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2009-10 Budget Analysis Series

Health

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CONTENTS

EXECUTIVE SUMMARY

In this report we (1) provide an overview of state spending on health programs, (2) analyze the Governor's budget proposals and present our own recommendations to assist the Legislature in balancing the 2009-10 budget, and (3) identify issues that could potentially have a significant impact on future state expenditures.

Overview of Health Program Expenditures

A Wide Array of Programs. California's major health programs provide health coverage and additional support services for various groups of eligible persons—but primarily poor families and children as well as seniors and persons with disabilities. Medi-Cal is by far the largest state health program both in terms of funding and persons served. In addition, the state supports health care insurance for children, various public health programs, substance abuse treatment programs, and community services and state-operated facilities for the mentally ill and developmentally disabled.

Governor Proposes to Hold General Fund Spending for Health Virtually Flat. The budget proposes General Fund expenditures of $20.7 billion for health programs in the budget year, which is about 22 percent of total proposed General Fund expenditures. This would be an increase of $14 million General Fund, or 0.1 percent, above the adjusted spending level for 2008-09, holding General Fund spending virtually flat compared to the current-year spending level. The budget plan does this by using two basic approaches: (1) making reductions to control expenditures that are generally caused by caseload, cost, and utilization growth in health programs, and (2) using alternative funding sources for certain programs that are currently funded by the General Fund.

Balancing the 2009-10 Budget

Federal Stimulus Package Would Likely Provide Fiscal Relief. At the time this analysis was prepared, various key provisions of the federal fiscal stimulus package under consideration in Congress had yet to be finalized. However, based on our review of the available draft legislation, it appears that the stimulus package will provide substantial fiscal relief to California in the form of enhanced federal contributions to the state's Medi-Cal Program. The draft legislation also includes other provisions that would expand Medi-Cal eligibility for certain groups and provide funds to encourage the adoption of health information technology. We note that the options to expand eligibility pose a significant financial risk to the state at a time when it is likely to continue to have a sizable and ongoing structural budget.

Federal Program Reauthorization Allows for Program Expansion. At the time this analysis was prepared, Congress appeared to be close to agreement on federal legislation that would reauthorize the State Children's Health Insurance Program (SCHIP) through September 2013.

We note that some provisions would allow the state to draw down additional federal funds for newly qualified immigrants and thus reduce state costs. Other provisions, such as new identification and documentation requirements, would increase state costs. We recommend that the state forego at this time an option available under the new federal legislation to expand children's coverage up to 300 percent of the federal poverty (FPL) level because of the state's current fiscal condition.

Proposition 99: Options for Legislative Consideration. Under the existing provisions of Proposition 99, a 1988 initiative approved by voters, the Legislature only has limited flexibility to prioritize the use of the tobacco tax revenues for the programs it deems to be the highest priority. These restrictions include the requirements for six separate accounts with distinct funding purposes, limits on the use of some of these monies to leverage federal funds, and prohibitions on the use of funding to pay for existing General Fund-supported programs. We propose seeking voter approval for modifications to Proposition 99 to "unlock" spending now earmarked for certain Proposition 99 programs, a step that could allow the Legislature to achieve substantial General Fund savings in the budget year.

LAO Alternatives for Achieving Savings. Based on our review of the Governor's budget plan, and our own independent analysis, we recommend several alternatives to achieve savings in health programs in 2009-10.

Other Issues

The Broker Model for Medicaid Nonemergency Medical Transportation (NEMT). In order to help Medicaid enrollees obtain better access to health care services, the federal government requires state Medicaid programs to provide necessary medical transportation to and from health care providers, even if no emergency is present. This benefit is known as NEMT, and includes such services as trips to and from scheduled medical appointments, return trips from hospital emergency rooms, and transfers between hospitals. Our review indicates that Medi-Cal potentially could improve the availability and quality of its NEMT services while reducing costs by contracting with a transportation broker to manage a portion of its NEMT services. We recommend that the state conduct a pilot program by contracting with such a vendor for two years to evaluate the potential for improvement.

Failure to Promulgate Medi-Cal Regulations Leads to Inefficiency. How counties administer Medi-Cal eligibility determinations affects access to care for the poor, compliance with federal laws, and overall state costs for the Medi-Cal Program. We find that the state's failure to promulgate regulations regarding eligibility functions can cause inefficiency at the county level and impede the state's ability to manage county administration. We recommend that the Legislature require the Department of Health Care Services (DHCS) to take steps to promulgate such regulations.

BACKGROUND

California's major health programs provide health coverage and additional support services for various groups of eligible persons—primarily poor families and children as well as seniors and persons with disabilities. Medi-Cal is by far the largest state health program both in terms of funding and persons served. In addition, the state supports health care insurance for children, various public health programs, substance abuse treatment programs, and community services and state-operated facilities for the mentally ill and developmentally disabled.

Expenditure Proposal and Trends

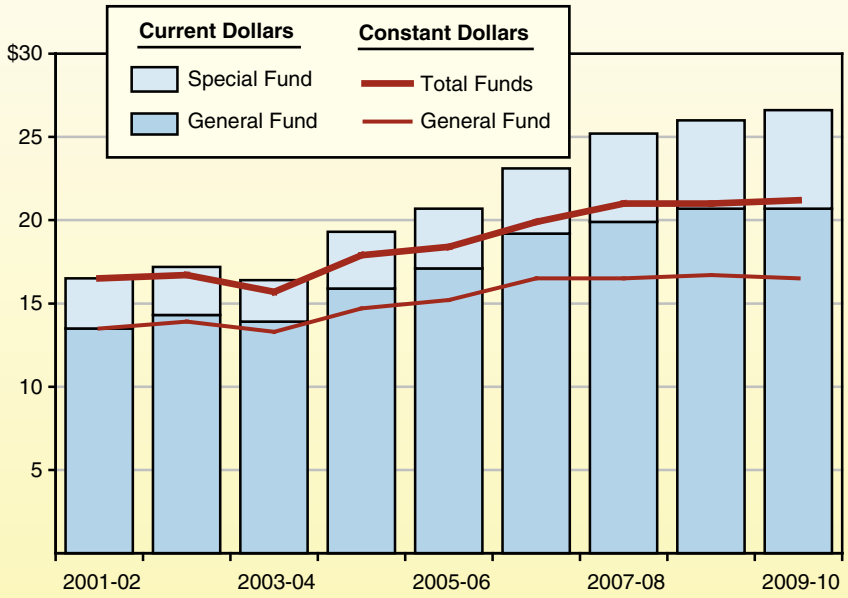
Budget Year. The budget proposes General Fund expenditures of $20.7 billion for health programs in the budget year, which is about 22 percent of total proposed General Fund expenditures. The budget proposes an increase of $14 million General Fund or 0.1 percent above adjusted spending for 2008-09, holding General Fund spending virtually flat compared to the current-year spending level. The budget also proposes to increase special funds spending for health programs by about $589 million, or 11 percent, to about $5.9 billion, due mainly to an administration proposal to shift support for drug and alcohol treatment programs to a new special fund.

Adjusting for Inflation. Figure 1 displays the spending for these programs adjusted for inflation (constant dollars) using the California Consumer Price Index. On this basis, General Fund expenditures are estimated to increase by almost 22 percent from 2001-02 through 2009-10. Combined General Fund and special funds expenditures from 2001-02 through 2009-10 are estimated to increase by 28 percent during this same period, an average annual increase of 3.1 percent.

Figure 1

Health Expenditures: Current and Constant Dollars

2001-02 Through 2009-10
(In Billions)



Spending by Department

Figure 2 (see next page) shows General Fund expenditures by department/agency for the prior year, current

year, and budget year. It also shows the percentage change between the administration's revised proposal for the current year and the budget year.

Major Health Programs

The state administers six major programs that represent almost 96 percent of the total health spending proposed by the administration. Figure 3 summarizes the actual and estimated General Fund expenditures for these programs from 2001-02 through 2008-09. As can be seen in Figure 3, between 2001-02 and 2008-09 General Fund spending has grown for all of the major health programs. The combined average annual growth rate for the programs shown in Figure 3 is 6.9 percent. In some cases, funding shifts between programs may make it appear as if a program is growing faster than is really the case.

Description of Major Health Programs

Medi-Cal (DHCS). In California, the federal Medicaid program is administered by DHCS as the California Medical Assistance Program (Medi-Cal). The Medi-Cal Program provides health care services to qualified low-income persons, primarily consisting of families with children and the aged or disabled. Federal law establishes some minimum requirements for state Medicaid programs regarding the types of services offered and who is eligible to receive them. Required services include hospital inpatient and outpatient care, skilled nursing care, and doctor visits. In addition, California offers an array of services considered optional under federal law, such as coverage of prescription drugs and adult dental care. California also has expanded eligibility beyond the levels required under federal law.

Figure 2

Governor's January 10 Budget Plan—General Fund Spending

(Dollars in Millions)

Department/Agency	2007-08	2008-09[a]	2009-10[b]	Current Year to Budget Year Difference	Current Year to Budget Year Percent
Department of Health Care Services	$14,357.1	$14,731.2	$15,175.5	$444.3	3.0%
Department of Developmental Services	2,548.1	2,788.3	2,777.9	-10.4	-0.4
Department of Mental Health	1,930.9	2,118.7	1,972.9	-145.8	-6.9
Managed Risk Medical Insurance Board	389.4	399.9	406.4	6.5	1.6
Department of Public Health	361.7	349.9	351.9	2.0	0.6
Department of Alcohol and Drug Programs	285.1	299.0	—	-299.0	-100.0
Emergency Medical Services Authority	13.3	11.5	12.0	0.5	4.3
Secretary for Health and Human Services	4.6	4.3	3.9	-0.4	-9.3
Office of Statewide Health Planning Development	5.0	0.4	0.1	-0.3	-75.0
California Medical Assistance Commission	1.3	1.3	1.3	—	—
State Council on Development Disabilities	—	—	—	—	—
General obligation bonds	8.9	15.6	32.5	16.9	108.3
Totals	**$19,905.4**	**$20,720.1**	**$20,734.4**	**$14.3**	**0.1%**

[a] Revised.
[b] Proposed.

Figure 4 provides basic expenditure and caseload information on the program.

Community Services Program (Department of Developmental Services [DDS]). This program provides community-based services to developmentally disabled persons through 21 nonprofit corporations known as regional centers (RCs) that are located throughout the state. The RCs are responsible for eligibility determinations and consumer assessment, the development of an individual program plan for each consumer, and case management. They generally pay for services only if an individual does not have private insurance or they cannot refer an individual to so-called "generic" services that are provided at the local level by counties, cities, school districts, and other agencies. The RCs also purchase services such as transportation, health care,

Figure 3

Major Health Programs

(In Millions)

General Fund Spending[a]	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	Estimated 2008-09
Medi-Cal	$9,740.9	$10,554.1	$9,879.2	$11,592.6	$12,362.9	$13,406.0[b]	$14,036.0	$14,413.7
Regional Centers	1,342.1	1,510.6	1,582.1	1,718.7	1,831.3	2,106.8	2,120.9	2,366.4
Developmental Centers	344.9	344.7	354.8	385.1	386.5	397.6	398.8	387.8
Community Mental Health Services	383.0	324.9	306.1	303.9	313.6	775.2[b]	766.1	849.2
Mental Hospitals/Long-Term Care Services	488.7	507.0	573.6	660.9	802.2	959.2	1,099.4	1,202.5
Healthy Families Program	2.1	24.1	276.4	288.4	316.7	347.7	387.0	397.5
Totals	**$12,301.7**	**$13,265.4**	**$12,972.2**	**$14,949.6**	**$16,013.2**	**$17,992.5**	**$18,808.2**	**$19,617.1**

a Excludes headquarters.

b Reflects technical funding shift in budget display from Medi-Cal to Community Mental Health Services.

Figure 4

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

(Dollars in Millions)

	Expenditures			Change From 2008-09	
	Actual 2007-08	Estimated 2008-09	Proposed 2009-10	Amount	Percent
Local Assistance					
Benefits (medical services)	$13,167	$13,524	$13,976	$452	3.3%
County Administration (eligibility processing)	781	782	806	24	3.1
Fiscal Intermediary (claims processing)	92	108	102	-6	-5.3
Totals, Local Assistance	**$14,040**	**$14,414**	**$14,884**	**$470**	**3.3%**
Support (State Operations)	**$128**	**$125**	**$127**	**$2**	**1.6%**
Caseload (Thousands)	**6,650**	**6,798**	**6,673**	**-125**	**-1.8**

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

day programs, and residential care provided by community care facilities. The department contracts with RCs to provide services to more than 230,000 clients each year.

Developmental Centers (DC) Program (DDS). The department operates five DCs, and two smaller leased facilities, which provide 24-hour care and supervision to approximately 2,400 clients. All of the facilities provide residential and day programs as well as health care and assistance with daily activities, training, education, and employment. About 6,900 permanent and temporary staff serve the current population of about 2,400 clients at all seven facilities. We note that Agnews DC is slated for closure in the current year and, at the time this analysis was prepared, only 64 clients remained there.

Community Services (DMH). Community mental health services include a variety of programs administered by DMH, generally through state-county partnerships. Based on total expenditures, the four biggest programs are services funded by the Mental Health Services Act (MHSA); Early and Periodic Screening, Diagnosis, and Treatment (EPSDT); Mental Health Managed Care (MHMC); and AB 3632 Special Education Pupils. Generally, the services provided by theses programs are intended to help improve the health and functionality of individuals with mental illness while also minimizing their potential for disability, homelessness, criminal activity, and hospitalization. Specifically:

- The MHSA, passed by voters in 2004, imposes a 1 percent income tax on personal incomes in excess of $1 million to support the expansion of community mental health services. Most MHSA services are provided by the counties, although some MHSA activities are coordinated by DMH at the statewide level.
- The MHMC program provides specialty mental health services to Medi-Cal eligible adults through county Mental Health Plans which are "carved out" of regular Medi-Cal services.
- The EPSDT, a federally mandated program, requires states to provide a broad range of screening, diagnosis, and medically necessary treatment services to Medi-Cal beneficiaries under age 21 even if these services are optional under the state's Medicaid plan.
- Chapter 1747, Statutes of 1984 (AB 3632, W. Brown), and related statutes established the Special Education Pupils Program, also known as the "AB 3632" program, and shifted the responsibility for providing special education related mental health services from local education agencies to counties.

State Hospitals/Long-Term Care Services (DMH). The DMH administers the Long-Term Care Services Program, which includes the state's five mental hospitals, the Forensic Conditional Release Program, and the Sex Offender Commitment Program. The state's mental hospitals provide inpatient treatment services for judicially and civilly committed clients, mentally disabled county clients, and transfers from the California Department of Corrections and Rehabilitation (CDCR). In addition, the Long-Term Care Services Program manages state prison psychiatric treatment services at the California Medical Facility at Vacaville and at 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.

Healthy Families Program (HFP), (Managed Risk Medical Insurance Board [MRMIB]). The HFP was created in 1997, with funding provided under the federal SCHIP. Under SCHIP, California receives roughly two federal dollars for each state dollar used to provide health care coverage to children through HFP. Currently, over 900,000 children receive comprehensive health care—including dental, vision, and basic mental health benefits—through HFP.

