spending. Another 18 RCs accounted for the remaining $1.7 million and 2 RCs did not report any expenditures under this expenditure code.
- Total expenditures under the service expenditure code for day care family member were $23.9 million, with two RCs accounting

for about $11 million, or 46 percent, of the total spending. Another 18 RCs accounted for the remaining $12.9 million and 1 RC did not report any expenditures under this expenditure code.

Possible Explanations for Significant Variation in Spending. In some cases, the differences in spending patterns we have identified in the DDS data can be explained, at least in part, by the number of clients actually receiving a service, differences in the units of the services that are usually provided to clients, regional differences in the cost of providing a particular service, and the varying availability of generic services between regions. But our review indicates that these factors still do not fully explain some of the wide variations seen in spending among RCs for selected services, such as those discussed above.

One possible explanation is that RCs are reporting expenditures under incorrect expenditure codes as the result of a clerical error or misinterpretation of DDS regulations and expenditure code definitions. In theory, the existing audit process should be addressing such problems on an ongoing basis. However, at the time that this analysis was prepared, we were unable to determine whether DDS audit protocols are sufficient to identify and correct such problems on a system-wide basis.

Another possible explanation is that DDS and some RCs may be exercising inadequate fiscal control over purchases of some services. This appears to have been the case for one RC that had increased its spending under the supported living services expenditure code from about $9 million in 2000-01 to about $29 million in 2003-04. At this spending level, its outlays for this one expenditure code were more than twice those of the next highest RC. As a result of concerns of potential fiscal mismanagement of its RC services, DDS stepped in to exercise increased oversight of its operations.

As the examples we have identified show, the expenditures for selected expenditure codes have sometimes varied in the millions of dollars annually from one RC to another. This in turn could mean that even larger amounts of state funding—how much exactly is unknown—may be lacking adequate state fiscal controls.

Oversight of RC Purchase of Services Could Be Improved

DDS Making Some Efforts to Tighten Expenditure Controls. As a result of the situation discussed above, in which an RC faced tighter oversight in the aftermath of high rates of expenditure for supported living services, the DDS has begun taking some steps to improve its fiscal control of these services on a statewide basis. Specifically, DDS is conducting a comprehensive review of this expenditure code and has identified several

cost containment measures involving regulatory changes and closer review of relevant RC expenditure and utilization data.

Also, the DDS has indicated that, as part of an ongoing project to reform the way rates are set for certain services, it is considering a variety of options to increase its oversight of these services. We are advised that the reforms being considered include: (1) adding time limits to the use of selected expenditure codes, (2) strengthening these expenditure code definitions, (3) moving certain expenditure codes into official regulations, and (4) consolidating some of the expenditure codes into a single code.

The DDS also reports that, in preparation for implementation of the CADDIS information technology project, it has recently been undertaking significant efforts to ensure that purchase of services data, including expenditure code data, are "clean" and being properly used by RCs. A DDS workgroup is refining the list of expenditure codes, and a revised list is awaiting final approval.

Finally, biennial audits are continuing as a condition of the HCBS waiver, providing some additional fiscal controls for those RC services made available under the waiver program.

DDS Actions Unlikely to Fully Address the Issue. The steps being considered by DDS could provide greater assurance that RC spending on purchase of services, which has grown considerably in recent years, is subject to appropriate fiscal controls. However, our analysis suggests that the proposed actions are not likely to prove sufficient to fully address this issue.

Notably, at the time this analysis was prepared, DDS was considering additional fiscal controls only on the 17 expenditure codes that are a part of its rate reform initiative. However, that rate reform effort will not examine all of the expenditure codes that data show reflects wide variation in spending among RCs. One such service code, for client/parent support behavior intervention training, is included under the rate reform effort, but two other expenditure codes with a pattern of wide variation in spending that we described above, behavior analyst and day care family member, are not now contemplated to be reviewed or modified.

Furthermore, at this time, DDS' strategy of relying on CADDIS to help to address the issue is problematic. Implementation of CADDIS is behind schedule and its development has been plagued with technical difficulties, unforeseen problems, and cost overruns. It is now questionable whether CADDIS will ever be successfully implemented.

Also, while the biennial audits of RC expenditures continue to occur, we note that the irregular patterns of spending, such as those we have highlighted in our analysis, extend back three or more years. That raises questions

as to whether the current auditing procedures are effectively addressing the wide variations in spending that have occurred in recent years.

Audit of Purchase of Service Data Warranted

We recommend that the Legislature direct the Department of Finance's Office of State Audits and Evaluations to conduct an audit to evaluate the accuracy and the consistency of the purchase of services data now being reported by the regional centers.

The Benefits of Improved Reporting. We recommend that the Legislature take steps now to ensure that spending by RCs for the purchase of services is accounted for in a consistent manner, with purchases of like services being accurately reported under the same expenditure code by all 21 RCs. Given the wide variation we see in the expenditures being reported under some expenditure codes, it is not clear that the existing biennial audits are providing sufficient fiscal controls in this area.

Because the accuracy and the consistency of these data are now uncertain, the state lacks the tools that are needed to exercise strong fiscal oversight over RC spending and to identify those RCs and those specific categories of expenditures that warrant increased scrutiny. The exact fiscal benefit to the state is unknown, but we believe that improved fiscal controls over the reporting of RC purchase of service expenditures could help hold down the significant increases in costs that the state has experienced in recent years for RC purchase of services.

An improvement in the way expenditure data are reported has additional potential benefits. It could also improve the quality of the data used by DDS for its budget forecasts, so that its budget requests to the Legislature could more closely match the actual funding required to support community services programs. More reliable expenditure data for these services could also result in more informed policy decisions when issues arise regarding the provision of specific services in the community.

Furthermore, reliable expenditure data could be used by the Legislature and the Department of Finance (DOF) in their fiscal oversight roles to more closely monitor RC expenditures.

Audit Should Target Specific Issues. As a first step toward addressing these issues, we recommend that the Legislature direct the DOF's Office of State Audits and Evaluations (OSAE) to conduct an audit to evaluate the accuracy and consistency of the purchase of services data now reported by the RCs. Because of their past focus on issues pertaining to fiscal controls, we believe OSAE is the appropriate choice to conduct an audit of this nature. The audit conducted by OSAE is likely to result in recommendations

for improved oversight that could be appropriately implemented by DOF in its role as a state fiscal control agency.

The audit should address the following issues:

- The extent to which RCs are now purchasing identical services but reporting them under different expenditure codes.
- Whether RCs are reporting their purchase of services under the correct expenditure code.
- Appropriate additional steps that DDS could take to ensure that RCs report their purchase of services expenditures in a consistent and accurate manner.
- How improved RC expenditure data could be used to strengthen oversight of RC expenditures, including the biennial audits now being conducted for waiver compliance.

The Legislature should direct that the audit be completed by April 1, 2007, and the findings reported to the appropriate budget committees. Accordingly, we recommend the adoption of the following budget bill language:

> It is the intent of the Legislature that the Office of State Audits and Evaluations (OSAE) review regional center (RC) expenditures for purchase of services as reported under the expenditure codes used to capture data on RC spending. The OSAE shall examine the following: (1) the extent to which RCs are now purchasing identical services but reporting them under different expenditure codes, (2) whether RCs are reporting their purchase of services under the correct expenditure code, (3) appropriate measures that could be taken by the Department of Developmental Services (DDS) to ensure that RCs report their purchase of services in a consistent and accurate manner under the expenditure codes, (4) how improved RC expenditure data could be used to strengthen oversight of RC expenditures by the Legislature and the Department of Finance, and (5) how audit protocols for the biennial audits conducted by DDS on RC expenditures could be adjusted to improve departmental oversight. The OSAE shall report its findings April 1, 2007 to the Chair of the Joint Legislative Budget Committee and the chairs of the fiscal committees of both houses of the Legislature.

COMMUNITY SERVICES PROGRAM

Caseload Overbudgeted for RCs

We recommend that the Legislature adjust the regional center budget request based on updated caseload data. Recently available data indicate that the General Fund support needed for purchase of

services is overbudgeted by $25 million, $9 million in the current year and $16 million in the budget year. (Reduce Item 4300-101-0001 by $16 million.)

Background

Long-Term Trend Shows Strong Caseload Growth. Between 2001-02 and 2006-07, the average annual RC caseload is projected to grow under the Governor's budget proposal from about 172,714 clients to more than 213,000 clients, an average annual rate of growth of about 5 percent. By means of comparison, the RC caseload would continue to grow at a faster rate than the population of California, which is projected to grow at an average annual rate of about 1.6 percent during that same time period. Similarly, the RC system would continue to experience a significantly faster rate of growth than most of the state's other health and social services programs. We discuss some possible reasons for this relatively high rate of RC caseload growth later in this analysis. The RC caseload trend is shown in Figure 2.

Figure 2

Regional Center Caseload Growth Still Strong

Average Annual Population		Increase From Prior Year	
Fiscal Year	Caseload	Amount	Percent
2001-02	172,714	9,101	5.6%
2002-03	182,175	9,461	5.5
2003-04	190,030	7,855	4.3
2004-05	197,355	7,325	3.9
2005-06[a]	205,165	7,810	4.0
2006-07[a]	213,740	8,575	4.2

[a] Administration caseload estimate.

What Are the Reasons for These Growth Trends? Several key factors appear to be contributing to strong ongoing growth in the RC caseload. Improved medical care and technology has increased life expectancies for the developmentally disabled. It is also possible that medical professionals are identifying more developmentally disabled individuals at an earlier age, and referring more persons to DDS programs. The RC caseload growth

also reflects a significant increase in the diagnosed cases of autism, the causes of which are not yet fully understood.

Governor's Budget Proposal

Estimate Based on Caseload, Costs, and Utilization of Services. Each year, the Governor's budget plan is based on updated assumptions regarding four main factors that "drive" costs in the RC system: (1) the number of clients in the RC system, (2) the mix of clients, who have varying needs for services based on their different developmental disabilities, (3) the rate at which these clients are utilizing RC services, and (4) how the cost of those services is changing over time.

In accordance with past practice, the 2006-07 budget plan reflects DDS' updated projections for the number of RC system clients for the current and budget years. The budget plan estimates the average annual caseload for the current year as 205,165, or just ten clients more than the estimate of 205,155 that was the basis for the RC system's allocations under the *2005-06 Budget Act*. The budget plan further estimates that the average annual RC caseload will grow to 213,740 in 2006-07, a year-to-year increase of 8,575 clients, or 4.2 percent.

Thus, the administration's budget plan for 2005-06 assumes that the actual caseload in the RC system in 2005-06 is tracking very closely to the original budgeted level. Additionally, the administration proposes to significantly reduce the level of funding provided for RC purchase of services by a total of about $45 million (including about a $37 million reduction in General Fund resources). These further adjustments reflect updated expenditure data on baseline costs for RC purchase of services expenditures.

For 2006-07, the Governor's budget proposes to increase spending for the RC system by about $178 million, including an increase of about $130 million from the General Fund. This increase mainly reflects estimated growth in caseloads, costs, and the utilization of services by RC clients.

Recent Data Suggests Caseload Overstated. The Governor's budget request is based on the caseload data that was available through July 2005. However, more recent data through December 2005 indicate that the average annual caseload is likely to be about 1,300 below the level that DDS has estimated in the current year and about 2,100 below the level that DDS has estimated in the budget year. If this caseload trend were to hold, it also could mean that the Governor's budget plan has overestimated the funding needed for the support of RC purchase of services. Our analysis indicates that the spending plan may be overestimated in the current year by about

$15 million from all fund sources (about $9 million from the General Fund). The budget year level of funding may be overestimated by about $25 million from all fund sources ($16 million from the General Fund).

Analyst's Recommendation. We recommend that the Legislature make an adjustment to the RC purchase of services budget to take into account the most recent available information on caseload trends. Specifically, for 2005-06, we recommend a reduction of $15 million from all fund sources (with a General Fund reduction of $9 million). A further reduction would be made for 2006-07 of $25 million from all fund sources (with a General Fund reduction of $16 million).

The administration has indicated that it will provide updated information on the overall RC caseload trend, any change in the mix of RC clients, and trends in the cost and utilization of services at the time of the May Revision. We will continue to monitor caseload trends and will recommend appropriate further adjustments in May when DDS' updated budget request is presented to the Legislature.

Rate Increase No Substitute for Rate Reform

As it decides whether to provide a proposed 3 percent rate increase for certain regional center (RC) providers, we recommend that the Legislature enact legislation requiring the Department of Developmental Services to incorporate into the rate-setting methodologies that it develops for RC services measurements of quality and access to specific services.

Background

Rates a Key Fiscal Control. The Legislature has taken some steps in recent years to slow the growth in state costs for the RC system. Beginning in 2003-04 and continuing through 2005-06, it acted to control costs by adopting legislation imposing rate freezes and other cost-control measures on selected community services. These measures affected contracted services, community-based day programs, in-home respite service providers, habilitation services providers, and community care facilities—the services which make up the bulk of RC spending. The rate freezes and cost-containment measures were intended to be temporary actions to help address the state's serious fiscal problems while allowing time to consider permanent and ongoing strategies to help contain RC program costs.

Rate Reform Effort Under Way. The *2004-05 Budget Act* provided four permanent staff positions as well as $500,000 in one-time funding for contract resources to enable DDS to develop standardized rates for certain types of RC vendors. The DDS indicates that this system-wide rate reform

effort will require several years to complete. As we discussed in detail in our *Analysis of the 2005-06 Budget Bill* (page C-167), there is great variation in the way that rates are set for the RC vendors who provide services, and the rate-setting approach overall lacks a rational and consistent approach. The rate reform activities approved by the Legislature were intended to address these concerns as part of a more comprehensive cost-containment program for the RC system.

The Governor's Budget Proposal

Three Percent Rate Increase Proposed for Some Providers. The Governor's budget plan proposes about $68 million from all fund sources ($46 million General Fund) to provide a 3 percent cost-of-living rate increase mostly for providers of services that were subject to the rate freezes and other cost-containment measures discussed above. Subsequent to release of the Governor's budget plan, DDS identified some types of providers that were inadvertently included in the rate increase proposal and other types of providers that were inadvertently excluded from the proposal. The DDS has indicated that it will provide a revised rate increase estimate reflecting these adjustments at the time of the May Revision. According to the administration, the proposed rate increase is intended to help prevent programs from closing due to insufficient funding, thereby maintaining continuity of services for RC clients and promoting stability in the RC's system of providers.

