

# SUBCOMMITTEE NO. 3

## HEALTH and HUMAN SERVICES

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## Medi-Cal Managed Care

### BACKGROUND:

The Medi-Cal program provides health care services to about 7.7 million low-income Californians, including children, seniors, and people with disabilities. The Medi-Cal 2011-12 budget includes total expenditures of \$50.2 billion (\$15.3 billion General Fund). Generally, each dollar spent on health care for a Medi-Cal enrollee is matched with one dollar from the federal government.

**Medi-Cal Delivery and Payment Systems.** Medi-Cal uses a variety of service delivery and payments systems. Originally, the primary payment mechanism was fee-for-service (FFS). Under FFS, a Medi-Cal enrollee obtains services from an approved Medi-Cal provider who is willing to take him/her as a patient for the service and accepts the Medi-Cal payment rate set by the state. In contrast, under Medi-Cal managed care, the Medi-Cal enrollee receives a defined package of benefits through a managed care plan. The plan is paid a per member capitated rate for each enrollee. Medi-Cal managed care currently covers approximately 4.3 million Medi-Cal beneficiaries in 30 counties.

Medi-Cal managed care is delivered through three models for its full-scope of services. These are:

- **County Organized Health System.** A County Organized Health System (COHS) is a local agency created by a county board of supervisors to contract with the Medi-Cal program. There are 14 counties in the COHS model. (COHS counties are: Marin, Mendocino, Merced, Monterey, Napa, Orange, San Luis Obispo, Santa Barbara, Santa Cruz, San Mateo, Solano, Sonoma, Ventura, and Yolo.)
- **Two-Plan Model.** Under the Two-Plan model, each designated county has two managed care plans, a local initiative and a commercial plan. (Two-Plan counties are: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare.)
- **Geographic Managed Care.** There are two Geographic Managed Care (GMC) counties in the state. In both counties (Sacramento and San Diego), the Department of Health Care Services (DHCS) contracts with several commercial plans to provide choices to the beneficiaries.

**Mandatory Enrollment of Seniors and Persons with Disabilities into Managed Care.** In November 2010, California received federal approval for a Section 1115(b) Medicaid waiver from Centers for Medicare and Medicaid Services (CMS) authorizing (among other provisions) expansion of mandatory enrollment of seniors and persons with disabilities (SPDs) into Medi-Cal managed care. This mandatory enrollment began on June 1, 2011 and will last twelve months. Approximately 20,000 people per month are being enrolled. Prior to this, enrollment into managed care was mandatory for children and families in the 30 counties with managed care and SPDs in the 14 COHS counties.

**GOVERNOR’S PROPOSAL:**

The 2012-13 Medi-Cal budget includes total expenditures of \$57.7 billion (\$14.8 billion General Fund). It also includes multiple proposals to expand Medi-Cal managed care and to contain costs for this delivery system.

**General Fund Savings (dollars in thousands)**

<b>Proposal</b>	<b>2012-13</b>
<b>Medi-Cal Managed Care Expansions</b>	
Managed Care Expansion to Dual Eligibles and Long-Term Care Integration	-\$621,793
Healthy Families Program Transition to Medi-Cal Managed Care	-\$64,377
Federally Qualified Health Center Payment Reform	-\$26,046
Managed Care Expansion into Rural Counties	-\$2,680
Eliminate the Sunset Date for the Gross Premium Tax	-\$161,843
<b>Medi-Cal Managed Care Cost Containment</b>	
Value Based Purchasing	-\$75,000
Align Managed Care Policies	-\$56,984
Annual Open Enrollment	-\$3,568
Managed Care Default Assignment	-\$2,409

The administration notes that many of these proposals generate savings immediately; however, since the Department of Health Care Services (DHCS) is budgeted on a cash basis, the incorporation of wrap-around payments for these proposals into the managed care capitation rates will result in an initial first year cost to DHCS, with savings achieved in each subsequent year. To address this cost, the administration is proposing a one-time deferral of managed care payments to the next fiscal year.

**Expansions to Medi-Cal Managed Care Timeline**

	July 2012	October 2012	January 2013	June 2013	January 2014	January 2015
Dual Eligibles (Medi-Cal benefits)*			phase in over 12 months			
Dual Eligibles' Medicare Benefits*			phase in three years starting with 10 counties			
Long-Term Care Services*			-----phase in over three years-----			
Federally Qualified Health Centers and Rural Clinics*	-----> phase-in period not specified					
Healthy Families Children*		-----phase in over nine months----				
Rural Counties				-----> phase-in period not specified		

\*Beneficiaries in non-managed care counties would begin their transition to managed care beginning in 2014-15.

**Enrollment of Dual Eligibles into Medi-Cal Managed Care**

**Background**

About 1.2 million of Medi-Cal beneficiaries are enrolled in both Medicare and Medi-Cal and are referred to as “dual eligibles.” Medicare is the primary payer for dual eligibles and covers health services, such as physician and hospital services and short-term skilled nursing. Medi-Cal is the secondary payer and typically covers Medicare cost sharing and services not covered by Medicare, as well as services delivered after Medicare benefits have been exhausted. Most long-term care costs are paid for by Medi-Cal including longer nursing home stays and home and community based services designed to prevent institutionalization.

Dual eligibles tend to be low-income seniors and persons with disabilities with multiple chronic conditions and are among the state’s highest-need and highest-cost users of health care services. As of January 2011, 70 percent of the dual eligibles were age 65 or older and 30 percent were between 22-64 years of age.

In 2007, California’s spending on dual eligibles was about \$7.6 billion, representing 23 percent of total Medi-Cal expenditures. The vast majority (about 85 percent) of these beneficiaries access services through the “fee-for-service” delivery system. It is estimated that about 16 percent (175,000) dual eligibles are in a managed delivery system, such as the Program for All-Inclusive Care for the Elderly (PACE), Two-Plan Model managed care, or COHS. (PACE is a capitated benefit provided primarily to certain Medi-Cal and Medicare beneficiaries that offers a

comprehensive service delivery system and integrates Medicare and Medicaid financing. Participants must be at least 55 years old, live in the PACE service area, and be certified as eligible for nursing home care.)

Chapter 714, Statutes of 2010 (commonly referred to as SB 208), directs the California Department of Health Care Services (DHCS) to create new models of coordinated care delivery for dual eligibles through four pilot demonstrations. To assist with this process, California received a \$1 million planning grant from CMS' Office of the Duals and the federal Center for Medicare and Medicaid Innovation.

### ***Governor's Proposal***

The administration is proposing to expand the enrollment of dual eligibles into Medi-Cal managed care (dual eligibles in COHS counties are already in managed care) from the four demonstration pilots described above to statewide. The transition of this population and Medicare benefits into Medi-Cal managed care would be phased-in. Starting January 1, 2013, dual eligibles would be mandatorily enrolled into Medi-Cal managed care and would receive their Medi-Cal benefits via managed care. Also starting January 1, 2013, but only in 10 counties, Medicare benefits for dual eligibles would be provided via managed care. Medicare benefits would be phased-in to managed care throughout the state over three years. Medicare and Medi-Cal funding would be combined into a single payment to a managed care plan with this transaction.

Since federal law prohibits the mandatory enrollment of Medicare beneficiaries into managed care, the administration is proposing a passive enrollment of these individuals whereby, dual eligibles would be enrolled into managed care but given the option to return to fee-for-service for Medicare benefits.

### ***Issues to Consider***

**Administration Has Foregone Pilot Phase and Opportunity to Learn From Demonstrations.** The purpose of SB 208 was to develop dual eligibles pilot demonstrations in order to develop effective health care models that integrate Medicare and Medi-Cal services and to learn from these pilots. Under SB 208, the administration is required to conduct an evaluation to assess outcomes and the experience of dual eligibles in these pilot projects and is required to report to the Legislature after the first full year of pilot operation and every year after. With this proposal, the administration has forgone this pilot stage and the ability to learn from the demonstration projects by proceeding with the *statewide* enrollment of dual eligibles into managed care.

**Challenges Identified in Mandatory Enrollment of SPDs into Managed Care.** The mandatory enrollment of SPDs into managed care that is still underway has identified challenges with ensuring that beneficiaries receive uninterrupted and coordinated care. For example, policies allowing beneficiaries to remain with their fee-for-service provider because of medical instability for 12 months appear to have been misunderstood and inconsistently applied. Additionally, given that about 60 percent of SPDs are defaulted into a managed care plan, it is likely that more beneficiary and provider outreach and education are necessary to ensure continuity of care.