The program allows low-income families to purchase subsidized health insurance for uninsured children. Specifically, children (ages 1 to19) in families making up to 250 percent of the FPL and infants (up to age 1) in families making up to 300 percent of the FPL are eligible for coverage through HFP. Eligible families pay monthly premiums based on their income, which range from $4 to $17 per child, up to a family maximum of $51 per family.

Caseload Trends and Cost Drivers For the Major Programs

As noted before, General Fund spending for major health programs grew at an average annual rate of 6.9 percent between 2001-02 and 2008-09. Much of the increase in General Fund expenditures has been driven by increases in caseload, costs, and utilization of services in Medi-Cal. In addition, increased expenditures for prescription drugs, hospitalization, and long-term care for the aged and disabled have been significant health cost drivers. Growth in caseload, and increased utilization and costs for services for persons with developmental disabilities has also contributed significantly to the increase in General Fund spending for health services. Similarly, the costs of operating state mental hospitals have more than doubled between 2001-02 and 2008-09 due in part to the opening of a new state hospital at Coalinga and enhanced staffing ratios that were implemented to address issues raised by the U.S. Department of Justice (U.S. DOJ) under the Civil Rights of Institutionalized Persons Act (CRIPA).

Major Budget Changes

Some Major Budget Proposals Are Continued. The budget plan reintroduces the major cost-reduction proposals that the administration put forward in the special sessions of the Legislature called in November and December 2008. These proposals include the following:

- ***Eliminate Medi-Cal Optional Benefits.*** Eliminate certain Medi-Cal optional benefits including dental, optometry, and psychology to achieve General Fund savings of $19.7 million in the current year and $129.4 million in the budget year.

- ***Implement Month-to-Month Eligibility for Undocumented Immigrants.*** Shift undocumented immigrants from annual to month-to-month Medi-Cal eligibility for General Fund savings of $4.8 million in the current year and $71.2 million in the budget year.

- ***Reduce Eligibility for the 1931(b) Program.*** Reduce income eligibility and modify eligibility for two-parent families for the Medi-Cal 1931(b) program for General Fund savings of $2.6 million in the current year and $88.6 million in the budget year.

- ***Shift Safety Net Care Pool Funding.*** Reduce reimbursement rates for public hospitals by $54.2 million in federal funds and instead use these federal funds to pay for certain health programs currently supported from the General Fund.

- ***Impose Share of Cost for Aged, Blind, and Disabled Individuals.*** Impose a share-of-cost requirement on certain aged, blind, and disabled Medi-Cal recipients for General Fund savings of $14.3 million in the current year and $185.8 million in the budget year.

- ***Limit Benefits for Certain Immigrants.*** Limit benefits to newly qualified immigrants and immigrants who permanently reside in the United States under the color of law to the same level as currently provided for undocumented immigrants, for General Fund savings of $9.4 million in the current year and $139.9 million in the budget year.

- ***Impose 3 Percent Reduction on RC Programs.*** Implement a 3 percent discount of payments made to RC service providers and RC operations, for General Fund savings of $24.6 million in the current year and $60.2 million in the budget year.

Budget Contains Major New Proposals. In addition to the above major cost-reduction proposals, the Governor's January budget proposal includes the following additional major cost-reduction proposals:

- ***Fund MHMC With Proposition 63 Monies.*** The budget plan proposes to use almost $227 million of Proposition 63 monies to pay for MHMC in lieu of General Fund. Under Proposition 63, revenues are to be used to create *new* community mental health programs and to *expand* some existing programs. Due to Proposition 63's non-supplantation requirements, voter approval would be required in order to implement this proposal.

- ***Establish Savings Target for RCs.*** The budget plan establishes a budget-year savings target of $334 million General Fund for RCs. According to the administration, DDS will work with the Legislature and stakeholders in the coming months to achieve $334 million in savings while ensuring RC program and service integrity are maintained. At the time this analysis was prepared, no specifics were available on how the savings would be achieved.

- ***Increase Alcohol Excise Tax to Fund Alcohol and Drug Programs.*** The budget plan proposes to raise the excise tax on each type of alcohol by a "nickel-a-drink" to generate an estimated $585 million annually in new revenues. These new revenues would be deposited in a

new special fund called the Drug and Alcohol Prevention and Treatment Fund (DAPTF). Of the $585 million in new revenues, $312 million would support alcohol and drug programs in the Department of Alcohol and Drug Programs (DADP), $54 million would support such programs in the Department of Social Services (DSS), and $220 million would support such programs in CDCR. All of these programs are currently paid for from the General Fund.

- ***Delay Payment to Medi-Cal Providers.*** The budget plan proposes to delay payments to Medi-Cal providers at the end of the current year for a one-time General Fund savings of $85.5 million. The state generally makes weekly payments to Medi-Cal fee-for-service (FFS) providers to reimburse them for the claims they have submitted. The providers would receive a payment in the budget year that was due to them in the current year. This proposal is in addition to previously authorized delays.

- ***Suspend Cost-of-Living Adjustment (COLA) for County Administration.*** The budget plan proposes to suspend the statutory COLA for county administration in the Medi-Cal Program, for General Fund savings of $24.7 million in the budget year.

Overall Impact of Budget Plan on Health Programs. As described above, the budget proposes a negligible year-over-year General Fund spending increase for health programs in 2009-10. The administration's plan holds General Fund spending virtually flat using two basic approaches:

- First, the budget plan proposes reductions to control expenditures that are generally caused by caseload, cost, and utilization growth. For example, the administration proposes to reduce: (1) *caseload* by tightening eligibility requirements for the 1931(b) program, (2) *costs* by imposing a 3 percent discount of payments made to RC operations and certain services, and (3) *utilization* by limiting the benefits received by certain immigrants.

- Second, the administration proposes alternative funding sources for certain programs. For example, the administration proposes to fund DADP with new revenues from an increase in the alcohol excise tax, which would be routed into a new special fund for drug programs. Another example of this approach is the administration's proposal to fund the MHMC program with Proposition 63 funds instead of General Fund.

The overall budget-year impact of the spending plan on health programs would be to appreciably reduce services for Medi-Cal beneficiaries, RC clients, and some other programs. However, there would likely be little or no reduction in services for other health programs, such as HFP administered by MRMIB and the Drug Medi-Cal Program administered by DADP.

BALANCING THE 2009-10 BUDGET

DHCS—Federal Economic Stimulus Package: Implications for Medi-Cal

The federal government is currently developing legislative proposals to help state governments balance their budgets. The U.S. Senate and the House of Representatives have each proposed fiscal assistance packages that would channel substantial federal funds to states through a variety of existing and newly authorized federal programs. The House passed its proposal on January 28, 2009. The Senate had not yet passed its version of the stimulus package at the time this report was prepared.

California stands to gain substantially under either proposal, with significant federal assistance available through the Medicaid program (known as Medi-Cal in California) and other health-related programs. The largest portion of additional funding by far would come in the form of an increased federal share of costs for Medi-Cal. Other significant components would provide new options to states to provide Medicaid coverage for the unemployed, expand transitional coverage, and finance an investment in state health information technology systems.

At the time this analysis was prepared, we were continuing to examine additional provisions of the evolving federal economic stimulus package that could have important ramifications for California. Below, we summarize the key Medicaid components of the proposed congressional packages that we have identified so far and discuss their implications for California.

Increased Federal Share of Support for Medi-Cal

Federal Funds Currently Share a Portion of Medicaid Costs. The federal government provides a share of the cost of each state's Medicaid program. The percentage of program costs funded with federal funds is known as the federal medical assistance percentage (FMAP), and is determined annually by a federal statutory formula that compares the state's average income to the national average income. The Medi-Cal Program currently receives the 50 percent minimum FMAP for most services, meaning that the program generally receives one dollar of federal funds for each state dollar it spends on those services.

No state receives less than a 50 percent FMAP, which is only available for services and enrollee groups that are required or optional under federal law. States also may expand their Medicaid programs beyond these federally approved levels, but FMAP is not available for costs related to those services. The federal government also offers an "enhanced FMAP" for certain program costs, such as groups with particular medical conditions or the implementation of information technology systems. For example, a program to provide certain breast and cervical cancer treatment for eligible low-income women receives roughly two federal dollars in support for each dollar of state funds. In addition, the state has delegated administrative responsibility for some portions of the Medi-Cal Program to local governments. In some of these cases, local governments provide a share of the nonfederal portion of the program costs.

Federal FMAP Enhancement Proposals. Both the House and the Senate proposals would provide federal funds to increase FMAP for all states. An increase to FMAP would shift a portion of the costs for states' existing programs to the federal government. Both of the proposals likely would result in billions of dollars in additional federal funds for California over a little more than two federal fiscal years and then cease. The increase in the federal share of cost for Medi-Cal would be retroactive back to last October, as the bills are now drafted, meaning that the state would benefit from significant federal fiscal relief in both the current state fiscal year and the budget year as well as into part of 2010-11. Local governments that share in a portion of Medi-Cal costs would also benefit.

Key provisions of these proposals (as of the dates indicated below) are summarized in Figure 5.

Implications for California. Under these provisions, according to some estimates, California state and local governments could potentially receive between roughly $9 billion and $11 billion through an increase in its FMAP through December 31, 2010. Based on recent employment data, the state likely would qualify for either the second-highest or highest bonus FMAP increase available under each of the two proposals.

However, based on our review of the proposed eligibility restrictions, the state would currently be ineligible for enhanced FMAP due to an eligibility procedure change the state enacted as part of the *2008-09 Budget Act*. This change required families to submit a status report on behalf of their children every six months to confirm their continuing eligibility for Medi-Cal. (The parents are already required to submit this report.) In order to receive the new federal funds, the state would need to reverse this policy prior to July 1, 2009. This reversal would result in additional costs to the state of $92 million General Fund in 2009-10 (as estimated at the current Medi-Cal FMAP rate of 50 percent).

In addition, the Governor's 2009-10 budget plan incorporates other proposed reductions in Medi-Cal Program eligibility rules that, if adopt-

Figure 5

Key Provisions of Proposals to Increase the Federal Medical Assistance Percentage (FMAP)

	House (As of 1-28-09)	Senate (As of 2-2-09)
Enhancement period	October 2008 to December 2010	Same as House
Base FMAP increase	4.9 percentage points	7.6 percentage points
Additional unemployment-related FMAP increase	Bonus increases of 3, 6, or 7 percentage points, depending on state quarterly unemployment rate changes since January 2006.	Bonus increases of roughly 1, 2, or 3 percentage points, depending on state quarterly unemployment rate changes since January 2006.
Eligibility restrictions	States must maintain eligibility provisions that were in place July 1, 2008.	Includes House restrictions. Also, eligibility expansions made after July 1, 2008 would not receive enhanced FMAP.
Other restrictions	Funds from increased FMAP cannot be placed in reserve funds.	Includes House restrictions. Additionally requires that states meet Medicaid requirements for "prompt payment" of providers.

ed, would achieve $324 million in General Fund savings in 2009-10. In particular, the budget proposes to:

- Lower the income eligibility level and restore stricter work limitations for certain parents.
- Reduce the income eligibility level for certain aged or disabled persons.
- Limit the eligibility of undocumented immigrants to the months in which they actually receive services.

The state would have to forego these reductions—at least for about two years—if it wished to qualify for the increased federal Medicaid funding.

New State Medicaid Options

In addition to the FMAP enhancement provisions, the House and Senate federal stimulus proposals would also establish certain new options for state Medicaid programs to expand coverage and benefits, or make other improvements to the health care system. Key provisions included in one or both proposals include:

- A Medicaid coverage option for certain unemployed persons, to be paid for entirely with federal funds. Only the House proposal includes this option.
- An extension of certain "transitional" Medicaid benefits.
- New options to provide funding and other oversight for expanded use of health information technology.

We discuss each of these proposals in more detail below.

New Medicaid Option for the Unemployed

Medicaid Eligibility Currently Limited to Certain Groups. Under current federal Medicaid rules, federal cost sharing is available for states to provide health coverage primarily for low-income families with children and the aged or disabled. Simply having a low income is insufficient for an adult to be eligible for the Medicaid program; a low-income adult must generally also be the caregiver for a child or have a disability to be enrolled. (Also, other elderly and disabled persons receive care under the federal Medicare Program.) States may provide Medicaid coverage to groups without these "linkages," but the federal government will generally not provide matching funds for those groups. States that wish to expand coverage to such groups must do so now entirely at their own expense.

New Options Proposed for the Unemployed. The House proposal would provide federal funds to pay 100 percent of the costs until December 31, 2010 for states that choose to provide Medicaid coverage to these new groups of adults:

- Adults who are receiving unemployment benefits or who exhausted their unemployment benefits.
- Adults who lose their jobs and have family incomes of no more than 200 percent of the FPL.
- Adults who lose their jobs and whose family participates in the federal food stamp program (see the *2009-10 Budget Analysis Series: Social Services* for a description of the food stamp program).

Implications for Medi-Cal. California currently does not offer Medi-Cal coverage to these groups proposed by the House. Persons in these categories now may be uninsured or may have health insurance through a spouse's employer. Also, counties have financial responsibility for providing care for indigent adults and children who do not qualify for Medi-Cal coverage, and some private medical providers offer charity care to persons who are ill and do not qualify for Medi-Cal assistance or other state health care programs. This proposal breaks new ground, in that it would potentially make a new publicly funded source of coverage available to this population at no cost to the state (or counties) over the short-term. However, under the current House proposal, the federal funding for this expansion of health coverage would terminate as of January 1, 2011.

Transitional Medi-Cal

Current federal law requires states to provide a transitional Medicaid benefit to assist families who increase employment income while receiving Medicaid coverage. Under this benefit, families enrolled in Medicaid for a certain minimum period, and who increase their earnings beyond the income ceiling that would otherwise make them ineligible for coverage, can retain their coverage for an initial six-month period. States must also offer these families a second six-month period of coverage, but may charge premiums or limit the benefits available during the second six months.

Under the House and Senate proposals, effective July 1, 2009, states could elect to (1) extend the initial six-month transition coverage to 12 months, instead of providing extensions of coverage in six-month increments, and (2) waive the minimum enrollment period now needed to qualify for transitional coverage. The transitional benefit would end December 31, 2010.

Implications for California. In Medi-Cal, about 148,000 enrollees currently receive transitional coverage. We estimate that the state would incur General Fund costs in the tens of millions of dollars annually (assuming the standard 50 percent FMAP) to extend the initial six-month coverage period for an additional six months. It is unclear how many additional enrollees would be newly eligible for transitional Medi-Cal if the state were to waive the minimum enrollment period now in place. This further modification of program rules would result in unknown additional state costs for these benefits.

Health Information Technology

Background. Health information technology (HIT) refers to a variety of information-sharing technologies and processes related to the electronic generation, storage, and sharing of health information among health care providers and patients. Please refer to our February 2007 report entitled, *A State Policy Approach: Promoting Health Information Technology in California*, for a more detailed discussion of HIT and its potential benefits.