Rate-Setting Reform Still Warranted

Information Lacking to Evaluate Provider Rate Increase. The administration has not provided the Legislature any specific basis for providing a 3 percent rate increase, as opposed to a higher or lower percentage adjustment. Consequently, the Legislature lacks the information it needs to systematically and objectively evaluate the impact that the temporary rate freeze has had on providers.

We believe a better approach is warranted. In our *2005-06 Analysis,* we voiced concern about what we termed the inconsistent manner in which rate increases for some RC vendors had been determined in the past. We found that such decisions had often been made in response to some improvement or deterioration of the state's financial condition, and without regard to the state's goals as a purchaser of these services. We also found that the Legislature lacks information on two critical factors—(1) the potential effect of those rates on the access to care available to RC clients, and (2) the effect of those rates on the quality of care received by those clients. We offered a number of steps the Legislature could take to move toward permanent rate reform based on having a systematic and rational

process for adjusting vendor rates in keeping with these critical factors. In our view, the administration's proposal continues its past practice of taking an inconsistent approach to rate-setting that lacks a rational basis and does not address the need for meaningful rate reform.

Analyst's Recommendation

As noted earlier, the Legislature lacks the critical information identified above to determine whether the 3 percent rate increase proposed by the administration is warranted for the specific categories of services it has identified to ensure either quality of care or access to care for RC clients. The underlying conditions that led the Legislature to adopt and continue these rate freezes for selected RC services have not changed since 2003-04. The RC system costs for the purchase of services continue to grow at a significant rate that exceeds growth in state revenues.

As it balances the various programmatic and fiscal concerns in deciding whether to provide the proposed 3 percent rate increase for providers, we recommend that the Legislature enact legislation requiring DDS to incorporate measurements of quality and access to specific services into the rate-setting methodologies that it develops for RC services. Our recommended approach is explained in more detail in the *2005-06 Analysis*.

DEVELOPMENTAL CENTERS PROGRAM

Legislature Should Proceed Cautiously On Law Enforcement Expansion

The Governor's budget plan proposes an expansion of Department of Developmental Services' law enforcement operations. Given the declining caseload and increasing per-capita costs of the developmental center (DC) system, we recommend that the Legislature approve only part of the headquarters' staffing request and limit any increases in DC resources and personnel to those critically needed to maintain the health and safety of DC clients.

Background

Facilities Provide 24-Hour Care. The state's five DCs and two smaller leased facilities provide 24-hour care to about 3,000 individuals with developmental disabilities. The DCs provide a full range of care, including medical and recreational services, in a campus-like setting.

Office of Protective Services (OPS). The DDS's OPS provides all law enforcement and fire protection services in the DCs and the two smaller leased facilities. The Law Enforcement Division (LED) of OPS, which includes both uniformed peace officers and special investigators, is responsible for keeping the peace; preventing crime; investigating alleged offenses occurring on the grounds of DCs; and protecting clients, employees, visitors, and state property.

DC System Subject of Investigations

The DC system has been the subject of two investigations conducted in recent years by the state Attorney General and the U.S. Department of Justice (U.S. DOJ) that could result in major operational changes at these facilities. We discuss the investigations and their ramifications below.

Attorney General Critical of Safety and Security Operations. In response to a 2001 legislative request, the state Attorney General conducted an investigation of DDS' law enforcement and fire protection services. The Attorney General issued a March 2002 report which found that DDS' law enforcement services were poorly managed and poorly organized.

The Attorney General offered 28 specific recommendations on how to improve the OPS, including the following:

- The number of senior special investigators should be increased, their role and responsibilities expanded, and the current vacant positions filled.
- The DDS should create an executive management position with the responsibility and authority to manage the LED. According to the Attorney General, the lack of a unified command structure for LED is its most critical problem.
- The LED should develop and implement a new organization plan that established a clear law enforcement chain of command. Under this structure, law enforcement personnel would report up the chain of command to the Chief of OPS at headquarters instead of to the executive director of the individual DCs.

The DDS has indicated that, to the extent possible within its existing budgetary resources, it has acted in recent years to reorganize the existing OPS operations into a centrally managed system consistent with the Attorney General's recommendations.

U.S. DOJ Investigates Lanterman DC. In October 2004, U.S. DOJ conducted an on-site investigation of the Lanterman DC near Los Angeles pursuant to the Civil Rights for Institutionalized Persons Act (CRIPA), a federal civil-rights law that protects persons who are in public institutions

such as the DCs. A U.S. DOJ report released in January cites incidences of abuse and neglect and physical assaults of clients.

Although DDS indicates it is already taking steps to address the problems identified at Lanterman, it is not yet known what specific further actions federal authorities may require to resolve the CRIPA investigation. Notably, CRIPA investigations of other State of California facilities, such as the state mental hospital system, have resulted in demands by federal authorities for significant changes in their operations as well as sizable increases in staffing and funding that could go beyond licensing and certification requirements that must be met to receive federal support for DC operations.

Governor Proposes Additional Resources for OPS

In order to reorganize the OPS along the lines recommended in the DOJ report, the administration is requesting additional positions and resources for both DDS headquarters and for the DCs. The budget plan proposes $752,000 from all fund sources (including $452,000 from the General Fund) and six DDS headquarters positions in the budget year to develop and implement policies, train personnel, manage OPS, and centralize its command structure.

In addition, the budget plan would provide the DCs with an augmentation of $660,000 from all fund sources ($380,000 General Fund). These additional resources would be used to support 81 additional law enforcement and fire services positions to help implement the recommendations of the Attorney General. According to DDS, part of these additional resources would be used for the ongoing support of 65 staff positions that were previously established for OPS through the department's internal redirection of resources. Also, the budget request proposes to add 16 staff positions (six permanent positions and ten two-year limited-term positions) to address a backlog of pending investigations and a projected future increase in the investigation workload. The Governor's budget request does not indicate what the fiscal impact of these proposals would be in 2007-08.

Per-Capita Costs Increasing as Population Drops

In our *Analysis of the 2003-04 Budget Bill* (page C-99), we described how the cost of care on a per resident basis in the DC system had grown significantly even though the population of the system was continuing to decline.

Since our *2003-04 Analysis*, the trends we identified in 2003 have continued. The DC population has declined from about 3,800 clients to 3,000, and is expected to drop to about 2,800 during 2006-07 as Agnews

closes. The cost per client in the DC system continues to escalate. We had estimated this cost at about $171,000 for 2000-01, but now estimate it to be about $236,000 in 2005-06.

Analyst's Recommendation

Given the declining caseload and increasing costs of the DC system, we recommend that the Legislature approve only those increases in resources and personnel critical to maintaining the health and safety of DC clients. On this basis, we recommend approval of part of the budget request to strengthen OPS law enforcement operations at headquarters. However, we withhold recommendation on the balance of the request relating to DC staffing until it is clear how the CRIPA investigation has been resolved and, in particular, what if any actions are proposed to modify OPS' operations.

Approve Two Headquarters Positions. Specifically, we recommend the Legislature approve two of the six additional staff positions requested for DDS headquarters. Approval of the proposed new OPS chief and deputy chief would enable DDS to implement the Attorney General's most critical recommendations, including the creation of a stronger central chain of command. However, we recommend the rejection of the additional four headquarters positions proposed by the administration because they go beyond what our analysis indicates is needed to establish a functional chain of command.

Withhold Recommendation on DC Positions. We withhold recommendation at this time on all 81 additional positions requested by the administration to expand law enforcement operations in the DCs. We believe some of the 81 positions may be required to comply with federal funding requirements. The Legislature, in our view, should not act on this request until the Lanterman DC CRIPA case has been resolved.

The resolution of the CRIPA case at Lanterman could well result in significant requests for additional state resources to address the problems identified in that federal investigation. Given the nature of U.S. DOJ's findings, it appears likely that federal authorities will require significant funding and staffing increases for Lanterman (and perhaps eventually other DCs) as well as potentially significant changes in OPS' law enforcement operations. Absent a resolution of the U.S. DOJ matter, DDS' budget request for the expansion of OPS personnel at the DCs is premature. We will continue to monitor this situation and advise the Legislature of our findings at the time of budget hearings.

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) provide for the delivery of mental health services through a state-county partnership, (2) operate five state hospitals, (3) manage state prison treatment services at the California Medical Facility at Vacaville and at Salinas Valley State Prison, and (4) administer various community programs directed at specific populations.

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

Budget Proposal Decreases DMH Overall Budget. The budget proposes $3.4 billion from all fund sources for support of DMH programs in 2006-07, which is a decrease of about $173 million, or 5 percent, below the revised estimate of current-year expenditures. The decrease in overall DMH spending, when all fund sources are taken into account, is mainly due to the discontinuation of one-time current-year expenditures. Specifically, the Governor's spending plan reflects (1) a reduction of about $139 million in reimbursements related to one-time costs incurred in 2005-06 for settling past Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program claims and (2) one-time General Fund spending of $120 million for two state-mandated programs for mentally ill children (known together as the "AB 3632" mandates) that would not be continued in the DMH budget for 2006-07.

The budget proposes about $1.6 billion from the General Fund, which is an increase of about $316 million, or 25 percent, above the revised estimate of current-year expenditures. If some significant budget adjustments had not been included in the Governor's budget proposal, the DMH General

Fund budget for 2006-07 would have grown by about $96 million, or about 7.5 percent, above the revised estimate of current-year expenditures.

The increase in General Fund spending is mainly due to a technical budget adjustment in which General Fund support previously displayed in the Department of Health Services (DHS) Medi-Cal budget for the EPSDT program (which provides mental health services to children who are enrolled in Medi-Cal) would now be displayed in the DMH budget item. This transfer of about $340 million in General Fund support is offset in the DMH budget with a corresponding reduction in reimbursements.

Another significant technical change is the shift of funding for support of AB 3632 services from the DMH budget item to the Commission on State Mandates (CSM) budget item. (We discuss the Governor's further proposals to modify the AB 3632 mandates in *The 2006-07 Budget: Perspectives and Issues*.) As a result of the AB 3632 budgeting change, $50 million in General Fund spending that would otherwise have been included in DMH spending totals in 2006-07 appears instead in the CSM budget item.

Budget Proposal Includes Proposition 63 Funds. In November 2005, California voters approved Proposition 63, the Mental Health Services Act. This measure established a surcharge of 1 percent on the portion of a taxpayer's taxable income that exceeded $1 million beginning in January 2005. Revenues are deposited into a newly created Mental Health Services Fund. For the first time, the Governor's budget display reflects the expenditure of these Proposition 63 resources, with proposed spending of $649 million in local assistance in 2005-06 and $656 million in 2006-07.

Budget Proposal Includes Some Increases. Although the budget plan provides for an overall net decrease in total funding, it does include some significant proposals to increase spending on some programs. About $38 million from the General Fund would be spent to add 453 staff positions to the state hospital system to resolve U.S. Department of Justice (U.S. DOJ) civil rights investigations of four state hospitals. We discuss this proposal in more detail later in this analysis. The budget plan also requests an increase of about $19 million in General Fund for additional caseload costs for EPSDT.

RESPONSE TO FEDERAL INVESTIGATIONS PREMATURE

The Governor's proposed budget requests additional resources to address deficiencies in state hospitals cited in civil rights investigations conducted by the U.S. Department of Justice. We withhold recommendation on the proposal at this time because this request is premature until a final agreement to resolve federal findings

of deficiencies has been finalized and until documents detailing a remediation plan for the hospitals have been provided to the Legislature. Also, we find the proposed timetable for hiring 453 new staff by July 2006 to be unrealistic.

Background

Deficiencies Found at State Hospitals. Pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), a federal civil rights law to protect individuals housed in public institutions such as mental hospitals, the U.S. DOJ has undertaken a series of actions affecting California's state hospital system.

The U.S. DOJ completed an on-site review of conditions at Metropolitan State Hospital (MSH) for both the children and adult programs in July 2002. The U.S. DOJ has since issued reports finding a number of deficiencies, including wrong diagnoses, improper medication, and insufficient protection of some patients from other patients. The U.S. DOJ recommended improvements in several program areas, including assessment, treatment, and medication of hospital patients.

The U.S. DOJ has also conducted on-site visits at Atascadero State Hospital and Patton State Hospital but at the time this analysis was prepared, had not yet reported its findings from these on-site visits. However, in June 2005, without first conducting an on-site visit, U.S. DOJ issued a report on the operations at Napa State Hospital that identified a number of deficiencies and recommended changes similar to those presented for MSH.

We are advised by DMH that the conditions that U.S. DOJ found and cited at MSH and Napa exist at all state hospitals except Coalinga State Hospital, which has been open less than one year. The DMH expects U.S. DOJ to issue findings similar to those for MHS and Napa in forthcoming reports on Atascadero and Patton. Accordingly, DMH has already undertaken program improvements to address CRIPA deficiencies at all state hospitals.

Proposed Remediation Plan. According to DMH, U.S. DOJ has developed a remediation plan detailing the specific actions the department must take to resolve the problems identified at MSH. We are further advised by DMH that the proposed remediation plan, and a related draft settlement agreement, could serve as the basis for resolving CRIPA issues at all four state hospitals. The department has indicated that a consent decree between the state and the federal government settling all of these matters could be completed by late February.

The proposed remediation plan was considered confidential and thus was not available for review by the Legislature at the time this analysis was

prepared. According to DMH, the document sets out measurable performance standards and establishes a timeline for state hospitals to address the U.S. DOJ's findings of deficiencies. We are advised that the proposed remediation plan also includes agreements related to treatment planning, patient assessments, patient discharge planning, patient discipline, and documentation requirements. It also apparently addresses issues surrounding the use of seclusion and restraint of patients, incident management, quality improvement, and safety hazards in hospital facilities.

Probable Consequences if the State Does Not Act. We have been advised by DMH that if the state fails to address CRIPA deficiencies, the state hospitals could be placed into federal receivership by the federal courts. Such an action could be similar to the recent federal court decision to place CDCR's health care program into receivership.

The Governor's Budget Proposal

Additional Resources for CRIPA Compliance. The Governor's budget proposes about $43 million in total funds (about $38 million from the General Fund) in 2006-07 to implement the U.S. DOJ remediation plan. Most of the funds would be used to add 453 additional staff positions to the state hospital system. About $1.8 million of the budget-year funding would be for consulting contracts and about another $1.8 million would be spent on special repairs to address potential safety hazards in hospital facilities.