**Consumer Protections and Continuity of Care Assurances Are Critical.** The administration's goals of enrolling dual eligibles into managed care include: (1) improving the beneficiary's health care, quality of life, and satisfaction with the health care system by eliminating fragmentation and inefficiencies that result from the incongruities between Medicare and Medi-Cal, (2) developing financial models that drive streamlined and coordinated care through shared savings and the elimination of cost shifting, and (3) promote and measure improvements in health outcomes. While these are important goals, it is critical to ensure that consumer protections and quality measures are in place to ensure that a beneficiary receives uninterrupted quality care especially given that dual eligibles have significant health care needs.

**Significant Work Needs to Be Done with Federal Government.** Integrating Medicare and Medi-Cal services and financing will require a considerable amount of time and effort. These programs have different policies, standards, and appeals processes. Although representatives from CMS have been involved in the discussions regarding the dual eligibles pilots, navigating the differences between these programs will be challenging.

## **Integration of Home and Community Based and Long-Term Care Services into Medi-Cal Managed Care**

### ***Background***

Medi-Cal provides long-term care services in both institutional (nursing home) and home and community based settings. In 2011-12, Medi-Cal will spend over \$4 billion for nursing home care.

California's home and community based services include:

- **In-Home Supportive Services (IHSS) program.** IHSS provides personal care services to about 445,000 individuals who are blind, aged (over 65), or who have disabilities. The 2011-12 IHSS budget includes \$5.0 billion total funds (\$1.4 billion General Fund). See the IHSS section of this report for a detailed discussion of the Governor's IHSS proposal.
- **Multipurpose Senior Service Program (MSSP).** With a budget of \$50.5 million (\$25.2 million General Fund), MSSP provides case managed services for frail, elderly clients who wish to remain in their own homes and communities. Clients must be age 65 or older, eligible for Medi-Cal, and certified (or certifiable) as eligible to enter into a nursing home. A team of health and social service professionals assess each client to determine needed services and then work with the clients, their physicians, families, and others to develop an individualized care plan. Services that may be provided with MSSP funds include, but are not limited to: care management, adult social day care, housing assistance, in-home chore and personal care services, respite services, transportation services, protective services, meal services, and special communication assistance. The California Department of Aging (CDA) currently oversees the operations of the MSSP program statewide and contracts with local entities that directly provide MSSP services. The program operates under a federal

- Medicaid Home and Community-Based, Long-Term Care Services Waiver and serves approximately 12,000 clients per month.
- **Community-Based Adult Services (CBAS) program.** The CBAS program will replace the Adult Day Health Care (ADHC) program on March 1, 2012. AB 97 (Chapter 3, Statutes of 2011) eliminated ADHC services from the Medi-Cal program effective July 1, 2011. A class action lawsuit sought to challenge the elimination. A settlement of the lawsuit was reached that establishes a new program, CBAS. Approximately 15,000 of the 35,000 people that were formerly eligible for ADHC will be eligible for CBAS. ADHC/CBAS is an organized day program of therapeutic, social and health activities and services provided to elderly persons or other persons with physical or mental impairments. The ADHC/CBAS budget for 2011-12 is \$289 million (\$144.5 million General Fund).

Medi-Cal managed care health plans bear limited financial risk for beneficiaries who are placed in long-term care institutions, such as nursing homes, and for the most part, do not cover home and community based services. These services are covered under Medi-Cal FFS.

### *Governor's Proposal*

The governor proposes to integrate long-term institutional care and home and community based services into the Medi-Cal managed care benefit. The inclusion of these benefits into managed care would begin January 1, 2013 and be phased in over three years. The administration's goal with incorporating long-term care and HCB programs into managed care is to promote the coordination of health and social care for Medi-Cal beneficiaries and to create fiscal incentives for health plans to make decisions to keep their members healthy and out of institutions (given that hospital and nursing home care is more expensive than HCB care). Since the rates for these health services are set by the state, the administration argues that health plans would be required to pay this rate. Consequently, the administration expects a decrease in institutional care utilization and an increase in HCB services.

Additionally, as part of this proposal, the administration is proposing to develop a standard tool that would be used to assess a beneficiary's need for home and community based programs. (Currently, each of the above mentioned programs has their own assessment tool and questions.) The administration is also proposing a stakeholder process to begin in June 2013 that would be used to gather feedback and perspective to shape the future phasing in of these services.

This proposal and the enrollment of dual eligibles into managed care discussed above, would save \$678.8 million General Fund in 2012-13 and \$1 billion General Fund in 2013-14. The 2012-13 savings would be due to a payment deferral to Medi-Cal providers (since Medi-Cal is budgeted on a cash basis). The administration estimates the proposal would achieve ongoing savings of \$1 billion starting in 2013-14.

### *Issues to Consider*

**Integration of Medical and Social Services Valuable Goal.** Long-term care has traditionally been dominated by the medical model, in which focus is placed primarily on an individual's disease or condition rather than their overall needs. However, this model fails to take into account the effect an individual's behavioral health and social supports has on their physical

health. Some of the most successful long-term care programs are those that integrate medical and social services, and in doing so, improve a person's health status and overall quality of life. Furthermore, most studies have found that managed long-term care programs reduce the use of institutional services and increase the use of home and community based services relative to fee-for-service programs, and that consumer satisfaction is high. However, this integration is a complex endeavor and will require extensive stakeholder engagement.

**Potential for Improved Care Coordination But Must Monitor Outcomes.** The current fragmented system of programs and services can leave beneficiaries on their own to link their needs with available services. Making a health plan responsible for the delivery of all benefits, health and social, could lead to better care coordination. However, under such a proposal, it would be important for the state to develop measures to evaluate enrollee outcomes to ensure that managed care plans are not cutting long term care services and costs inappropriately. Additionally, it would be important for the capitation payment to be set at the right level to encourage plan behavior that leads to improved health outcomes.

**Incorporating IHSS Services and Funding a Major Policy Proposal.** This is a major policy proposal that is linked to substantial General Fund savings. While improved health outcomes may be linked to integrating these services, careful review of the trailer bill will be required. Additionally, please see the IHSS section of this report for a discussion on issues to consider regarding the integration of IHSS into Medi-Cal managed care.

## **Payment Reform for Federally Qualified Health Centers and Rural Health Clinics**

### ***Background***

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are community based centers that provide primary and preventative health care services to medically underserved populations or areas without regard to a patient's ability to pay. In addition to receiving grants from the federal government, these health centers are reimbursed for providing Medicare and Medi-Cal services. There are 681 FQHCs and 293 federally designated RHCs in California. In 2009-10, FQHCs and RHCs represented over 90 percent of Medi-Cal expenditures for clinic-based care.

Federal law requires Medi-Cal to reimburse FQHCs and RHCs based on reasonable costs. The current reimbursement system is based on a prospective payment system (PPS). Under PPS, Medi-Cal generally reimburses centers a per-visit rate, which is adjusted by the Medicare Economic Index annually. (FQHCs and RHCs were exempt from the 10 percent provider rate reduction authorized in the 2011-12 budget.)

Medi-Cal managed care plans commonly contract with FQHCs and RHCs as part of their provider networks and are required to reimburse FQHCs and RHCs in their networks for providing services to plan beneficiaries at rates that are, at a minimum, comparable to other providers of similar services in the same network. Federal law requires Medicaid programs to make up the difference between negotiated rates paid by managed care plans and a center's guaranteed PPS fee-for-service rate. An annual reconciliation determines the total difference



between plan payments and PPS payments for the number of patient visits. These “wrap-around” payments (or supplemental payments) paid by Medi-Cal to FQHCs and RHCs with managed care contracts totaled \$229 million General Fund in 2009-10.

### ***Governor’s Proposal***

The administration proposes to integrate all FQHC and RHC costs into managed care capitated rates by reforming the payment methodology under Medi-Cal. Under this proposal, payments made to FQHCs and RHCs (participating in Medi-Cal managed care contracts) will change from the PPS system--a cost and volume-based payment--to a fixed payment to provide a broad range of services to its enrollees. The administration argues that this would create a performance, risk-based payment model that rewards clinics for providing more efficient and better care. The “wrap-around” payment funds would also be included in the capitated rate; thereby requiring health plans to be fully responsible for reimbursement to FQHCs and RHCs. (Payments to FQHCs and RHCs for beneficiaries who are both Medicare and Medi-Cal eligible would be exempt from this proposal.)