The federal government currently provides some policy oversight and funding to promote the adoption of HIT in the U.S. health care system. In California, the California Office of Health Information Integrity, within the state Health and Human Services Agency, has recently expanded its involvement in coordinating HIT privacy policies and convening stakeholder working groups to integrate the use of HIT into the California health care systems. Various private organizations and local governments in California also

provide some funding or coordination for various HIT efforts.

Proposed HIT Provisions. Both the House and Senate proposals would establish various policies intended to promote and coordinate the adoption of HIT. These provisions include increased oversight of technology standards and health information privacy, as well as several types of funding assistance. Funding provisions include paying for a portion of the costs for qualifying Medicaid providers, such as physicians and children's hospitals, to implement and administer HIT. To qualify for the funds, providers would need to serve specified minimum percentages of Medicaid patients and use technologies that meet certain standards. In both the House and Senate proposals, the state would need to administer a HIT oversight program to ensure that providers who receive the federal funds adhere to the proposals' specified criteria.

The proposals pending in Congress also would establish various HIT programs not directly linked to Medicaid, including grants and other financial and technical assistance to be distributed through states, as well as financial incentives for health care providers in the federal Medicare Program. These programs require varying levels of nonfederal funding to draw down this federal assistance—in some cases as little as $1 of nonfederal funding for every $10 received from the federal government. For example, proposed grants to states to develop loan programs for the adoption of electronic health records would require $1 in nonfederal funding for each $5 in federal funds. These nonfederal shares could be provided by states or potentially by local governments or private entities.

Implications for California. Increasing the adoption of HIT among health care providers in California holds the potential to reduce the costs and increase the quality of health care in the future through such systemic improvements as reducing the number of unnecessary medical tests and procedures, decreasing the number of costly medical errors, and streamlining health care administration. Improvements throughout the health care delivery system are also likely to reduce costs, or at least their growth, in Medi-Cal and other state-administered health care programs such as HFP. It is unclear at this time what portion of funding proposed by the House and the Senate would be allocated to California, or what funds the state or other nonfederal sources might need to provide in order to participate in the proposed programs.

Federal Medicaid Funds Available for Budget Savings

State Budget Situation Remains Fragile. As we described in our recent publication regarding the state budget (see the *2009-10 Budget Analysis Series: Overview of the Governor's Budget*), the state faces severe fiscal problems due to an ongoing gap between state revenues and program expenditures and the severe economic downturn. Additionally, the 2008-09 Medi-Cal budget is itself subject to considerable uncertainty, with potential increases in General Fund costs in the low hundreds of millions of dollars if, for example, the rough economic conditions add to Medi-Cal caseloads.

Federal Medicaid Funds Free Up State General Fund. The additional Medicaid funds proposed by the House and the Senate do not include requirements that states maintain current levels of state funding support for their Medicaid programs. As such, the additional FMAP funds that the state would receive for Medi-Cal could

be used to reduce state General Fund support for the program. In effect, this would permit a temporary shift of General Fund resources currently used for Medi-Cal to support other state programs and achieve at least a short-term state budget solution for a couple of years.

Legislature Should Be Cautious About Eligibility Expansions

Eligibility Expansions Could Result in Ongoing Cost Increases. The Medi-Cal options included in the House and Senate bills described above could be of great benefit to individuals and families in California who lack health coverage or are at risk of losing their health benefits due to severe economic problems. However, the options to expand eligibility also pose a significant financial risk to the state at a time when it is likely to continue to have a sizable and ongoing structural budget deficit.

First, some of the options made available to states under the proposals now pending in Congress, such as expanding transitional Medicaid coverage, would require the state to commit additional state matching funds to draw down additional federal assistance at a time when the budget is already facing a severe deficit. Moreover, some aspects of the pending federal legislation, such the 100 percent federal funding to expand eligibility for such new groups as unemployed adults, would expire in about two years, as the bills are now drafted. If the state were to continue coverage for these groups after federal support for these program expansions runs out, the state would need to augment General Fund spending considerably during the second half of the 2010-11 fiscal year and thereafter. Thus, this short-term federal assistance could actually aggravate the state's fiscal problems in the longer run.

Accordingly, we would caution the Legislature about expanding the Medi-Cal Program in the ways proposed by the federal economic stimulus bills. At the very least, any change in state law to incorporate the federally authorized expansion of services now contemplated by Congress should specify that the expansions of eligibility will cease when the additional federal funding to support them runs out.

HIT Provisions Provide Potential Opportunity. As noted above, both the House and Senate proposals offer opportunities to leverage federal funding for HIT improvements with relatively small contributions of state or other nonfederal sources of funding. The proposals also would allow non-state entities to contribute the requisite matching funds on behalf of the state. Given the potential opportunity to improve services for state health program beneficiaries and to substantially reduce state administrative costs for these programs in the long term, we recommend that the state seek to identify non-state sources of funding from private health care foundations or provider organizations in order to participate in the proposed HIT programs to the extent possible. The Office of Health Information Integrity should be directed to take the lead in these efforts.

DHCS—Nursing Home Fee Program Should Be Revised

The Legislature enacted the Medi-Cal Long Term Care Reimbursement Act (hereinafter referred to as the "act"), as Chapter 875, Statutes of 2004 (AB 1629, Frommer), with the intent of devising a Medi-Cal long-term care rate-setting methodology that (1) effectively ensures individual access to long-term care services such as skilled nursing facilities (SNFs) and (2) promotes quality resident care. The act also established

what is termed a quality assurance fee (QAF) that some long-term care providers must pay to the state. The rate-setting methodology and other provisions of the act were to have automatically expired on July 31, 2008, but Chapter 758, Statutes of 2008 (AB 1183, Committee on Budget), extended the so-called "sunset" provision until July 31, 2011.

In this analysis, we provide an overview of the act and how it works, assess its financial effect on the General Fund, discuss problems the state has experienced in collecting QAFs, and recommend steps to address these concerns.

Act Increases Reimbursements for SNFs. The state has about 1,200 long-term care facilities, of which about 1,000 are SNFs, which provide medical, rehabilitative, and skilled nursing care for those who cannot receive such care in a home setting. The act institutes a facility-specific, cost-based, rate-setting methodology for specified classes of SNFs. The new rate-setting methodology replaces a methodology that based rates on average facility costs in geographic regions. The new methodology reimburses facilities for investments they have made in staffing and provides compensation for administrative and capital costs. While, as noted above, the rates set for SNFs are specific to individual facilities, an annual cap limits the amount that rates can be increased on average for all SNFs. Subsequent legislation has adjusted these caps, with the current cap on the average annual rate increase set at 5 percent.

Most California SNFs participating in the Medi-Cal Program are financially better off because of these changes. Under this new rate-setting methodology, between 2005-06 and 2007-08, nursing home rates increased from an average of $142.11 per patient day to $152.48 per patient day, or at an annual average rate of 3.6 percent. In comparison, during this same time period, most other classes of Medi-Cal providers did not receive any rate increases.

Fee Revenues Offset General Fund Costs of Rate Increase. The act imposed a QAF on providers that is intended to offset the General Fund cost increases resulting from the new rate-setting methodology. Federal regulations limit the amount states can charge providers as a QAF to 5.5 percent of a provider's gross revenues (as defined by federal Medicaid program authorities). This fee mechanism works to benefit the state General Fund.

How QAFs Work. Federal Medicaid law permits states to impose fees on certain health care service providers and in turn repay the providers through increased reimbursements. Because the costs of Medicaid reimbursements to health care providers are split between states and the federal government, this arrangement provides a mechanism by which states can draw down additional federal funds for support of their Medicaid programs. (In California, the Medicaid program is known as Medi-Cal.) These funds can then be used to offset state costs. Our *Analysis of the 2004-05 Budget Bill* (page C-52) provides a more detailed description of how such a fee mechanism works.

Under federal law, *all* the providers in a provider class such as SNFs must pay a QAF. Therefore, the QAF must be paid by all SNFs, regardless of whether they benefit from a higher Medi-Cal rate. For more on the different SNF revenue sources, see the nearby box.

The DHCS, which administers Medi-Cal, calculates each facility's QAF using a projection of what the facility's net revenue will be for the annual period beginning August 1 of each year.

Each facility must pay 6 percent of their projected net private-pay and Medi-Cal revenue as a QAF. (California excludes Medicare revenues from the fee calculation, which, in part, makes it possible for the fees to remain under the 5.5 percent federal cap mentioned above.) The cost

Skilled Nursing Facility Revenues

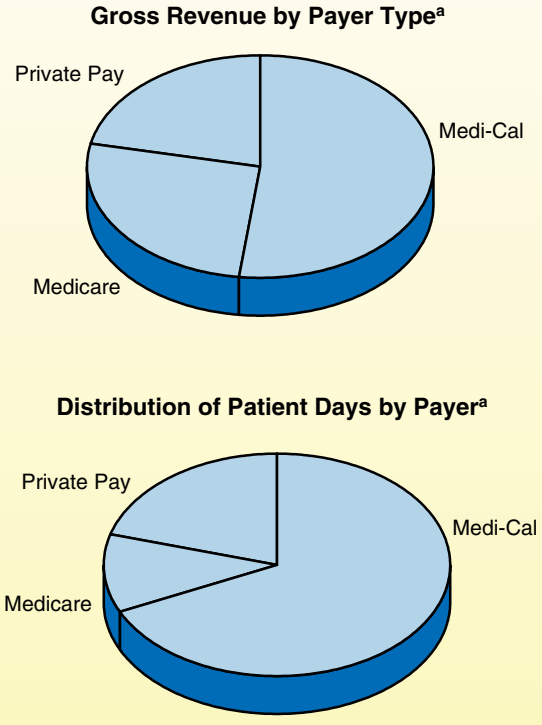
These facilities receive revenues from three main sources:

- ***Medi-Cal:*** Medi-Cal pays for the majority of nursing home days in California. These residents must meet Medi-Cal eligibility requirements.
- ***Medicare:*** Medicare is a federal health insurance program that provides coverage to eligible beneficiaries at federal expense. However, Medicare provides only a limited nursing home benefit for beneficiaries recovering from a hospital stay. In addition, Medicare generally only pays for 100 days of nursing home care per beneficiary per year.
- ***Private-pay:*** Some private-pay nursing home residents pay for care out of their own pocket. Other private-pay residents have their care paid for through long-term care insurance or their existing health care insurance policies.

We display skilled nursing facility revenue and the distribution of patient days in Figure 6.

Figure 6

Skilled Nursing Facility Revenue and Patient Days Distribution



[a]Data is from Office of Statewide Health Planning and Development.

of each facility's QAF is then reimbursed to the facility in the form of a higher Medi-Cal rate. Facilities with a high percentage of Medi-Cal beds, therefore, generally experience net gains after paying the QAF.

However, the fee does create "winners" and "losers" within the SNF industry depending on the percentage of Medi-Cal beds that a provider operates. For example, a SNF that dedicates 100 percent of its beds to Medi-Cal beneficiaries receives a rate increase for all of its beds. In contrast, a SNF that only serves private-pay and Medicare clients does not receive any rate increase but is still subject to paying the fee.

Nursing Home QAF Interacts With Licensing and Certification Fees. The Licensing and Certification program, located in the Department of Public Health (DPH), is responsible for ensuring that health care facilities comply with state and federal laws and regulations. This program is almost entirely funded through fees imposed on the regulated facilities. The fees used to fund this program count towards the 5.5 percent federal cap. Currently, the total combined amount collected under the QAF and by the Licensing and Certification program does not reach the federal cap.

What Financial Effect Has the Act Had on the General Fund?

Below, we examine the act's effect on the General Fund and also examine ways in which the original legislation might be amended to better benefit the General Fund.

General Fund Will Benefit Less in Future Years. The rate-setting methodology adopted under the act has resulted in increased rates for SNFs and, therefore, additional state costs. At present, these increased state costs are being more than offset by QAF revenues. However, the General Fund offset provided by the fees is likely to erode over time. This is primarily because the revenues upon which the QAF is based grow at a slower pace than the costs of the projected rate increases permitted under the act. Under the long-term care rate-setting methodology, the costs experienced by nursing homes are the basis for their annual rate increases. Our analysis indicates that, in the future, revenue generated by QAF will not be enough to offset the higher General Fund costs associated with the rate increases that have resulted from the new rate-setting methodology. The current provisions of the act, if not changed by the Legislature, could result in a net loss to the General Fund, potentially in the low tens of millions of dollars annually, beginning in 2010-11.

Some Revenue Is Exempted From the QAF. As noted earlier, DHCS exempts a SNF's Medicare revenue from their calculation of net revenue, which lowers the total amount of QAF collected. This arrangement benefits facilities that have a high proportion of patients that are paid for through Medicare because these facilities pay a smaller QAF. This exclusion of Medicare revenue from the state's calculation of net revenue reduces the QAF revenues significantly. Based upon projections of Medicare revenue for the 2008-09 budget year, the state is foregoing imposing a QAF on approximately $1.7 billion dollars of revenue. This exclusion of Medicare revenues is costing the state approximately $26 million General Fund in the budget year.

Some Facilities Fail to Pay the QAF

Despite the exclusion of Medicare revenue from the QAF, about 10 percent of facilities had initially failed to pay the fees they owed for 2006-07. (This percentage is likely to drop as fur-

ther collections occur.) The SNFs that are delinquent in paying the fees are generally those with patient populations that are mostly Medicare or private-pay patients. In large part, this is because these facilities benefit little from the higher Medi-Cal reimbursement rate, since they likely are taking few, if any, patients with Medi-Cal.

At the time this analysis was prepared, facilities collectively owed over $71 million to the General Fund for the two-year period ending with 2006-07. Although repayment agreements have been reached to recover part of these monies, no repayment agreement is in effect for almost $30 million of the delinquent amounts. A larger amount ($100 million) is still owed for fiscal year 2007-08, but according to DHCS much of this amount has only recently become due and thus is likely to eventually be paid by SNFs.

DHCS Has Three Options to Address Nonpayment. The DHCS has some recourse under current law if the operator of a facility chooses not to pay the QAF. If a facility with Medi-Cal beds does not pay the fine, DHCS can institute a payment withhold from future Medi-Cal payments to collect the amount owed. However, this approach does not work with facilities that do not have Medi-Cal beds.

In these cases, DHCS can institute a financial penalty for late payment or nonpayment of the QAF. The act mandates that the fine be equal to 50 percent of a facility's unpaid fee. At the time this analysis was prepared, DHCS had not imposed such a fine upon any facilities, although it has notified some facilities that they may find themselves subject to a fine if they continue nonpayment.

The fine structure is problematic for the following reasons:

- If the fine amount is large, it could affect the facility's cash flow to the extent that it impairs the facility's ability to operate, potentially putting at risk the health care of the residents.
- The imposition of a large fine may discourage a facility from accepting Medi-Cal patients because, if it later did so, DHCS would likely withhold payments in order to recover the fees that were owed. This would be contrary to the state's long-term interest in having a large number of providers willing to accept Medi-Cal patients.