New Treatment Program Would Be Implemented. The DMH proposes to use most of the additional staff to implement a "recovery model" in which the hospitals would assist individuals through individualized mental health treatment to achieve their own goals and to recover the ability to effectively function in the community. The DMH describes this as a shift away from the present approach that focuses more on medical treatment of the patient's mental illness.

According to DMH, the U.S. DOJ's proposed remediation plan assumes that some of the problems found at MSH are the result of inadequate clinical staff (psychiatrists, psychologists, rehabilitation therapists, social workers, nurses, and psychiatric technicians) relative to the number of patients. We are advised that the staffing increases proposed by the Governor increase staff in some categories so as to establish patient-staffing ratios consistent with the proposed remediation plan.

CRIPA Settlement Agreement Has Not Been Finalized

We have two main concerns with the administration's budget request. The first is that the request is premature until an agreement to address

federal findings of deficiencies has been finalized and until documents detailing the proposed remediation plan for the hospitals have been provided to the Legislature. Our second concern is that the proposed timetable for hiring 453 new staff by July 2006 is unrealistic. We discuss both of these concerns below.

Budget Request Is Premature. At the time this analysis was prepared, DMH and U.S. DOJ had not yet finalized the proposed remediation plan or the terms of the consent decree. Moreover, the documents that are identified as being the basis of resolving the CRIPA investigations have been kept confidential and are not yet available for legislative review.

Under these circumstances, the Legislature has no way to determine at this time whether the staffing expansions and other measures proposed by DMH meet or exceed what is actually being required by U.S. DOJ in response to the deficiencies cited in the CRIPA reports. If DMH is correct and an agreement is finalized in February, and if the remediation plan is subsequently made available for review, the Legislature will be in a much better position to assess the administration's budget request.

In our view, it would be premature to approve the administration's request for these additional staff and funding until and unless DMH reaches a final settlement agreement with U.S. DOJ for each hospital subject to investigation. Until such time as both parties have signed final agreements completely addressing all of the CRIPA findings of deficiencies affecting all four of the state hospitals, the Legislature has no assurances that still further costly demands from U.S. DOJ would not follow.

Administration's Plan Assumes 453 New Staff in July 2006. The administration's plan provides full-year funding for 453 positions that are all assumed to join the staff of the state hospital system as of July 2006. However, our analysis indicates that it is unlikely that all of the proposed new positions could possibly be filled by that time. Typically, state agencies, including the state hospital system, cannot recruit and appoint individuals to fill newly created positions until months after they have been established.

Based on State Controller's Office data, about 2,030, or 24 percent, of the authorized positions in the four state hospitals subject to the CRIPA investigation were vacant in January 2006. Some of the new clinical positions proposed in the Governor's budget request could prove to be very difficult to fill. The administration proposes to add about 47 senior psychiatrists and about 48 registered nurses. Increasingly in recent years, the state hospitals have had difficulties filling these types of positions and often experience large numbers of staff vacancies in these classifications. If the Legislature were to provide full-year staffing and funding for the 453 new positions proposed by the administration for 2006-07, it is likely

that the state hospital system would be significantly overbudgeted as it encountered delays in actually using these resources.

Analyst's Recommendation

We withhold recommendation at this time on the administration's entire budget request for additional resources to respond to the CRIPA investigations. Once the consent decree has been finalized, and the documents resolving the matter have been provided to the Legislature, we will review this additional information and provide the Legislature with our recommendations on this matter.

If the Legislature does choose to approve some or all of the positions requested by the administration, we recommend that it budget any such positions on a half-year basis. This approach would recognize that it will take DMH several months in many cases to fill these new positions after they have received approval in the budget process.

HOSPITAL CASELOAD FUNDING OVERBUDGETED AS STAFFING PROBLEMS MOUNT

Updated caseload data indicate that the amount of General Fund needed for support of the state hospital system is overbudgeted by a combined $39 million in the current and budget year. Accordingly, we recommend that the Legislature make appropriate budget adjustments. (Reduce Item 4440-011-0001 by $20 million.) We also recommend that the administration clarify whether it intends to continue to operate a children's unit at the Metropolitan State Hospital given the dwindling caseloads at this facility.

Background

The DMH operates five state hospitals: Atascadero, Patton, Napa, Metropolitan, and Coalinga. The DMH also operates two acute psychiatric programs at the California Medical Facility in Vacaville, and the Salinas Valley State Prison. Forensic patients are generally committed by the courts to state hospitals under one of four categories: "incompetent to stand trial" (ISTs), "mentally disordered offender" (MDOs), "not guilty by reason of insanity" (NGIs), and "sexually violent predator" (SVPs). Some inmates and wards of CDCR receive care in the Vacaville and Salinas Valley facilities, while additional offenders in the custody of CDCR are transferred to the state hospitals for mental health treatment. Also, counties contract with the state to purchase beds at state hospitals for adults and children

committed for mental health treatment under the provisions of the Lanterman-Petris-Short (LPS) Act.

The cost of caring for various categories of forensic patients is generally supported from the state General Fund. Counties reimburse the state hospitals using funds they receive from the state under the 1991 state-local realignment of tax revenues and mental health program responsibilities. About 90 percent of occupied beds are now utilized for forensic patients while about 10 percent are purchased by the counties.

Governor's Budget Proposal

The Governor's budget proposes a net increase of about $12.4 million from all fund sources compared to the revised current-year estimate of expenditures. The increase is a result of updated estimates for the state hospital system population and baseline adjustments. The overall hospital population (including CDCR inmates in the Vacaville and Salinas psychiatric programs) is projected to grow from the revised estimate of 5,591 patients by the end of 2005-06 to 5,830 patients by the end of 2006-07, for an increase of 239 patients.

Hospital Caseload Lagging as Coalinga Activation Stalls

Updated Caseload Information Shows Overall Population Lagging. The DMH's current-year hospital caseload adjustment is based on comparing the estimated population for September 30, 2005 to the actual caseload at that time for ISTs, NGIs, MDOs, and SVPs (the main population groups traditionally supported from the state General Fund).

However, more recent hospital population data we have reviewed through January 2006 indicate that the caseload is likely to be about 190 patients below DMH's revised and reduced estimate of patients for the current year. On this basis, we believe that the spending plan overestimates the funding needed in the current year by about $10 million from the General Fund. Similarly, our analysis indicates that the spending plan overestimates the funding needed in the budget year by about $20 million from the General Fund.

Coalinga Startup Behind Schedule. The 2005-06 budget provided an additional $65.7 million in General Fund support for the activation of the new Coalinga State Hospital. The 1,500-bed hospital began accepting its first patients in September 2005. The patient population was projected to be about 250 patients initially, increasing during the current year to a total of about 680 patients (or about 430 more) by March 2006.

In order to accommodate the first wave of 250 patients, the 2005-06 DMH budget plan assumed hiring about 875 clinical and support staff by

August 2005. It also assumed that another 449 staff would be hired by January 2006 in order to receive the second wave of 430 additional patients.

However, neither the actual patient population nor staffing levels assumed in the state budget plan are close to being achieved. As of mid-January 2006, the total Coalinga patient population was about 140—approximately 300 patients below the number assumed in the hospital's activation plan. Staffing efforts were also well behind schedule. Data provided by the State Controller's Office indicate that, as of January 2006, about 58 percent of the staff positions authorized at that point in time were still vacant.

Why Is the Coalinga Activation Off Track? We are advised by DMH that the slowdown in activation of their new hospital facility is due mainly to the difficulty being experienced by the department in recruiting and hiring qualified staff for the new facility. Key clinical staff positions, we have been advised by DMH, have been particularly difficult to fill, and some clinical staff that had been initially recruited and hired to work at the hospital have already left to work elsewhere.

The department indicates that its difficulties in hiring and retaining staff stem in part from the recent federal *Plata* court case involving problems with the provision of health care at state prisons. On December 1, 2005, the federal judge in the case ordered the state to immediately increase compensation for several classes of prison medical personnel (such as physicians, nurse practitioners, and registered nurses). State hospital administrators advised us that soon after the *Plata* ruling, efforts to recruit and hire additional clinical staff for Coalinga hit a snag for medical personnel in part because compensation levels at Coalinga were not competitive with nearby prisons.

Coalinga Staffing Problem Has Ripple Effects. At the time this analysis was prepared, DMH indicated it was seeking administration approval to increase pay rates for its clinical staff to help offset the effects of the *Plata* decision. Even with the funding and position authority already available in its budget, Coalinga's beds cannot be activated without the appropriate staff in place to care for additional patients.

The problems in opening up Coalinga are already having a significant ripple effect throughout the state hospital system. For example, state hospital administrators had been counting on the activation of Coalinga to relieve overcrowding at Atascadero and Patton as some of their patients were transferred to Coalinga. Both Atascadero and Patton are currently over their licensed bed limit. Consequently, administrators of these two state hospitals have contended that their operations are at some risk if DHS, which licenses these hospital beds, will not continue to permit the "overbedding" of the two facilities.

The maximum patient population permitted at Patton, which is established in statute, was supposed to decrease by 334 patients one year after Coalinga was activated. Instead, the administration budget plan proposes statutory language to allow Patton to maintain its current maximum population for four years after the date Coalinga was activated.

This situation is also complicating efforts by CDCR to comply with federal court orders to provide additional mental health treatment beds for prison inmates. The Coalinga activation plan included 50 intermediate care beds at the hospital for inmates. Recent caseload information indicates that none of these 50 beds has been occupied.

County jail operations are also apparently being affected by this situation. According to the DMH budget request, the state hospital system has a waiting list of 350 individuals who have been committed to their system by the courts, but who remain in county jails because state hospitals are operated at their maximum staffed capacity. According to DMH, the size of that list is increasing daily.

LPS and Children's Population in Decline

LPS Patient Count Under Budgeted Level. The caseload data we have reviewed also show that the number of beds being occupied by county LPS patients is running somewhat below the level assumed in the *2005-06 Budget Act*. As of mid-January, there were 526 LPS patients in Napa and MSH, the two hospitals that care for this patient group, instead of the 555 that were expected, continuing a slow but steady decline that has occurred in recent years. Notably, the Governor's budget plan assumes that the number of LPS beds occupied in 2006-07 will hold steady at 520, but that figure now appears likely to be overstated.

Children's Caseload at MSH Has Dropped by One-Half. One subset of this population is a unit at MSH that provides mental health services for severely emotionally disturbed children and adolescents. This population has also been in decline. Recently, however, we were advised by state hospital administrators that the remaining population of 50 in this unit is down by half to a total of 25 patients. As a result, we are advised that DMH had held up the bidding process for an estimated $8.8 million project to construct an on-site school building at MSH for these clients, and is reviewing whether the current population (if it holds) is sufficient to justify the continuation of this unit.

Analyst's Recommendation

Based on (1) the updated caseload information we have reviewed, (2) the problems evident in the activation of Coalinga, and (3) the declining

LPS population, including the children's unit at MSH, we recommend that the Legislature take the following actions in regard to the budget proposal for state hospital population adjustments:

- ***Caseload Adjustment for Certain Forensic Groups Warranted.*** Based on our analysis of updated caseload information for ISTs, NGIs, MDOs, and SVPs, we recommend the Legislature reduce the General Fund budget for the state hospital system by $10 million General Fund for 2005-06 and by $20 million General Fund for the budget year. We anticipate that DMH will propose further adjustments for state hospital population trends for these specific patient groups at the time of the May Revision.
- ***Adjust for Unavailable CDCR Beds at Coalinga.*** We recommend the Legislature reduce the General Fund budget for the state hospital system by $8.5 million in the current year because Coalinga is unlikely to have the staffed capacity to accept the 50 patients anticipated when the 2005-06 budget was enacted. This amount represents the funding provided in the *2005-06 Budget Act* for these 50 beds.
- ***Monitor and Respond to the Coalinga Problems.*** Given the ongoing problems in activating the new Coalinga hospital, and uncertainty as to how and if these staffing difficulties can be overcome, we recommend approval of the administration's proposed statutory language to allow Patton to maintain its present capacity for three more years. We will continue to monitor the situation at Coalinga and will advise the Legislature whether additional budget adjustments are warranted for the budget of the hospital at the time of the May Revision. If significant progress is not made in hiring staff and bringing more patients into the facility, further budget and staffing adjustments may be warranted.
- ***MSH Intentions Should Be Clarified.*** The DMH should report to the Legislature at budget hearings regarding the outcome of its evaluation as to whether operation of the children's unit at MSH can and should continue. The department should also report on its final decision in regard to the construction of the new school on the grounds of MSH, and whether budget authority for the project should be reverted.

CALIFORNIA WORK OPPORTUNITY AND RESPONSIBILITY TO KIDS (5180)

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

The budget proposes an appropriation of $5 billion ($2 billion General Fund, $153 million county funds, $33 million from the Employment Training Fund, and $2.9 billion federal funds), to the Department of Social Services (DSS) for the CalWORKs program in 2006-07. In total funds, this is a decrease of $111 million, or 2.2 percent, compared to estimated spending of $5.1 billion in 2005-06. This decrease is primarily attributable to estimated savings from (1) reductions in county block grant funds and (2) implementation of welfare reform activities enacted in 2004. Compared to the current year, General Fund spending in 2006-07 is essentially unchanged (a reduction of 0.4 percent).

GRANT LEVELS FOLLOW CURRENT LAW

Typically, the maximum grant payment is adjusted each July based on the change in the California Necessities Index (CNI). Chapter 78, Statutes of 2005 (SB 68, Committee on Budget and Fiscal Review), suspended the July 2005 and July 2006 state cost-of-living adjustments (COLAs). The CNI increase for 2005 was 4.07 percent and the CNI increase for 2006 was

3.75 percent (based on the change from December 2004 to December 2005). The Governor's budget follows current law and holds grants at their current levels by suspending the application of the statutory COLA. Specifically, the maximum monthly grant for a family of three in a high-cost county remains at $723. The corresponding grant in a low-cost county is $689.

Compared to the requirements of prior law, these COLA suspensions result in savings of about $120 million in 2005-06 and $270 million in 2006-07. Along with the parallel actions in Supplemental Security Income/State Supplementary Program (SSI/SSP), these COLA suspensions represent one of the significant multiyear budget reductions adopted by the Legislature and the administration during 2005-06 to address the state's budget gap.

GOVERNOR PROPOSES TO INCREASE TANF EXPENDITURES ON CWS

By using federal Temporary Assistance for Needy Families (TANF) block grant funds to replace General Fund support for certain Child Welfare Services (CWS) costs (emergency response hotline call activities), the Governor's budget achieves General Fund savings of $32 million in 2005-06 and $26 million in 2006-07. Because this is the first time that TANF would be used for these program costs, the Legislature should assess whether this proposal is consistent with its priorities for limited TANF block grant funds.