The administration is seeking a waiver from the federal government to reform the payment methodology and to eliminate current restrictions that prevent best practices, such as group visits, telehealth, performing multiple services on the same day, and telephonic disease management. It argues that eliminating these operating constraints would create efficiencies and allow FQHCs and RHCs to institute best practices. These efficiencies would result in a ten percent efficiency adjustment; thereby saving \$26 million General Fund in 2012-13 and about \$58 million in 2013-14. In order to realize the budget year savings, the administration is proposing to delay \$43.6 million (General Fund) in managed care payments to FQHCs and RHCs into 2013-14.

### ***Issues to Consider***

**Rate Cut’s Impact on Sustainability of these Centers.** Though the elimination of operating restrictions to allow centers to provide care the best way they see fit could allow for system efficiencies and could lead to better quality care; the reduction in payment to these centers may impact access. It is unclear the extent to which centers might achieve operating efficiencies and savings with the removal of certain restrictions. Given that in 2010, 64 percent of primary care visits for Medi-Cal beneficiaries was provided in these centers, it is critical that any type of rate reform not impact the sustainability of these centers.

**Major Redesign of Payment and Delivery System.** This is a major policy proposal with a very aggressive timeline. This proposal would require federal approval and have a major impact on the clinic delivery system.

## **Healthy Families Program Transition to Medi-Cal**

### ***Background***

The Healthy Families Program (HFP) offers low cost insurance that provides health, dental, and vision coverage to children up to age 19 in families with incomes up to 250 percent of the Federal Poverty Level (FPL) who do not have insurance and do not qualify for no-cost Medi-Cal. Families pay a monthly premium and the program subsidizes the remaining cost of coverage.

The HFP has a tiered premium structure that specifies low premiums for families under 150 percent of FPL and higher premiums for higher-income families. The General Fund supports 35 percent of the program and federal Children’s Health Insurance Program (CHIP) fund reimburses 65 percent of total program costs. There are currently about 877,000 children in the HFP.

Federal health care reform implements changes to the nation’s health care system. Among these changes, it requires states to expand Medi-Cal eligibility for children in families with income up to 133 percent of FPL in 2014. Currently children age 1 to 5 in families with income up to 133 percent of the FPL and children age 6 to 19 in families with income up to 100 percent of the FPL are eligible for Medi-Cal.

**Governor’s Proposal**

The budget proposes to reduce the rates paid to health, dental, and vision plans for the Healthy Families Program (which average \$103.44) to the average combined Medi-Cal rate of \$76.86. This is projected to result in General Fund savings of over \$64 million in 2012-13. (The state would still claim federal reimbursement of 65 percent for these children under this proposal.)

Additionally, the budget transfers the approximately 877,000 children in HFP into Medi-Cal over a nine-month period beginning October 2012. The administration proposes that this transfer would create benefits for children, families, health plans, and providers by simplifying eligibility and coverage for children and families, improving coverage through retroactive benefits, increased access to vaccines, expanded mental health coverage, and eliminating premiums for lower-income beneficiaries. To the extent possible, HFP children enrolled in managed care or dental managed care plans that are also contracted plans under Medi-Cal will remain with the plan; otherwise, they will be afforded the option of choosing from available Medi-Cal managed care or dental plans in their respective county. Children residing in counties without a Medi-Cal managed care plan will receive their Medi-Cal under the FFS delivery system until managed care is available.

**Healthy Families Program Transition to Medi-Cal Timeline**

Transition Period	Impacted Beneficiaries	Number Impacted
<b>Phase 1</b> October – December 2012	HFP children enrolled in a managed care plan that directly contracts with Medi-Cal	410,666
<b>Phase 2</b> January – March 2013	HFP children enrolled in a managed care plan that subcontracts with Medi-Cal	424,103
<b>Phase 3</b> January 1, 2013 →	HFP children in counties without Medi-Cal managed care	43,090

**Issues to Consider**

**Transition Plan Information Not Yet Available.** Last year’s budget act included language requiring the administration to develop a transition plan for the transfer of administrative functions for the operation of HFP (and the Access for Infants and Mothers Program) to the Department of Health Care Services and submit the plan to the Legislature no later than

December 1, 2011. This plan has not yet been submitted. Additionally, details on the assurance of network adequacy and provider continuity and access; enrollment and eligibility timeframes and standards; notification and outreach efforts; and process for stakeholder consultation are not yet available.

**Some HFP Children Will Be Shifted to Medi-Cal Under Federal Health Care Reform.**

Additionally, as discussed above, under federal health care reform, HFP children with incomes under 133 percent of the federal poverty level (approximately 186,000 children as of November 2011) would become Medi-Cal beneficiaries on January 1, 2014. With this proposal, the administration has decided that children in families with incomes *over* 133 percent of FPL should also move to Medi-Cal even though this is not required by health care reform. As implementation of health care reform moves forward, including the development of the Health Benefit Exchange, the Legislature may want to consider if it would be more appropriate for these children in higher income families to obtain coverage from the same provider as their parents.

**Incorporate HFP's Strengths into Medi-Cal.** Generally speaking, based on 2009 HEDIS (Healthcare Effectiveness Data and Information Set) quality measures, HFP and Medi-Cal show relatively little difference in quality of care indicators. Furthermore, each program has historically had its own strengths, for example, most would agree that HFP has provided better access to care than Medi-Cal (HFP's higher reimbursement rate is likely a contributing factor to this) and that the Managed Risk Medical Insurance Board has a stronger focus on children's issues, while Medi-Cal's mental health coverage is more broad than HFP and Medi-Cal has more rigorous due process regarding grievances. If these children are shifted to Medi-Cal, the administration should work to ensure that the strengths of the HFP program are incorporated into the Medi-Cal program.

**Reduction to HFP Rate Could Impact Access and Continuity of Care.** Finally, it is unclear how plans that contract with HFP will behave if their reimbursement rate is reduced by 25 percent, as proposed by the administration, and how this might impact access to care for these children. Additionally, some children in HFP could experience an interruption in care as their provider may choose not to be part of the Medi-Cal managed care network.

## **Expand Medi-Cal Managed Care into Rural Counties**

### ***Governor's Proposal***

The budget proposes to expand managed care into the remaining 28 rural counties that are now fee-for-service only beginning in June 2013. The administration proposes that the above described expansions to managed care would support the development of adequate provider networks in rural counties. This would result in \$2.7 million General Fund savings in 2012-13 and \$8.8 million in 2013-14.

### ***Issues to Consider***

**Unclear if Provider Network in Rural Counties Would be Adequate.** Critical to the expansion of managed care into rural counties is ensuring provider participation in a managed care network. Other states which have made managed care mandatory in rural areas have faced challenges finding providers willing to participate. Similarly, it is unclear if health plans are

willing to participate in rural areas. Without participating providers and health plans, expansion of managed care into rural areas may not be feasible.

## **Eliminate Sunset Date of Gross Premium Tax on Managed Care Plans**

### ***Background***

The managed care gross premium tax is a tax on the gross revenues of a managed care plan. It is used by the state to draw down federal funds to fund children's health services under the Healthy Families Program and to increase the capitation rates paid to Medi-Cal managed care plans.

### ***Governor's Proposal***

The budget proposes to eliminate the sunset date of the Gross Premium Tax on Medi-Cal managed care plans. Continuing the tax, coupled with the proposed increased managed care utilization discussed above, would generate General Fund savings of \$161.8 million in 2012-13 and \$259.1 million in 2013-14. Since this tax is based on a managed care plan's gross revenue, if any of the proposed expansions to Medi-Cal managed care (discussed above) are not implemented, the General Fund savings would be reduced.

## **Value Based Purchasing**

### ***Background***

Currently DHCS must use regulations or statute to add, modify, limit, or eliminate reimbursement and services in the Medi-Cal program. The regulatory process can often take at least a year to complete.

### ***Governor's Proposal***

The budget proposes trailer bill language to develop a process to evaluate the cost-effectiveness of services and payment and rate design to ensure that Medi-Cal beneficiaries and the state are receiving value. Generally, under the new process, DHCS would review scientific literature and stakeholder input regarding a particular service, for example, to determine if that service provides little or no value to a beneficiary. If it finds that the service provides minimal value, then it would engage stakeholders to discuss the proposed changes to services. After a review of stakeholder input, which may include stakeholder meetings, DHCS could make changes to benefit design and seek federal approval, if necessary. Additionally, the administration proposes to include a post-implementation assessment to ensure that changes achieve the intended results. Examples of potential program changes include reducing laboratory rates, no longer funding avoidable hospital admissions, and no longer paying for services of limited value.