As a last recourse, DHCS can work with the DPH's Licensing and Certification division to revoke or delay issuance of the renewal of a facility's license. At the time this analysis was prepared, no facility had lost its license or had the renewal of its license delayed because of failure to pay the QAF. The DPH has indicated its reluctance to revoke or delay renewal of a facility's license as a punitive measure on the grounds that such a revocation may create instability in the nursing home industry. According to DPH, the expenses and disruption of service involved with a facility's loss of license often means a facility will close and be unable to reopen.

Analyst Recommendations: Expand Fee and Adopt More Effective Enforcement Mechanisms

Realign Rates and QAF to Ensure Continued Cost Avoidance. When the rate-setting methodology and the QAF sunset at the end of 2010-11, we recommend that the Legislature reexamine the provisions of the act and its costs and benefit to the General Fund. At that time, the Legislature should specifically consider whether QAF

revenues remain sufficient to offset General Fund costs that are driven by the rate-setting mechanism established under the act. The Legislature should also consider at that time whether the various provisions of the act have continued to meet its original legislative intent.

Restructure Waiver Agreement to Include Medicare Revenue. We recommend that DHCS be directed to include Medicare revenue in its calculation of revenues owed under the QAF. This would potentially result in a $26 million per year benefit to the state General Fund.

Create a More Effective Enforcement Mechanism to Collect Overdue Fees. We recommend that the Legislature amend the act to provide more effective enforcement mechanisms for nonpayment of the QAF. Specifically, we recommend that the Legislature create a sliding-scale of fines in lieu of the currently required fine of 50 percent of the amounts owed. Initially imposing a more modest fine, perhaps 10 percent of the amount owed, and escalating the fine over time as the QAF remained unpaid, would probably result in a more effective enforcement mechanism that resulted in timely payments of these fees. The fiscal effect of our proposed change in collection enforcement procedures is unknown. If it resulted in a 10 percent increase in revenues, as much as $10 million in additional fees would be collected annually.

DHCS—IHSS Fraud Investigation

Background. The In-Home Supportive Services (IHSS) program provides in-home care to persons who cannot safely remain in their homes without assistance. The program is administered mainly by DSS. However, the Medi-Cal Program, administered by DHCS, has responsibility for investigating fraud within the IHSS program. The DHCS currently has two fraud investigators assigned to the IHSS program, which has a caseload of 456,000 persons.

Budget Proposal. The DHCS has indicated that its two investigators are unable to meet the growing workload associated with suspected fraud, and that the department currently has a backlog of approximately 400 cases that warrant investigation. On this basis, DHCS has requested six positions and $362,000 ($181,000 General Fund) to augment fraud investigation for the IHSS program.

We believe that the additional fraud positions may be warranted. However, we note that current IHSS policies regarding the receipt of provider time cards hamper the effectiveness of the fraud investigators. We believe that better controls over the time cards are needed in order for the positions to be used effectively. We discuss these policies and reforms the Legislature could take to increase accountability in our *2009-10 Budget Analysis Series: Social Services* document, in a report entitled "IHSS Time Card Reforms."

LAO Recommendation. We recommend that the requested positions be approved by the Legislature only if the additional resources are provided alongside legislation to reform current IHSS time card practices. The combination of these actions would increase program oversight and accountability.

DHCS—Technical Change to County Administration Funding

Background. The state delegates various administrative functions, including intake and eligibility determinations of new Medi-Cal applicants, to counties. The state reimburses the counties for the administration of this task based on expected county workload and costs.

Governor's Budget Proposal. The budget

plan proposes $19.6 million General Fund in the current year and $28.7 million in the budget year to pay county administration costs associated with eligibility determinations for new Medi-Cal applicants. However, both the current-year and budget-year proposals underfund county administration in that they do not accurately reflect upwards adjustments that DHCS made to its caseload growth projections due to the continued economic downturn. As such, the Governor's proposal technically underfunds the county administration function by $1.3 million General Fund in the current year and $3.5 million in the budget year. Figure 7 below provides detailed information on proposed county administration funding for new eligibles.

We also note that the Governor's budget plan achieves $24.7 million in General Fund savings on county administration of the Medi-Cal Program by suspending a statutory COLA. We believe it is reasonable to expect counties to take actions to constrain increases in their operating costs at a time when the economy and state finances are struggling.

However, we believe a different approach is warranted for budgeting for administrative costs directly related to changes in the Medi-Cal caseload. This additional caseload-driven funding would help to ensure that some key county activities, such as screening and removing ineligible persons from the Medi-Cal caseload, are conducted on a timely basis. Delays by counties in undertaking these activities could result in additional state caseload costs for ineligible persons amounting to the tens of millions of dollars or more annually.

LAO Recommendation. We recommend that the Legislature concur in the budget proposal to forego the COLA for counties, but recommend that the Legislature increase the county administration budget by $3.5 million General Fund in the budget year to account for increased workload due to expected caseload growth.

DPH—AIDS Drug Assistance Program (ADAP) Growing Rapidly

The Governor's spending plan proposes $418 million from all fund sources for the support of ADAP, an increase of almost $56 million or 15 percent over adjusted current-year expenditures. This augmentation is proposed to fund projected caseload and other increases in program costs. Under the budget plan, General Fund spending would remain flat at $96.3 million in both the current year and budget year. Monies from the ADAP Rebate Fund would be used to increase spending by $30.1 million in the current year and $86.1 million in the budget year over the spending level approved in the *2008-09 Budget Act*. According

Figure 7

County Funding for Medi-Cal Eligibility Determinations

(Dollars in Thousands)

	2008-09		2009-10	
Caseload	New Eligibles	Funding	New Eligibles	Funding
Funded	128,788	$19,576	189,142	$28,750
Unfunded	8,351	1,269	22,911	3,482
Totals	**137,139**	**$20,845**	**212,053**	**$32,232**

to DPH, this projection represents the high end of the range of likely costs, and it is possible that actual costs will be lower.

The ADAP Rebate Fund, made up of rebates paid to the state by the manufacturers of the drugs provided to HIV/AIDS patients under the program, has a sufficient balance to fund the entire increase in projected program costs for 2009-10. We note that the administration projects that the balance in the ADAP Rebate Fund will drop from $80.3 million at the end of 2007-08 to $24 million by the end of 2009-10.

Low Fund Balance Will Increase Need for General Fund Support in Future Years. We find that using the proposed level of ADAP Rebate Fund monies for support of ADAP in the budget year will likely result in a very significant increase in General Fund support for ADAP in 2010-11 and beyond. The General Fund would have to backfill the reduced level of ADAP Rebate Funds available in future years, program costs would have to be reduced, or some combination of these actions would be needed.

As noted above, the requested increase in expenditure authority for the budget year is likely to be the worst-case scenario for the program. Due to drug price fluctuations, uncertainty regarding timing of costs associated with new drug therapies, and interactions with Medicare Part D, ADAP expenditures are difficult to predict with accuracy. Our analysis indicates that ADAP expenditures could be less than presented in the Governor's budget plan. For example, using an alternative estimation model, the DPH Office of AIDS projected ADAP costs at $32 million less than actually requested in the current year and $68 million less in the budget year. If this alternative estimate proved correct, General Fund support would not have to increase until 2011-12 as long as the overall growth in program costs was paid for using rebate funds.

However, even if actual costs in the budget year reflected this much more optimistic projection, our projection of out-year costs show that General Fund support would need to increase significantly beginning in 2011-12 to maintain current service levels. If program costs grew as quickly as projected by the Governor's budget, the General Fund support necessary to maintain current service levels could increase by $100 million as early as 2010-11. Aside from two years in which ADAP growth slowed because of the implementation of the new federal Medicare Part D drug benefit, costs in the ADAP program have been growing consistently at over 15 percent per year.

Cost-Cutting Actions Now Can Avert More Difficult Choices Later. In order to prevent the ADAP Rebate Fund balance from declining to the point where there are significant additional pressures on the state General Fund, we recommend that the Legislature begin to implement modest cost-cutting measures for ADAP in the budget year. This phased-in approach would preserve a larger balance in the ADAP Rebate Fund and decrease the need to make more severe reductions beginning in 2010-11. Other states with budget shortfalls in their ADAP programs have implemented such cost-cutting measures as capping client enrollment, eliminating drugs from formularies, modifying copayment requirements, and limiting per-patient expenditures.

Cost-cutting measures in ADAP would likely increase the barriers to receiving care for some patients, potentially impacting the health of HIV/AIDS patients and increasing the associated public health risks. It is also possible that additional federal aid could mitigate the future need for

program reductions. The Ryan White Care Act, which provides federal funding for ADAP, will likely be extended or reauthorized by September 2009. Since program growth in most states has been significant and federal funds have not increased commensurately in recent years, it is possible that federal support for these programs could increase.

Nevertheless, based on the information currently available, our analysis suggests that measures should be implemented now to control the growth of costs in this program and avert the need to take more drastic actions later. We find that a reasonable initial target level of reductions would be in the several millions to low tens of millions of dollars annually. This recommendation is based on the fiscal condition of the state without prejudice to the merits of ADAP. Updated information will be available at the May Revision about the caseload and cost trends for ADAP. We will provide a more specific recommendation at that time that takes this additional information into account.

DPH—Modifying Proposition 99: Options for Legislative Consideration

Background. In November 1988, the voters enacted Proposition 99, the Tobacco Tax and Health Protection Act of 1988, which established a surtax of 25 cents per pack on cigarettes and other tobacco products. In addition to payment of certain tax collection costs, Proposition 99 revenues are allocated to six separate accounts established by the measure as follows: (1) the Health Education Account (20 percent of revenues), (2) Hospital Services Account (35 percent), (3) Physician Services Account (10 percent), (4) Research Account (5 percent), (5) Public Resources Account (5 percent), and (6) Unallocated Account (25 percent). Under the terms of the initiative measure, the funds in the Proposition 99 accounts may only be used for the purposes described in the measure and can only be used to supplement existing levels of services.

Problems With Proposition 99. As we discussed in our *Analysis of the 2005-06 Budget Bill* (page C-129), the revenues collected under Proposition 99 have declined substantially since 1988, both in real terms due to inflation and due to a decrease in smoking. In inflation-adjusted dollars, the revenues available have dropped by 66 percent since 1989-90, and now amount to about $308 million for Proposition 99 programs. Pending federal legislation that would increase federal taxes on tobacco products by 61 cents as soon as April 2009 would further reduce consumption of tobacco products, resulting in a reduction in Proposition 99 revenues of about $20 million.

Dozens of different types of programs and services are still supported from the Proposition 99 special fund and its subaccounts. In effect, there are too few dollars to support so many programs from a funding source that is projected to continue to decline slowly in the future in nominal dollars and even more significantly in real terms.

We also concluded in our *Analysis of the 2005-06 Budget Bill* that Proposition 99 contains a number of provisions that limit the Legislature's flexibility in the expenditures of these revenues. In recent years, due to recurring state fiscal problems, the Legislature has taken some steps to prioritize the use of Proposition 99 funding and to achieve state General Fund savings. Some additional steps along these lines are possible under existing terms of the measure. However, the total savings that could be achieved by these actions

are limited by various restrictions written into the language of Proposition 99. These restrictions include the requirements for six separate accounts with distinct funding purposes, remaining limits (some have been lifted) on the use of Proposition 99 funds as a match to draw down additional federal resources, and prohibitions on the use of funding to pay for existing General Fund-supported programs.

Options to Unlock Proposition 99 Funding. In our recently published *Overview of the 2009-10 Governor's Budget*, we proposed that the Legislature address a very difficult budget shortfall in part by adopting an expanded package of ballot measures to increase state tax revenues, provide greater budgetary flexibility, and generate additional state savings. As the Legislature considers some specific proposals along these lines to unlock spending now earmarked for after-school and social services programs, it could also seek voter approval of changes to Proposition 99 that would give the Legislature greater flexibility in how it allocates these funds and permit the state to achieve significant General Fund savings. Specifically, the Legislature could seek approval for the following changes:

- ***Enable Proposition 99 to Provide Additional General Fund Relief.*** Current law requires all Proposition 99 funds to be used to supplement current services, thereby restricting funds from being used to supplant existing funding sources. Given the state's severe fiscal problems, this non-supplantation provision could be modified to allow Proposition 99 funds to be reprioritized to fund existing programs that are currently supported by the General Fund, and that the Legislature considers to be a high priority.

- ***Consolidate Six Accounts Into Two.*** The Legislature may wish to pursue consolidation of the six subaccounts into two—one that would fund tobacco control programs and the other that would fund health services programs in general. This option could preserve a specific level of funding for tobacco control programs, which evidence indicates have helped to reduce smoking by Californians, and allow the remainder of the funding to be used for a broad range of health programs. Under this approach, the separate health-related subaccounts would be abolished and folded into the main Health Services Account, and the Public Resources, Research, and Unallocated accounts would be eliminated. Under our concept, the new Tobacco Control account could be used to fund all tobacco-control related activities, including tobacco-related research currently funded through the Research account.

- ***Allow All Accounts to Draw Down Federal Funds.*** Provisions that restrict certain Proposition 99 accounts from drawing down federal funds reduce the state's ability to leverage state dollars. Removing these provisions and allowing all Proposition 99 funds to draw down federal funds would maximize the state's ability to leverage state dollars. (We note that the Legislature has already enacted legislation that allows the state to leverage federal funds in the Hospital Services, Physician Services, and Public Resources accounts.)

Budgetary Implications of This Option. We have proposed that a statewide ballot on budgetary ballot measures be submitted to voters in April. If the voters approved a measure enacting changes to Proposition 99, this decision could potentially come in time to permit the Legislature to modify the 2009-10 budget plan to conform to these changes. Under our approach, the restrictions on more than $200 million in Proposition 99 funds would be lifted and the Legislature would have additional flexibility to allocate these funds. Based on our review of these programs, we find that the state could achieve about $100 million in General Fund savings by redirecting some of these funds from current proposed uses to other health programs currently funded with General Fund dollars. The remaining funds would continue to be used for targeted tobacco control and health-related activities. In Figure 8, we summarize some programs currently funded under Proposition 99 that we believe could be considered for reductions or elimination in order to achieve this level of benefit to the General Fund.

There are several key aspects to such a strategy that the Legislature may wish to consider. The newly established Health Services Account would, under our approach, provide greater spending flexibility than the various health-related accounts it would replace. This means that the Legislature could devote these Proposition 99 funds to programs that it may deem a priority, such as HFP, while at the same time offsetting General Fund costs on such programs. If Propo-

Figure 8

Proposition 99 Funding Shift Option Could Reduce General Fund Costs in Budget Year

(In Millions)

Expenditure Category	Proposed Savings	Rationale for Reduction
County health programs/ Emergency Medical Services Appropriation (formerly California Healthcare for Indigents and Rural Health Services)	$25.6	Eliminates reimbursement for care of indigents (indigent care is a county responsibility under 1991 realignment).
Expanded access to primary care	13.9	Eliminates funding for clinic grant program that serves indigents (indigent care is a county responsibility under 1991 realignment).
Department of Education Tobacco Use Prevention and Education Program	22.1	Eliminates funding for school-based programs, which have not been proven effective at reducing smoking. Preserves limited funding for administration and implementation of pilot projects.
California Tobacco Control Program: Competitive grants	8.8	Reduces grants to non-profit and community-based organizations by half.
California Tobacco Control Program: TEROC/Evaluation and Surveillance	1.0	Reduces evaluation and surveillance activities by one-fourth.
Public resources programs	15.3	Eliminates Proposition 99 funding for a variety of resources programs. Parks operations funding loss could be offset with park fees.
University of California Tobacco-Related Disease Research Program	10.0	Preserves funding for California-specific and policy-related research and eliminates funding for general medical research.
Total	**$96.7**	

sition 99 special fund dollars were allocated to HFP, for example, the program could leverage federal matching funds on a two-to-one ratio.