TANF Expenditures May Offset General Funds Costs in Other Programs. Each year California receives $3.7 billion in federal TANF block grant funds. The majority of these funds are used for the CalWORKs program. However, federal law permits the expenditure of TANF funds on a variety of programs and activities. The TANF block grant funds may be expended on any program designed to (1) provide assistance to needy families and children; (2) end the dependence of needy parents on government benefits by promoting job preparation, work, and marriage; (3) prevent and reduce the incidence of out-of-wedlock pregnancies; and (4) encourage the formation and maintenance of two-parent families. Moreover, TANF funds can be spent for any purpose permitted under the AFDC program (the predecessor of TANF) or under AFDC Emergency Assistance (EA). (For example, AFDC-EA could be used for juvenile probation.) Finally, up to 10 percent of TANF funds may be transferred to the Title XX Social Services Block Grant and then expended in accordance with the federal rules pertaining to Title XX. Unexpended TANF funds can be carried over indefinitely into future years.

The *2005-06 Budget Act* includes TANF appropriations for programs other than CalWORKs of $139 million for CWS, $47 million for emergency assistance Foster Care, and $398 million to fund Stage 2 child care costs at the California Department of Education (CDE). In addition, the act transfers $193 million into the Title XX Social Services Block Grant to fund CWS, child care, and foster care. If not spent for these purposes, these funds would be available to support the CalWORKs program, including grant costs and employment services.

Reduction in Federal Matching Funds for CWS. Prior to 2005-06, California funded CWS emergency response hotline activities with a combination of General Fund, federal IV-E matching funds, and county funds. Beginning in 2005-06, the federal government denied some state claims to use federal IV-E matching funds for certain hotline activities. For 2005-06, the loss in federal funds is estimated to be $19 million, falling to $15 million in 2006-07 as the state revises its claiming practices in order to draw down some of the lost federal funding. Absent the TANF funding proposal discussed below, this denial would have resulted in a General Fund cost.

Governor's Proposal. For 2005-06 and 2006-07, the Governor's budget proposes to backfill the loss in federal IV-E funds for emergency response hotline activities with respectively $19 million and $15 million in TANF block grant funds. In addition, the budget proposes to replace certain General Fund expenditures of $13 million in 2005-06 and $11 million 2006-07 for hotline activities with TANF federal funds. Total General Fund savings from these proposed fund shifts are $32 million in 2005-06 and $26 million in 2006-07, for a total savings of $58 million.

Legislative Oversight. On a technical level, the Governor's proposal to save $58 million General Fund by using TANF for emergency response hotline costs is permissible under federal law. Whether to make this fund shift is a fiscal policy issue for the Legislature. Because TANF can be used for both CalWORKs and non-CalWORKs purposes, the Legislature should review this proposal to determine if it is consistent with its priorities for TANF and General Fund. In recent years, the Legislature has started to move away from using TANF to offset General Fund costs. For example, California formerly expended about $200 million in TANF funds each year for county youth probation costs. Now these youth probation costs are funded with General Fund, freeing up TANF funds for the CalWORKs program. If the Legislature rejects the Governor's fund shift proposal, it would need to adopt some offsetting budget solution to avoid increasing the state's budget problem.

Current Year Proposal Should Wait for Legislative Action. Because this proposal affects both the current year and the budget year, we recommend that the Department of Finance not implement its current year proposal until the budget subcommittees have heard the budget-year issue.

PROPOSED MIDYEAR REDUCTIONS CONTRARY TO LEGISLATIVE INTENT

In 2005-06 and 2006-07, the Governor's budget proposes a net $93 million reduction to county block grant funds for child care, administration, and employment services. Because some of the savings are likely to occur on the natural, we recommend adoption of budget trailer bill language to achieve savings as of August 2006.

Background

The CalWORKs Budget System. Funding for CalWORKs employment services, child care, and program administration is provided to the counties in a block grant known as the "single allocation." Counties have the discretion to move these block grant funds among program elements in order to address specific needs at the local level. Unspent single allocation funds eventually revert to the TANF reserve, however, counties have up to nine months to file supplemental claims. Accordingly, unspent funds do not revert to the TANF reserve until nine months after the end of a fiscal year.

Governor's Proposal. During 2005-06 and 2006-07, the Governor proposes a series of changes to the CalWORKs county block grants. Over the two-year period, the proposal reduces total funding by $93 million. Figure 1 shows the proposed changes in county block grant funds. In the current year, the Governor proposes to reduce child care funding by $114.6 million because child care claims are running significantly lower than budgeted. To achieve these savings the Governor proposes trailer bill language which would amend the *2005-06 Budget Act* to delete this funding. The proposal also places $11.5 million in a reserve to pay child care claims in the event that actual child care costs are higher than the revised current-year budget proposal. For both years, the budget proposes an additional $25 million to recognize that savings from moving from monthly to quarterly income reporting (referred to as "prospective budgeting"), have been lower than anticipated. Finally, the budget decreases county block grant funds by $40 million in 2006-07, suggesting that counties use their unspent performance incentive funds from prior years to make up for this reduction.

Comments on the Governor's Proposal

Increase for Prospective Budgeting Is Reasonable. Our review of county administrative claims suggests that the administrative savings from prospective budgeting are less than anticipated. Therefore, we believe the proposed $25 million increase in both 2005-06 and 2006-07 is reasonable.

Figure 1

CalWORKs County Block Grant Funds Governor's Proposed Changes

TANF and General Fund (In Millions)

Description	2005-06	2006-07	Total
Increase for prospective budgeting	$25.0	$25.0	$50.0
Reduce county administration backfill with incentive funds	—	-40.0	-40.0
Recover welfare reform child care funds	-114.6	—	-114.6
Reserve for child care claims	11.5	—	11.5
Totals	**-$78.1**	**-$15.0**	**-$93.1**

Reduction for Counties With Unspent Performance Incentives. From 1998 through 2000, counties earned approximately $1.1 billion in performance incentives. Counties were able to spend these funds on program enhancements or regular CalWORKs program activities. The DSS estimates that counties will have at least $40 million in unspent incentive funds at the start of 2006-07. As long as the proposed $40 million reduction is allocated among counties so as not to exceed their available performance incentive balance, we have no issues with this proposal.

Child Care Savings Likely to Occur Naturally. The Governor's proposal achieves savings by retroactively reducing the child care funds from the current budget act through the enactment of trailer bill legislation. Although in past years we have expressed concerns about midyear reductions to county block grant funds because of the potential for disruption to county operations, this particular child care reduction merits the Legislature's consideration. This is because the proposed child care reduction is likely to occur on the natural.

Based on actual expenditures to date, the Governor's budget estimates that counties will not expend $114.6 million for child care. Most of this child care funding was for an anticipated increase in child care costs as counties implemented certain welfare reforms enacted in 2004. (The reforms were designed to increase work participation. The Governor's budget now estimates that these provisions will not be fully implemented until 2006-07.) This increase in demand for child care due to increased work participation has not yet occurred. From a strictly technical budgeting perspective, we believe it is unlikely that these child care funds will be expended by the counties during 2005-06. Under current law, any unexpended funds from 2005-06

would revert by April 1, 2007. The Governor's proposal captures the savings from these unexpended funds upon enactment of his trailer bill.

Analyst's Recommendation. In our view, the $114 million in child care savings will occur on the natural. The question for the Legislature is whether to accelerate when the savings can be scored. To achieve the savings with minimal disruption to counties, we recommend adopting budget trailer bill legislation specifying that the supplemental claiming period for these child care funds would be limited to one month, rather than the usual nine months. Under this approach, the funds would revert in August 2006.

DEFICIT REDUCTION ACT OF 2005 CREATES POTENTIAL FOR SUBSTANTIAL FISCAL PENALTIES

The* Deficit Reduction Act of 2005 *effectively raises the required work participation rate to 50 percent for all families and 90 percent for two-parent families. Failure to meet these work participation rates in the future will result in substantial annual fiscal penalties on California. We describe the key provisions of the act, and assess California's status with respect to meeting these work participation rates.

Scope of Legislation

The *Deficit Reduction Act of 2005* (the act) makes sweeping changes to the federal budget and federal law. The legislation includes ten separate titles covering a wide range of topics including health and human services programs, student loans, agricultural research, bank deposit insurance, digital television transition, and pension guarantee premiums. In this analysis, we focus on the provisions affecting the TANF program and its state counterpart, the CalWORKs program. For a broader discussion of the potential fiscal impact of the act, please see our publication *Fiscal Effect on California: Pending Federal Deficit Reduction Act of 2005* (January 20, 2005). Although some provisions of the act take effect immediately, most of the TANF changes become effective on October 1, 2006.

Current Federal Law

TANF Block Grant and Maintenance-of-Effort (MOE). To receive the federal TANF block grant, states must meet an MOE requirement that state spending on behalf of 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, which is $2.9 billion in California if the state fails to comply with federal work participation requirements.)

Countable MOE expenditures include those made on behalf of CalWORKs recipients as well as for families who are *eligible* for CalWORKs but are not receiving cash assistance. Although the MOE requirement is primarily met through state and county spending on CalWORKs and other programs administered by DSS, state spending in other departments is also counted toward satisfying the requirement. The *2005-06 Budget Act* includes $524 million in countable MOE expenditures outside of the CalWORKs program ($26 million from other DSS programs and $498 million from other departments).

Current Federal Work Participation Rates. Currently, states must meet a work participation rate equal to 50 percent of all cases with adults, minus the percentage reduction in their caseload since 1995. This percentage reduction is referred to as the "caseload reduction credit." There is a separate 90 percent work participation rate requirement for two-parent families and a corresponding caseload reduction credit. (As discussed later in this analysis, California has placed its two-parent cases in a separate state-funded program which removes these cases from the federal work participation calculation. Thus, the all-families rate currently applies only to single-parent cases, because the two-parent cases are removed from federal consideration.)

Required Hours of Work. To comply with federal work participation rates, adults must meet an hourly participation requirement each week. For single-parent families with a child under age 6, the weekly participation requirement is 20 hours. The requirement goes up to 30 hours for single parents in which the youngest child is at least age 6. For two-parent families the requirement is 35 hours per week. The participation hours can be met through unsubsidized employment, subsidized employment, certain types of training and education related to work, and job search (for a limited time period).

Work Participation Penalties. If a state fails to meet the work participation rates, it is subject to a penalty equal to a 5 percent reduction of its federal TANF block grant. For each successive year of noncompliance, the penalty increases by 2 percent to a maximum of 21 percent. For California, the 5 percent penalty would be approximately $173 million annually. States that fail to meet their work participation requirements are required to (1) backfill their federal penalty (that is loss of federal funds) with state expenditures and (2) increase their MOE spending by 5 percent.

Penalty Reductions. Current regulations give states opportunities to avoid or reduce penalties. For example, if a state is in compliance with the all-families rate, but is out of compliance for the two-parent rate, the penalty would be prorated down based on the percentage of cases that are two-parent cases. Also, states that have reached at least half the of the

required rate, may, at the discretion of the federal Secretary of Health and Human Services, enter into corrective compliance plans which could delay or eliminate penalties if the state ultimately reaches the required rate.

Caseload Reduction Credit Substantially Reduces Required Participation Rate. From 1995 through 2004, California's caseload declined by approximately 46 percent, but has been relatively stable since then. Thus, California achieved a substantial caseload reduction credit pursuant to current law. Specifically, this 46 percent reduction reduced California's required participation rate to about 4 percent (the 50 percent requirement, less the 46 percent credit). Currently, California's participation level is 23 percent for single-parent families, well above the 4 percent required rate.

Removing Cases From Participation Calculation With Separate State Programs. States may assist families using federal TANF funds, state MOE funds, or a combination of both funding streams. If a family is provided cash aid and services (such as training, case management, and child care) through a separate state program that is funded exclusively with state MOE funds (but not TANF funds), then the case is not subject to the federal work participation calculation. Beginning in FFY 2000, California placed all of its two-parent cases into a separate state program funded exclusively with state MOE funds. Accordingly, California is not subject to federal work participation rates for two-parent families, because there are no federally funded two-parent cases. (Pursuant to state law, two-parent families are subject to a state participation requirement of 35 hours per week.)

Key Changes in Work Participation Rate and MOE Calculations

The act makes three key changes in the way work participation rates are calculated. These changes substantially raise California's required participation rate beginning in October 2006, essentially the state's 2006-07 fiscal year. In addition, the act expands the types of expenditures which may be counted for purposes of satisfying the MOE requirement.

Resetting the Base Period for the Caseload Reduction Credit. Currently, the caseload reduction credit is determined by finding the state's percentage reduction in the caseload since 1995. Beginning in FFY 2007, the act resets the base period for the caseload reduction credit to 2005. In the short run, this change essentially eliminates the value of the credit (because California's caseload has not declined since 2005) thereby creating work participation requirements of 50 percent for all families and 90 percent for two-parent families. Because California's current participation rate is well below the required 50 percent rate, California faces federal penalties that begin at about $173 million per year.

Cases in Separate State Programs No Longer Excluded From Work Participation Calculation. The act makes cases served in separate state funded MOE programs subject to the work participation calculation. Accordingly, California will no longer be able to avoid the 90 percent rate for two-parent families by using a state-only MOE funded program. Failure to meet the two-parent rate results in a penalty. However, if the state meets the all-families rate, a penalty for failing the two-parent rate would be reduced by about 85 percent because the amount of the penalty is tied to the relative size of the two-parent caseload in comparison to the overall caseload.

New Regulatory Authority Concerning Work Participation. The act gives the Secretary of the U.S. Department of Health and Human Services new authority to promulgate regulations concerning "verification of work and work eligible individuals." This gives the Secretary specific authority to define work participation activities, how participation in these activities is documented, how participation is reported, and whether nonaided adults residing with children that are aided with TANF or MOE funds may be subject to work requirements. Currently cases with children and an unaided adult are known as child-only cases and are not subject to the work participation calculation. (Examples of child-only cases include those with nonneedy caretaker relatives, undocumented parents, or sanctioned adults.) If the future regulations from the Secretary specify that adults in child-only cases are subject to work participation, then meeting federal work requirements would be even more difficult.