This proposal would save \$75 million General Fund in 2012-13 and annually thereafter. Of the \$75 million, \$26.6 million in 2012-13 and \$30 million in 2013-14 is estimated to be a result of adjusting managed care plan rates for situations when a person acquires a preventable health condition in a health care setting as required by federal health care reform. (CMS will begin enforcing this requirement by July 1, 2012.)

This new process would mostly apply to the FFS system; however, the administration argues that this process may drive changes in managed care as health plans often follow FFS policy.

### *Issues to Consider*

**Safeguards to Ensure Stakeholder Participation Unclear.** While the administration argues that the Medi-Cal health care delivery system needs to be able to more rapidly respond to the changing field of health care than the current regulatory process allows, the proposed process is outside the current regulatory framework which has established safeguards to ensure stakeholder participation and disclosure of departmental actions. How this process would ensure an appropriate level of input from stakeholders and accountability to the public and Legislature is unclear.

## **Align Managed Care Policies**

### *Background*

Medi-Cal covers the cost of medical services provided to beneficiaries during a retroactive period of 90 days before their enrollment into Medi-Cal. County Organized Health Systems (COHSs) cover the cost of the retroactive period through an adjustment in their capitation rates. The Two-Plan and Geographic Managed Care (GMC) health plans are not responsible to cover the costs of their enrollees during the retroactive period, as these costs are paid via fee-for-service (FFS) (outside of their capitation payment).

### *Governor's Proposal*

The administration proposes to align COHS' responsibility for the retroactive period with the Two-Plan and GMC methodology and pay for these services through FFS. An estimated savings for \$57 million General Fund would be achieved in 2012-13 and \$7.5 million General Fund annually thereafter.

## **Institute Annual Enrollment Process for Medi-Cal Managed Care**

### *Background*

Current law allows Medi-Cal beneficiaries in a Two-Plan Model and Geographic Managed Care (GMC) model to change health plans once per month or up to 12 times in a year. Mandatory enrollment of SPDs into managed care began June 2011 and will be completed at the end of the current budget year. Managed care is a new approach for hundreds of thousands of individuals many of whom have unpredictable and changing needs that may require them to change plans more than once per year to ensure, for example, that they have access to particular specialty care providers.

### *Governor's Proposal*

The budget proposes trailer bill language to change this existing managed care enrollment policy to only allow Medi-Cal enrollees in Two-Plan and GMC counties to change plans once a year. Essentially, a notification would be mailed to each health plan member to allow the individual the opportunity to change health plans during a specified enrollment period. The administration estimates that instituting an annual enrollment process for Medi-Cal managed care would result

in a General Fund savings of \$3.6 million in 2012-13 and \$6 million in 2013-14. It should be noted that this proposal requires an amendment to California's 1115 Medicaid Waiver, and is a change to SB 208, Statutes of 2010, which provided the framework for the mandatory enrollment of SPDs into Medi-Cal managed care.

### *Issues to Consider*

**Mandatory Managed Care Enrollees Need Ability To Change Plans.** The administration submitted a similar proposal in last year's May Revision. This proposal was rejected by the Legislature given that SPDs are still in the process of being enrolled into a managed care plan and need transition time to make changes and feel comfortable with their plans. Furthermore, given that about 60 percent of SPDs are being defaulted into a managed care plan, it is important to ensure that these beneficiaries have time to understand the changes to how their health care services will be provided and have the opportunity to change plans in order to meet their health care needs.

## **Change Default Health Plan Assignment for Medi-Cal Managed Care**

### *Background*

When a Medi-Cal beneficiary is enrolled in managed care but does not select a health plan, a default health plan is assigned to the beneficiary. In 2005, DHCS developed default ratios to base this default assignment on health plan quality of care measurements and safety net populations.

### *Governor's Proposal*

The administration seeks to change the default health plan assignment (for families and SPDs) to consider health plan costs in addition to quality of care and safety net population factors. The administration finds that this new assignment methodology would reward plans with lower costs with additional default enrollment. This would result in \$2.4 million General Fund savings in 2012-13 and \$5.8 million in 2013-14.

### *Issues to Consider*

**Does Low Cost Ensure Quality Care?** While costs should be a consideration when defaulting a person into a managed care plan, careful consideration must be made to ensure that the low-cost health plans offer quality care and that cost does not become the most important factor in this assignment.

# Department of State Hospitals

## BACKGROUND:

The Department of Mental Health (DMH) operates five state mental hospitals and two psychiatric programs within state prisons (California Medical Facility and Salinas Valley State Prison), which provide inpatient mental health treatment. Four of the mental health hospitals – Napa, Metropolitan (Norwalk), Atascadero, and Patton (San Bernardino) – were constructed more than 50 years ago. In 2005, DMH opened the Coalinga Mental Hospital to provide treatment for sexually violent predators. DMH also oversees a variety of state and local public mental health programs. In 2011, funding for some local mental health services was realigned to counties.

The majority of the state hospital population, approximately 92 percent, is forensic or penal code related. Major categories of state hospital patients include:

- Judicial commitments directly from superior courts - Not Guilty by Reason of Insanity (NGI) and Incompetent to Stand Trial (IST)
- Civil commitments as Sexually Violent Predators (SVPs)
- Referrals/transfers from California Department of Corrections and Rehabilitation (CDCR) including Mentally Disordered Offenders (MDOs) and Parolees
- Civil commitments from counties under the Laterman-Petris-Short Act

On May 2, 2006, the United States Department of Justice (USDOJ) and the State reached a settlement concerning civil rights violations at four state mental hospitals. The judgment called for Metropolitan State Hospital, Napa State Hospital, Patton State Hospital, and Atascadero State Hospital to implement an “Enhancement Plan” to improve conditions. Coalinga was not covered by the agreement because it had just opened, but it has similar reforms in place now. The extensive reforms required by the five-year Consent Judgment were to ensure that individuals in the hospitals are adequately protected from harm and provided adequate services to support their recovery and mental health.

The USDOJ conducted its investigation pursuant to the Civil Rights of Institutionalized Persons Act of 1980 (CRIPA). This statute allows the federal government to identify and root out systemic irregularities such as those identified in this case, rather than focus on individual civil rights violations.

In November of 2011, the USDOJ released Patton State Hospital and the Atascadero State Hospital from oversight, deeming them in compliance with the bulk of the consent judgment's demands. However, DOJ officials asked a judge to extend federal oversight of Napa State Hospital and Metropolitan State Hospital, saying the facilities have failed to comply with critical provisions of the consent judgment.

In July of 2011, DMH commissioned a report to assist in the proposal for a state mental hospital department to be included in the 2012-13 Governor’s Budget. The scope of the project was to recommend the administrative structure for a state mental hospital department, to identify processes that might be organized differently for better performance and accountability, and to collect information on the department’s budget deficit. The report was released in December 2011.

**GOVERNOR’S PROPOSAL:**

The Governor’s budget proposes to eliminate DMH, proposes to create the Department of State Hospitals (DSH), and transfer responsibility for community mental health programs to other state departments. The budget includes \$1.4 billion from all fund sources and 9,861.3 positions to support 6,439 patients in 2012-13.