In general, our proposal reduces support from Proposition 99 for health programs for indigents that are a county responsibility and prioritizes funding for the support of health programs that are an ongoing state responsibility. A 1991 state-local realignment provided counties with additional state tax revenues in trade for their assuming certain responsibilities, including indigent care. (We note that some of the specific reductions for health programs we have proposed could be restored in the future using funding from the more flexible Proposition 99 Health Services Account if the state's financial condition improved.)

In abolishing the Public Resource Account and redirecting its proceeds to other purposes, the Legislature may wish to backfill a small share of the Public Resources Account spending—probably a couple million dollars—from the General Fund to ensure the continuity of high-priority programs. This would reduce the net savings from this budget option. However, additional funding used for support of state parks could be offset with increases in park fees to allow General Fund savings.

Overall, our proposal, while focusing on short-term General Fund relief in the budget year, would remove constraints in order to allow the Legislature more flexibility to allocate state revenues to the highest-priority tobacco control and health programs over the longer term.

Priorities Should Be Established for Use of Tobacco Control Funding. As discussed above, we propose consolidating all tobacco control-related activities now funded under Proposition 99, including research activities, into a single Tobacco Control Account. In order to help address the state's General Fund problems in the budget year, this option would reduce the $105.3 million in funds now earmarked for these purposes to $63 million. We suggest that Legislature adopt the following approach for the allocation of funding for these efforts:

- ***Flexibility Important.*** Tobacco control funding should be flexible, with funding allocated to the combination of smoking cessation activities, prevention programs, media communication campaigns, research and evaluation, and administration that best allow the state to achieve its tobacco control goals.

- ***Look for Opportunities to Achieve State Savings.*** Explicit consideration should be given to programs that would be most likely to save money for the state, such as reducing its Medicaid program costs (the program is known as Medi-Cal in California). The Center for Disease Control estimates 14 percent of state Medicaid costs nationally are attributable to smoking. In addition, according to data from the 2007 California Health Interview Survey, a comparatively high rate of Medi-Cal recipients (17.6 percent) are smokers compared to persons not in Medi-Cal (12.6 percent).

- ***Focus Research on Determining What Works to Reduce Smoking.*** Tobacco-related research funded by the state should focus on applied science that can be used to evaluate and improve state tobacco control policy and program implementation.

- ***Use Evidence-Based Approach.*** Tobacco control strategies that have already been proven effective should be prioritized over other strategies. Funding for school-based programs, for example, should be limited to pilot programs until they can be implemented effectively, given a 2005-06 evaluation of school-based tobacco control programs that found no association between program implementation and smoking behavior.

HFP—Caseload Likely Understated For Current and Budget Year

The Governor's budget proposes a General Fund increase for HFP of $6.4 million, or 1.6 percent, over revised current-year spending levels. The caseload is projected to grow from the revised estimate of about 906,000 enrollees in the current year to about 942,000 enrollees in the budget year.

Budget Plan Probably Overestimates Impact of Premium Increase. Chapter 758, Statutes of 2008 (AB 1183, Committee on Budget) increased the premiums that certain subscribers to HFP pay in order to reduce state costs. The premium increase went into effect on February 1, 2009. The increase is likely to have some impact on enrollment, but our analysis indicates that the caseload projections may overstate this impact. For example, in the budget year, MRMIB estimates a 7 percent decrease in caseload among the 69 percent of total subscribers affected by the premium increases.

We are concerned that the caseload estimate may overstate the impact of the premium increases for the following reasons:

- Based on information provided by MRMIB, the estimated reduction is based on the premium increases proposed by the Governor for the 2008-09 budget, not on the smaller premium increases that were actually implemented by Chapter 758. The administration's premium increase(s) would have been significantly larger than the $2 to $3 per month increases for subscribers that were enacted.

- Analysis of the impact of premium increases on caseload in other states suggests that the effect of the California premium increases would likely be smaller than MRMIB projects.

- The HFP subscribers have the option of enrolling in a health plan designated as the "community provider plan" in each county. They receive a $3 discount on their monthly premiums if they do so. Although one-third of subscribers are already enrolled in community provider plans, subscribers who are not could choose to reduce their premiums by transitioning to these discounted plans. To the extent this occurred, it could further blunt the impact of the premium increases on caseload.

Effect of Rising Unemployment on Caseload Not Considered. The caseload estimate does not take into account the potential for increased enrollment due to a high and growing unemployment rate. The Kaiser Family Foundation recently estimated that for every 1 percent increase in the unemployment rate, the percentage of children enrolled in either Medicaid or SCHIP would rise 0.78 percent. California's unemployment rate

was under 5 percent as recently as 2006, but it is projected to reach 9.5 percent or higher in 2010. While we do not have a specific estimate of how rising unemployment will impact HFP at this time, we believe that it could lead to significant increases in caseload that have not yet been taken into account.

Conclusion. Based on the factors above, we believe that caseload for the current and budget years may be understated. However, at this time we are not recommending any specific adjustment. At the time of the May Revision, additional data on the effects of the premium increase, state economic conditions, and HFP caseload trends will be available, and we will update our recommendation based on information available at that time.

DDS—"Cost-Effective" Services Should Be Clearly Defined

Background

The Lanterman Developmental Disabilities Services Act and related laws (also known as the Lanterman Act) provide the statutory framework for operation of the state's community services program for the developmentally disabled. The term cost-effectiveness is used in the Lanterman Act related to the provision of services. For example, the Lanterman Act states that, among other service and support options, RCs shall consider the use of paid roommates or neighbors, personal assistance, technical and financial assistance, and all other service and support options which would result in greater self-sufficiency for the consumer and *cost-effectiveness* to the state.

Terms such as cost-effective are frequently defined in statute in order to clarify legislative intent. For example, the Lanterman Act includes definitions of many terms including "services and supports," and "planning teams." However, the term cost-effective is not defined in the Lanterman Act.

Generally, the dictionary definition of the term cost-effective is used to refer to an activity that (1) is productive relative to its cost, (2) returns a benefit that justifies the initial cost, (3) produces the most economical outcome, or (4) is the lowest-cost alternative means of achieving the same end result or objective.

Meaning of Cost-Effective Is Open to Interpretation

Because the term cost-effective is not defined in the Lanterman Act, its meaning with regards to the provision of services to the developmentally disabled has been open to interpretation.

In a December 2007 report titled *Controlling Regional Center Costs,* DDS identified various options for controlling costs in the RC system, including changes to define cost-effectiveness in the Lanterman Act. The department indicated that the lack of a statutory definition meant it was difficult for teams that plan services for developmentally disabled consumers to apply the cost-effectiveness requirement. The department found that defining the term would have several advantages, including:

- Significant cost savings on RC services.
- Statewide consistency in applying the cost-effectiveness principle to the provision of services.
- Clear guidance to administrative law judges who adjudicate and conduct fair hearings for cases involving disputes over the RC services that must be provided to consumers.

- ➢ Ensuring that teams which develop Individualized Placement Plans (IPPs) for consumers give due consideration to the cost of the services they include in the plans.

The DDS report also indicated that this option had some disadvantages, in that the statutory definition that was put in place could inadvertently undermine efforts to ensure that the individual needs of all consumers are met.

Defining the Term Clearly Would Help Ensure Efficient Use of Program Dollars

We recommend that the Legislature (1) define the term cost-effective with clear elements that generally require RCs to choose the least costly services that are appropriate for an RC consumer, (2) insert the term into additional key sections of the Lanterman Act, and (3) clarify how the requirements for providing cost-effectiveness are to be balanced with a consumer's preference in the services they receive.

Definition of Cost-Effective Should Contain Certain Elements. We believe the term cost-effective should be defined in the Lanterman Act in a way that is meaningful and ensures that it can be applied in a practical way to the decisions that RC staff must make about their purchase of services or supports needed to implement a consumer's IPP. We recommend that the definition clarify that cost-effective services and supports are those that are: (1) either evidence-based or consistent with the current standard of practice, (2) purchased at an economical rate or price, and/or (3) the least costly appropriate option that results in the desired measurable outcome for the consumer. Generally, a definition of cost-effective that contains the elements described above should require RCs to choose the least costly option when choosing between two or more appropriate options.

Cost-Effectiveness Requirement Should Be Applied More Broadly. We also recommend the term cost-effective be inserted into some additional key sections of the Lanterman Act. For example, the Legislature could modify a provision of the Lanterman Act that provides that persons with developmental disabilities and their families are to be assisted in securing services and supports which maximize opportunities and choices in living, working, learning, and recreating in the community. The language could be changed to ensure that *cost-effective* services and supports are to be provided for these purposes. Our review of the Lanterman Act indicates that there are other sections where the term cost-effective could be inserted to clarify legislative intent.

Clarify Relation Between Cost-Effectiveness and Consumer Preference. The Legislature should also clarify how a consumer's choices and preferences in their services are to be balanced against the requirement that cost-effective services be provided to them. State law should specify that when two equally cost-effective and appropriate services are available, consumer preference should generally be the deciding factor, but that the more cost-effective services must be the ones provided if the services preferred by a consumer are a less cost-effective alternative.

Savings Would Grow Over Time. In the report cited above, DDS estimated that codifying the definition of the term cost-effective in the Lanterman Act would result in General Fund savings of approximately $29 million annually. This estimate was based on the assumption that RC costs for purchases of services would be reduced by 1 percent. It would take about three years to implement such a change as new IPPs are devel-

oped for consumers. Accordingly, we estimate that the changes we propose would result in roughly $5 million in General Fund savings in the first year. These savings could grow to as much as the low tens of millions of dollars annually after three years of implementation.

DDS—Implement Regulations to Govern RC Expenditures

Background

Purchase of Services Fall Into Ten Major Categories. The purchase of services for consumers by RCs fall into ten major service categories: (1) community care facilities, (2) medical facilities, (3) day programs, (4) habilitation services, (5) transportation, (6) support services, (7) in-home respite, (8) out-of-home respite, (9) health care, and (10) miscellaneous services. Within the ten major service categories, about 190 different and more specific service expenditure codes are authorized by DDS and used by the RCs to classify purchase of service expenditures for entry into the central purchase of services database. The budget plan's proposed spending levels for the ten major service categories is shown below in Figure 9.

Some service categories consist of more service expenditure codes than others. For example, the transportation category is comprised of ten different service expenditure codes. The largest category by far in terms of number of service expenditure codes is miscellaneous services, which is comprised of about 100 different codes. This category includes client and parent behavior intervention training, socialization training program services, and specialized therapy services for children less than three.

The DDS periodically adds new service expenditure codes and deletes obsolete codes as necessary to ensure that RC purchases are properly reported. However, it sometimes creates the codes without establishing regulations to guide RCs in the use of the codes. These newly created service expenditure codes are broadly defined by the department. However, these definitions are generally not as restrictive in regards to what

Figure 9

Regional Center Purchase of Services by Service Category

(All Funds, In Millions)

Service Category	2008-09[a,b]	2009-10[a]	Difference	Percentage
Community care facilities	$787.0	$806.1	$19.1	2.4%
Day programs	782.6	864.9	82.3	10.5
Support services	629.0	722.4	93.4	14.8
Miscellaneous	**338.3**	**452.2**	**113.9**	**33.7**
In-home respite	233.0	264.4	31.4	13.5
Transportation	208.7	239.3	30.6	14.7
Habilitation services	148.9	146.6	(2.3)	-1.5
Health care	100.6	112.9	12.3	12.2
Out-of-home respite	57.7	63.4	5.7	9.9
Medical facilities	22.5	22.9	0.4	1.7
Subtotals	($2,521.4)	($2,889.1)	($367.7)	(14.6%)
Other adjustments[c]	$30.0	($35.9)	($66.0)	—
Totals With Adjustments	**$2,551.4**	**$2,853.1**	**$301.7**	**11.8%**

a Reflects Governor's midyear proposal for 2008-09 and the budget proposal for 2009-10, excluding the Governor's General Fund reduction of $334 million in 2009-10 as a savings target.

b Excludes 2008-09 reappropriation of $18.7 million for Agnews Developmental Center.

c Reflects budgetary and technical adjustments.

may be purchased as the codes that are under regulations. About 100 of the approximately 190 service expenditure codes are established in regulation. Most of the expenditure codes which lack regulations fall into the miscellaneous services category.

Extraordinary Growth in Miscellaneous Expenditures

The DDS estimate for community services projects that expenditures for the miscellaneous services category will grow from $338 million in the current year to $452 million in the budget year, or by about 34 percent. (We note that the Governor's 2009-10 budget plan proposes to reduce overall General Fund spending for the RCs by $344 million relative to the DDS estimate. However, the budget plan does not allocate this reduction among the various service categories, leaving it unclear how miscellaneous services would be affected by the reduction.) Between 2004-05 and 2007-08, for example, the service expenditure code for special therapy services for children less than three years old almost doubled from $18.8 million to $37.2 million, according to DDS data. On a per-person basis during this same time period, spending increased from $1,699 to $2,399 or by $700 per person for these services. A number of other service expenditure codes, such as client and parent behavior intervention training and socialization training program services, have experienced similar growth.

This rate of growth is out of line with other categories of RC services. As shown above in Figure 9, the adjusted total growth rate is 11.8 percent. In comparison, miscellaneous services have been growing at an average annual rate of almost 34 percent. If expenditures for miscellaneous services had grown at the same rate as the adjusted total growth rate of 11.8 percent the proposed 2009-10 level of expenditures would be $74 million lower.

Regulation of Miscellaneous Services Would Slow RC Spending. State agencies frequently adopt regulations to clarify state law and to help ensure that it is applied consistently. In a number of cases, the adoption of regulations has helped to ensure that expenditures of state funds are properly controlled. Given the rapid rate of growth in the miscellaneous services category, we believe the promulgation of regulations governing the use of these expenditure codes is warranted. Notably, the nine other categories of services that are not growing as quickly as miscellaneous services are generally subject to DDS regulations. We believe it is likely that the adoption of regulations to more carefully limit expenditures for these services would slow the dramatic growth of RC spending for these services.

Analyst's Recommendation

For the reasons discussed above, we recommend that the Legislature direct DDS to adopt emergency regulations governing miscellaneous services. The promulgation of regulations defining miscellaneous services would clarify what services may be purchased under individual service expenditure codes, thereby limiting expenditures in this service category. We recommend that the department begin with adopting regulations for the miscellaneous services expenditure codes that have seen the largest growth in overall cost, caseloads, and per-person spending.