More Spending Countable Toward the MOE Requirement. The act expands the definition of what types of state spending may be used to meet the MOE requirement. Currently, countable state spending must be for aided families or for families who are otherwise eligible for assistance. The act allows state expenditures designed to prevent out-of-wedlock pregnancies or promote the formation of two-parent families to count toward the MOE requirement even if the target population is not otherwise eligible for aid. Essentially, the act removes the requirement that countable spending that promotes the formation and maintenance of two-parent families and teen pregnancy prevention be on behalf of low-income families. This change could help California meet the higher $2.9 billion MOE requirement if the state is unable to achieve compliance with work participation requirements.

Conclusion: California Faces a Significant Participation Gap

As described above, beginning in October 2006, California will be subject to a 50 percent work participation rate for all families and a 90 percent rate for two-parent families. Currently our respective participation rates

are 23 percent for single-parent families and 32 percent for two-parent families. When, pursuant to the act, the two-parent families are put back into the all-families participation rate, the all-families rate would rise to about 25 percent. Thus, if current state rates continue, California faces respective participation gaps of 25 percent and 58 percent. Strategies for addressing these gaps are discussed below.

STRATEGIES FOR MEETING HIGHER WORK PARTICIPATION REQUIREMENTS

To avoid federal penalties, California will have to substantially increase the work participation rates of California Work Opportunity and Responsibility to Kids recipients. We review a range of strategies including (1) increasing the participation of existing recipients, (2) bringing former recipients who are employed back into the participation rate calculation, and (3) establishing separate programs for those who may face substantial barriers to work.

As discussed previously, California's participation rates for all families and two-parent families are well below the respective required rates of 50 percent and 90 percent. To attain compliance with federal work participation requirements starting in October 2006, California must increase participation by 25 percentage points for all families and 58 percentage points for two-parent families. To address this participation gap, we review the participation status of single-parent and two-parent caseloads and then explore three different approaches to increasing work participation. First, we examine ways to increase participation within the existing caseload. Second, we look at how to bring former recipients who are working back into the participation rate calculation. Third, we discuss how creating separate programs for those who may have barriers to employment could improve the state's participation results.

Current Work Participation Status

Current Single-Family Participation. Currently, California has about 212,000 single-parent cases. Federal law excludes families with a child under age 1 and families who are sanctioned from the participation rate calculation. After making these adjustments, about 192,000 single-parent cases are subject to the work participation calculation. To meet a 50 percent participation rate, about 96,000 families would need to be working. Based on preliminary information, about 44,000 are currently working, so California would need to get an additional 52,000 families working the required minimum hours. Of the 52,000 families, roughly 24,000 families

are participating in the program but are working less than the required number of hours. In order to comply with federal work participation requirements, California would need to increase the hours for these 24,000 families and induce another 28,000 families to begin work or participation at the required hourly rate.

Current Two-Parent Participation. For two-parent families, about 37,000 cases are subject to the work participation calculation. To meet a 90 percent participation rate, about 33,000 cases would need to participate for the required hours. Currently, about 11,000 are working, so California would need to have an additional 22,000 families participating for the required hours.

Increasing Participation for Existing Cases

Increasing the Incentive to Work. Many states, including California, provide a work incentive to families known as an earned income disregard, whereby a portion of a family's earnings is not counted (disregarded) for purposes of determining a family's monthly grant. California has a relatively generous earned income disregard. Specifically, current law disregards the first $225 in earned income and 50 percent of each additional dollar earned when determining a family's monthly grant amount. (For a complete explanation of California's disregard, please see the "CalWORKs" write-up of the *Analysis of the 2005-06 Budget Bill*, page C-214.)

As we discussed in last year's *Analysis*, California could increase its work incentive by increasing the amount of earnings that are disregarded. A higher disregard would allow more working families to remain on aid, thus increasing California's participation rate. However, increasing disregards usually increases grant costs which puts pressure on scarce TANF and MOE funds.

Improving Communication About Program Obligations and Availability of Support Services. A significant portion of California's sanctioned caseload is sanctioned because they never attend an orientation session. A study from Los Angeles County indicated that about 65 percent of its sanctioned cases had never attended orientation. Effectively, this means that recipients become sanctioned before they fully understand what services are available to help them meet their participation requirements. With a better understanding of program obligations and the supportive services which are available (such as, training, interview preparation, job leads, child care, and transportation), it is possible that more recipients may make the transition to employment.

One way to improve this communication would be to make completion of orientation a requirement for receiving aid. This would insure that

adults have full knowledge of the program requirements and supportive services. However, in order to avoid an unnecessary delay in the receipt of aid, we would suggest that counties adopt strategies similar to those used in San Bernardino County. These include providing regular, daily orientations in the same office where the eligibility functions are carried out and providing drop-off child care during orientations to allow parents to participate easily.

Increasing Participation Among the Partially Engaged. As described above, California has roughly 24,000 families who are participating in CalWORKs activities but for insufficient hours each week to meet the federal participation requirement. Some of these families are receiving child care assistance. Because some in this group may be relatively close to meeting the requirement, intensive case management or other engagement might help them meet the hourly requirement.

Modifying the Sanction for Noncompliance. Currently, if a recipient does not comply with program participation requirements and cannot demonstrate "good cause" for noncompliance, the adult is sanctioned. In California (and 13 other states), the sanction involves the removal of the adult from the case for purposes of calculating the grant amount. A reduced aid payment, based on the number of children in the household, is provided to the sanctioned adult. For example, for a sanctioned family in a high-cost county, the monthly grant for a family of three with one adult and two children would be reduced from $723 per month to $584 per month.

In contrast to California, thirty-four other states impose some type of full-family sanction, meaning that the entire family may be removed from aid. Most of these states have a graduated policy where the first instance of noncompliance results in a partial sanction, but repeated or long-term noncompliance results in a complete cut-off of assistance for the entire family.

In order to encourage participation, California could consider increasing the sanction for families who do not cure their sanctions. For example, if a family did not cure its sanction within a specified time period, such as three to six months, the sanction would increase to 50 percent of the family's grant. Although increasing the degree of sanction may result in increased participation, it also has the potential to reduce resources to the families. Research from states with graduated full-family sanctions indicates that sanctioned families had to turn to other sources of support, primarily other family members when they were entirely removed from aid.

Adding in Former Recipients Who Are Now Employed

Another approach to increasing work participation is to provide some assistance to former recipients who are now employed. Currently there are about 110,000 former CalWORKs cases that have left aid and are receiving state subsidized child care. Most of these former cases are working, and many of them may be working for the 20 or 30 hours per week required for federal participation calculations. Prior to passage of the act, these former recipients helped California achieve its substantial caseload reduction credit. Because the base period for caseload reduction was reset to FFY 2005, these former recipients, even though they are working, no longer help California satisfy the federal participation rate.

Providing Work Allowances. In order to be counted in the work participation rate, a family must receive some form of "assistance." Under federal regulations, child care is not considered to be assistance. If California were to provide a monthly work allowance (for example, $25) to help defray the costs of transportation or other work expenses such as uniforms, this would be considered to be assistance. Any recipient of such a work allowance would become part of the work participation calculation. Payment of the work allowance could be made contingent upon demonstrating that sufficient weekly work hours are completed. If the work allowance were funded with state MOE funds, then its receipt would not effect the recipient's eligibility for five years of federally funded TANF assistance. (In other words, someone who worked their way off CalWORKs would not be using up their federal five-year time clock through receipt of this work allowance.)

Separate Programs for Recipients With Multiple Barriers to Employment

Some families face multiple barriers to employment including drug and alcohol addiction, mental health issues, domestic violence, and learning disabilities. For these recipients who have been unable to enter the labor market, a separate intensive program of barrier removal may be necessary. In a given month, there are about 50,000 cases with adults with no participation of any kind. California could shift some or all of these families into an intensive services program if case managers determined that such a program might help them remove barriers to employment and eventually become self-sufficient. If this program (including existing grant and service components) were funded with state funds that are not used to satisfy the MOE requirement, then these cases would not be subject to the federal work participation rate. Moreover, allowing these families to shift to the intensive services program would result in a caseload reduction credit. For example, if 30 percent of the two-parent caseload entered

the intensive services program, this would result in a caseload reduction credit of 30 percent, which would reduce the 90 percent required rate down to 60 percent.

Fiscal Considerations

The strategies discussed above may result in costs or savings compared to current law. The work allowance and intensive services programs would result in costs. An increase in the earned income disregard would also increase grant costs. Increasing the sanction would probably result in savings. In deciding which strategies to adopt, the Legislature must weigh any net costs of the strategies against the costs of potential federal penalties and the corresponding required General Fund backfills.

Funding Sources. The intensive services program for families with multiple barriers to employment is probably the most costly approach. However, substantial funding already exists that could be used for this program. For the grant costs for the intensive services program , California could use existing General Fund resources that are part of the CalWORKs program. Because this is to be a non-MOE funded program, its creation would result in an MOE shortfall. However, such a shortfall could be addressed with fund shifts that result in no net cost to the General Fund. For example, in CDE, there is approximately $40 million in spending for child care for CalWORKs eligible families that is not being counted for MOE purposes. Also, certain after school program expenditures which may foster prevention of teen pregnancy could be counted as MOE. Finally, replacing General Fund which is currently spent for county juvenile probation costs with TANF funds would free up about $200 million in General Fund monies which could be used for separate state non-MOE funded programs. All of these sources could be used to fill any MOE shortfall created by the establishment of the non-MOE funded intensive services program.

Conclusion

The Deficit Reduction Act of 2005 substantially raises California's work participation rates and the likelihood of significant fiscal penalties. As discussed above, there are several different strategies for addressing the increased work requirement. In determining which strategies to pursue, the Legislature should consider which policies are most likely to result in increased work participation and family self-sufficiency, while maintaining compliance with federal requirements so as to avoid federal penalties.

IN-HOME SUPPORTIVE SERVICES

The In-Home Supportive Services (IHSS) program provides various services to eligible aged, blind, and disabled persons who are unable to remain safely in their own homes without such assistance. An individual is eligible for IHSS if he or she lives in his or her own home—or is capable of safely doing so if IHSS is provided—and meets specific criteria related to eligibility for the Supplemental Security Income/State Supplementary Program (SSI/SSP). In August 2004, the U.S. Department of Health and Human Services approved a Medicaid Section 1115 demonstration waiver that made virtually all IHSS recipients eligible for federal financial participation. Prior to the waiver, about 25 percent of the caseload were not eligible for federal funding and were served in the state-only "residual" program.

The budget proposes just over $1.3 billion from the General Fund for support of the IHSS program in 2006-07, an increase of $52 million (4.1 percent) compared to estimated expenditures in the current year. Most of the increase is attributable to caseload growth partially offset by increased savings from full implementation of the quality assurance reforms enacted in 2004-05.

Current-Year Costs Are Overbudgeted

Our review of actual expenditures for the first six months of 2005-06 indicates that In-Home Supportive Services costs are overbugeted by $82 million ($26 million General Fund). We recommend that the Legislature recognize a General Fund savings of $26 million for 2005-06.

Current-Year Budget. For 2005-06, the total revised budget for IHSS services excluding administration is estimated at $3,418 million. Based on the number of case-months, which occur during the first half of the year, the budget through December 2005 is about $1,682 million. However, actual expenditures are significantly lower than budgeted. Specifically, expenditures during this time period were $1,618 million, about $64 million less than budgeted. Most of the overbudgeting occurred during the

first five months of the fiscal year. In December 2005, expenditures were overbudgeted by just $3 million.

Analyst's Estimate. Based on the most recent expenditure and caseload data, we project that IHSS services will be overbugeted by a total of $82 million ($26 million General Fund) for the current year. Accordingly, we recommend that the Legislature recognize a General Fund savings of $26 million for 2005-06. Because the December actual expenditures were just slightly below the budget, we cannot at this time project further savings in the budget year. However, we will monitor caseload and expenditure trends and advise the Legislature of any changes at the time of the May Revision.

Legislature Needs More Information About Fraud Prevention Activities

Current law requires the Department of Social Services (DSS), the Department of Health Services (DHS), and county welfare departments (CWDs) to collaborate in the prevention and detection of fraud in the IHSS program. In order to assure proper coordination of anti-fraud activities, we recommend that the DSS, DHS, and CWDs report jointly at budget hearings on their progress in improving program integrity.

Background. Chapter 229, Statutes of 2004 (SB 1104, Committee on Budget and Fiscal Review) established an IHSS quality assurance initiative designed to improve the accuracy of service needs assessments and program integrity. The initiative included additional funding for state and county staff to implement these changes. With respect to program integrity, Chapter 229 made several changes such as (1) defining the terms "fraud" and "overpayment," (2) expanding DHS's fraud prevention authority to the "residual" program, and (3) establishing state level program integrity functions.

Fraud Investigation Workload Shifted from Counties To State. Chapter 229 required CWDs and DSS to refer all suspected IHSS fraud to DHS for investigation, thereby shifting a county workload to the state. Although other DHS staff may assist with fraud investigations, DHS has only two designated investigators assigned to IHSS fraud. There is currently a backlog of about 1,800 IHSS fraud referrals awaiting investigation at DHS. This backlog may result from DHS's decision to focus its resources on other program areas (such as dentistry) which are perceived to have a greater risk of substantial General Fund loss due to fraud.

Legislative Oversight. To assess progress with the program integrity components of Chapter 229, we asked DHS and DSS a series of questions including (1) how many suspected cases of fraud have been identified, (2)

how many have been investigated, (3) what were the results of the investigations, and (4) what is the level of county staffing for IHSS program integrity. At the time this analysis was prepared, DSS and DHS could not answer these questions, in part because the program integrity initiatives were in the early stages of implementation. The DSS indicated that it was in the process of completing its first quarterly program integrity report. This report, beginning with the fourth quarter of 2005, will show for each county the number of fraud investigations, referrals, and their disposition. We understand that DHS is also in the process of compiling data on fraud referrals, investigations, and dispositions.

Analyst's Recommendation. We recommend that that DSS, DHS, and the CWDs report jointly at budget hearings on the implementation of the program integrity initiatives required by Chapter 229. It is our understanding that the first DSS program integrity quarterly report should be available at the time of budget hearings.

SUPPLEMENTAL SECURITY INCOME/ STATE SUPPLEMENTARY PROGRAM

The Supplemental Security Income/State Supplementary Program (SSI/SSP) provides cash assistance to eligible aged, blind, and disabled persons. The budget proposes an appropriation of $3.6 billion from the General Fund for the state's share of SSI/SSP in 2006-07. This is an increase of $58 million, or 1.7 percent, above estimated current-year expenditures. This net increase is primarily due to costs from (1) caseload growth of 2.4 percent and (2) restoring the one-time savings from delaying the "pass-through" of the January 2006 federal cost-of-living adjustment (COLA) until April 2006; partially offset by savings from further delaying the pass-through of the 2007 federal COLA from April 2007 until July 2008.