(dollars in millions)

Program	Positions	Funding
In-Patient Services Program	9,594.7	\$1,411.6
Evaluations and Forensic Services	75.1	\$21.4
Legal Services	24.7	\$5.6
Administration	166.8	\$16.7
Distributed Administration	-	-\$16.7
<b>Total</b>	<b>9861.3</b>	<b>\$1,438.6</b>

The budget proposes to transfer the majority of community mental health programs for DMH to the Department of Health Care Services (DHCS). In total, the budget transfers \$104.7 million from DMH to other state departments or entities, as follows:

(dollars in millions)

Department	Function/Program	Positions	State Ops.	Local Assist.	Total
Health Care Services (DHCS)	Financial Oversight, Certification Compliance, Quality Improvement, Mental Health Services Act (MHSA) State Functions, County Data Collection and Reporting, Suicide Prevention, Co-Occurring Disorders, Veterans Mental Health, Substance Abuse and Mental Health Services Administration Block Grant, Projects for Assistance in Transition from Homelessness, Training Contracts, CA Institute for Mental Health, CA Health Interview Survey, Policy Management, Admin Staff, CA Mental Health Planning Council	41	\$11.1	\$61.2	\$72.3
Social Services	Licensing/Quality Improvement (Mental	12	\$1.1	\$-	\$1.1



(DSS)	Health Rehabilitation Centers, Psychiatric Health Facilities)				
Mental Health Services Oversight and Accountability Commission	Training Contracts – Consumer Groups, MHSa Program Evaluation	-	\$1.7	\$-	\$1.7
Public Health	Office of Multicultural Services, Disaster Services and Response	4	\$2.3	\$-	\$2.3
Education (CDE)	Early Mental Health Initiative	0	\$-	\$15.0	\$15.0
Office of Statewide Health Planning and Development	Mental Health Services Act Workforce Education and Training	1	\$1.1	\$12.2	\$12.3
<b>Totals</b>		<b>58</b>	<b>\$16.3</b>	<b>\$88.4</b>	<b>\$104.7</b>

**ISSUES TO CONSIDER:**

**The department must improve fiscal oversight.** DMH hospitals experienced deficits in 2009-10 and 2010-11. As previously mentioned, a thorough evaluation of the state hospital system and its budget was performed in developing the new DSH. The report highlighted unfunded activities within the system, some of which were the result of federal court orders. However, the report also found that the deficit was the result of appropriation reductions that were not operationalized, coupled with expenditure increases, one of which was for an expansion of the court-ordered Enhancement Plan that was not authorized by the Legislature. Further, the report found that the department contributed to the deficiency through a lax approach to fiscal management and broad fiscal oversight deficiencies, including:

- Lack of management support for cost-consciousness and fiscal accountability.
- Lack of detailed base budgets and other fiscal systems necessary for budget control.
- Lack of training for budget control; and rudimentary implementation of the accounting system resulting in the inability to collect necessary cost data.
- An overall system of appropriation control that is deficient.
- Detailed base budgets missing in headquarters and the hospitals.
- No shared culture of cost containment in the department as a whole, much less for patient care.

The report also proposed a plan to address the current year funding shortfall of approximately \$180 million. In the budget, through a combination of current year cost saving measures, the shortfall is reduced to approximately \$63 million. However, achieving the cost saving measures that are included in the budget and containing costs in general will not be easy without

addressing the issues noted above. The department must provide the Legislature with assurance that it has the proper structure, processes, and tools to effectively manage its resources.

**Staff and patient safety.** Over the past 20 years, the hospital system has moved away from its community origins. The percentage of forensic and penal code patients has increased, bringing an increasing risk of violence, sometimes different treatment objectives, and an aging, more medically fragile patient population. With the exception of Coalinga, DMH hospitals were not built for a forensic population.

Each state hospital has varying specialty treatment programs, security, and staffing patterns. Some differences are:

- Napa and Metropolitan, due to the nature of their campuses, are restricted in how many penal code-related patients may reside at their facilities and only accommodate lower-level/less-security risk individuals.
- Metropolitan does not have a perimeter fence and has limited security.
- Coalinga receives the SVP patients and, generally, the more difficult to serve MDOs.
- Patton has had the highest population for many years and the state has the authority to “over-bed” at this facility per a long-standing licensing agreement.
- Patton has historically had CDCR staff patrol the perimeter fence and provide additional security.

Last February, the subcommittee discussed DMH hospital safety and security issues due to a number of assaults on hospital staff and patients, including a homicide of a staff member at Napa in October of 2010. In addition, the DMH evaluation conducted last year also highlighted safety as a key concern of staff. Although a number of steps to enhance hospital safety have been taken, or are planned, this issue must not be overlooked in the department’s restructuring. Initiatives taken or underway to address violence within the state hospitals include:

- In response to the homicide, Napa has been developing and implementing several safety enhancements, including: development of an Enhanced Safety Plan by hospital police, revisions of various policies/procedures and leadership changes, and stakeholder meetings and summits to address violence issues.
- The 2011 budget includes measures to address the increase in violence and aggressive behavior in the state hospitals, including: implementation of Grounds Presence/Safety Teams to monitor secure treatment areas and a pilot project for personal alarms at Napa.
- Current proposals include enhanced resources for the Napa personal alarm system and to roll the alarm system out to other four state hospitals over the next two years; establishment of an Enhanced Treatment Unit at Atascadero, creating flexible patient and staff ratios based on aggression; and developing and implementing new safety and response policies with the California Occupational Safety and Health Administration.

**State hospital role in treating CDCR inmate-patients.** As DMH’s forensic population has increased, so too has their role in treating CDCR inmate-patients. The DMH provides inpatient mental health care services in licensed beds to *Coleman* (lawsuit and court order pertaining to deficiencies of CDCR’s Mental Health Program) class inmate-patients referred by the CDCR.

System wide, DMH operates a total of 886 beds for *Coleman* class inmate-patients of which 336 are in state hospital programs and 550 are in psychiatric programs imbedded in two CDCR institutions. In addition, the budget proposes to free up additional beds at Atascadero as part of a plan to reduce the *Coleman* bed waitlist and the department is committed to operate 475 licensed inpatient mental health beds at a new 1,722 bed CDCR facility that is scheduled to activate in December 2013.

As DMH's role in treating inmate-patients increases, it is important to examine the continuum of care for CDCR mental health patients. Questions to consider include:

- How does mental health treatment compare between the two departments (are there comparable outcome measures)?
- What is the process for referring patients from CDCR to state hospital programs?
- As DMH's role within CDCR institutions increase, should their role be expanded further in treatment of inmate-patients?
- Is the state maximizing efficiencies in care and resources (staff classifications, drug purchases, contracts, etc.)?

## In-Home Supportive Services (IHSS)

### BACKGROUND:

With a 2011-12 budget of \$5.0 billion (\$1.4 billion GF), the IHSS program provides personal care services to approximately 440,000 qualified low-income individuals who are blind, aged (over 65), or who have disabilities. IHSS services include tasks like feeding, bathing, bowel and bladder care, meal preparation and clean-up, laundry, and paramedical care. These services frequently help program recipients to avoid or delay more expensive and less desirable institutional care settings. The maximum number of monthly hours a beneficiary can receive is 283.

#### *A Few Facts About IHSS:*

- ❖ There are 440,000 low-income IHSS recipients who are aged, blind, or who have disabilities.
- ❖ Services include personal care (bathing, grooming, etc.), as well as domestic and related activities of daily living.
- ❖ There are 366,125 IHSS providers whose wages vary from \$8.00 to \$12.20 hourly.
- ❖ In 2012-13, services are estimated to cost an average of \$11,420 annually per client.

**Funding and Oversight:** IHSS is funded with federal, state, and county resources. Recently, the state opted to implement the program under a new federal Medicaid waiver option called the Community First Choice Option (CFCO), which offers an enhanced rate of 56 percent federal financial participation (six percent over the base rate of 50 percent). The state is also benefitting from an additional enhanced rate of 75 percent for a period of one year for IHSS recipients transitioning from nursing facilities to community-based settings. The state and counties split the non-federal share of IHSS funding at 65 and 35 percent, respectively. The average annual cost of services per IHSS client is estimated at \$11,420 for 2012-13. The Department of

Health Care Services is the statewide agency responsible for administering and supervising the state's Medicaid plan, including federal funding for IHSS. At the same time, the Department of Social Services oversees local administration of the program, which is usually managed by county social services agencies and public authorities.

**Program Structure and Employment Model:** County social workers determine eligibility for IHSS after conducting a standardized in-home assessment, and periodic reassessments, of an individual's ability to perform specified activities of daily living. Once eligible, the recipient is responsible for hiring, firing, and directing an IHSS provider or providers. The counties or public authorities must conduct a criminal background check and provide an orientation before a provider can receive payment. At the end of 2011, there were just over 366,000 working IHSS providers. County public authorities are designated as "employers of record" for collective bargaining purposes, while the state administers payroll, workers' compensation, and benefits. Hourly wages for IHSS providers vary by county and range from the minimum wage of \$8.00 per hour in nine counties to \$12.20 in one county. The state participates in the costs of wages up

to \$12.10 (\$11.50 plus \$.60 for health benefits) per hour, with counties paying the difference if they negotiate a higher wage. In approximately 72 percent of cases, IHSS recipients choose a family member to provide care (including roughly 45 percent of providers who are a spouse, child, or parent of the recipient). In around half of cases, IHSS providers live with the recipients. Public authorities also maintain registries of approved caregivers for recipients who want assistance finding a provider.