DMH—State Hospital Caseload Needs Adjustment

Governor's Budget Plan

State Hospital Budget Proposals. The Governor's budget proposes a net increase of about $19 million General Fund for state hospital operations compared to the revised current-year estimate of expenditures (excluding department headquarters and lease-revenue debt service). The increase is primarily due to the continued activation of Coalinga State Hospital, increases in the numbers of certain staff in the Salinas Valley Psychiatric Program, inflation adjustments to offset increases in certain operating costs, and caseload adjustments. The budget plan also proposes to extend statutory language through 2012 that allows Patton State Hospital (PSH) to hold up to 1,530 patients. If this measure were not enacted, the statutory cap on the number of patients at PSH would revert to 1,336.

Current- and Budget-Year Caseload. Under the Governor's 2009-10 budget plan, the overall state hospital population (including two DMH-operated psychiatric facilities for inmates held in state prisons in Vacaville and Salinas) is projected to decrease slightly from 6,075 patients by the end of 2008-09 to 5,998 patients by the end of 2009-10. The budget-year decrease of 77 patients is due to a reduction of 86 IST and 70 MDO patients, partially offset by an increase of 69 SVP patients and 10 other forensic commitments. In addition, the Governor's plan assumes that the number of LPS and CDCR beds will remain steady through the budget year.

LAO Assessment

Current-Year Caseload Overbudgeted. Our analysis of recent state hospital population data through mid-January 2009 indicates that the caseload adjustment should be about 94 patients below DMH's estimate of patients for the current year. Our caseload estimate assumes that the caseload includes 38 fewer ISTs and 69 fewer MDOs than budgeted, but 13 more of the other types of forensic patients. On this basis, we believe that the Governor's budget plan overestimates the General Fund support needed in the current year by about $6 million. This budget adjustment assumes that the average half-year funding per bed is $64,000. The hospital census numbers upon which we base our recommendation are shown in Figure 10.

Figure 10

State Mental Hospital 2008-09 Census Lower Than Expected

2002 Methodology

	Budgeted Census for 1/14/2009	Actual Census On 1/14/2009	Difference	Percentage Difference
IST	1,141	1,103	-38	-3.3%
NGI	1,221	1,220	-1	-0.1
MDO	1,288	1,219	-69	-5.3
SVP	750	759	9	1.2
Other forensic	118	131	13	11.0
Totals[a]	**4,518**	**4,432**	**-86**	**-1.9%**

[a] Excludes (1) County Lanterman-Petris-Short patients and (2) California Department of Corrections and Rehabilitation inmates and wards at state hospitals and Department of Mental Health psychiatric programs at Salinas Valley Prison and California Medical Facility.

IST = Incompetent to Stand Trial; NGI = Not Guilty by Reason of Insanity; MDO = Mentally Disordered Offender; SVP = Sexually Violent Predator.

Current-Year Adjustment Methodology. Under a methodology agreed to by the Legislature and the administration in 2002, current-year caseload adjustments are generally made for *each* major commitment category (IST, MDO, NGI, SVP, and "other forensic") if they vary by 2.5 percent from the budgeted amount. Our calculation, that the Governor's spending plan has budgeted $6 million more than is needed for state hospital caseload, is consistent with this past agreement.

We note, however, that the state hospitals have changed significantly since the budgeting methodology agreement made in 2002 in ways that suggest it may be time to revisit how such caseload adjustments are made. For example, significant changes in patient treatment models and staff training have been made due to federal requirements. Please see our analysis of the state hospital budgeting improvements in the "Other Issues" section of this report for a more detailed discussion of the state hospital's budget and these federal requirements.

Budget-Year Caseload Projections Seem Reasonable. Our analysis shows that the Governor's budget-year projections appear reasonable given current caseload trends. We will continue to monitor the state hospital caseload trends and will recommend any appropriate adjustments to the budget-year estimate at the May Revision.

Continuation of PSH Cap Necessary. Our caseload analysis shows that the forensic patient population is increasing at the state hospitals. Based on this trend, we find that the Governor's proposal to continue the statutory patient population cap at PSH is necessary and will allow DMH the flexibility it needs to accommodate projected hospital caseload.

OTHER ISSUES

DADP—Proposed New Drug Program Special Fund Unnecessary

Beginning July 1, 2009, the Governor proposes to fund some drug and alcohol treatment services in three state departments using the additional revenues from a proposed increase in the excise tax on alcoholic beverages. The revenues from this so-called nickel-a-drink increase in the alcohol excise tax would generate an estimated $585 million annually in new revenues in the budget year.

Under the administration budget plan, these new revenues would be deposited into the General Fund and then would subsequently be transferred into a newly created special fund called DAPTF for the support of alcohol and drug programs. As a result, the new alcohol tax revenues would be considered proceeds of taxes for the purposes of Proposition 98 and could affect the minimum funding requirement for K-14 education. The budget plan assumes that $312 million of the new revenues generated from the tax increase in 2009-10 would support programs for drug and alcohol treatment in DADP, $54 million for such a program in DSS programs, and $220 million for such programs operated by CDCR.

DADP Spending. The DAPTF funds would support DADP's major programs that are now supported from the General Fund including the Drug Medi-Cal Program, various discretionary

state grants for county drug and alcohol treatment programs, drug courts, and Proposition 36 programs. As shown in Figure 11, which summarizes the Governor's spending plan for DADP, the year-over-year spending level for the Drug Medi-Cal Program is estimated to increase in 2009-10 due to caseload, cost, and utilization growth, while the funding for DADP's other programs would generally remain flat.

Administration's Proposal for Special Fund Has No Fiscal Benefit. Under the proposed statutory language we have reviewed funding for the DADP programs shown in Figure 11 is contingent upon approval of the Governor's proposed tax increase. If the Legislature does not approve the tax increase, the Legislature would need to continue funding the cost of the DADP, DSS, and CDCR programs from the General Fund or find other funding sources. However, the state could face other serious fiscal consequences for DADP's drug and alcohol programs if it did not continue to fund the programs in that department from the General Fund. That is because the DADP funds count towards the federal maintenance-of-effort (MOE) requirements for a federal program, the Substance Abuse Prevention and Treatment (SAPT) block grant. The state currently receives about $260.1 million annually under the federal SAPT block grant program that it shares with county drug and alcohol systems. If state support for DADP programs fell below about the $308 million level, the state would fail to meet federal MOE requirements. As such, the state would be at risk of losing one federal dollar of SAPT block grant funding for every state dollar spent below the required MOE level.

Proposal Limits Legislature's Ability to Set Fiscal Priorities. We are concerned that the Governor's proposal limits the Legislature's ability to set fiscal priorities by dedicating the General Fund revenues from the proposed tax increase to a specific fund for a specific purpose. Our analysis of the available information regarding the proposal indicates that there would be no fiscal benefit from creating the DAPTF. For example, under the administration plan, the new tax revenues would "count" for purposes of determining the Proposition 98 funding guarantee for schools and community colleges. Dedicating the revenues to spending on alcohol and drug programs would limit the Legislature's flexibility for no apparent purpose.

Moreover, this change adds needless technical complexity to budgeting for DADP, DSS, and CDCR in the future. As the cost of these three programs changed, up or down, over time, the

Figure 11

Department of Alcohol and Drug Programs
Summary of Major Program Funding

(Dollars in Millions)

	2008-09 General Fund	2009-10 DAPTF	Change From 2008-09 Amount	Change From 2008-09 Percent
Drug Medi-Cal	$100.9	$114.3	$13.4	13.3%
Proposition 36 programs	108.1	108.0	—	—
Drug Courts	27.9	27.9	—	—
Various discretionary grants	27.5	26.5	-1.0	-3.5
Other	34.7	34.7	—	—
Totals	**$299.1**	**$311.5**	**$12.4**	**4.2%**

DAPTF = Drug and Alcohol Prevention and Treatment Fund.

administration and the Legislature would have to determine how these changes were aligned with the additional increment of alcohol excise tax revenues. Moreover, nothing in the proposed statute creating the special fund would require the departments to limit program spending over time to the amounts available from the alcohol tax increase. If additional funding were needed for the support of these programs, the departments could seek additional General Fund resources in future budgets to supplement their DAPTF allocations—monies that, in any event, were appropriations from the General Fund in the first place.

Missed Opportunity for Program Improvements. The administration's proposal does not propose any programmatic improvements in the drug and alcohol programs that would receive the dedicated revenues from the alcohol tax increase. The proposal simply amounts to a funding shift. But other structural and financing changes are possible that could improve the management and outcomes of the state's drug and alcohol treatment programs.

In our 2004 report entitled *"Remodeling" the Drug Medi-Cal Program*, we recommended dedicated state funding for these programs through a block grant or a realignment of state revenues and program responsibilities to counties. Under our approach, the state would abolish burdensome state laws and regulations to allow for more county flexibility in service delivery. We believe that our proposed approach would encourage a number of programmatic improvements, including reducing overall administrative costs for the programs and allowing counties to focus these resources on their highest priority drug and alcohol problems in their communities.

Reject Governor's Special Fund Proposal But Consider a Realignment Approach

For the reasons described above, we recommend that the Legislature reject the Governor's proposal to dedicate revenues from the excise tax increase on alcohol to drug and alcohol programs in DADP, DSS, and CDCR. The creation of the DAPTF is unnecessary. We also recommend that the Legislature consider funding alcohol and drug treatment programs with a realignment approach or state block grant that would give counties more administrative flexibility and control over programs and encourage programmatic improvements in drug and alcohol treatment services. As mentioned earlier, we believe the Governor's proposal has missed an opportunity for improvements that could create program efficiencies, improve quality of care, and generate savings for the state.

DHCS—The Broker Model for Medicaid Nonemergency Medical Transportation

In order to help Medicaid enrollees obtain better access to health care services, the federal government requires state Medicaid programs to provide necessary medical transportation to and from health care providers, even if no emergency is present. This benefit is known as NEMT, and includes such services as trips to and from scheduled medical appointments, return trips from hospital emergency rooms, and transfers between hospitals. Our review indicates that Medi-Cal potentially could improve the availability and quality of its NEMT services while reducing costs by contracting with a transportation broker to manage a portion of its NEMT services. We recommend that the state conduct a pilot pro-

gram by contracting with such a vendor for two years to evaluate the potential for improvement.

Background

NEMT in California. In California, NEMT is available only to those enrollees who have a documented medical condition that prevents them from travelling via ordinary means of transportation, such as taxies or buses. For example, persons who are confined to wheelchairs may be unable to ride in cars or public buses. Even if no permanent physical limitation is present, patients still may be unfit to travel without assistance following some types of medical treatment. A common example of this circumstance is a person who routinely receives dialysis treatments, which tend to leave the recipient at least somewhat unsteady for some time following treatment. The Medi-Cal Program offers three forms of NEMT: a wheelchair van, a gurney van (also known as a litter van), and an ambulance. Each of these is suitable in different types of medical circumstances.

The NEMT benefit is available both to Medi-Cal enrollees in managed care plans and to enrollees who receive treatment through FFS providers. We estimate that Medi-Cal provides about $100 million ($50 million General Fund) in NEMT services through FFS arrangements. Comprehensive data regarding how much Medi-Cal managed care plans spend on NEMT is not available because these costs are embedded in the rates paid to the health plans.

Medi-Cal Restrictions on NEMT Use. In order to ensure that enrollees indeed have a condition that requires NEMT services, Medi-Cal requires the transportation provider to submit a treatment authorization request (TAR) to Medi-Cal. Program staff located in two Medi-Cal regional offices review the TARs and either approve, modify, or deny them. Providers must submit documentation along with each TAR, such as a prescription or order signed by a physician, dentist, or podiatrist, that confirms the medical reasons necessitating the use of NEMT. For certain chronic medical conditions that require routine service, such as kidney dialysis, the department will approve a TAR for one year of service.

Medi-Cal NEMT Shows Potential for Improvement

Our review indicates that Medi-Cal's NEMT benefit is not functioning as well as it could. Burdensome administrative requirements for providers may be limiting the types of services available to enrollees.

TAR Process Is Cumbersome. Ideally, a provider would obtain a TAR decision from Medi-Cal *prior to* transporting the recipient, but in practice the TARs are almost always evaluated *after* the service has been rendered. The DHCS indicates that it approves 80 percent of NEMT TARs submitted, while the remainder are modified, denied, or deferred for further consideration. Discussions with industry participants indicate that most Medi-Cal NEMT recipients are dialysis patients. That is due in part to the administrative effort needed to obtain TAR approvals. The NEMT companies are more likely to make the effort for those requiring dialysis on an ongoing basis, since each approved TAR is good for up to a year of services.

Adjudicating TARs also requires a disproportionate share of manpower for DHCS. The NEMT benefit generates nearly 300,000 TARs annually that the department must process. Only hospital inpatient services generate more TAR submis-

sions, with more than 400,000 TARs annually, even though NEMT benefit costs are less than 2 percent of hospital inpatient costs.

Access to NEMT Providers May Be Uneven Around the State. Our review of NEMT claims data indicates that the services are not distributed evenly around the state. Medi-Cal enrollees who are aged, blind, or disabled use nearly all of the FFS NEMT wheelchair van services. Roughly one-third of these enrollees live in Los Angeles County, but over one-half of all wheelchair van services in the state occur in Los Angeles County.

Transportation Brokers Could Manage NEMT More Efficiently

A number of other states have achieved Medicaid program improvements by contracting some or all of their NEMT services to a transportation broker, a concept that we believe could work for Medi-Cal as well. By managing the NEMT benefit more efficiently, such brokers can better match patients with appropriate providers, improve the quality of services provided, and reduce costs.

How Transportation Brokers Work. Brokers can offer a range of service levels, from handling only the administrative tasks of screening transport requests to managing the full scope of the NEMT benefit. Under the full-scope approach, the broker may be likened to a managed care plan specifically for NEMT. Brokers often contract on a per member, per month basis for their services, similar to more traditional managed care plans that provider comprehensive benefits. In exchange, the broker screens NEMT companies and subcontracts with vendors it chooses to establish a network of service providers. The broker also establishes a single point of contact for patients to call when they need transportation services. When a patient calls to request transportation, the broker determines whether a wheelchair van or other level of service would be more appropriate, depending on the patient's individual circumstances. The broker then finds a provider that serves that patient's area and arranges with the provider to pick up the patient.

Advantages of Broker Management. Closer management of NEMT benefits via the use of brokers, from provider enrollment through the arrangement of services for beneficiaries, could improve this Medi-Cal benefit in several ways:

- ***Consistent Contact Point for Patients.*** Currently, enrollees in Medi-Cal FFS are responsible for finding providers themselves for all services, including NEMT. If a provider stops serving Medi-Cal patients or goes out of business, the enrollee is responsible for finding another provider. By providing one point of contact for beneficiaries, the broker eliminates the need for patients to look for available providers and makes it easier for them to receive these services.