In December 2005, there were 356,825 aged, 21,545 blind, and 825,584 disabled SSI/SSP recipients. In addition to these federally eligible recipients, the state-only Cash Assistance Program for Immigrants (CAPI) was estimated to provide benefits to about 8,050 legal immigrants in December 2005.

BUDGET PROPOSES TO FURTHER DELAY FEDERAL 2007 COLA UNTIL JULY 2008

By further delaying the 2007 federal cost-of-living adjustment from April 2007 until July 2008, the budget achieves General Fund savings of $48 million in 2006-07 and $185 million in 2007-08.

Background. Typically, both the federal and state grant payments for SSI/SSP recipients are adjusted for inflation each January, pursuant to state and federal law. The COLAs are funded by both the federal and state governments. The state COLA is based on the California Necessities Index and is applied to the combined SSI/SSP grant. The federal COLA (based on the Consumer Price Index for Urban Wage Earners and Clerical Workers) is applied annually to the SSI portion of the grant. The remaining amount needed to cover the state COLA on the entire grant is funded with state monies.

Previously Enacted Budget Legislation Suspends and Delays COLAs for 2005-06 and 2006-07. Chapter 78, Statutes of 2005 (SB 68, Committee on Budget and Fiscal Review), suspended the January 2006 and January 2007 state COLAs. In addition, the legislation delayed the effective pass-through of the federal January 2006 and January 2007 COLA until April 2006 and April 2007 respectively. (State savings from delaying the federal COLAs are achieved by reducing the state funded SSP portion of the grant by an amount equal to the federal COLA increase in the SSI portion of the grant.) Compared to the requirements of prior law, these COLA suspensions and delays result in savings of about $200 million in 2005-06 and $450 million in 2006-07. These COLA changes represent one of the most significant long-term budget reductions adopted by the Legislature and administration during 2005-06 to address the structural deficit.

Governor's Proposal for 2006-07. As discussed above, current law delays the effective pass-through of the federal January 2007 COLA until April 2007, resulting in a savings of $48 million compared to prior law. The Governor proposes to further delay the pass-through of the federal COLA until July 2008. This would increase the savings from $48 million to $96 million in 2006-07 and save about $185 million on a full-year basis in 2007-08.

Impact on Recipients. Figure 1 (see next page) shows the SSI/SSP grants for April 2007 for individuals and couples under both current law and the Governor's proposal. Under current law, the total grant for an individual would increase from $836 to $850 per month starting April 2007. Under the Governor's proposal, the total grant would remain at $836 per month, with the SSP portion dropping by $14, or 6 percent. Figure 1 (see next page) also compares the grants under current law and the Governor's proposal to the 2005 federal poverty guidelines. Specifically, the maximum monthly grant for individuals would be 107 percent of poverty under current law, but would fall to 105 percent under the Governor's proposal. Grants for couples would be 140 percent of poverty under current law, but would fall to 138 percent under the Governor's proposal. (We note that poverty guidelines are adjusted annually for inflation.)

OPTIONS FOR PROVIDING BENEFITS FOR SPONSORED IMMIGRANTS

Beginning in September 2006, sponsored immigrants who have resided in the United States for at least ten years will become eligible for income maintenance payments from the Cash Assistance Program for Immigrants (CAPI). Under current law, costs for providing CAPI benefits to these sponsored immigrants will be about $12 million in 2006-07, rising to over $40 million in 2007-08. We review the history of CAPI, comment on the Governor's proposal for avoiding these costs, and provide the Legislature with other options.

Figure 1

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

Recipient Category	April[a] 2006	January 2007	April[a] 2007 Current Law	April[a] 2007 Governor's Budget	Change from Current Law Amount	Change from Current Law Percent
Individuals						
SSI	$603	$617	$617	$617	—	—
SSP	233	219	$233	219	-$14	-6.0%
Totals	**$836**	**$836**	**$850**	**$836**	**-$14**	**-1.6%**
Percent of Poverty[b]	105%	105%	107%	105%		
Couples						
SSI	$904	$926	$926	$926	—	—
SSP	568	546	$568	546	-$22	-3.9%
Totals	**$1,472**	**$1,472**	**$1,494**	**$1,472**	**-$22**	**-1.5%**
Percent of Poverty[b]	138%	138%	140%	138%		

[a] The *2005-06 Budget Act* delayed the January 2006 and January 2007 federal cost-of-living adjustments until April of the respective year.

[b] 2005 U.S. Department of Health and Human Services Poverty Guidelines. The guidelines are adjusted annually for inflation.

Federal Restrictions

Federal Eligibility Restrictions for Noncitizens. Pursuant to federal legislation enacted in 1996 and 1997, most immigrants entering the United States after August 1996 are ineligible for federal SSI/SSP benefits. Immigrants who entered the U.S. prior to August 1996 were also made ineligible for benefits unless they were already on aid or became disabled. Refugees are limited to seven years at SSI/SSP benefits.

Legislative History

Original CAPI. In response to the federal restrictions described above, the Legislature created CAPI in 1998 through the enactment of Chapter 329, Statutes of 1998 (AB 2779, Aroner). As originally enacted, CAPI was limited to pre-August 1996 immigrants and to post-August 1996 sponsored immigrants whose sponsors were dead, disabled, or abusive. (Sponsored immigrants have sponsors—usually family members—who have signed affidavits indicating they will financially support the immigrant so that the immigrant does not become a "public charge.")

Subsequent CAPI Expansions. Chapter 147, Statutes of 1999 (AB 1111, Aroner) made non-sponsored post- August 1996 immigrants eligible for CAPI for one year (from September 1999 through September 2000). With respect to sponsored immigrants (other than those with dead, disabled or abusive sponsors), Chapter 147 deemed (counted) the income of the sponsor to the post 1996 immigrant for a period of five years. Because of this deemed income, sponsored immigrants were generally not financially eligible for CAPI. Chapter 108, Statutes of 2000 (AB 2876, Aroner) extended the eligibility period for non-sponsored post 1996 immigrants for an additional year, through September 2001.

Further Legislative Changes. Chapter 111, Statutes of 2001 (AB 429 Aroner) permanently eliminated the sunset of benefits for post-August 1996 non-sponsored immigrants. In addition, Chapter 111 extended the period for deeming a sponsor's income to the post-1996 immigrant from five years to ten years. Effectively, this ten-year deeming provision makes most sponsored immigrants ineligible for cash assistance through August 2006.

Caseload and Cost Trends

CAPI Caseload Trends. Following the implementation of the program in October 1998, the caseload climbed from about 3,200 cases in 1998-99 to just over 10,000 cases in 1999-00. The caseload peaked at just over 11,200 in 2000-01 and has slowly declined since then. For 2005-06, the caseload is estimated to be just over 8,000. In addition to natural attrition, the recent caseload decline can be attributed to some individuals transferring to SSI/SSP because they have either become disabled or attained U.S. citizenship. The CAPI caseload would have declined even more except for the impact of refugees leaving SSI/SSP and entering CAPI following their first seven years of residence.

CAPI Costs. The CAPI program's expenditures are supported exclusively by the state General Fund. The state pays the grants and reimburses the counties for their administrative costs. For 2005-06, total costs (including administration) are estimated to be about $78 million. By statute, CAPI maximum monthly grants are set at $10 less than the corresponding SSI/SSP grant for a citizen. In 2005-06, the average monthly CAPI grant was $753 and the average monthly cost for administration was $118.

Estimated Fiscal Impact of Expiration of Deeming Period

What Happens When the Ten-Year Deeming Period Ends? As discussed above, beginning in September 2006, immigrants who arrived ten years earlier will no longer have their sponsors income deemed to them. If they meet the financial eligibility rules for the SSI/SSP, and assuming they have not attained citizenship, they would be eligible for CAPI. For

purposes of estimating the budget for CAPI, the key question is how many sponsored immigrants would be eligible each month and how many will apply for CAPI. Answering these questions is difficult because detailed data concerning immigrants, their sponsors, and their current citizenship status is not available.

Denial Rate Data. One bit of useful information is program data about the number of monthly denials of CAPI applications. Each month somewhere between 500 and 700 CAPI applications are denied. According to county sources, about two-thirds of these denials are due to income from the immigrant's sponsor. Once these immigrants have been in the United States for ten years, their sponsor's income would no longer affect eligibility. Accordingly, there are a substantial number of immigrants who have applied for CAPI in the past, and once they have been in the United States for ten years and meet eligibility rules, they could apply for and receive CAPI benefits.

Estimated Costs. According to the Department of Social Services (DSS), under current law approximately 2,500 sponsored noncitizens would become eligible for CAPI during 2006-07, resulting in General Fund costs of $12.5 million. The DSS further estimates that these costs will grow to over $43 million in 2007-08. The DSS bases its cost estimate on denial rate data, other assumptions about attrition, and the potential for sponsored noncitizens who have not previously applied for assistance to apply once their deeming period ends. We have reviewed the DSS methodology and believe the estimate is reasonable.

Policy Options

Given the substantial cost implications of this program, and the Legislature's previous decision to extend the deeming period by five years (back in 2001), we discuss the Governor's proposal and present alternatives for legislative consideration.

Option 1: Governor's Proposal—Extend the Deeming Period. The Governor proposes to extend the deeming period for sponsor's income from the current ten years to fifteen years. From a fiscal standpoint, this avoids all CAPI costs from sponsored immigrants for another five years. Moreover, it would reduce future costs (beginning in September 2011) because under a 15-year deeming period, there would be greater attrition, making less recipients eligible, than under the current ten-year deeming period. This approach is similar to the Legislature's action in 2001, when it extended the deeming period from five years to ten years.

Option 2: Retain Current Law. Under this approach, sponsored immigrants would begin receiving state-funded CAPI benefits if they are

eligible after the ten-year deeming period. As noted earlier, this results in costs of about $12.5 million in 2006-07 (compared to the Governor's budget) rising to about $43 million in 2007-08.

Option 3: Eliminate Benefits for Post-1996 Sponsored Immigrants. Similar to Option 1, the Legislature could decide to eliminate this benefit for sponsored immigrants who arrived after August 1996. This would achieve budgetary savings (compared to current law). To date, no post-1996 immigrant with a financially supportive sponsor has received this state-funded benefit because of current deeming provisions. Moreover, it is likely that some sponsored immigrants could continue to rely on the support of their sponsors.

Option 4: More Narrowly Target Benefits for Sponsored Immigrants. Another approach would be to limit eligibility to sponsored immigrants who can demonstrate a barrier to becoming citizens. Under current federal law, sponsored immigrants may receive federal benefits once they become naturalized citizens. Under this option, state benefits would be provided to sponsored immigrants ten years after entering the United States if (1) they are actively pursuing naturalization or (2) can demonstrate that it is not possible for them to naturalize. Naturalization requires passing tests which demonstrate sufficient proficiency with the English language and sufficient knowledge of U.S. government and history. Immigrants could demonstrate progress towards citizenship by applying for citizenship and enrolling in appropriate courses of study in the English language and U.S. government. Immigrants could demonstrate that obtaining citizenship is not possible by showing good cause (such as advanced age, or inability to complete necessary coursework) for why they cannot complete the naturalization process. This approach would avoid providing state funded benefit programs to citizens who voluntarily choose not to become citizens. This approach would provide an incentive for sponsored immigrants to begin the naturalization process as soon as possible. This approach would also result in administrative costs for verifying progress with respect to naturalization.

Conclusion

All of the options discussed above have some merit. Given the significant costs associated providing benefits to sponsored immigrants, we would favor options 3 and 4 because they result in savings compared to current law and provide relative certainty for both sponsored immigrants and the state budget.

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 *2006-07 Governor's Budget* proposes $2.2 billion from all funds and $630 million from the General Fund for CWS. This represents an increase of 1.7 percent (0.2 percent General Fund) from the current year. The increase is primarily due to the Governor's children's initiative and a small increase in the average cost per case.

CALIFORNIA FAILING TO MEET PERFORMANCE IMPROVEMENT GOALS

Federal law requires California to improve its performance on federal outcome measures established for the child welfare system. We review the state's progress toward meeting the federal outcome measures, and provide an estimate of the risk of penalties based on current performance.

Background

What Are the Federal Requirements? In 2002, the federal Administration for Children and Families (ACF) conducted a performance review of California's child welfare system for the first time. The performance review, referred to as the Federal Child and Family Services Review, included two broad sets of evaluation criteria. Both sets of criteria contained seven separate subareas for review. The first part of the review, referred to as "systemic," focused on factors such as training, statewide data collection,

and the state's quality assurance processes. The second part of the review focused on seven measurable outcomes within three broad areas: safety, well-being, and permanency of children involved in the system.

In 2002, California passed two of the seven systemic factors and failed all seven of the outcome measures pertaining to child safety, well-being, and permanency. As a result, the state was required to develop and implement a Performance Improvement Plan (PIP) in order to avoid penalties in the form of reductions in federal funding. The PIP outlined the degree of improvement that the state needed to achieve in order to avoid penalties, as well as a number of action steps that the state was required to take.

California's Current Performance

As of July 2005, ACF certified that the state had successfully met all seven of the systemic factors and completed the required action steps in the PIP. Final data review for the other seven outcome measures will not occur until April 2007, based on data collected through the third quarter (end of September) of 2006.

Current Status. Although final federal review will not occur until 2007, we have compiled outcome data for California based on the most recent information available. Figure 1 (see next page) shows the state's standing as of January 2006 with respect to the seven outcome measures. Child safety outcomes focus on the protection of children from abuse in either out-of-home care or if they remain in their homes. Permanency outcomes measure the state's success at providing stability to children in foster care and providing a permanent resolution for children when they cannot return home. Finally, the well-being outcomes seek to measure other issues that affect children in the child welfare system such as educational, physical, and mental health needs, and connections to their family and communities. Each outcome may contain a number of sub-goals, all of which must be met in order to receive a "passing" grade for the measure. Current results show that the state, though improving in some areas, has not yet fully passed any of these outcome measures.

Assessing California's Performance. Although the state has not passed any of the seven outcome measures, it has improved its performance in some important subgoals. For example:

- Within the permanency category (outcome number 3), the state has exceeded the goal for the percentage of children who are reunified or adopted within the specified time period.
- Also within the same category, the state has increased the proportion of cases that have a plan for permanency in a timely manner.