**Recent Changes:** The last three budgets included significant changes to IHSS. The following are in effect or pending implementation (savings are annual for 2012-13 unless otherwise noted):

Additional <b>program integrity measures</b> , including background checks and criminal records exclusions for providers, more training for social workers, changes to time sheets, and directed mailings or unannounced home visits when there is a concern.
Savings of \$151.1 million General Fund from a requirement for recipients to obtain from a licensed health professional a <b>certification of their need</b> for services to prevent risk of out-of-home care.
Savings of \$145.1 million General Fund from the federal <b>CFCO waiver</b> option.
Upon federal approval, savings of \$95.5 million General Fund as a result of a <b>sales tax on supportive services</b> and matching funds for the use of the tax revenues.
Current year savings of \$64.4 million General Fund from an <b>across-the-board reduction</b> of 3.6 percent in all recipients’ authorized hours until July 1, 2012.
Increases in <b>out-of-pocket costs for consumers</b> (resulting from elimination of what was called a “share-of-cost buy-out”).
Reductions in administrative funding for Public Authorities.

The following changes were also enacted, but federal courts have stopped them from taking effect as a result of ongoing litigation:

Savings of approximately \$222.0 million General Fund (full year impact) from an across-the-board reduction, subject to specified exemptions and exceptions, of 20 percent of authorized hours. This reduction was triggered by lower than anticipated 2011-12 revenues.
Savings of \$65.5 million General Fund from reducing to \$10.10 (\$9.50 plus \$.60 per hour for health benefits) the maximum provider wages the state participates in.
Elimination of eligibility, subject to exemptions, for domestic and related services or all services, for individuals whose needs were assessed to be below a specified threshold. <sup>1</sup>

The 2011-12 budget also established a pilot that requires DHCS to identify Medi-Cal beneficiaries at high risk of not taking medications as prescribed and to procure automated

<sup>1</sup> This reduction has been statutorily delayed until July 1, 2012, subject to a final court order upholding the policy. No updated estimate of the savings associated with the policy is available at this time.

machines to assist them. If the pilot and any enacted alternatives for achieving savings would not together result in \$140 million General Fund, an across-the-board reduction in IHSS services, with specified exceptions, would begin October 1, 2012.

#### **GOVERNOR'S 2012-13 BUDGET PROPOSALS:**

**Across-the-Board Reductions and Medication Dispensing:** Although the 20 percent reduction in authorized hours is not occurring today because of the court order mentioned above, the budget assumes a full-year impact from the policy. At the same time, the Administration proposes a set-aside to fund the program in the event that the reduction continues to be enjoined. If the reduction takes effect, DSS anticipates that 233,000 recipients will lose the full 20 percent of their services in the budget year. Of the remaining recipients, the Department estimates that counties would partially restore hours for 152,000 clients and fully restore hours or exempt from the reduction 38,000 clients. The budget also proposes to repeal statutory requirements for the medication-dispensing pilot and associated across-the-board reduction trigger. DHCS indicates that further research led the Department to conclude that the pilot may not result in savings (and savings from a 20 percent across-the-board reduction are already included in the budget).

**Proposed Move to Managed Health Care and Efforts to Better Coordinate Services:** As described in greater detail in the Health section of this publication, the budget proposes to improve the coordination of certain health and social services by: 1) making long-term care and home and community-based services, including IHSS, benefits under managed health care, 2) expanding managed health care statewide, and 3) expanding a previously authorized demonstration project intended to better integrate services for individuals who are dually eligible for Medi-Cal and Medicare. The vast majority of IHSS recipients (85 percent) are dually eligible beneficiaries. All of these changes would happen simultaneously, though phased in at varying paces, through 2015. The budget does not propose any accompanying programmatic changes in IHSS in 2012-13 related to this policy. However, DHCS indicates that “over time, managed care plans will take on increasing responsibility for home and community-based services, including IHSS.” The Administration has not yet specified what that increasing health plan responsibility over the long-term would entail or detailed how the IHSS program may or may not be altered as a result.

**Proposed Restrictions on Domestic & Related Services:** The budget proposes \$210.5 million General Fund savings in 2012-13 from the elimination of domestic and related IHSS services for approximately 245,000 recipients who reside in shared living arrangements. Domestic and related services include housework, shopping for food, meal preparation and cleanup, laundry, and other shopping and errands. Currently, when IHSS beneficiaries reside in a shared living arrangement and some of their needs for domestic or related services are met by other household members (e.g., shopping is done in common), authorized hours for those services are pro-rated by county social workers based on the number of household members. The budget proposes to instead make IHSS beneficiaries residing in a shared living arrangement ineligible for domestic and related services. The proposal includes exceptions when all other household members are IHSS recipients or have medically verified conditions that prevent them from performing domestic and related services. The proposal extends to minor recipients with disabilities who

live with their parent(s). The parent would be presumed available to perform these tasks unless the parent can provide medical verification of his/her inability to do so. The Administration made a substantially similar proposal last year, which was rejected by the Legislature.

#### ISSUES TO CONSIDER:

**As indicated in the preceding section on Medi-Cal Managed Care, better integration of long-term care supports and services is a valuable goal and could improve care coordination. At the same time, the Administration's proposals to expand the use of managed care and to make IHSS a managed care benefit raise a number of significant, unanswered programmatic questions.** These questions include whether and how that change might lead to future changes in: 1) consumers' ability to hire, fire and direct their care providers, 2) the assessment process for determining consumers' eligibility for services, 3) the scope and number of hours of IHSS services available, 4) the state and counties' roles in financing and overseeing care, 5) the employment relationships, wages, and benefits paid to providers, and 6) the outcomes and performance measures that would guide measurement of the program's success. Much of the policy governing these programmatic aspects is currently detailed in state law, and many potential changes in these areas would require statutory change. Some options for programmatic changes may also be constrained by requirements associated with federal funding for the IHSS program. The Administration acknowledges these questions and sets forth core values with which the Departments intend to approach them, including continued consultation with stakeholders and the protection of consumers' rights. But, while trailer bill language is not yet available, the Administration has thus far indicated that it does not anticipate making detailed proposals related to these long-term programmatic questions this year.

**It is unclear whether the proposed elimination of domestic and related IHSS services for recipients who reside in shared living arrangements would comply with federal law and whether it accurately targets the reduction to recipients whose needs can be met in common.** According to the Legislative Analyst's Office, Washington State recently enacted a restriction on domestic and related services for individuals who lived with their IHSS providers. The state's Supreme Court determined, however, that the policy violated federal requirements regarding the equal treatment of similarly situated Medicaid beneficiaries. Also, the Administration's proposal is predicated on an assumption that domestic and related responsibilities can be met in common in a household so long as the other residents are not also IHSS recipients and do not have a medically verifiable condition that prevents them from performing the tasks. There may be other circumstances in which household residents are not available, able, or willing to perform those services on the recipients' behalf. Some recipients could also have difficulty finding shared living arrangements (e.g., if unable to obtain their own groceries, safely prepare and clean up their own meals, or contribute to the upkeep of a household).

# CalWORKs

## BACKGROUND:

California Work Opportunities and Responsibilities to Kids (CalWORKs) provides cash assistance and welfare-to-work services to eligible needy families with children. The program supports 587,000 needy families with 1.2 million children<sup>1</sup> by helping them to attain self-sufficiency and by providing a safety net so that children can have their most basic needs met.

### *Some Information About CalWORKs Recipients:*

- ❖ Nearly half (46%) of child recipients are under the age of 6.
- ❖ Around 27% of children who were served in the Child Welfare Services system were also served by CalWORKs.
- ❖ 92% of heads of recipient households are women. Two-thirds of them are single and have never married.
- ❖ Nearly half of these adults (41% of the 76% with data available) have 11<sup>th</sup> grade or less education, and 10-28% are estimated to have learning disabilities.
- ❖ Around 80% of these adults report experiencing domestic abuse at some point; and
- ❖ An estimated 19-33% have mental or emotional health problems.

Absent the Governor's proposals, CalWORKs would have a budget of \$5.8 billion in combined federal, state, and local funds.