- ***Improved Service Delivery.*** Because the broker manages the network of providers, it can better match patients with providers in their area. Some brokers perform this function using computer software that allows them to map which providers would be best suited given the patient's location. This can reduce the miles travelled by the provider, resulting in shorter trips for providers that allow them to fit more trips into each day. Additionally, the broker can better monitor the quality of services provided by working more closely with providers.

- ***Advance Review and Approval of Service Delivery.*** Because the broker itself matches the transportation service provider with the Medi-Cal enrollee for each needed service, the state would discontinue use of the expensive and cumbersome TAR process for NEMT services. This could encourage providers to offer a wider range of enrollees beyond dialysis patients.

- ***State Cost Management.*** A typical contract to manage the NEMT FFS benefit would pay the broker a capitated monthly premium that would not change regardless of how many services a particular enrollee used. The broker would be responsible for paying for all services needed by the Medi-Cal FFS population covered in the broker's territory, and so would bear the financial risk if service utilization exceeded expectations. This arrangement gives the state more predictability for its NEMT costs.

Risks of Broker Management. Although the transportation broker model offers a number of advantages, it poses some potential risks as well. As with other managed care arrangements, brokers with capitation contracts benefit financially by providing fewer services to Medicaid enrollees, creating the incentive to deny more services than may be appropriate under program requirements. Also, some NEMT providers who serve FFS Medi-Cal may not wish to contract with a broker or may not meet the broker's standards for quality of service. A switch to a broker may create disruptive situations for some Medi-Cal beneficiaries in cases in which a Medi-Cal enrollee's customary FFS transportation provider is not part of the broker's network.

Other States' Use of Brokers. Our review indicates that 24 other state Medicaid programs were using brokers to manage at least some part of their NEMT services in 2008, including New York, Colorado, Florida, and Massachusetts. These brokerage arrangements vary significantly by state in terms of what specific functions the broker performs and what geographic area of the state the broker manages. Some states contract with different brokers in different regions of the state, while other states delegate NEMT to local governments, who may contract with a broker or manage the benefit in-house. Reasons cited by states for switching to broker models include improved NEMT cost management, improved access to NEMT services, and reduction of NEMT fraud and abuse.

LAO Recommendation

Improved Service Delivery and Cost Savings Possible. Our review indicates that Medi-Cal could achieve both improvements in the performance of its NEMT FFS benefit as well as lower state costs. Other states' experiences suggest that savings ranging between 15 percent and 35 percent (net of brokerage fees) are possible on the cost of these services. For Medi-Cal, those savings percentages could yield General Fund savings ranging from $7 million to $15 million annually on a statewide basis for benefit costs. Significant administrative savings—amounting to about $1 million General Fund annually could also result from the elimination of NEMT TARs and other NEMT administration.

Contract With Broker on Pilot Basis. While we believe that both programmatic and fiscal benefits are likely under a broker model, we also recognize that the brokered model would rep-

resent a substantial shift in the way this service is delivered for FFS beneficiaries. Additionally, it is not clear whether a statewide FFS benefit or a regional contracting system operated by one or more brokers would be more cost-effective and best improve service delivery.

Therefore, we recommend that the state implement a pilot program to evaluate a NEMT broker model for two years. The pilot program should operate in several counties and include both rural and urban areas to allow the state to evaluate the model in both settings. The state could ensure that the pilot project costs no more than the present cost of these services to the Medi-Cal Program by limiting the total reimbursement to the broker to the amount budgeted for NEMT in the counties where this new approach would be tried.

Following a two-year pilot, the state could evaluate the broker's performance to determine whether it would be cost-effective to expand the contract to include additional FFS regions or all FFS NEMT services statewide. In the longer term, the state could also explore the idea of allowing a wider range of options than the existing three modes of transportation—wheelchair van, litter van, and ambulance—in order to assist more enrollees in accessing services at a reduced cost. The Legislature should adopt a statutory framework to guide the pilot program and to ensure that it is appropriately evaluated.

DHCS—Failure to Promulgate Regulations Leads to Inefficiency

Background

State Delegates the Eligibility Processing Function to Counties. Counties administer Medi-Cal eligibility determinations for new applicants and redeterminations for persons who are enrolled and wish to remain in the program. How counties perform this function affects access to health care for the poor, compliance with federal laws and regulations, and overall state costs for the Medi-Cal Program. The state reimburses counties for the cost of performing these eligibility-related functions.

How the State Directs County Eligibility Administration Activities. Counties receive direction from DHCS regarding how to perform eligibility-related functions in two main ways. Many directives to counties involve the issuance of state regulations. Regulations act to define and clarify statute. In California, the Office of Administrative Law (OAL) has responsibility for overseeing the promulgation of regulations. Before a regulation is promulgated, it normally must go through a development process in which it is available for review and public comment. This process generally takes 6 to 24 months to complete.

However, on a number of issues, the department issues what are termed All County Welfare Director's Letters (ACWDLs). An ACWDL is an administrative tool used by departments to communicate changes in policy or to provide clarification on various issues. The issuance of ACWDLs is not under the jurisdiction of the OAL and is, therefore, not subject to the same development and review process. Departments can develop and issue ACWDLs relatively quickly, usually in about one to six months.

DHCS Has Not Updated Eligibility Regulations in a Number of Years. Although DHCS has indicated that a number of regulation packages are currently undergoing the formal OAL process, the latest update to county administration regulations occurred in November 1998. The department has preferred to use ACWDLs to implement changes to county eligibility-related

functions because they can be issued so much more quickly than regulations. For this reason, it is common practice among state departments that direct county programs to first publish documents comparable to ACWDLs to provide immediate direction on how to implement programmatic changes, such as changes to federal or state statute. However, most departments then follow up on the initial letter to counties with the completion of formal regulations to ensure that their directions are clear, effective, and subject to review by the public and OAL.

Overuse of ACWDLs Can Be Problematic

While the ongoing use of ACWDLs is convenient for DHCS, our analysis indicates that this practice creates additional administrative workload for the counties and impedes legislative oversight over the county administration of Medi-Cal. We discuss these concerns below.

Counties Often Find ACWDLs Unclear. We are advised by county personnel that they consider DHCS's heavy reliance on ACWDLs to be problematic. According to county officials, the letters are often unclear and are drafted in a way that require county eligibility workers to review and reference several previous related letters to fully understand how to implement a new policy or statute change. Our review of some recent ACWDLs found that these letters pose real challenges for county officials.

Among the key problems:

- ***Multiple Letters Regarding the Same Issue.*** The DHCS regularly issues several ACWDLs to address different facets of the same issue. For example, after the passage of Chapter 1088, Statutes of 2000 (SB 87, Escutia), which altered the way counties process eligibility redeterminations, DHCS issued two letters that provided immediate direction to the counties. Over a year after the release of the two initial letters, DHCS released another ACWDL to provide further clarification of its intended direction.

- ***Unclear References to Prior Policy.*** When DHCS issues a new ACWDL, it is often unclear whether the ACWDL invalidates processes implemented under prior letters. For example, DHCS issued an ACWDL to implement a recently enacted change to children's eligibility for Medi-Cal. However, the department did not indicate which prior ACWDLs should be deemed to have been invalidated by the new ACWDL. This confusion, we are advised, creates extra workload for counties, because they must often research and reconcile prior ACWDLs to determine what procedures to reference in their training of eligibility workers.

If DHCS followed up ACWDLs with regulations, all the information would be organized and accessible in one location, facilitating the consistent implementation of statute. As we noted, however, that has not been the past practice of the department.

Lack of Clear Direction Can Cause Inefficiency. When counties are unable to easily reconcile and interpret ACWDLs regarding eligibility determinations, they must commit time and resources to sort through these issues and have less time to focus on ensuring that processing eligibility determinations is being properly implemented by their staff. We find that the promulgation of regulations by DHCS, as a follow-up to the release of ACWDLs, would likely improve county

efficiency and consistency in the administration of eligibility-related functions.

Current Process Impedes State's Ability to Manage County Administration. The widespread use of ACWDLs impedes the state's ability to manage the county eligibility functions. The confusion at the local level over how to follow DCHS's directions on the administration of Medi-Cal eligibility has hampered the state's efforts to improve the efficiency of these functions. For example, the Governor's budget for 2007-08 initially proposed to increase the county performance standard regarding the timely processing of applications and redeterminations from a 90 percent accuracy threshold to a 95 percent threshold. However, counties argued that such a change would pose extreme difficulties for them in large part because of the lack of clear guidance from the state on eligibility functions. As result, the performance standard was not improved. If the state is not able to effectively manage the county administration function, it also loses some of its ability to control its Medi-Cal caseload, as the counties determine who is eligible for Medi-Cal.

Analyst's Recommendations

We recommend that the Legislature direct DHCS to report at budget hearings on the status of its plans to issue regulations necessary for the county administration of Medi-Cal eligibility functions. Specifically, the department should identify how many regulatory packages would be necessary to fully update the regulations governing the county administration function, what steps the department would take to promulgate the regulations, and how long it would take for the department to do so. We believe this is a reasonable first step to bring about more efficient administration by counties and the state of these activities, which are critical for the operation of the Medi-Cal Program.

HFP—SCHIP Reauthorization, Rule Changes Expected Very Soon

In the "Background" section of this analysis, we discussed SCHIP, a federal program to provide health coverage for children that is the source of funding for HFP. Federal authority and funding for SCHIP expires March 30, 2009. At the time this analysis was prepared, the House of Representatives and the Senate appeared to be close to agreement on federal legislation that would reauthorize SCHIP for four and a half years, through September 2013. This reauthorization, funded through a 61-cent increase in federal excise tax on cigarettes and tobacco products, would approximately double federal funding for SCHIP.

In its current form, the legislation under consideration contains several provisions which may have a fiscal impact on California. These provisions are summarized in Figure 12 (see next page) and include the following:

- ***New Funding Formula.*** The current formula used to allocate SCHIP funding among the various states is based on estimates of the number of low-income uninsured children in each state. The new formula instead allocates funds based on actual and projected expenditures for SCHIP programs in each state. This new methodology should increase the stability of federal funding for HFP by basing future funding levels on actual program costs.

- ***Identity Documentation Requirement.*** This legislation extends the Medicaid citizenship and identity documentation requirement to SCHIP effective October 1, 2009. Currently, MRMIB collects *citizenship* documentation (such as a birth certificate), but not documentation of the *identity* of recipients (such as a school identification card with a student's photograph). This new provision would require MRMIB to operationalize new administrative procedures in order to collect identity information. The state cost to implement these new procedures is unknown at this time, pending a final decision on what type of identification documentation MRMIB and the federal government will require and negotiations with the administrative vendor on the associated additional workload.

- ***Federal Funding Match for Newly Qualified Immigrants.*** Currently, states are prohibited from using federal funds to cover legal immigrant children who have been in the country less than five years. California currently covers these children entirely with state funds. The pending legislation modifies this provision, which could eventually result in General Fund savings of about $12 million annually in HFP, provided that California can satisfactorily comply with new identification requirements mentioned above.

- ***Other Options for Expanding Coverage.*** The pending legislation contains provisions that would provide SCHIP funding to states to cover children in families with somewhat higher incomes than at present. Currently, California covers children up to 250 percent of the FPL and receives SCHIP funds at a matching rate of about two federal dollars for every state dollar. The new federal law would allow states to draw down the enhanced SCHIP matching funds to cover children up to 300 percent of the FPL. This would cost the state an additional $13.2 million General Fund. (If the state combined this option with the option to draw down

Figure 12

Fiscal Impacts of State Options and Requirements Under Federal SCHIP Reauthorization

(In Millions)

Options for Modifying Healthy Families Program	General Fund Impact
Expand coverage to 300 percent of federal poverty level	$13.2
Draw down federal funds for legal immigrant children	-12.0
Net effect of adopting both options shown above	0.8
Requirements	
Collect identification documentation	Unknown (Not likely to exceed $5 million)
Enhanced data collection on children's health	Unknown (Some federal funding available)

federal funds for newly qualified immigrants, the net cost to the state would be less than $1 million.) The legislation also contains provisions that allow the state to cover children over 300 percent of the FPL, although state expenditures for these children would be matched by the federal government at the 50 percent Medi-Cal rate.

- ***Provisions Restricting SCHIP Funding for Certain Groups.*** The pending legislation also prohibits states from offering coverage to nonpregnant childless adults under SCHIP, and prohibits states that do not currently cover parents from covering them under SCHIP in the future.

- ***New State Reporting Requirements.*** The pending legislation requires states to collect additional data on the quality of health care provided to children in the program. States will receive additional funding for collecting and reporting such data.

New Rules Bring Benefits, Choices for California

Overall, we find that the federal legislation to reauthorize SCHIP contains several provisions that will benefit California: an increased federal appropriation, increased stability of federal funding, and the opportunity to expand coverage to higher income levels at the state's discretion. Notably, California could eventually draw down some additional federal funds without increasing General Fund support, resulting in General Fund savings. At the very least, this legislation will allow MRMIB to maintain HFP at current levels of eligibility and caseload growth.

If the Legislature wishes to expand eligibility for coverage under HFP, increased federal support for this purpose will be contingent on providing matching General Fund or other state support. Considering the success of HFP in providing health insurance to currently eligible low-income children and the favorable federal matching rate available for covering children, we believe that expanding the program to 300 percent of the FPL has merit on a policy basis. However, in light of the state's current fiscal situation, we recommend against an eligibility expansion of HFP at this time.

Federal Tax Increase to Fund SCHIP Will Reduce State Tobacco Tax Revenues

The federal government proposes to pay for the SCHIP reauthorization with a 61-cent increase in federal excise tax on cigarettes and tobacco products, which could go into effect as early as April 1, 2009. The new tax is predicted to decrease consumption of tobacco products, which would reduce the revenues collected under current state tobacco taxes for various special funds and the General Fund.

Overall, we estimate that the new federal tax would reduce state tobacco tax revenues for various special funds by approximately $60 million in 2009-10. This estimate includes a reduction of about 7 percent for each of these programs, or about $21 million in Proposition 99, $38 million in Proposition 10, and $1.4 million for breast cancer research.

However, the imposition of the increased federal excise tax will also result in a net increase in General Fund revenues of about $9.3 million. The net increase in General Fund revenues is a combination of (1) a reduction in revenues collected through the General Fund portion of the

tobacco excise tax of $7.1 million (because tobacco sales will have declined), coupled with (2) an increase in sales tax revenues of $16.4 million (because the federal excise tax would increase the price of cigarettes subject to the sales tax).

DMH—Governor's Proposal for Budget Display Could Be Improved

Background. The DMH budget display shows expenditures by programs, which are further broken down into program elements in order to provide additional spending detail. The DMH's Long-Term Care Services program is generally comprised of the department headquarters and five other elements. These elements are (1) Lanterman-Petris-Short, (2) the Penal Code and Judicially Committed, (3), CDCR, (4) Other Long-Term Care Services, and (5) the Conditional Release Program.

Governor Proposes to Eliminate One Program Element. The Governor's budget proposes to eliminate the "Other Long-Term Care Services" program element. According to DMH, this element, which includes $3.4 million in reimbursements in the current year, was established to track various miscellaneous spending items, such as the provision of adult education services and the collection of rent from employees residing on hospital grounds. The DMH states that there is not a compelling need to separately track these reimbursements and they will instead be rolled up into the Penal Code and Judicially Committed program element.