Figure 1

California's Performance Improvement Status

As Reported January 2006[a]

Performance Outcomes	Goal	Results	Status
Safety			
(1) Children are protected from abuse and neglect (two goals)			**Failing**
Children with incidence of repeat maltreatment	8.8% or less	8.7%	Passing
Maltreatment of children in foster care	0.74% or less	0.78%	Failing
(2) Children are safely maintained in homes whenever possible and appropriate			**Failing**
Recurrence of abuse for children who remain in their homes	21% or less	22.6%	Failing
Permanency			
(3) Children have permanency and stability in their living situations (six goals)			**Failing**
Children who reenter foster care after exit	9.4% or less	10.1%	Failing
Children/family reunified within 12 months	57.2% or more	68.2%	Passing
Children adopted within 24 months	20.9% or more	29.3%	Passing
Children with no more than two foster care placements in 12 months	86.7% or more	85.2%	Failing
Timely establishment of permanency goals	70.4% or more	74.3%	Passing
Proportion of children with goal of long-term foster care	31.3 % or less	31.3%	Passing
Well-Being			
(4) Children whose family relationships and connections are preserved	92.3% or more	90.5%	**Failing**
(5) Families have enhanced capacity to provide for their children's needs	Improve by 3%	__[b]	**Failing**
(6) Children receive appropriate services to meet their educational needs	Improve by 3%	__[b]	**Failing**
(7) Children receive adequate services to meet their physical and mental health needs	Improve by 3%	__[b]	**Failing**

[a] Based on data from October through December 2005.

[b] The state is failing outcomes 5 through 7 because it has only met 3 of 12 subgoals for these measures.

- Within the safety category (outcome number 1), the state has met the standard for a reduction in the repeat maltreatment of children who have previously been referred for abuse and neglect.

Other positive progress has been made on some of the subgoals for the well-being outcomes shown in Figure 1, but few have yet to surpass the PIP goal of 3 percentage point improvement required to pass an outcome.

There is significantly less improvement for safety (outcome number 2), which measures the rate of recurrence of abuse for children who remain in their homes, and for the rate of maltreatment of children in foster care. The state is also still below the level required to meet the outcome for stability in foster care placements.

Penalty Exposure

How Are Penalties Calculated? As previously indicated, the federal review of the state's performance will not occur until April 2007. Consequently there is time for the state to improve its performance beyond that shown in Figure 1, thereby avoiding federal penalties. Nevertheless, should federal penalties be assessed at that time, this is how they would be calculated.

The federal penalties are assessed based on whether the state meets its goal for each outcome. For each outcome not met, a penalty of 1 percent is assessed on a portion of the state's federal fund allocation. This penalty formula is applied to each year's federal funding, beginning with federal fiscal year 2002. Because the state has negotiated a PIP, the federal government holds these penalties in abeyance until a final review of the state's progress, however they continue to accumulate for each year. At the time this analysis was prepared, the state still had not met seven outcome measures. As of July 2005, the federal funding penalty for the current level of performance is $42 million. However, penalties will continue to accumulate until ACF's final review of the state's data in April 2007, adding approximately $17 million if no additional outcomes are met, resulting in a total penalty of about $59 million. If, at that time, the state successfully meets any of the seven outcomes, the penalty would decrease accordingly.

Assuming California fails to attain compliance in its PIP by April 2007, a new PIP based on a second federal review would be negotiated. The penalty for each missed outcome rises from 1 percent to 2 percent of federal funds during the second PIP.

When Will Penalties Be Applied? Once ACF receives the final data for review in April 2007, it is anticipated that penalties will be applied soon after, possibly by the summer of 2007.

Current Improvement Efforts

What Has the State Done to Improve Performance? The state has funded performance improvement activities in each year since the development of the PIP. Specifically, $19.5 million ($0.9 million General Fund) and $ 28.4 million ($12.3 million General Fund) were allocated, respectively, for 2004-05 and 2005-06. The budget proposes $28.6 million ($16.3 million General Fund) for these activities in 2006-07. These improvement funds have been applied to two major efforts, system improvement pilots and the implementation of the statewide outcome and accountability system created by Chapter 678, Statutes of 2001 (AB 636, Steinberg). Each of these efforts are described below.

System Improvement Pilots. Beginning in 2004-05, 11 counties have received funds for pilot projects to improve their CWS outcomes. The pilots have focused on three methods for improving CWS delivery: (1) differential response intake, (2) standardized safety assessment, and (3) improving permanency and youth services. Differential response focuses on improving the child abuse hotline response system to provide multiple paths for child safety and to refer families for community services when appropriate. The standardized safety assessment system provides consistent procedures to determine if a child is safe when a situation is initially assessed and throughout the course of a child welfare case. Improving foster youth permanency focuses on team-based case planning to support family reunification or transition planning. This strategy also increases the involvement of youth and families in their own case planning. Together, these projects have been allocated $32.5 million (all funds) in the past two years, in order to test their potential to improve outcomes.

Outcome and Accountability System Established by Chapter 678. The other major effort to improve the state's performance on the federal outcomes is the implementation of Chapter 678, which established a framework for measuring performance and tracking improvement in CWS, hereafter referred to as the AB 636 system. The AB 636 system also aligned state performance outcomes with the federal performance outcomes described earlier. The implementation of this system began in 2004 when counties examined their performance data, met with their communities, and developed Self Improvement Plans (SIPs). These SIPs, like the state's PIP, identify the level of improvement counties anticipate making on outcomes, and their action plans to make the improvements. Counties receive quarterly reports from the Department of Social Services (DSS), in order to monitor their progress on outcomes and adjust their approaches accordingly. (The state contracts with UC Berkeley to compile data by county for each outcome measure.)

Funding to implement changes outlined in SIPs began in the current year, when the state made $12.8 million available through a grant process, for counties to execute performance improvement strategies. The DSS has requested reports on the interim results of this funding from the counties in April of 2006. Based on our review, 38 counties received funds for various strategies, many of which are closely modeled on the System Improvement Pilot activities.

Further Improvement Efforts

We recommend that the Department of Social Services report at budget hearings on evaluation results for the 11 improvement pilots.

Report Evaluation Results for System Improvement Pilots. Though funding has been provided to the 11 pilot counties since 2004-05 to improve their CWS performance, there has been no evaluation of the pilot strategies used by these counties. The original intention of these pilots was to disseminate statewide the three strategies they have used, once lessons and evaluation results were available from them. In the intervening two years, however, many other counties have begun to implement similar strategies without this information to guide their efforts. Although a formal evaluation has not begun, DSS has indicated that it will use preliminary information regarding the operations of these pilots to adjust the budget for the May Revision. We believe that the Legislature should have this same information when it is available to guide its decisions about further investment in these strategies. Accordingly, we recommend that DSS report at budget hearings on the evaluation results for the 11 pilot improvement counties.

Funding for CWS Should Be Flexible

The Governor proposes a total of $32.8 million ($19.1 General Fund) for (1) new initiatives in adoption, kinship support, and transitional housing for foster youth, and (2) implementation of recently enacted legislation. We recommend approval of the $18 million proposed to fund recently enacted legislation and transitional housing for foster youth. However, we recommend that the Legislature redirect the remaining $15 million (all funds) from the Governor's initiative into flexible grants which would allow counties to target resources to the needs they have identified as part of the state's outcome and accountability framework.

Outcomes and Accountability Framework

Counties Have Identified Critical Areas for Improvement. As discussed earlier, Chapter 678 established a statewide outcome and accountability system, commonly referred to as the AB 636 system. Through this system, counties now receive data quarterly that measures their performance against state and federal outcome standards. In addition, through the development of SIPs, they then target specific efforts to the areas that need improvement. This process provides counties, who are in the best position to assess children's needs, with the flexibility to adopt appropriate performance improvement strategies.

Current Funding. In 2005-06, the state provided $12.8 million to assist counties to implement the strategies they had identified in their SIPs. This funding allocated grants, through a competitive proposal process, to 38 counties to fund improvement strategies identified in their SIPs.

Governor's Proposal

The Governor proposes an initiative which funds recently enacted legislation, increases the number of adoptions finalized, and augments funding for two existing programs providing services to children and families in the child welfare system. Figure 2 summarizes the funding for each component of the initiative, which is discussed in detail below.

Increasing Adoptions. The Governor's budget proposes a total of $12.5 million to fund additional adoptions social workers. Of this amount, $ 1.3 million ($0.7 million General Fund) would support 16.5 additional positions within the state's adoptions services bureau, which provides adoption services to 28 counties. The remaining $11.2 million ($6.3 million General Fund) would be provided to the counties who operate their own adoption programs. The new adoptions workers are projected to increase finalized adoptions by 1,121 cases through 2007-08.

Expanding Kinship Support Services. The Governor's budget proposes to increase kinship support funding by $2.5 million to a total of $4 million. Kinship support is provided to relatives caring for foster children and typically includes services such as respite care; mentoring/tutoring; or assistance with furniture, clothing, food, or transportation. Eleven counties currently operate kinship support service programs. The additional $2.5 million would be available to these counties as well as other counties who wish to offer this service.

Transitional Housing for Foster Youth. The budget proposal would add approximately $2.6 million total ($1.4 million General Fund) to the existing transitional housing program for foster youth. The program provides grant payments to foster youth as they leave foster care to enable

them to find housing independently. Though this program has been in effect since 2002, some counties have not participated because the funds require a county match of 60 percent.

Funding for Recently Enacted Legislation. The Governor proposes $0.8 million ($0.3 million General Fund) to fund Chapter 630, Statutes of 2005 (SB 500, Kuehl), which increases foster care payments for the child of a teen parent in foster care. The budget also proposes $14.4 million ($7.8 General Fund) to implement Chapter 640, Statutes of 2005 (AB 1412, Leno). This statute expands activities to engage foster children in their own case planning as well as increases efforts to find and support mentorship relationships for them.

Figure 2

Proposed Child Welfare Service Initiatives

2006-07
(In Millions)

Description	Total Funds	General Fund
Increasing Adoptions Provides funds to State Adoption Services Bureau and counties to hire additional adoptions social workers to increase number of finalized adoptions.	$12.5	$7.1
Expanding of Kinship Support Services Provides increased funds to expand current county programs and allow additional counties to apply for kinship support services grants.	2.5	2.5
Foster Care Infant Rate Provides funds to implement Chapter 630, Statutes of 2005 (SB 500, Kuehl). Increases foster care payment for infant child of a teen parent in foster care.	0.8	0.3
Child Relationships Implements Chapter 640, Statutes of 2005 (AB1412, Leno). Engages foster children in the development of their case plan and expands activities to find and support mentorship relationships for them.	14.4	7.8
Transitional Housing for Foster Youth Provides additional funds to allow more counties to participate in program funding transitional housing for emancipating foster youth.	2.6	1.4
Totals	**$32.8**	**$19.1**

Comments on the Governor's Proposal

We have no issues with the $18 million that is proposed to fund recently enacted legislation and to expand the transitional housing program. However, the remaining $15 million for adoptions and kinship proposals raise several issues as described below.

Preserve County Flexibility. Although providing additional resources for adoptions and kinship services has merit, we believe that the Governor's proposal represents a "one size fits all" approach. Counties, rather than the state, are in the best position to allocate resources among various CWS improvement strategies. As discussed earlier, through the AB 636 system, counties have analyzed outcomes and developed improvement goals. Some counties may choose to focus on adoptions while others may choose strategies such as foster home recruitment or developing networks of community services.

Adoptions Funding Choice Not Justified by Performance. As discussed earlier, (see Figure 1) current data indicate that reducing the length of time for adoption is an area in which the state has successfully improved its performance. Specifically, the state has increased the percentage of adoptions occurring within 24 months, to 29 percent, up from 18 at the start of the PIP. Given the recent improvement in meeting both state and federal adoption outcomes, we believe that directing funds to this area is not the best use of resources.

Additional Reporting Requirement Unnecessary. The kinship support services proposal would require that counties provide outcome improvement goals in order to receive grants. However, counties have already set improvement goals in their SIPs as part of the AB 636 system requirements. Since these detailed plans are approved by the administration, it is not necessary to require counties to establish additional goals and provide measurement data outside of the existing accountability system.

Analyst's Recommendation. The Legislature has already established a statewide performance and tracking system to improve CWS that relies heavily on county assessments and improvements. Consistent with that framework we recommend that $15 million ($9.6 General Fund), designated for improving adoptions outcomes and increasing kinship support services, be redirected into flexible grants to continue support for county self-improvement strategies, pursuant to this AB 636 system. This would allow maximum flexibility for counties to improve outcomes in their communities.

DEPENDENCY DRUG COURT FUNDING

Current law requires that the dependency drug court (DDC) program be funded unless it is determined that the program is not cost-effective with respect to the Foster Care and Child Welfare Services Programs. The proposed budget does not provide funding for DDCs or provide trailer bill language to suspend this requirement. Accordingly, we recommend that the Department of Social Services report at budget hearings on why they have not funded this program.

Background. The DDCs provide intensive substance abuse treatment along with close court supervision to parents who are involved in dependency court cases. Prior evaluations of the DDC model, including one conducted for the federal Department of Health and Human Services, have produced evidence that the model reduces time to reunification, increases reunification rates, and increases participation in substance abuse treatment. This approach would result in cost avoidance in Foster Care and CWS programs. Based on our review of existing studies, we believe that cost avoidance in Foster Care and CWS exceeds the cost of the drug court program.

During the 2005-06 budget process, the legislature approved funding for the continuation of DDC activities in nine counties, in coordination with the Department of Alcohol and Drug Programs. This funding also supported an evaluation to determine the cost-effectiveness of the programs. Trailer bill language accompanied the *2005-06 Budget Act* to specify that "dependency drug courts be funded unless an evaluation… demonstrates that the program is not cost effective."

Analyst's Recommendation. We recommend that DSS report at budget hearings regarding why this program has not been funded according to the requirements of current law.

FOSTER CARE

Foster care is an entitlement program funded by federal, state, and local governments. Children are eligible for foster care grants if they are living with a foster care provider under a court order or a voluntary agreement between the child's parent and a county welfare department. The California Department of Social Services provides oversight for the county-administered foster care system. County welfare departments make decisions regarding the health and safety of children and have the discretion to place children in one of the following: (1) a foster family home, (2) a foster family agency home, or (3) a group home. Seriously emotionally disturbed (SED) children are identified by the State Department of Education and are typically placed in Group Homes to facilitate a greater degree of supervision and treatment.