**Caseload and Spending Trends:** Prior to federal welfare reform in the mid-1990s, California's welfare program aided more than 900,000 families. By 2000, the caseload had declined to 500,000 families. During the recent recession the caseload has grown; but at 587,000 cases, it has not returned anywhere close to the levels of the early 1990s. The caseload grew one percent in 2007-08, eight percent in 2008-09, ten percent in 2009-10, and six percent in 2010-11. Caseload growth has slowed to a projected two percent in 2011-12; and the Administration forecasts a small decline in 2012-13. According to the California Budget Project, welfare assistance represented 6.8 percent of the state's overall budget (including federal, state, and local resources) in 1996-97, compared with 2.9 percent in 2011-12.

**Welfare-to-Work Caseload:** In 270,000, or just under half of CalWORKs cases,

families receive cash assistance for an adult (or adults) in addition to children. The adult's eligibility is subject to a lifetime limit of 48 total months. The overall average grant for recipient families is currently \$471 monthly (up to a maximum of \$638 for a family of three in a high-cost county). In approximately seventy percent of these cases, aided adults must participate in work

<sup>1</sup> Information about these families in the pull-out box comes from sample data collected by the Department of Social Services (DSS) & from studies in single or multiple counties, as summarized in *Understanding CalWORKs: A Primer for Service Providers and Policymakers*, by Kate Karpilow and Diane Reed. Published in April 2010; available online.



and other welfare-to-work activities<sup>2</sup>. To support that participation, the program offers these adults related services, such as childcare and transportation. In the other thirty percent of cases, the aided adult is exempt from work participation requirements for reasons such as disability or caregiving for an ill or incapacitated family member. Recipients who are exempt do not receive supportive services, and their time on aid does not count against the time limit.

**Child-Only Caseload:** In 315,000, or more than half of CalWORKs cases (called “child-only” cases), the state provides cash assistance on behalf of children only and does not provide adults with cash aid or welfare-to-work services. There is no time limit on aid for minors. The maximum grant for two children is \$516 monthly. In most child-only cases (87 percent), a parent is in the household, but ineligible for assistance due to receipt of Supplemental Security Income, sanction for non-participation in welfare-to-work requirements, time limits, a previous felony drug conviction, or immigration status. In a minority of cases (13 percent), no parent is present, and the child is residing with a relative or other adult with legal guardianship or custody.

**Federal Context:** Federal funding for CalWORKs is part of the Temporary Assistance for Needy Families (TANF) block grant program. TANF was scheduled for reauthorization in 2010, but the federal government has enacted several temporary extensions since that time (the most recent through February 29, 2012). TANF currently requires states to meet a work participation rate (WPR) for all aided families or face a penalty of a portion of their block grant. States can, however, reduce or eliminate penalties by disputing them, demonstrating reasonable cause or extraordinary circumstances, or planning for corrective compliance. It is also important to note that federal formulas for calculating a state’s WPR do not give credit for families who are partially meeting requirements. For example, a single-parent family with a work requirement of 30 hours in which the parent is working 25 hours per week is not counted as participating at all. According to the County Welfare Directors Association in 2009, data showed that 65 percent of adults the state required to work were participating, including 50 percent of work-required families who had employment earnings. As federally calculated, the state’s WPR was 22.3, 25.1, and 26.8 percent in federal fiscal years 2007, 2008, and 2009, respectively. As a result, California did not meet its WPR requirements of 32.3, 29.0, and 29.0 percent for those years. The federal government did not assess a penalty for 2007. The state is, however, appealing penalties of \$47 million and \$113 million that were assessed for 2008 and 2009.

**Recent Reductions:** From 2009-10 through 2011-12, the budgets included significant ongoing, annual savings from long-term changes to CalWORKs policy. These reductions have included:

Policy	GF savings (in 000s) <sup>3</sup>
Suspension of an annual cost of living adjustment (COLA) and a 4% grant cut in 2009-10	\$226,000
Additional 8% grant cut in 2011-12	\$314,000
Reducing adults’ lifetime time limit from 60 to 48 months	\$104,000
Changes to earned income disregard	\$83,000

<sup>2</sup> Based on data from 2008-09. Does not take into account short-term reforms enacted in 2009 and authorized through July 1, 2012.

<sup>3</sup> Savings figures are annual in the first full-year of implementation. On an ongoing basis, exact savings will vary with caseload and other policy changes.

From July 1, 2009 to July 1, 2012, short-term program changes have resulted in approximately an additional \$375 million General Fund savings each year. These changes included temporary exemptions from welfare-to-work requirements for additional parents of young children (i.e., one child between the ages of 12 and 23 months or two children under the age of six), and a corresponding reduction in the costs of childcare and employment services funding. In 2011-12, the suspension of intensive case management services for pregnant and parenting teenagers through the CalLearn program resulted in an additional \$43.6 million General Fund savings.

### GOVERNOR'S 2012-13 BUDGET PROPOSALS:

The budget proposes to restructure the CalWORKs program and to significantly reduce the cash assistance and services available to most recipients. The Administration estimates that these proposals would result in \$946.2 million net savings to the state.

**Proposed Restructuring:** The Governor proposes to create two new subprograms within CalWORKs--CalWORKs Basic and CalWORKs Plus--as well as a new Child Maintenance Program outside of CalWORKs. Effective October 1, 2012, the proposed **CalWORKs Basic** program would continue much of the current welfare-to-work program for eligible adults. However, assistance through CalWORKs Basic would be available for only 24 months in an adult's lifetime (compared with the current time limit of 48 months).

Adult recipients working sufficient hours (30 hours for single-parent families, 35 hours for two-parent families, and 20 hours for single-parent families with a child under the age of six) in unsubsidized employment would be eligible for 24 additional months (up to 48 months total) of cash assistance and some supportive services through **CalWORKs Plus**. With a more generous disregard of earned income, CalWORKs Plus would also allow recipients up to \$44 more income per month before they would become ineligible. Children in these families would continue to qualify for this disregard after their parents time out of CalWORKs Plus. The Administration estimates that 25,500 families will qualify for CalWORKs Plus.

The proposed **Child Maintenance** program would include any families currently served in the CalWORKs child-only caseload, as well as 109,000 families in which the adult would lose eligibility under the Governor's proposals. Child maintenance grants would not be time-limited for minors. Compared with current child-only policies, the Child Maintenance program would require families to undergo eligibility determinations less frequently (from quarterly to annually), but would newly require proof that parents or caregivers have taken recipient children to annual well-child exams.

Families in the Child Maintenance program that include a work-eligible adult would be eligible for up to one month of child care to attend a job search program every six months. If the adult is working sufficient hours in an unsubsidized job and has time remaining on the 48-month time limit that applies to the CalWORKs Plus program, the family could also move to that program. If a sanctioned adult still has time remaining on the 24-month time limit for CalWORKs Basic, a family could move from Child Maintenance to that program after complying with a welfare-to-work plan for at least two months.

**Proposed Changes to Time Limits and Services:** In addition to the reduction from 48 to 24 months of the time limit for adults not working sufficient hours in unsubsidized employment, the Governor's proposal would narrow the scope of work activities that count toward meeting program requirements. Some activities that currently qualify under state, but not federal, definitions of work participation would no longer count. Those activities include, for example, adult basic education, higher education beyond 12 months of vocational training, and a longer time in which to participate in substance abuse, domestic violence, or mental health treatment. The Governor also proposes to apply the new 24-month time limit retroactively to all participating adults, as well as those whom the state previously exempted from work participation requirements and those whom the state stopped giving aid and services because they were sanctioned for non-participation. As a result of all of these proposed changes, in April 2013 (after six months of transitional services), the Administration estimates that 109,000 families in which the adult has reached the 24-month time limit for CalWORKs Basic without working a sufficient number of unsubsidized hours would transfer to the Child Maintenance program. The Administration also proposes to eliminate state support for intensive case management that was formerly available through CalLearn.

**Proposed Reductions in Cash Assistance:** The budget proposes a reduction of 27 percent in the maximum level of child-only grants available under the proposed Child Maintenance program. For a family with two recipient children (no aided adults), the maximum monthly grant would drop from \$516 to \$375. For the 109,000 families moving from CalWORKs to the Child Maintenance program, the loss of the adult portion of their grants would result in an even steeper loss. In a high-cost county, the maximum grant would drop from \$638 for a family with three recipients (including one adult) to \$375 for a family with two child recipients. As a result of the proposed lower grant levels, 63,000 recipient families with 125,000 children would lose all aid because their incomes would be too high for the resulting new eligibility thresholds. Additionally, the new program would reduce Child Maintenance recipient families' incomes by capturing for the state 100 percent of the child support payments made by non-custodial parents. Under the current program, the first \$50 is passed through to the recipient family before the state begins to capture the support payments.