Overall, More Detail Is Needed in Budget Display. We do not take issue with the Governor's proposal to eliminate the Other Long-Term Care program element. However, if the administration is proposing to change its budget display for DMH Long-Term Care Services, in our view this is the appropriate time to consider making other improvements. We have identified additional modifications that could be made to provide more useful information on program expenditures.

Spending Information by Facility. The current budget display lacks detailed spending information on a facility-by-facility basis that would allow for improved legislative oversight. Tracking spending on a facility-by-facility basis is important because each of the five state hospitals, as well as DMH-run psychiatric programs at two state prisons, are somewhat unique. For example, Coalinga State Hospital was built in 2005 and primarily houses SVPs, while Napa State Hospital was built in the late 1800s and generally houses all commitment types except SVPs. These differences have important cost implications for the state as it manages a growing $1.2 billion General Fund Long-Term Care Services Program. Displaying expenditures on a facility-by-facility basis would allow the Legislature to more easily and accurately track long-term expenditure trends.

Modify Governor's Proposal to Require Facility-Specific Expenditure Data. We concur with the Governor's proposal to eliminate the Other Long-Term Care spending element. However, we recommend that the Legislature modify the request by directing the Department of Finance (DOF), which prepares the Governor's annual budget plan, to take a technical budget action to include in its Long-Term Care Services budget display a breakout of expenditures by state-operated facility. This would allow for better tracking of facility-by-facility expenditures over time.

DMH—Budgeting Improvements Could Help Ensure Efficient Use of State Resources

Due to concerns about DMH's increasing state hospital costs and budgeting accuracy, the Legislature enacted budget bill language that required an audit of DMH's budget estimation methodologies. In this analysis, we (1) provide background on the significant growth in the state hospitals budget, (2) review the findings from the audit required by the *2008-09 Budget Act*, (3) discuss how DMH's methodologies do not follow an agreement made with the Legislature in 2002, and (4) recommend actions for the Legislature to take to improve DMH's budgeting processes.

Background

General Fund Growth Expected to Continue. The General Fund expenditures for the state hospitals have grown at an average annual rate of about 20 percent over the last three years and now exceed $1.1 billion annually. Many factors are driving these significant increases in state hospital spending, including medical inflation, new laws, litigation affecting staff salaries, and caseload increases. However, one major additional factor contributing to this rise in costs are state efforts at compliance with the CRIPA.

The CRIPA is a federal civil rights law designed to protect individuals in public institutions such as mental hospitals. Starting in June 2002, the U.S. DOJ conducted on-site reviews of the state hospitals and found significant deficiencies with California's compliance with CRIPA. In May 2006, a formal consent decree was reached between the U.S. DOJ and DMH to address identified deficiencies. State hospital cost increases are partly due to ongoing efforts towards achieving CRIPA compliance through enhanced staff-to-patient ratios and the rollout of a new "recovery model" of care to improve patient treatment. The requirement that the state comply with CRIPA and implement the terms of the consent decree negotiated with U.S. DOJ limits the state's options with respect to controlling costs in state hospitals.

Audit Raises Concern Regarding State Hospital Operations

The *2008-09 Budget Act* directed the state Office of State Audits and Evaluations (OSAE) within DOF to conduct an audit of DMH's budget estimation process. The OSAE audit makes several findings regarding state hospitals. It concludes that:

- The current staffing model may not adequately reflect hospital workload.
- Funding is insufficient for annual operating expenditures.
- State hospitals may not be efficiently using their staff.

The OSAE's findings indicate a misalignment of the way funding is budgeted for state hospitals for personal services and operating expenditures and equipment (OE&E). For example, the audit identified that cost savings from personal services, known as salary savings, are being used to offset OE&E costs. As a result, the OSAE found that the state hospitals are at risk for operational shortfalls in the future. That is because salary savings will eventually decrease when vacant positions are filled and thus will no longer be available to be redirected to pay OE&E costs.

Audit Indicates Staff Possibly Being Used Inefficiently. Personal services expenditures make up the majority, or about 80 percent, of to-

tal hospital costs and have grown about 35 percent over the last three fiscal years. These cost increases are due in large part to level-of-care (LOC) staff activities related to CRIPA compliance as well as changing patient demographics, such as the increasing medical needs of an aging state hospital population. Our discussions with OSAE indicate, however, that another cost factor may be the inefficient use of hospital staff. Specifically, the audit found that some LOC staff, who are assigned to provide direct patient care, are regularly performing administrative duties not directly related to patient care. We are advised that some LOC staff are taking double shifts in order to complete paperwork and data entry tasks. The OSAE reports that some of this workload could possibly be shifted to non-level-of-care (NLOC) staff, who are generally less costly than LOC staff.

Staffing Ratios and Standards May Require Adjustment. The workload issues described above suggest that the current staffing ratios and standards may need to be adjusted. Staffing ratios and standards are generally guidelines for the number of LOC and NLOC staff needed per patient, per facility, or both. The DMH generally adjusts the state hospital budget for changes in population using LOC staffing ratios that are based on patient acuity levels as well as CRIPA and licensing requirements.

In addition, DMH has staffing standards for NLOC positions that generally appear to be based on guidelines dating back to the mid-1990s and early 2000s. The DMH reports that in recent years, budget requests for additional non-LOC staff have usually been based on specific, identified workload rather than these general guidelines.

Based on our discussions with OSAE, these potential workload issues, which in some cases have resulted in LOC staff performing administrative NLOC functions, appear to be driving some of the significant growth in overtime. Thus, the current LOC staffing ratios may not reflect the actual workload for these positions. This also raises question as to whether the NLOC staffing standards are up to date.

Agreed-Upon Budgeting Methodology Not Being Followed

We find that the department has deviated from an agreed-upon budgeting methodology for population requests established in 2002 among the Legislature, DOF, and DMH. As we describe below, the department's current methodology differs from the 2002 agreement in two key ways: (1) when and how budget adjustments for the current year are triggered and (2) how funding adjustments for changes in the hospital caseload are calculated.

How the 2002 Agreement Worked. In 2002, the Legislature and the administration were in disagreement over the way that the state hospital budget should be adjusted when the population of various groups of patients turned out to be larger or smaller than originally budgeted. A compromise reached that year established a methodology for making such adjustments. It requires current-year adjustments if the actual patient census in *any* of five forensic commitment categories varies by 2.5 percent from the numbers assumed in the budget act for that year. This variance analysis was to be made, and result in appropriate budget adjustments, both at the time the Governor's January budget was submitted to the Legislature as well as at the time of the May Revision. The budget-year caseload estimate

was to be based on a projection reflecting the trend of actual hospital caseload data over the prior two years. These basic methodologies were used to adjust funding for state hospital caseload for the current year and the budget year based on an estimate of the annual cost of operating a state hospital bed.

Department Has Departed From the 2002 Methodology. Our analysis indicates that DMH has modified the way it adjusts its budget for unanticipated changes in its state hospital caseload so that it is no longer fully complies with the 2002 agreement. Specifically, as the annual January budget plan is prepared, DMH is now adjusting its budget only when the *combined total change* among these five categories of patients is higher or lower by 2.5 percent than assumed previously in the current year. At the May Revision, DMH uses yet a different method to develop its caseload estimate for the state hospitals in the current year. It creates a new projection of the state hospital population based on recent caseload trends. It then proposes budget adjustments if the *total* population projection varies from the budgeted amount by 2.5 percent, but does not propose changes when the projected number of patients in a particular forensic group is 2.5 percent larger or smaller than assumed in the original budget plan.

In addition, DMH no longer uses an average cost per bed to adjust its caseload budget requests. It instead computes such adjustments based on staffing ratios and the associated wage and salary costs for LOC staff.

Significant Changes Since 2002. We recognize that state hospitals have chanced significantly since 2002, particularly due to CRIPA related requirements, and that these changes have dramatically impacted staffing ratios and patient treatment models. Due to these changes, we believe that revisiting the agreed-upon methodology for making caseload adjustments may be warranted.

State Hospital Budgeting Procedures Should Be Reviewed

Our analysis of DMH's budget estimation methodology, and the findings from the OSAE audit, demonstrate that improvements are possible to ensure more accurate budgeting of personal services and OE&E and the most efficient use of state resources. We also find that, due to significant changes to the state hospital system in recent years, the agreed-upon budgeting methodology between the administration and the Legislature from 2002 warrants review. Based on these findings, we recommend the following actions:

Contract Through OSAE for Independent Consultant. We recommend that the Legislature adopt budget bill language requiring OSAE to contract with an independent consultant to identify what, if any, improvements are necessary to the current staffing model for the hospitals. The consultant should provide an evaluation of workload distribution issues, all staffing ratios, and overtime. In addition, we recommend this consultant review whether the staffing levels established to meet CRIPA requirements are appropriate. The DMH would pay for the costs of the consultant out of its existing resources, given the high vacancy rates (about 19 percent across the state hospital system) for hospital staffing.

Report on Operating Expenditures. We recommend that the Legislature direct the department to report at budget hearings on the extent to which (1) personal services funds are being used to support operating expenditures in

state hospitals and (2) this practice may result in budget shortfalls in the future.

Revisit Agreed-Upon Budgeting Methodology. We recommend the Legislature direct the administration to work with the Legislature to establish a new caseload adjustment methodology agreement that considers the significant changes in the operation of the state hospitals since 2002. Please see the "Balancing the 2009-10 Budget" section of this report for a discussion of our recommendations for adjusting the Governor's budget request for state hospital caseload, which are based on the agreed-upon methodology from 2002.

DMH—State Hospital Estimate Package Still Needs Improvement

Background

In order to address concerns regarding the clarity and completeness of the budget proposal submitted each year for DMH, the Legislature adopted statutory budget language (as part of Chapter 758). The measure requires DMH to include specified information regarding the state hospital budget requests that are submitted annually to the Legislature each January 10 and at the time of the May Revision.

Historically, DMH has submitted its budget request in the form of a few summary tables and charts and several budget change proposals (BCPs). (A BCP is a proposal to change the level of service or funding for activities authorized by the Legislature, propose new program activities not currently authorized, or to delete existing programs. BCPs are prepared and submitted in a standard format.) Chapter 758 requires DMH to instead provide the Legislature with a fiscal estimate package. Generally, a fiscal estimate package combines the information contained in BCPs in a condensed format and provides additional information beyond what is typically provided in BCPs. In addition to overall requirements under Chapter 758 for information on patient caseload, staffing requirements, and OE&E, DMH's state hospital estimate package is required to include information on the following: (1) key budget assumptions and the methodologies used to estimate caseloads, staffing costs, and operating expenses and equipment; (2) policy changes; (3) fiscal "bridge" charts showing how the budget would change relative to the budget adopted in the prior year; and (4) additional information, as necessary, to provide the Legislature with a comprehensive fiscal picture.

These requirements would make the budget information related to the state hospital system more like the budget estimates provided for other departments with caseload- driven programs. For example, DDS submits an estimate package to the Legislature for its DCs. The DDS also provides a so-called "blue book" with additional caseload and budget information to the Legislature. The DDS estimate package and other important budget information are publicly available and easy to locate on DDS' Web site.

State Hospital Budget Request Does Not Meet All Chapter 758 Requirements

In our view, the hospital package submitted with the Governor's January 10 budget plan does not fully meet the requirements of Chapter 758. For example, the budget documents do not provide sufficient descriptions of budget assumptions and methodologies. Figure 13 illustrates what elements of Chapter 758 we believe DMH meets, partially meets, or does not meet in the budget request submitted to the Legislature on January 10, 2009.

Legislature Needs More and Better Information

Chapter 758 required the estimate package to include certain information, but also allows the department to provide additional information as deemed appropriate to provide a comprehensive fiscal perspective to the Legislature about the state hospital system. Our review indicates that it would be helpful for the department to provide additional demographic and performance data. Below, we describe why we believe this data would be useful to the Legislature.

Demographic Information Is Limited. Minimal demographic data for the state hospital patient population is currently being made available to the Legislature by DMH. We believe that tracking and reporting additional demographic information could help inform legislative policy. For example, the aging of the state hospital population is putting increasing demands on the medical capabilities of the state hospital system. However, up-to-date information on the characteristics of the state hospital caseload, including age distribution and the major diagnosis of patients, is not currently available.

Better Reporting of Performance Needed. The DMH estimate could include the reporting of key performance information that would be useful for the Legislature to help determine how effectively the state hospital system is meeting its goals and performing its mission. For example, data on the average length of stay for patients—broken out according to their state hospital, commitment category, and major diagnosis—would allow the Legislature to track how the length of stay of patients changes over time. An increasing length of stay, for example, may be an indicator of ineffective treatment practices. Other possible performance measures are accounting for the average number of IST patients participating each day in training to

Figure 13

State Hospital Budget Request Does Not Meet All Chapter 758 Requirements

	Status of Compliance		
	Meets	Partially Meets	Does Not Meet
Overall Requirements			
The estimate package shall address:			
• Patient caseload by commitment category	X		
• Non-level-of-care staffing requirements			X
• Level-of-care staffing requirements		X	
• Operating expenses and equipment		X	
Assumptions and Methodology			
The estimate package shall include a statement articulating the assumptions and methodologies used for calculating the following:			
• Patient caseload factors		X	
• All staffing costs		X	
• Operating expenses and equipment			X
Policy Changes			
The estimate package submitted shall include, where applicable, individual policy changes containing a narrative and basis for proposed and estimated costs.	X		
Fiscal Bridge Charts			
The estimate package shall include fiscal bridge charts to provide the basis for the year-to-year changes.		X	

regain their competency and the proportion of IST patients deemed competent to stand trial after completing treatment.

In response to federal CRIPA requirements that the state improve its care of state hospital patients, DMH is continuing to develop and implement a new centralized statewide database reporting system called the Wellness and Recovery Model Support System (WaRMSS). This new system generally allows for tracking of treatment activities and outcomes. As such, we believe that DMH's capacity to gather and easily report performance indicators for the state hospitals will be significantly improved and thus could be incorporated into the state hospital budget estimate.

Additional Information for Comprehensive Fiscal Picture. Chapter 758 allows for DMH to provide additional information to the Legislature necessary to give a comprehensive fiscal picture of the state hospital system. At this time, for these purposes, we believe that DMH should include information in the estimate package regarding the status of CRIPA compliance, waiting lists for state hospital admissions, as well as staffing vacancies and related recruitment efforts. This information, in particular, has significant cost implications for the state hospital system. For example, poor progress on CRIPA compliance could result in additional federal actions regarding the state hospitals and increased costs for the state.

Require Further Improvement Of the Estimate Package

As noted above, DMH is not yet in full compliance with the requirements of Chapter 758 and its estimate package could be significantly improved. We therefore recommend that the Legislature direct the administration to participate in a workgroup with legislative staff to develop an improved format for its January and May Revision budget requests. This process should further identify key spending, operations, and performance information, including information from WaRMSS, that should be included in the state hospital budget package.

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