The Governor's budget proposes expenditures of $1.6 billion ($396 million General Fund) for the Foster Care Program in 2006-07. This represents a 3.6 percent decrease in General Fund expenditures from the current year. Most of this decrease is attributable to a one-time General Fund cost in the current year to backfill a federal fund disallowance.

FOSTER FAMILY AGENCY CASELOAD OVERSTATED

We recommend that proposed General Fund spending for Foster Care grants be reduced by $1.4 million for 2005-06 and $3.9 million for 2006-07 and that the foster care administrative funding be reduced by $220,000 in 2006-07 because the caseload projections overestimate the number of children in foster family agency homes. (Reduce Item 5180-101-001 by $3,900,000 and Reduce Item 5180-141-0001 by $220,000.)

Foster Care Caseloads. Foster care has four caseload components: foster family homes, foster family agencies (FFA), group homes (GHs), and SED children. Although we concur with the department's caseload forecast for the FFH, GH and SED caseloads, we believe that the estimates for the FFA caseloads are overstated, as discussed below.

FFA Caseload. The FFA caseload is made up of children who have been placed in a certified foster family home that is overseen by a FFA. Generally, these children need slightly more intensive services than children placed in a licensed foster family home. This is a more expensive placement than foster family homes but considerably less expensive than group homes. For 2005-06 and 2006-07, the department is estimating that the average monthly FFA grant will be about $1,700 per child.

Recent Caseload Trends. The FFA caseload has increased slightly in recent years, with an increase of 1.4 percent in 2003-04 and 1.3 percent in 2004-05. Contrary to this two-year trend, the department has estimated that FFA cases will increase by 3 percent in the current year and 2.6 percent in the budget year. The department was unable to provide evidence to suggest that the FFA caseload will experience a doubling of its recent growth rate. Based on recent caseload trends, we estimate that the caseload will increase by 1.5 percent in 2005-06 and 2006-07. Based on our caseload estimates, General Fund spending for FFA cases is overstated by $1.4 million General Fund in the current year and $3.9 million in the budget year. Accordingly, we recommend reducing the budget by $3.9 million in 2006-07 and recognizing savings of $1.4 million for 2005-06. We further recommend a corresponding General Fund administrative reduction of $220,000 for 2006-07.

FINDINGS AND RECOMMENDATIONS

Health and Social Services

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Crosscutting Issues

Improving Long-Term Care

Licensing and Certification Reform Proposals

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C-47 ■ **Governor's Proposal Does Not Address Enforcement Gaps.** Because of its focus on inspection frequency, the Governor's proposal ignores gaps in the enforcement process, which is designed to ensure that facilities are safe or cease operation. We discuss concerns with enforcement, and provide recommendations to increase CCL's enforcement effectiveness.

Some Practical Steps to Increase Children's Enrollment

C-56 ■ **Some Practical Steps to Increase Children's Enrollment.** Some of the proposals to increase children's enrollment in Medi-Cal and the Healthy Families Program appear reasonable, but others appear ineffective or overbudgeted. Recommend that the Legislature reject the funding proposed for the statewide media campaign and the increased incentive payments for certified application assistance. Also recommend that the Legislature reduce the funding associated with the caseload increase projected to result from streamlining the Medi-Cal annual reenrollment form, which appears overstated.

Budgeting for County Administration

C-65 ■ **Budgeting for County Administration.** The Governor proposes trailer bill legislation which would freeze state participation in county administrative costs in health and social services programs at the 2005-06 level. State support for county administration would be adjusted for caseload and workload but not for inflation. We review the budgeting history for county administration and recommend rejecting the Governor's proposal.

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Getting Better Budget Information

C-72 ■ **Additional Information Needed for Oversight of Health Program Spending.** Recommend that the Legislature adopt Budget Bill language directing the Department of Finance (DOF) to include in its annual Governor's budget a schedule of local assistance appropriations for Medi-Cal and public health programs as well as a Proposition 99 spending plan. Also, recommend the Legislature direct DOF to establish new budget item numbers for certain major health expenditure programs so that changes for the budget can be tracked separately and more easily.

Department of Alcohol and Drug Programs

C-78 ■ **Proposition 36 at a Crossroads.** Withhold recommendation on the proposed one-time General Fund appropriation of $120 million to support Proposition 36 and reauthorization of 29.7 staff positions, pending receipt of a cost benefit study on the program due April 1, 2006.

Medi-Cal

C-91 ■ **Medi-Cal Caseload Projection Reasonable.** We find that the budget's overall estimate for the Medi-Cal caseload is reasonable. We will continue to monitor the caseload trends and will recommend any appropriate adjustments to the caseload estimate at the May Revision.

C-94 ■ **The Impact of the Medicare Drug Benefit on Medi-Cal. Reduce Item 4260-101-0001 by $275 Million.** Recommend the Legislature reduce Medi-Cal local assistance item by the combined amount of about $330 million in the current

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year and budget year to account more appropriately for when drug rebates revenues will be lost to the state and to reflect updated federal estimates of California's claw-back payments. Recommend that the Legislature revert at an earlier date than scheduled excess General Fund resources provided for emergency drug coverage for dual eligibles.

C-103 ■ **A Targeted Strategy to Constrain Medi-Cal Costs and Improve Access to Community Care.** Recommend that the Legislature enact policy legislation to promote use of the most cost-effective and medically appropriate settings for primary care within Medi-Cal through a combination of (1) a targeted copayment for nonemergency use of emergency rooms and (2) the use of available federal grant funding to improve access to primary care through a program comparable to the existing Rural Health Demonstration Project program.

C-112 ■ **Hospital Waiver Increasing State General Fund Costs. Reduce Item 4260-111-0001 by $35 Million.** The Governor's budget proposal estimates that a new federal hospital financing waiver will result in a net increase of state General Fund costs over the first two years of about $39 million. Recommend that the Legislature use federal funds to offset General Fund costs in additional state "safety net" programs in order to instead achieve net General Fund savings.

C-118 ■ **Medi-Cal's Bitter Pill: High Payments to Pharmacies.** Recommend that the Legislature adopt statutory language that enables Medi-Cal to be flexible when defining its reimbursement methodology for prescription drugs to help ensure that reimbursement rates are appropriate.

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C-125 ■ **Coordinated Care Proposal Should Be Modified. Reduce Item 4260-001-0001 by $208,000, Reduce Item 4260-001-0890 by $79,000 and Increase Item 4260-001-3085 by $127,000.** Recommend the Legislature not approve a new coordinated care management pilot project that would largely duplicate a disease management pilot project now in development. Recommend approval of another proposed pilot project to assist Medi-Cal beneficiaries who have both mental health and physical health problems using Proposition 63 mental health funding.

C-126 ■ **Reduce Funding for Disease Management Contract. Reduce Item 4260-101-0001 by $375,000 and Item 4260-101-0890 by $375,000.** Recommend the Legislature reduce funding for the disease management contract in the current year and budget year to reflect the delay in awarding the contract.

C-127 ■ **Requests for Added Staff Excessive. Reduce Item 4260-001-0001 by $3.5 Million, Reduce Item 4260-101-0001 by $2 Million, Increase Item 4260-001-3098 by $241,000.** The budget request for the Department of Health Services includes various proposals for additional staff and contract funding generally related to the administration of the Medi-Cal Program. Recommend that some of the requests for funding for additional staff and contract resources be approved, but that others be reduced or deleted because they are not justified on a workload basis.

Public Health

C-137 ■ **Public Health Program Expenditures.** Recommend the adoption of trailer bill language (1) requesting the Bureau of State Audits to audit the funding provided for vari-

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ous Department of Health Services (DHS) public health programs and (2) requiring the administration to include public health program expenditure information annually in the budget documents because DHS is unable to provide the Legislature with detailed information about these expenditures on a timely and regular basis.

C-138 ■ **Women, Infants, and Children.** The state faces a risk of tens of millions of dollars in penalties for paying vendors more than permitted under federal limits in the Women, Infants, and Children (WIC) nutrition program. Recommend that DHS report at budget hearings on the status of federal enforcement actions related to this issue and the implications of this situation for the state budget and the WIC program.

Managed Risk Medical Insurance Board

C-142 ■ **Future Federal Funding Unlikely to Meet Program Needs.** Future uncertainties surrounding the reauthorization of federal funding and the eventual exhaustion of unspent federal funds pose a risk of significant future increases in General Fund expenditures for the Healthy Families Program (HFP). In light of this potential problem, we present alternatives to hold down increases in overall HFP costs and to obtain additional financial support for the program.

C-149 ■ **Healthy Families Program Caseload Projection Too High. Reduce Item 4280-001-0001 by $14 million and 4280-001-0890 by $26 million.** For the last two years, MRMIB has overestimated HFP caseload. We find the budget year projection for HFP also to be high. Conse-

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quently, we recommend the Legislature make a downward adjustment to the HFP budget.

C-150 ■ **Protect Legislative Oversight of Expenditure Authority.** Recommend the rejection of the administration's request to eliminate Budget Control Sections 28 and 28.5 requirements for HFP expenditures.

C-151 ■ **Request for Additional Staff Positions Unjustified. Reduce Item 4280-001-0001 by $248,000, Item 4280-001-0236 by $35,000 and Item 4280-001-0890 by $513,000.** The Governor's budget requests ten additional staff positions to address current and anticipated workload within the customer service, policy, legal, research, and special program functions at the Managed Risk Medical Insurance Board. We recommend the approval of only two of the positions.

Department of Developmental Services

C-156 ■ **Better Oversight of Regional Center (RC) Purchase of Services Needed.** Recommend that the Legislature commission an audit by the Department of Finance's Office of State Audits and Evaluations on the RC's reporting of purchase of services expenditures. The audit would provide the Legislature with the information it needs to improve fiscal oversight of RC spending for these purposes.

C-164 ■ **Caseload Adjustments Warranted for RCs. Reduce Item 4300-101-0001 by $16 Million.** Recommend reduction of $15 million from all fund sources (with a $9 million General Fund reduction) in the current year to adjust for lower-than-anticipated caseload levels. Recommend

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a further reduction of $25 million from all fund sources ($16 million General Fund) in the budget year for the same reason.

C-167 ■ **Regional Center Provider Rate Increase.** Recommend the Legislature enact legislation requiring the Department of Developmental Services (DDS) to incorporate measurements of quality and access to specific services into the rate-setting methodologies that it develops for RC services.

C-169 ■ **Legislature Should Proceed Cautiously on Law Enforcement Expansion. Reduce Item 4300-001-0001 by $258,000.** Recommend the Legislature reject four positions proposed for the Office of Protective Services located at DDS headquarters. Withhold recommendation on the request for 81 developmental center (DC) positions pending updated information on settlement negotiations between the department and the U.S. Department of Justice related to findings of deficiencies at Lanterman DC.

Department of Mental Health

C-174 ■ **State Response to Federal Investigations Premature.** Withhold recommendation on the administration's request for additional resources to address deficiencies in state hospitals as cited by the U.S. Department of Justice in its Civil Rights of Institutionalized Persons Investigation until a final consent decree has been issued.

C-178 ■ **Hospital Caseload Projections Need Adjustment. Reduce Item 4440-011-0001 by $20 Million.** Recommend General Fund reductions of $10 million in the current year and $20 million in the budget year to adjust for lower than an-

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ticipated caseloads for certain forensic groups of patients. Further recommend $8.5 million reduction in the current year because beds for prison inmates at the new Coalinga hospital have not been activated.

California Work Opportunity and Responsibility to Kids (CalWORKs)

C-184 ■ **The Governor Proposes to Increase Temporary Assistance for Needy Families (TANF) Expenditures on Child Welfare Services.** The Governor's budget achieves General Fund savings of $32 million in 2005-06 and $26 million in 2006-07 by replacing certain General Fund support for child welfare services activities with TANF federal funds. Because this is first time that TANF would be used for these program costs, the Legislature should assess whether this proposal is consistent with its priorities for limited TANF block grant funds.

C-186 ■ **Reductions in County Block Grant Funds Are Contrary to Legislative Intent.** In 2005-06 and 2006-07, the Governor's budget proposes a net $93 million reduction to county block grant funds for child care, administration, and employment services. Because some of the savings are likely to occur on the natural, we recommend adoption of budget trailer bill language to achieve savings as of August 2006.

C-188 ■ **Deficit Reduction Act of 2005 Creates Potential for Substantial Fiscal Penalties.** The act effectively raises the required work participation rate to 50 percent for all families and 90 percent for two-parent families. Failure to meet these work participation rates results in substantial annual fiscal penalties on California. We describe the key

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provisions of the act, and assess California's status with respect to meeting these work participation rates.

C-192 ■ **Strategies for Meeting Higher Work Participation Requirements.** To avoid federal penalties, California will have to substantially increase the work participation rates of CalWORKs recipients. We review a range of strategies including (1) increasing the participation of existing recipients, (2) bringing former recipients who are employed back into the participation calculation, and (3) creating separate programs for those who may face substantial barriers to work.

In-Home Supportive Services (IHSS)

C-197 ■ **Current Year Costs Are Overbudgeted.** Our review of actual expenditures for the first six months of 2005-06 indicates that IHSS costs are overbugeted by $82 million ($26 million General Fund). We recommend that the Legislature recognize a General Fund savings of $26 million for 2005-06.

C-198 ■ **Legislature Needs More Information About Fraud Prevention Activities.** In order to assure proper coordination of anti-fraud activities, we recommend that the Department of Social Services , Department of Health Services , and county welfare departments report jointly at budget hearings on their progress in improving program integrity.

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Supplemental Security Income/ State Supplementary Program

Child Welfare Services (CWS)

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initiative into flexible grants which allow counties to target resources to the outcome improvement needs they have identified as part of the state's outcome and accountability framework.

C-215 ■ **Dependency Drug Court (DDC) Funding.** Current law requires that the DDC program be funded unless it is determined that the program is not cost-effective with respect to the Foster Care and CWS programs. The proposed budget does not provide funding for DDC or provide trailer bill language to suspend this requirement. Accordingly, we recommend that DSS report at budget hearings on why they have not funded this program as required by current law.

Foster Care

C-216 ■ **Foster Family Agency Caseload Overstated. Reduce Item 5180-101-001 by $3,900,000 and Reduce Item 5180-141-0001 by $220,000.** We recommend that proposed General Fund spending for the Foster Care Grants be reduced by $1.4 million for 2005-6 and $3.9 million for 2006-07 and that the foster care administrative funding be reduced by $220,000 in 2006-07 because the caseload projections overestimate the number of children in foster family agency homes.