**New Work Incentive Benefits Outside of CalWORKs:** The budget proposes changes to the Work Incentive Nutritional Supplement (WINS) program that is currently scheduled to take effect by October 1, 2013, with full implementation by April 1, 2014. WINS is designed to provide a supplemental food benefit to working families who are receiving CalFresh, but not CalWORKs, benefits. To the extent that the state relies on TANF or TANF Maintenance of Effort (MOE) funding for the program, the Administration indicates that recipient families can be counted in federal work participation calculations. WINS was originally scheduled to begin in 2009-10, but has been statutorily delayed in recent years. The Administration proposes to increase from \$40 to \$50 the monthly supplemental benefit provided by the program. The Administration also proposes to expand WINS to low-income working families who receive subsidized child care, but not CalWORKs benefits, in a program called WINS Plus. DSS estimates that monthly caseloads for WINS and WINS Plus would be 95,000 and 25,000 respectively, beginning in 2013-14 (growing to 144,000 and 60,000 ongoing). Funding for implementation of the programs would include \$45.2 million and \$15.4 million General Fund in 2013-14 (growing to \$88.9 million and \$36.1 million on an ongoing basis). The Department

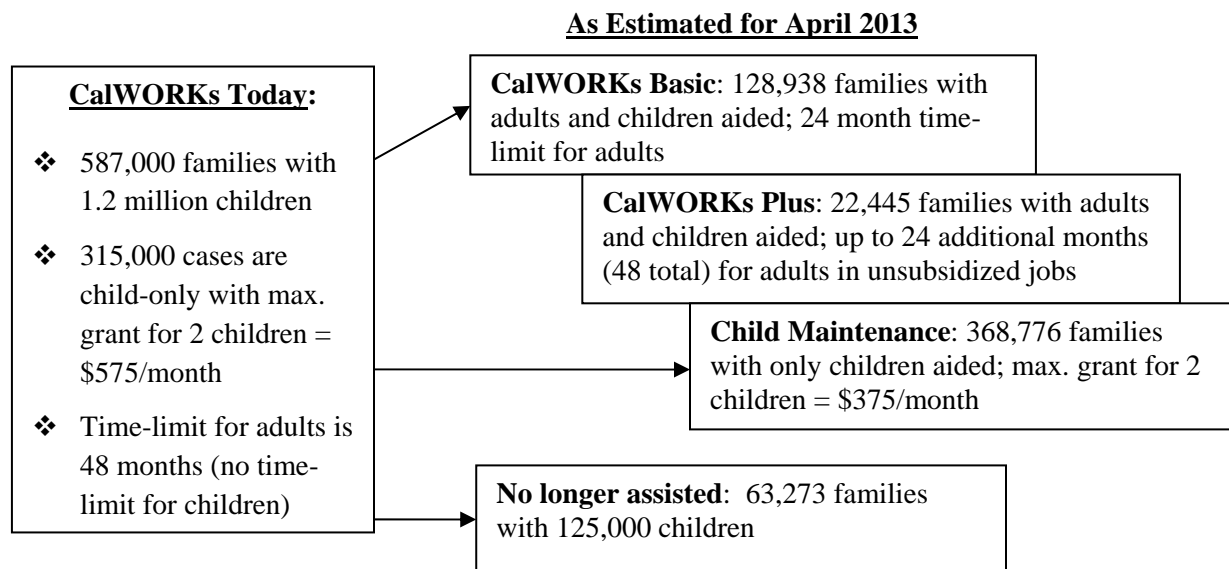
estimates that implementation of these programs will result in a 15-20 percent increase in the state's WPR.

**Effects on Work Participation Rates:** Aside from the positive impacts of WINS described above, the Administration's proposal to redesign CalWORKs would result in only a potential minimal WPR increase in 2012-13. The Administration indicates, however, that if a separate Child Maintenance program could eventually be funded without TANF or TANF MOE, there could be a positive impact on the WPR at that point.

**Funding Transfer:** To achieve the proposed savings, the Governor's budget would transfer \$736 million in TANF funds to the Student Aid Commission to offset a like amount of General Fund support for Cal Grants. According to the Administration, this would be an allowable use of TANF funds because support for low-income, unmarried students age 25 or younger could prevent and reduce out-of-wedlock pregnancies, which is one purpose of TANF.

**ISSUES TO CONSIDER:**

**These proposals, which comprise a large portion of the reductions the Governor relies on to balance the budget, would result in a significant reduction of benefits and services to low-income families with children.** At \$638 per month for a family of three in a high-cost county, maximum CalWORKs grants (the grant level available for families without other income) are the same in actual dollars today as they were in 1987. After adjusting for inflation, the California Budget Project calculates that the purchasing power of these grants is already less than half of what it was in 1989-90. Said another way, if the slightly higher 1989-90 maximum grant of \$694 had been adjusted for inflation every year, it would be \$1,368 in 2012-13. When combined with CalFresh (formerly called food stamps) benefits, the proposed reductions to the maximum Child Maintenance grant would place families who receive it at 64 percent of the federal poverty level. As illustrated below, the proposed reductions would also change eligibility thresholds such that many families and children would lose all assistance.



**The Governor's proposals change the rules retroactively and restrict the types of activities that adults can take advantage of to move from welfare to self-sufficiency.** A significant number of adults who would lose CalWORKs eligibility after six transitional months are individuals whom the state previously exempted from work requirements (again, because of age, a disability, caregiving for an ill family member, etc). During the time they were exempt, these individuals did not receive welfare-to-work services and supports. Nonetheless, the proposed changes would require counties to go back and newly count that time against shorter time limits retroactively. In addition, aspects of the proposal to align state and federal policies would restrict participants' ability to count certain educational and other services (such as mental health and substance abuse services) toward work participation. Some of these activities would remain countable for only the 24 months in which participants can utilize the CalWORKs Basic program; others would be available for less time during those 24 months or no longer count at any time. The state has previously opted to allow for the broader array of these services with the goal of helping participants to overcome barriers that may otherwise prevent them from working.

**These proposals come at a time when Californians, especially in low-income families, are facing high unemployment and rising poverty.** According to the California Employment Development Department, unemployment rates for the state rose each year from 2007 to 2010, growing from 5.3 percent to 12.4 percent. Available monthly data for 2011 shows a seasonally adjusted unemployment rate of 11.8 percent in June and 11.3 percent in November. Some research on the effects of economic recessions indicates that it takes several years after a recession for employment to rebound and families to return to pre-recession income levels.<sup>4</sup> Further, low-income families are more likely to be unemployed than the workforce as a whole, and during economic downturns less educated workers sustain bigger job losses than those with more educational attainment.<sup>5</sup> Recent reports additionally indicate that women are recovering from the recession more slowly than men are, and that the economic downturn reduced employment for single mothers far more than it did for married parents.<sup>6</sup>

According to the U.S. Census Bureau, nearly one in four children in California (23 percent) was impoverished in 2010. This represents an increase from a low of 16 percent in 2001. Los Angeles County has also documented a 98 percent increase since 2006 (from approximately 5,500 to 11,000) in the number of homeless families receiving CalWORKs there. Research indicates that children who live in poverty are at significantly higher risk for health problems, lower educational attainment, and a number of other negative outcomes, well into their adulthood.<sup>7</sup>

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<sup>4</sup> *The Effect of the Recession on Child Well-Being: A Synthesis of the Evidence by PolicyLab, The Children's Hospital of Philadelphia* (Foundation for Child Development; November 2010).

<sup>5</sup> Wonho Chung, Phil Davies, and Terry J. Fitzgerald, *Degrees of Job Security* (Federal Reserve Bank of Minneapolis; December 2010); available online at:

[http://www.minneapolisfed.org/publications\\_papers/pub\\_display.cfm?id=4592](http://www.minneapolisfed.org/publications_papers/pub_display.cfm?id=4592).

<sup>6</sup> *Falling Behind: The Impact of the Great Recession and the Budget Crisis on California's Women and their Families* (California Budget Project; February 2012).

<sup>7</sup> *Turning Point: The Long Term Effects of Recession-Induced Child Poverty* (First Focus, May 2009); available online at <http://www.firstfocus.net/library/reports/turning-point-long-term-effects-recession-induced-child-poverty>.